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Editorial

STALLED HEALTHCARE INFRASTRUCTURAL PROJECTS IN GHANA: THE WAY FORWARD

The unceasing lamentations of Healthcare Managers on lack of adequate healthcare infrastructures in the country to render quality health services to clients is one that the Association of Health Service Administrators, Ghana (AHSAG) has followed with keen interest. The need to thoroughly examine the situation of stalled healthcare infrastructural project across the country cannot be overemphasized, particularly at this critical moment when efforts are being made to attain Universal Health Coverage (UHC) for all. Improving physical access to healthcare undoubtedly is one of the key ingredients of attaining UHC and with the current healthcare infrastructural deficit, the attainment of UHC by Ghana may highly be at risk.

The Association of Health Service Administrators, Ghana (AHSAG) notes with concern that there are several healthcare infrastructural projects that were commenced by successive governments but have stalled at various stages of completion. The non-completion of these projects several years after they were commenced continues to be one of the major obstacles to improving access to healthcare in the country.

At Asamankese Government Hospital in the West Akim Municipality of the Eastern Region, a Maternity Ward Project which was commenced in 2005 is yet to be completed after14 years. Although the project was initially scheduled to be completed and handed over to the Ghana Health Service within six months, this remains a dream of the management of the Hospital and the people of West Akim who are yearning for an improved maternal health services within the municipality. The inability to complete the project has compelled the Management of Asamankese Government Hospital to continue using a congested improvised Maternity Ward for delivery of maternal health services to our cherished mothers within the municipality and beyond. The contract for the project was determined in September, 2017 by the Eastern Regional Coordinating Council and there are no indications of re-award of the contract and resumption of work on the project at this moment.

Again, At Tema General Hospital in the Greater Accra Region, a Maternity Block which started in 2010 is only about 55% complete after 9 years. The project, just like the one at Asamankese Government Hospital, has stalled and there are no indications of commencement of work anytime soon. With the chorus of our healthcare policy makers being 'reduction of maternal mortality', it is naturally expected that focus will be on some of these maternal infrastructural projects. However, the situation we see appears contrariwise.

The Greater Accra Regional Health Directorate Project at Adabraka which was also commenced in 2004 was expected to have been completed by December, 2006. However, as at October, 2019, only 38% of work had been done on the project and the project had also stalled without any

indication of resumption of work.

At Sefwi Wiawso District Hospital in the Western North Region, a Maternity Ward project which was started in 2015 by the former Member of Parliament for the area and the then Western Regional Minister, Hon. Paul Evans Aidoo, has also been suspended. The project was suspended few months before the end of 2016 when Hon. Aidoo left office.

At Axim Hospital in the Western Region, reconstruction of an old Theatre by the Traditional Council has also stalled. The non-completion of this project is having serious impact on the delivery of surgical services at the Hospital, particularly pregnant women who are in labour and require emergency caesarean intervention to save the lives of both mother and child.

In the Upper West Region, remodelling/expansion of Health Centre at Eggu in the Wa West District which was commenced in September, 2012 with GoG funding has stalled. Similarly, expansion of Health Centres at Vieri and Gurungu in the same Wa West District which were commenced in September, 2012 with GoG funding have also been suspended. The Wa Municipal Health Directorate Project which was commenced in October, 1999 with GoG funding has also been abandoned without any indication of when work will resume.

The inability and/or failure of successive governments to continue with health infrastructural projects is the chief cause of the deficit in health infrastructure that we witness in most of our facilities across the country. Most of these projects were commenced as national projects, but suffer the usual partisan political gimmicks that have engulfed our dear nation. The implication is that the inadequate health infrastructure in Hospitals usually lead to mortalities that could have been prevented. We have catalogued a few of these stalled health infrastructural projects above which are scattered across the country to give a general indication that the situation deserves immediate attention from our policy makers.

We urge governments to solely apply funding that has been acquired for health projects in executing such projects only. Some of these projects had to be suspended and/or abandoned because the source of funding had either dwindled along the project life cycle or was not available at all after the initial mobilization had been advanced. We, therefore, urge government to as much as possible ensure the availability of funds for health projects before contracts are awarded for execution of health infrastructural projects.

We again call on all successive governments to adhere to the provisions of the Constitution, 1992 on continuity of projects commenced by previous governments. As provided for under Clause 7 of Article 35 of the 1992 Constitution, we expect that successive governments shall continue to execute health infrastructural projects and programmes that were commenced by previous governments.

The unceasing lamentations of Healthcare Managers on lack of adequate healthcare infrastructures in the country to render quality health services to clients is one that the Association of Health Service Administrators, Ghana (AHSAG) has followed with keen interest. The need to thoroughly examine the situation of stalled healthcare infrastructural project across the country

Abandoned Maternity Block at Tema General Hospital

NATIONAL EXECUTIVE COMMITTEE OF AHSAG MEETS WITH MINISTER FOR HEALTH, HON. KWAKU AGYEMANG-MANU (MP)

The National Executive Committee (NEC) of the Association of Health Service Administrators, Ghana (AHSAG) on 19th June, 2019 met with the Minister of Health, Hon. Kwaku Agyemang-Manu (MP) at his office to discuss pertinent issues bordering on healthcare delivery in Ghana and the promotion of the objectives of AHSAG.

The delegation was led by Dr. Kwasi Addai-Donkoh, Chairman of AHSAG National Council. NEC and the Hon. Minister had a fruitful discussion on a wide range of issues bordering on healthcare delivery in the country, particularly the key role Health Service Administrators play in our healthcare delivery system.

The Hon. Minister pledged his unflinching support to the cause of AHSAG in promoting efficient management and administration in the health sector.

NATIONAL EXECUTIVE COMMITTEE (NEC) OF AHSAG PAYS A COURTESY CALL ON MR. EBO HAMMOND, DIRECTOR, HEALTH ADMINISTRATION AND SUPPORT SERVICES DIVISION OF GHANA HEALTH SERVICE (GHS)

The National Executive Committee (NEC) of the Association of Health Service Administrators, Ghana (AHSAG) on Wednesday, 12th June, 2019 visited the Director, Health Administration and Support Services (HASS) Division of the Ghana Health Service (GHS) at his office.

NEC among other things congratulated him on his appointment as the substantive Director, Health Administration and Support Services of the Ghana Health Service.

The subsequent discussions focused chiefly on how NEC could effectively collaborate with the office of the Director HASS to promote the objectives of AHSAG and the HASS Division of the Service.

The Director shared his laudable vision for the HASS Division of the Service with NEC.

NEC pledged to support and collaborate effectively with him in the implementation of activities geared towards the realization of his marvelous agenda for the HASS Division of the Service

TRAINING PROGRAMME ON EFFECTIVE AND EFFICIENT MANAGEMENT AND ADMINISTRATION OF HEALTH FACILITIES HELD FOR NEWLY RECRUITED HEALTH SERVICE ADMINISTRATORS

Zone was held on the 9th and 10th of October, 2019 at the Ashanti Presbytery Hall, Adum, Kumasi while that of the Southern Zone was held on the 16th and 17th of October, 2019 at the Presby Ascension Hall, Koforidua.

The training was on the broad topic: 'Effective and efficient management and administration of health facilities for newly recruited Health Service Administrators'.

Directors and Deputy Directors of the Ghana Health Service with vast knowledge and experience in the fields of Cost Management of Health Facilities; Human Resource; Procurement and Supply Chain; Health Transport Management; Public Health; Financial Management, Control, Monitoring and Audit; Planning and Budgeting; Clinical Engineering; Estate Management; Health Records Management; Health Information Management and General Administrative Procedures were the Resource Persons for the training.

HEALTH SERVICE ADMINISTRATOR AS AN INTERNAL CONSULTANT: GAINING CREDIBILITY

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Introduction

Generally, administration is the process of coordinating activities and creating conducive environment for other departments to perform (Mawusi, 2017). Thus, administration is pivotal in the success of every organization. Therefore, Health Service Administrators are the anchors around which activities of the organization of Health Services are organized.

Roles of the Health Service Administrator as Internal Consultant

The Health Service Administrator is a middle level manager who is responsible for the day to day administration of the Hospital (Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525)). Strategically, the Health Service Administrator is concerned with ensuring high productivity of the health care organization, enabling change as well as solving problems of the organization.

The Health Service Administrator is pre-occupied with issues of organization-wide effectiveness and efficiency, responsiveness to clients' expectations as well as being accountable for resources entrusted to him. The Health Service Administrator is day-in-day-out consulted for solutions to problems. He/she is a core management team member who ensures that managerial decisions and policies are implemented. Also, the Health Service Administrator is virtually the advisor to management. This advisory role of the Health Service Administrator is no different from the Internal Consultant.

According to Block P, (1981), an Internal Consultant is a member of the organization who is in a position to have influence over an individual, group or organization, but who has no direct power to make changes or implement programs.

The advisory roles of Health Service Administrators offer them the opportunity to exert a lot of influence in the organization. Therefore, for the Health Service Administrator as an Internal Consultant to effectively perform his advisory role, there is the need for him to continuously learn to improve his competence level. A higher competency level will make him a better teacher of concepts and a problem solving coach (R. Glenn Ray, 1997). Glenn Ray also suggested learning to involve effective listening and being sensitive to peoples' needs and values.

As Health Service Administrators, we work in a

team with other professionals. It therefore requires us to respect peoples' needs, abilities, skills and knowledge and view them as huge resources for organisations' growth and development. There is the need to listen to other professionals so that we can contribute meaningfully to decision making. Networking is therefore important for Administrators as internal consultants to tap the skills and experience of a large pool of employees (Glenn Ray, 1997).

As administrators who are in the position of Internal Consultants, we are also enablers of change. The Health Service Administrator assists the change process and should know when to hand off the ball. The Health Service Administrator is an expert and a professional who should work within his expertise and guided by his professional dictates. Therefore, providing consultancy services outside the Health Service Administrator's area of expertise has the potential of losing his credibility.

Challenges and Tensions of the Health Service Administrator as Internal Consultant

Indeed, there are specific challenges and tensions that a Health Service Administrator as an Internal Consultant may experience or encounter. Barbara Kenton & Diane Moody (2003) identified the following as the key challenges faced by Internal Consultants in the performance of their roles in the organization.

Lack of Understanding of the Role within the Business

According to Barbara Kenton & Diane Moody (2003), a lack of understanding of the role of the Internal Consultant by both the Internal Consultant and his internal clients pose a serious challenge to the work of the Internal Consultant. Some of us as Administrators are very unclear about the boundaries of our roles and may not really know what we can offer as well as the expectations of our internal client's (organization and staff). Our clients equally may not know the specific roles, the scope of work of the Health Service Administrator as well as their own roles in the consultancy relationship. For instance, in some of our places of work you could see additional responsibilities given to Health Service Administrators for which they find difficulties in declining even when it did not seem to be high priority and outside their scope of work (Barbara Kenton & Diane Moody, 2003).

The situation leads to role ambiguity both on the part of the Health Service Administrators and other managers. It also has the potential of resulting in failures on the part of the Health Service Administrators. Therefore, to succeed and gain credibility as Administrators, there is the need to clearly understand our roles, work within our scope, competency and learn to 'say no' to what is outside one's capabilities. Barbara Kenton & Diane Moody (2003) refer to this as “the Internal Consultant being clear about the business case” and that is one of the ways of gaining credibility as a Health Service Administrator.

Lack of Trust

Lack of trust is one of the challenges facing Internal Consultants. As Administrators, issues of trust also have daring consequences on our jobs. Trust and credibility wins the support of other managers and staff. With trust, both the Health Service Administrators and clients (managers and staff) in the organization have the underlying conviction that the other person has the absolute best interest in

mind (Alan Weiss, 2003). In order to gain conceptual agreement, there must be trust. When there is no trust your superiors will not delegate, they are not going to share with you their true objectives, fears, beliefs, and insights if they don't trust you as an objective and honest partner. Unfortunately, some Administrators may not be seen to be credible due to past track records either within the same organization or their records in their previous places of work. Thus, your superiors and other line managers may be a little slower to trust you and recognize that you have something special to offer them (Block, 2001).

The Health Service Administrator because he/she is part of the organization, may be seen to be entangled in the culture of the organization which can affect his independence and impartiality. He/she would have the ability to identify with the culture and values of the organization and how they impact on behavior as well as access to information. Ultimately, the Health Service Administrator must demonstrate commitment to keeping confidence or else he loses trust.

Lack of Senior Management Support

The Health Service Administrator is the driving force in the change process of the organization, particularly in the Hospital. However, remember that senior management support that is essential to your success may be lacking. For instance, gaining access to senior managers for information and sponsorship can be difficult. In the change process, senior managers mostly may be used to the old ways of resolving their problems and may not show commitment to the change. Whilst the Health Service Administrator may have the verbal go ahead for change interventions, true sponsorship may be lacking. As the Health Service Administrator, you would feel frustrated when other managers do not give support for their change programs and the needed commitment.

In order to overcome these situations, one needs to assess your client's readiness and capability. Client's readiness constitutes willingness, motives and aims on the part of key stakeholders while capability means an analysis of power sources, influence and authority issues, skills and information required (Beckhard & Harris, 1987). An analysis of client readiness and capability will give the Administrator the opportunity to minimize resisting forces of change while increasing the driving forces.

One way to be able to overcome this challenge as internal consultants is to help the managers to define the form of sponsorship and identify alternatives sources of funding. Administrators need to allay the fears and anxieties of managers as a result of the change. For instance, where managers are taking on other responsibilities as part of the change process, they need to be supported and equipped with the necessary knowledge.

Lack of Power to accomplish Projects/proposals

Finally, the lack of power to accomplish projects or proposals is a critical challenge experienced by Administrators as Internal Consultants. Just like internal consultants, Health Service Administrators do not have the direct power to make change or implement programs. They influence change. The Health Service Administrator is a middle level manager who initially did not have authority and did not control resources. Our background as middle level managers presents challenges in influencing decision makers especially where the organization's financial resources are controlled by the Medical Directors and Accountants. To overcome this challenge, it is suggested that Internal Consultants

for that matter Health Service Administrators develop their skills around gaining credibility, visibility and influence.

In conclusion, just like Internal Consultants, Health Service Administrators are challenged with issues of role ambiguity, trust, lack of management support and lack of power to accomplish projects. These challenges hinder the success of Health Service Administrators. However, for Health Service Administrators to succeed in the organization, there is the need to overcome these challenges by developing their skills around gaining credibility, visibility and influence.

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Stalled Healthcare Infrastructural Projects in the Greater Accra Region: The Ghana Health Service in Focus

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"Nothing has ever become better by ignoring the reality"- Joe Kaeser, CEO of Siemens.

In accordance with Kaeser's assertion, one may submit that the health status of the Ghanaian will not become better if the stark realities of numerous stalled health infrastructural projects across the country and in the Greater Accra Region in particular are ignored by our leaders. Globally, preventive, rehabilitative and curative healthcare delivery happens not in a vacuum but within appropriate infrastructures designed architecturally and built for the purpose.

It may be indicated with a fair margin of certainty that without the most appropriate infrastructure accessibly provided in its required capacity for care delivery to a given population, healthcare delivery in itself becomes an unnecessary hurdle and quality of care is often compromised to the detriment of the citizens' wellbeing. On grounds of required capacity of healthcare infrastructures for example, if a 60 bed capacity hospital records an average daily occupancy (average number of patients admitted per

day) of 5 patients at a turnover interval of 4 days (the day interval between the time a patient is discharged and the time another patient is admitted), the hospital would experience admission which would naturally result into some patients sleeping on the floor. Overcrowding on the ward would tend to compromise quality of care and also lead to nosocomial (hospital acquired) infections.

One of the three objects of the Ghana Health Service (GHS) is to increase access to quality healthcare throughout the country. How can the GHS possibly increase access to quality healthcare to about 29 million people with huge infrastructural deficits? Can inadequate and inappropriate healthcare infrastructures be used to increase access to care geographically?

Over the years, healthcare infrastructural deficits have posed significant and widespread challenges for healthcare managers in Ghana thereby compromising quality of healthcare being delivered to the people and leading to preventable deaths.

Most public hospitals in Ghana were initially established in the past as clinics, health centers, or polyclinics. However, due to increased population coupled with availability of certain specialties of clinicians working at those facilities, the institutions were later designated as district or general hospitals.

Most often than not, such smaller health facilities that metamorphosed into hospitals remain the same in terms of infrastructural expansions or very little expansions are made even though their workload and specialties have increased significantly. In the case of Achimota Hospital for example, it was built in 1927 as a school clinic and in 1973, it was designated as a district hospital. Apart from a maternity block built by the Hospital Management from Internally Generated Funds and a Medical Ward built by the erstwhile MP of the area,

Hon. Elizabeth Sackey, all the wards are located within the small 1927 buildings that were once used for a school clinic.

In an attempt to secure their jobs, public servants working in those health facilities often keep mute over the infrastructural challenges as any effort to talk about them publicly is often politicized and met with vilification and victimization. The healthcare workers are expected to make do with what is available even if what is available is not appropriate to give the care.

In Ghana, it has been the practice that the responsibility of building healthcare infrastructures is that of central government while hospital managers carryout maintenance and repairs of such edifices as well as shoulder the overhead costs (procure the required medications and non-medical consumables) for healthcare delivery. However, the situation has worsened in contemporary times to the extent that hospital managers are compelled to carry out physical infrastructural expansions in order to attend to the numerous clients accessing healthcare on a daily basis.

Perhaps due to the healthcare infrastructural deficits and compromised quality of care throughout the country, some top-level politicians implement the "Group Areas Act" by seeking for healthcare in better health systems in Africa and beyond, leaving our hospitals for the masses and the have-nots to access. The situation apparently permeates Africa. Even though most Ghanaian political elites seek for healthcare in other countries such as South Africa

and Dubai, the paradox has been that Ministers of State from Liberia and other West African Countries also seek for healthcare in Ghana. Is it a perception that quality healthcare abounds outside one's home country or it is due to a paranoia of a sort?

Many on-going healthcare infrastructures in the Greater Accra Region have been abandoned leading to congestions on the hospital wards including labour wards. The inadequacy of infrastructures is also to blame for what is now termed as "no bed syndrome." The hospitals may even have modern hospital beds in their stores but they lack the space to put the beds and admit the patients. Therefore, no bed syndrome does not only mean that the hospitals do not have the beds. It may be no space syndrome.

Over the years, the Greater Accra Regional Health Directorate of the Ghana Health Service has been reporting its stalled health infrastructural projects dotted throughout the Region. At its recent half year performance review programme for 2019 held in Accra, the stalled projects had still been shown to remain in those same sorry states they have been in for ages.

Stalled Regional Health Directorate Project located at Adabraka. The project started in October 2004 and was to be completed in December, 2006 but only 38% of work had been done till date

Abandoned maternity block at Tema General Hospital. Even though the project started in April 2010, only 55% of work has been done within 8 years as we are in 2019

Chapter 6 of the 1992 (Fourth Republican) Constitution of Ghana enshrines the Directive Principles of State Policy (DPSP) which state inter alia, *"all Citizens, Parliament, the President, the Judiciary, the Council of State, the Cabinet, political parties and other bodies and persons in applying... and in implementing any policy decisions, for the establishment of a just and free society"* [Article 34(1)].

Perhaps most political leaders construe Article 34 (1) of the Constitution and all the other Articles under the DPSP to be non-justiciable provisions hence successive political leaders in power tend to think that no citizen can take action against them in the courts for projects they abandon and begin similar projects elsewhere just for their parochial interests.

The 1992 Constitution clothes the Supreme Court with the original jurisdiction to interpret provisions in the Constitution and Article 2 (1) (b) of the Constitution empowers citizens to bring in the Supreme Court, an action against any person for an act or omission by that person which is inconsistent with, or is in contravention of a provision of this Constitution.

On the grounds that the Directive Principles of State Policy are also provisions in the Constitution, failure of successive political leaders to continue and complete the unfinished infrastructural projects amount to illegality hence concerned citizens can take an action against the Government in the Supreme Court upon the strength of Article 2 (1) (b) of the Constitution.

In ***New Patriotic Party v Attorney-General*** (*The 31st December case)* [1993-94] 2GLR 35 at pp. 65-66 the Court decided and spoke through the lips of Adade JSC (as he then was) that *"I do not subscribe to the view that chapter 6 of the Constitution, 1992 is not justiciable: it is. First, the Constitution, 1992 as a whole is a justiciable document. If any part is to be non-justiciable, the Constitution, 1992 itself must say so. I have not seen anything in Chapter 6 or in the Constitution, 1992 generally, which tells me that Chapter 6 is not justiciable. The evidence to establish the non-justiciability must be internal to the Constitution, 1992, not otherwise, for the simple reason that if the proffered proof is external to the Constitution, 1992, it must of necessity conflict with it, and be void and inadmissible: we cannot add words to the Constitution in order to change its meaning."* An issue or a matter is justiciable if it is capable of being heard and determined by a jurisdictionally competent court.

Also, in ***Ghana Lotto Operators Association & 5 others v. National Lottery Authority (Suit. No. J6/1/2008***), the Supreme Court maintained that the Directive Principles of State Policy *"are legally binding and are not merely a matter of conscience for successive governments of our land."*

Article 35(7) of the 1992 Constitution is one of the Directive Principles and stipulates, *As far as practicable, a government shall continue and execute projects and programmes commenced by the previous Governments."* Once it was settled at the apex court that like any of the constitutional provisions this Article is justiciable, a citizen can take action against the Attorney-General for Government's failure to proceed with stalled projects which were started by a previous Government. Government officials must therefore not be under the erroneous impression that the Directive Principles of State Policy are mere

guidelines that are followed only per discretions of the polity.

In the 4th Republic, only two political parties, namely National Democratic Congress (NDC) and the New Patriotic Party (NPP) have had the opportunities to form governments and lead the country. These two political parties have been accused for polarizing the country politically hence projects started by one are mostly not continued by the other due to two main reasons. Firstly, when party A has come to power and it is continuing the projects started by party B, party B members accuse party A members for doing nothing new but just continuing, completing and inaugurating stalled projects that they did not initiate. Secondly, whenever party A abandons stalled projects started by party B, the same party B members discredit party A members for failure to continue with the stalled projects. What a cheap and retrogressive political game? In some cases, the projects still remain abandoned or stalled even when the political party that started it has returned to power. Discontinuation of such projects and programmes thwart national development and thereby bring hardships to the people.

Developmental agenda of the country is driven by the contents of political party manifestoes designed purposely with appealing words just to win elections for cynical interests as the Rational Choice Theory puts it. The Rational Choice Theory arguably postulates that by their nature, human beings are self-interested in calculating material satisfaction and so they are utility-maximizers. As such, they tend to act rationally in making choices that yield greater results than the energy exerted in undertaking an activity (Niskanen, 1971; Buchanan, 1972; Heywood, 2007; Adams, 2008; Knill & Tosun, 2008). Accordingly, political actors tend to act rationally in their quest to attain their own self-interests rather than altruistic public goals (Anderson, 2003).

After winning the elections, the rules or the campaign messages are often changed as it happened on George Orwell's Animal Farm. The national budget and for that matter the Appropriation Act is passed by Parliament every year in accordance with sugar-coated campaign promises and manifesto messages. In view of the reality that the winning political party's manifesto informs the projects and programmes contained in the national budget, the party in power before an election year does not prepare the budget and send it to Parliament for approval in that election year.

In an election year, the incumbent only prepares a three month provisional estimates for parliamentary approval. The party that wins the election and forms government prepares the national budget only after winning the elections so that some projects and programmes proposed in the party manifesto can be captured in the national budget. Within three months after the end of an election year therefore, government machinery runs only on the provisional estimates.

For example, Ghana's 2017 budget was prepared by the NPP, the party that won the 2016 general elections and not the NDC, the party that lost the elections. Or let me say that contrariwise to Article 179 (1) of Ghana's Constitution, the incumbent party in the 2016 elections (NDC) did not prepare the 2017 budget before the 2016 elections. Article 179 (1) states, *"The President shall cause to be prepared and laid before Parliament at least one*

month before the end of the financial year, estimates of the revenues and expenditures of the Government of Ghana for the following year."
In a non-election year therefore, it has been the practice in tune with this constitutional provision that the executive arm of government presents an ensuing year's national budget in the form of an Appropriation Bill to Parliament in November each year for approval.

The National Planning Commission either seems helpless or aligns to the campaign promises of the party in power in championing the developmental agenda. A unified national developmental course is virtually a mirage or is it rather followed with knee-jerk approaches? Other countries with limited natural resources compared to Ghana are developing faster. Yesterday, the maxim was *"Better Ghana Agenda"* and today, it is *"Ghana beyond Aid."* Are these maxims mere play on words to gain political power or they are actually relevant to national development?

Arguably, politicians think and speak policy but they do partisan politics. The public servants including healthcare managers in the public sector only dance to the music of the politicians with the hands of the latter "tied" while the former expects that work should be done productively.

Conclusion

A truly result-oriented health system must operate effectively with the required resources including but not limited to the most appropriate physical infrastructure and relevant equipment necessary for healthcare delivery.

Until the political leaders of Ghana cease to politicize social services such as health and education, the public servants in the social service sector of the economy will continue to either pretend to work and Government pretends to pay them as Former President Kuffuor once put it or they will not contribute meaningfully to the national developmental agenda. Quality healthcare delivery must occur within appropriate healthcare infrastructure hence stalled health infrastructural projects hamper quality healthcare delivery.

Whereas Ghana's Stephen Addae said, *Leadership is cause, everything else is effect"* America's John Maxwell said, *"Everything rises and falls on leadership."* I also dare to say, Leadership is the driving force of any developmental agenda, attribute the success or failure of the agenda to leadership. ~**Asante Sana**~

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IMPROVING FILING SYSTEM AT THE REGISTRY OF SALAGA HOSPITAL - A MANAGEMENT CHALLENGE PROJECT

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INTRODUCTION

Filing means keeping documents in a safe place and for easy retrieval (Athena, 2015). Filing guarantees documents adequate safety and helps registry staff to be more organized, systematic, efficient and transparent. Wendy Thome (2014) is of the view that a well-planned filing system contributes significantly to efficiency of operation as well as to company's ability to protect a good image.

The Registry is one of the units under the General Administration of Salaga Hospital supervised by the Health Services Administrator. The Registry stores the files of the Hospital which consist of mainly the administrative and staff personal files. The unit though manned by administrative manager, stenographer and typist productivity and efficiency seems to be low. Over the years there have been concerns raised by management about poor records keeping at the registry. Many managers and staff complain of the registry staff inability to retrieve stored documents and other financial documents. This concern has been raised in almost all the Administrators' handing over notes and discussed at management meetings. Though some registry staff have been sanctioned, the situation is not improving.

There were many reasons attributed to the poor performance of the Registry emanating from sections of the hospital. Some managers complained that Registry staff were lazy and called for strict sanctions. Staff leveled the ineffectiveness of the registry staff to the Health Service Administrators' lack of initiative and poor supervision. Some staff rumoured that the Registry staff were incompetent. Some Registry staff accused management of being insensitive to their welfare and general work conditions. They accused management of not paying attention to the Registry.

The situation created a poor image for the Registry staff amidst low morale. Managers were frustrated when Registry staff could not retrieve documents demanded. Registry staff wasted time searching for documents and most occasions were abused by managers. Information and communication flow was thus hindered by the poor filing system of the Registry. The filing system led to loss of vital documents and inability to trace them (Athena, 2015). This investigation is to identify the causes of poor filing at the Registry of Salaga Hospital and to design strategies to address them.

PROBLEM STATEMENT

Over the past years, many officers had complained about the Registry's staff inability to retrieve documents at the Registry. The Registry contained 432 administrative files. In 2015, out of 150 documents requested for, 38 representing 25% were retrieved. Again out of 120 documents demanded by various managers, 25 documents representing 21% were submitted. Out of three hundred (300)

documents requested for in 2017, only sixty (60) were retrieved representing twenty percent (20%) which fell short of the hundred percent (100%) target (Annual Report, 2017). As a result of that, officers were unable to attend to pertinent matters relating to the organization in those years. For instance in 2017, documents requested by the Administrator to answer audit observations could not be found making him unable to defend audit queries.

Most staff claims were not paid due to the registry's staff inability to trace approved memos thereby causing dissatisfaction among staff. Staff appointment and promotion letters needed for updating the Human Resource database for planning purposes could not be provided. The problem was not only a worry to management but to the Registry staff especially who felt that their image was dented and their competence questioned. This investigation is to resolve the issue of poor filing at the Registry unit of Salaga Hospital.

POSSIBLE CAUSES

Other literature suggest the following as causes of poor filing

1. Insufficient cabinets for filing
2. Low morale of staff
3. Poor supervision
4. Limited office space
5. Lack of shelves
6. Lack of retention policy
7. Lack of conducive work environment
8. Too many duplications of files
9. Absence of electronic filing
10. Uncommitted Registry staff
11. Uncommitted managers
12. Lack of security or inappropriate equipment/software
13. No plan for storage or disposal of inactive files
14. Obsolete/non-relevant information
15. No file guide or list of files and locations

MAIN OBJECTIVE

The overall goal of the project is to improve the filing system of the Registry unit of the Salaga Hospital.

Specific objectives

1. Identify the causes of poor filing
2. Recommend measures to improve on filing system
3. Implement measures to improve on filing system

METHOD OF INVESTIGATION

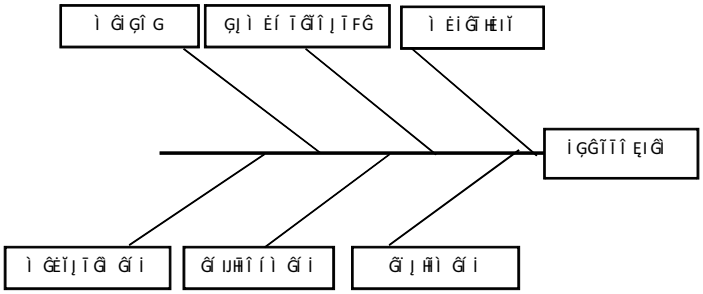
The project relied on the fishbone analysis developed by Professor Kaurou Ishikawa to identity the problem of poor filing, the causes and effects (Philips J, & Simmonds L, 2013). The fish bone is a useful diagnostic tool for analyzing and illustrating problems within root cause analysis (Galley, 2012). According to Hughes et al (2009), fishbone analysis provides a tool to identify all the possible causes of a problem and not just obvious ones. It seeks to identify the root cause of the problem from a systematic perspective rather than through personal gain (Hughes et al, 2009).

Though the fishbone analysis identify the causes and effects of a problem, others are of the view that the brainstorming exercise produces irrelevant potential causes along with relevant ones, resulting in time and energy drain. The brainstorming is based also on opinion and not facts (Karen P L Hardison, 2011).

The fishbone is a diagram with the resemblance of a fish. It begins with a problem and the fish bone

provides a template to separate and categorize the causes (Philips J & Simmonds L, 2013). The bone for each cause branches from the center bone. The complexity of the fish bone lies in the smaller branching bones supporting each potential cause and answering "why" (Karen P L Hardison, 2011). There are six major categories. However, the number can change depending on the problem (fig 1).

FIG 1: FISH BONE DIAGRAM

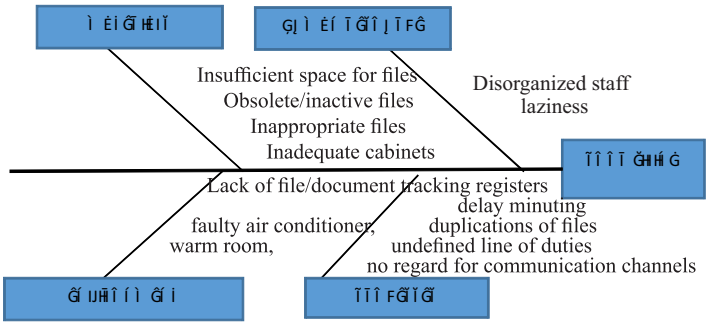


During the investigation, a focus group was formed with majority of the participants emanating from the Registry. The focus group comprised the Health Service Administrator, an intern Health Service Administrator and three Registry staff. The group held meetings in which pre-determined open-ended questions were used to guide the discussions to define the problem and brainstorm to come out with the possible causes of the problem. The questions helped participants to determine relationship between causes. The Health Service Administrator facilitated the group discussions. The facilitator was necessary so as to prevent the group from going off tangents (Philips J & Simmonds L, 2013). The focus group discussion was useful to obtain detail information about peoples' feelings and opinions of a problem and also provide a broader range of information as well as give opportunity to participants to seek clarifications (Leeds, 2006).

After discussions in the first meeting, the group defined the problem as poor filing. Participants were then asked why the filing system was poor. Some were of the view that Registry staff were disorganized due to laziness, others identified lack of sufficient space for filing. Others also attributed the lack of sufficient space to the huge number of obsolete files. Registry staff also complained that the flat files used as administrative files were inappropriate and needed to be changed. Group members further complained of lack of air conditioner in the office that made the environment unconducive for work. Unnecessary duplication of files was also identified as a possible cause. Registry indicated that sometimes they did not know where to file the document. It was revealed that the administrative files were 432.

After identifying the possible causes the group revisited each cause to understand how and why it affected the problem. The group also assessed how the problem affected them. Most members were of the view that the problem could create a bad image for the staff and their competence could also be in doubt. The group finally presented the problem and the possible causes in a fishbone diagram as in figure 2.

FIG 2: CAUSES OF POOR FILING



In the subsequent discussions, members identified the possible solutions to the problem. These solutions were ranked using matrix. An alternative solution that was ranked high was assigned (1) and the other low was ranked (0). In summing up the values in rows, the alternative that had the highest score was taken as the possible preferred alternative(s). The matrix ranking was used to rank solutions in order of priority and to select the best alternative(s) that could address the problem. The

Health Service Administrator then presented a budget to management to provide funds for the procurement of files and other equipment. The budget proposal was discussed at length and a decision to finance the budget was approved.

FINDINGS

a) It was found out that the Registry was using inappropriate files as administrative files. Flat files were mostly used. These files got torn with time. As a result, documents were not properly tagged and could easily drop from the files.

b) There was much duplication in terms of files created especially for administrative files. Staff were filing documents of similar nature in terms of subject in different files. The situation made the staff either unable to trace documents or wasted too much time tracing them.

c) It was found out that there was limited space for filing due to many obsolete files. Many staff that had either retired or on transfer had their files mixed up with active staff files. Some of the administrative files that had been closed were still on shelves.

d) Registry staff did not have a system of tracking the movement of files among officers. Registry staff could not produce files demanded. They had forgotten about officers who were in possession of these files.

e) The office was not conducive for work as the air conditioner had broken down beyond repairs. The Registry was hot when temperatures were high. As a result Registry staff could be seen idling under trees.

ALTERNATIVE SOLUTIONS

Members of the group identified the following solutions to the problem of poor filing

a) Provision of cabinets
b) Provision of Arc Files for administrative files
c) Institute sanctions
d) Provision of Air Conditioner
e) Create archives
f) Institute file/document registers
g) Re-categorization of administrative files

Ranked Alternatives

b) Provision of Arc Files for administrative files
g) Re-categorization of administrative files
f) Institute file/document registers
e) Create archives
d) Provision of Air Conditioner

Option	option							Score	Rank
	A Provision of cabinets	B Arc files	C sanctions	D air conditioner	E archives	F Registers	G Re-categorisation		
A Cabinets		0	1	1	0	0	0	2	4TH
B Arc files	1		1	1	0	1	1	5	1ST
C Sanctions	0	0		0	0	0	0	0	7TH
D air conditioner	0	0	1		0	0	0	1	5TH
E Archives	1	1	1	0		0	0	3	3RD
F Register	0	0	1	1	1		0	3	3RD
G Re-categorisation	1	0	1	1	0	1		4	2ND

FIG 3 DEVELOPING BEST ALTERNATIVE USING MATRIX RANKING

RECOMMENDATIONS

The project recommended the following:

Short Term

a) Management of the hospital should provide arch files for Registry staff to be used as administrative files.

b) The Registry staff and the Health Service Administrator should re-categorize the administrative files in terms of similar subject areas.

c) Management should ensure the creation of archives for obsolete files and inactive files.

d) Registry staff should introduce file movement register to keep track of files.

e) Management should provide more cabinets for the storage of files.

f) The work environment should be improved by replacing the non-functional Air conditioner.

Medium Term

Management should ensure:

a) Continuous monitoring and supervision to sustain the improvement in the system.

b) Establishment of electronic system of filing and introduction of software to further make the system more efficient.

CONCLUSION

The investigation has revealed through focus group discussions the causes of poor filing in the hospital of which staff of the Registry and management agreed to resolve. The investigation has further made recommendations which were implemented culminating in improvement in the filing system. It also suggested continuous monitoring and electronic filing in the medium term to sustain and modernize the system. The investigation however did not explore patient records filing system of the hospital due to resource and time constrains.

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Management 101: Lessons from my Experience

From the Village Wanderer

RITA ACQUAH,
Head of Administration,
International Maritime Hospital,
Tema

I have come to the realization that there are a few things you learn over a period of time, which we normally refer to as experience. It is never taught in the classroom. The learning process may come by accident, can be costly and sometimes painful but it ends up being worthwhile.

I endeavor to share a few of some of these experiences with the hope that it is beneficial to my readers. It is also worth critiquing.

There is a thin line between confidence, overconfidence and arrogance

i. **Confidence**: I know I have the skill, I know I am right but for some reason my advice is ignored. Let me retreat, re-strategize and wait for the best of time. They will definitely come. I will be better prepared and for whatever it is worth, they will learn that it was better to have listened to me in the first place. I keep that knowledge to myself and instead earn their grudging respect which they give behind my back. That is to me what I define as confidence.

ii. **Overconfidence**: I know I have the skill, I know I am right but for some reason my advice is ignored. I insist and insist but I am ignored. I throw a tantrum, I am ignored. I set up a parallel system to fight my opponents. You may be right but you will be undermined because the attitude is all wrong. The result of being overconfident.

iii. **Arrogance**: I think I am more skilled than everyone else. Without me the system cannot work, I am the typical "Kweku Ananse". So nobody can advise or equate to me. I am in myself a tin-god. I may not profess it but that is my style and thoughts; therefore I am beyond apology and reproach. My definition of arrogance.

Relationships

I. **Be wary of persons who befriend you immediately you get to a new station** especially if they are old staff. They may come in the guise of helping you to acquaint with your environment and/ or teaching you the ropes. Most times, you may live to regret that association or friendship.

ii. Be mindful of your discussions in official company; how you chat in your official vehicle when being driven or whilst in the company of colleagues at work. The snippets of gossip or conversation may be your undoing. A very senior officer's driver was the one who sent word round that the man had visited a fetish with the intention of killing a rival officer. It was a small community where this man was a prominent church elder. He was driven out by the chief and community

members in shame because in everyone's mind the Driver could not be wrong. The relationship between the Driver and this Officer were equal to the proverbial Siamese twins. The man did not live down that shame till retirement. **Be careful who you trust**.

Beware of Stereotyping

A good person goes beyond looks. Managers come in different shapes and sizes. Some are very precise and concise, their diction is good and their dress sense is on point. Others are from my village and may not know how to wear a tie. **Stereotyping will help you to get a mental blockage and you may not appreciate them for what they ARE WORTH**. Be extremely careful with your assumptions, try to shape your opinion not by what others think, but by tested principles. You are bound to get the best from what they have to offer.

Think smart and work hard. Cheers.

Retirement Planning

ONE YEAR AFTER RETIREMENT;
Reverberations of a Retiree

YAW BROBBEY-MPIANI,
CEO of YBM Consultancy and an Adjunct Lecturer at the Department of Public Administration and Health Service Management, University of Ghana Business School, Legon

You are young and beautiful
That is nice
You hope to remain so
That is fine
You may be disappointed
That is possible
You've got to prepare
That is wisdom
-Author Unknown-

In the mid-1980s when I received my maiden appointment letter in the public service, I rushed to my old man (father) with glee to show him this prized letter! "***Congrats but expect your retirement letter***", that was the response from the old man.

Several thoughts ran through my mind. Why think of retirement at such a youthful stage of my life? Later in the day as I was brooding over my father's pithy or terse response to my excitement it dawned on me that the old man meant well for me. I subsequently came to the realization that not all those who join the public service may retire compulsorily; some may be dismissed, retired prematurely on health grounds whilst others join their Maker prior to attaining the compulsory retirement age.

In the course of preparing for this reflective article, my mind went back to the aforementioned discourse I had in the days of yore with my old man and the above poem I learnt in my childhood days, which will serve as a prelude to the key issues I intend raising in this write-up for readers who are yet to retire in particular.

What is retirement in this context? It could be considered as "being *compelled by law due to one's age to stop or give up employment or normal work from which a living is earned"*. Retirement could also relate to a situation when a worker in either formal or informal sector is legally compelled to leave one's job and cease active or regular work, which could be attributed to old age, ill health, new opportunities, etc.

As alluded to earlier, every worker in the public, private and quasi-government entities is faced with four (4) key options when the issue of retirement crops up; either you live up to retirement age prior to joining your Maker or ancestors depending on your faith, being boarded out of active public service on grounds of permanent disability or incapacity due to sickness or accident, and fourthly retiring voluntarily before the prescribed legal age is due or when you are called by your Maker prior to the "*D-day"*.

It is noteworthy that those who are mindful of the negative or positive effects of retirement are habitually faced with the under-listed thorny questions;

How will your retirement be? (smile, hope or despair?)

The apparent frustrations which often bedevil or cause continual trouble to potential retirees could be effectively addressed if one makes it a point to address afore-mentioned questions as soon as you secure employment in the public, private or quasi-government organization. It is also applicable to those who are self-employed.

Why do some people get jittery or nervous when they are about to retire? I have encountered several public sector workers (senior, middle level and junior alike) who become unease or restless when they receive notification on their pay slip regarding their imminent retirement.

It is my conviction that such seemingly

apprehension could stem from loss of status or authority. Senior officers especially those in public health sector are bound to lose perks or privileges such as loss of some official car, accommodation, free rent, water, electricity, garden boy, house-help etc. which are part of their conditions of service.

Moreover, leaving a passionate work could be another factor for such anxiety; a well-known wit and a senior colleague of mine once remarked that those who virtually married their work during their stewardship in the public service find it extremely difficult to divorce their work when they are eventually retired.

Other factors that give sleepless nights to some workers who are about to retire relate to uncertainty of where to live after retirement; urban or rural / home town. The situation becomes worse when there is inadequate marital consensus about where to permanently settle with your spouse after retirement. This could be a potential factor for divorce for some couple.

Moreover, Ill-health and high medical expenses which are often associated with aging, high cost of life Insurance, potential loss of opportunity of getting loans from the Banks for want of regular income, loss of some friends in the organization or social circle and the wretched, pitiful, abject, pathetic life style of some retirees who could be our senior colleagues and relatives could pose a gloomy picture to some workers when they are about to retire.

It is noteworthy that personally, the uncertainty about how to finance life after retirement is one of the most critical or frightening threats for the potential retiree. This could lead to some workers contracting debilitating or devastating diseases which could fast track their premature demise. It becomes scarier when it dawns on you that **your monthly take home pay (pension) may not take you home. It is worthy of note that the average retiree under the SSNIT pension gets roughly one third of his or her salary (exclusive of allowances) whilst in active work.**

The afore-mentioned realities could compel some workers to deliberately doctor or falsify their biological date of birth with a view to remaining relatively longer in the public service. But why go through such stress? The answer is the response my old man gave me; “congratulations but expect your retirement letter”.

What has been my experience after one year of retirement from active public service?

I believe most readers of this article are itching to read my reverberations or after-effects regarding my recent retirement. I must state without any equivocations that mine has been what I humorously term as ***a mix feeling***.

Loss of status or authority, official perks attached to my position, not to mention loss of those I erroneously perceived as friends whilst in active service or social circle are some of what I consider as the negative effects of my retirement.

However, in spite of the aforementioned apparent negative effects which are axiomatic, it is my conviction that my retirement life has generally been exciting, restful and not regrettable. I was fortunate to receive good advice from my old man on the need to plan for my retirement the very day I joined the public service.

On my part, I have over the years planned systematically for my retirement with Proverbs 16:3 as my contemplation verse (***Commit your plans unto the Lord***). Some of my strategies whilst in active life included religiously saving a token of my earnings or going into some viable investments and finding workable solutions to the punchy questions that face potential retirees which I earlier alluded to in this write-up.

I have also observed that not doing any work at all (either paid or voluntary) could make some retirees grow old quickly. In the same way working and putting undue pressure on yourself as if you are still young could be devastating to your health. Hence **moderation is the key** in this regard.

Lastly indulging yourself in some hobbies or pastimes like taking a regular walk, playing golf or tennis, going to a public gymnasium or having a domestic gym to keep fit and kill the boredom often associated with retirement should not be under rated. The aforementioned piece sought to provide some highlights regarding potential misgivings on retirement and how you can overcome such negative and scary thoughts if you are desirous to have a restful and enjoyable retirement.

I therefore wish you the best retirement life devoid of all the negative trepidations associated with this unavoidable stage in your public life as you reflect on the poem below from an Unknown Author:

A LIFE WELL-LIVED

A life well lived is a precious gift
Of hope and strength and grace
From someone who has made our world
A brighter, better place
It's filled with moments, sweet and sad
With smiles and sometimes tears
With friendships formed and good times shared
And laughter through the years
A life well lived is a legacy
Of joy and pride and pleasure
A living lasting memory

AHSAG Personality Feature

MR. MOSES MACLEAN ABNORY
REGISTRAR, TAKORADI TECHNICAL UNIVERSITY (TTU)

Mr. Moses Maclean Abnory is well versed in Educational Reforms, Organizational and Team Effectiveness Assessment and Facilitation and Pedagogy. He also has vast experience in Strategic Management, Creative and Innovative Management and Administrative and Policy Formulation.

Mr. Abnory commenced his career at the University of Cape Coast in 1996 as a Senior Administrative Assistant, Public Relations Section and as Ag. Welfare Officer in 1997. By 1998, he was posted to head the Administrative staff at the Office of the Dean of Students of the University of Cape Coast. From 2000 to 2012, he assisted the Registrar in the Directorate of University Health Services. In 2010, Mr. Abnory became a Deputy Registrar and headed the Legal, Consular and General Services Division of the University of Cape Coast from October, 2012 to November, 2015. From December, 2015 to August, 2019, Mr. Moses Maclean Abnory was the Director of the Directorate of Legal, Consular and General Services of the University of Cape Coast.

Mr. Abnory is a member of Association of Health Service Administrators, Ghana (AHSAG). He served as the Vice President of the Association for the period 2006 to 2008 and contributed immensely towards the tremendous development of AHSAG at the time. He is also a member of Ghana Association of University Administrators (GAUA), International Professional Managers Association (IPMA), UK and a Graduate Member of the Chartered Institute of Administrators and Management Consultants (CIAMC), Ghana.

Mr. Moses Maclean Abnory obtained his Master of Business Administration in Health Service Administration from the University of Ghana in 2000. He also holds a Diploma in Education and a Bachelor's Degree in Arts (Social Sciences) awarded to him concurrently at the University of Cape Coast in 1996. Mr. Abnory was awarded a Postgraduate Diploma in Organizational Development at the University of Cape Coast in 2011. In 2014, he was again awarded a Master of Arts in Educational Development by the same University of Cape Coast. Mr. Abnory has an online Ph.D from Honolulu USA and is currently pursuing another Ph.D Programme in Public Health at the Kwame Nkrumah University of Science and Technology (KNUST), Kumasi. He is also currently pursuing two other terminal degrees.

Mr. Abnory has several publications to his credit with research interests in the areas of Health Service Management, Organizational

Development, Productivity Management, Human Resource and Relations Management.

Mr. Abnory was appointed by the Governing Council of the Takoradi Technical University (TTU) as the Registrar of the University at a meeting of the Council held on 20th June, 2019. His investiture as the Registrar of the University was done on Friday, 18th October, 2019.

The National Council and National Executive Committee of AHSAG celebrate Mr. Abnory's sterling career success on this occasion of the 43rd Annual Conference and Continuing Professional Education of AHSAG. Having been appointed to the high office of Registrar of TTU, AHSAG is optimistic that he will continue to excel and make the Association proud.

MR. SAMPSON OWUSU-AFRIYIE
DEPUTY DIRECTOR, SUPPLY CHAIN MANAGEMENT, KOMFO ANOKYE TEACHING HOSPITAL

Mr. Sampson Owusu-Afriyie is an accomplished Supply Chain Practitioner and a member of the Association of Health Service Administrators, Ghana (AHSAG). He is currently the Deputy Director of Supply Chain Management at Komfo Anokye Teaching Hospital (KATH), Kumasi.

Mr. Owusu-Afriyie obtained an MBA in Health Service Administration with specialization in Procurement and Supply from the University of Ghana Business School, Legon in June, 2002. Prior to this, he had already obtained a BSc. Administration in Health Service Management from the same University of Ghana Business School in June, 1996. He also possesses a Graduate Diploma from the Chartered Institute of Purchasing and Supply and Diplomas in Health and Humanitarian Logistics, and Health Systems Management from the Georgia Institute of Technology, USA. and Galilee College, Israel respectively. As an accomplished Supply Chain Practitioner, he also has to his credit Certificates in Goods Procurement, Works Procurement, Selection of Consultants, and Health Sector Goods Procurement from the Ghana Institute of Management and Public Administration (GIMPA) and the World Bank, Abuja Office.

He has about twenty-two (22) years experience in Procurement and Supply Chain Management and Health Service Management. He has also gained a lot of experience in Tender Administration, Procurement of Works, Selection of Consultants, Contract Administration, Contract Negotiation, Forecasting Techniques and General Logistics Administration.

Mr. Owusu-Afriyie is a Fellow and a Corporate Member of the Chartered Institute of Purchasing and Supply (UK). He is also a Fellow of the Ghana Institute of Procurement and Supply (FGIPS). He is a member of the Institute of Logistics and Transport (UK), Ghana Institute of Management and Council for Supply Chain Management Professionals, Denver, USA.

Mr. Owusu-Afriyie started his career at the Effia Nkwanta Regional Hospital, Sekondi as a Houseman Health Service Administrator in 1996. He also held the position of Ag. Procurement Officer and Secretary to the Tender Committee at the same Hospital immediately after the completion of his Housemanship until February, 1999 when he was posted to Kibi District Hospital in the Eastern Region as the Head of Administration. He left Kibi District Hospital in July, 2001 to take up the position of Supply Chain Manager at Komfo Anokye Teaching Hospital. He headed the Domestic Services Directorate of Komfo Anokye Teaching Hospital between August, 2003 and December, 2007 and acted as Director of Administration of Komfo Anokye Teaching Hospital in June, 2005. He became the Deputy Director, Supply Chain Management of Komfo Anokye Teaching Hospital in 2011 and has since remained in that position.

Our distinguished personality also served as an External Examiner for the BTEC Purchasing and Supply Programme of the then Takoradi Polytechnic in 2011. In the 2007/2008 academic year, he was also a part time Lecturer in Strategy and Strategic Procurement at the University of Education, Winneba, Kumasi Campus. He has also been the Chairman of Tender Review Boards of the Amansie Central and Kwabre District Assemblies.

He was adjudged as one of Ghana's Top 20 Procurement Leaders in the Ghana Procurement and Supply Chain Awards organized by Instinct Wave in collaboration with the Public Procurement Authority (PPA), Chartered Institute of Procurement and Supply (CIPS) and Ghana Institute of Procurement and Supply (GIPS) in both 2018 and 2019.

At the 2018 Procurement and Supply Chain award ceremony, He led the Procurement Unit of KATH to win the following awards:

a. Excellence in Procurement & Supply Chain of the Year: Healthcare/Pharmaceutical
b. Public Procurement & Supply Chain Team of the Year (Gold)
c. Best in Public Procurement & Supply Chain Compliance (Silver)

He also led the Procurement Unit of KATH to win the following awards at the Ghana Procurement and Supply Chain Awards, 2019:

a. Excellence in Procurement and Supply Chain – Healthcare (Silver)
b. Public Procurement & Supply Chain Compliance (Silver)
c. Public Procurement & Supply Chain Team of the Year (Bronze)

On this occasion of the 43rd Annual Conference and Continuing Professional Education of AHSAG, the National Council and National Executive Committee have duly recognized the excellent achievements of Mr. Sampson Owusu-Afriyie. The entire membership of AHSAG celebrate him as a shining star of our Association and wish him more and more successes.

Congratulatory Messages

Mr. Ebo Hammond

Director, Health Administration and Support Services
Division of the Ghana Health Service (GHS).

The Association of Health Service Administrators, Ghana (AHSAG) congratulates Mr. Ebo Hammond on his appointment as Director, Health Administration and Support Services Division of the Ghana Health Service (GHS).

The National Council (NC), National Executive Committee (NEC) and the entire membership of AHSAG are very proud to be associated with Mr. Hammond on the attainment of this great feat in his career. NEC is optimistic that Mr. Hammond will bring his expertise to bear and propel the HASS Division of the Service to greater heights.

We wish him the Almighty's guidance in steering the affairs of the HASS Division of the GHS to successful heights.

Dr. Lucio Gbeder Dery,

Deputy Director, Administration - Greater Accra Regional Health Directorate

The entire membership of AHSAG congratulates Dr. Lucio Gbeder Dery, Deputy Director, Administration of Greater Accra Regional Health Directorate, and a senior member of AHSAG. Dr. Lucio Gbeder Dery graduated with a Doctor of Business Administration in Health Planning and Management from the University of Keele, United Kingdom in August, 2019. The National Council, National Executive Committee (NEC) and the entire membership of AHSAG are proud to be associated with you on this great achievement.

Mr. Moses Maclean Abnory

Registrar, Takoradi Technical University (TTU).

The Association of Health Service Administrators, Ghana (AHSAG) congratulates Mr. Moses Maclean Abnory on his appointment as Registrar of the Takoradi Technical University (TTU).

Mr. Abnory served as the Vice President of AHSAG for the period 2006 - 2008 and contributed immensely to the development of AHSAG as a NEC member at the time.

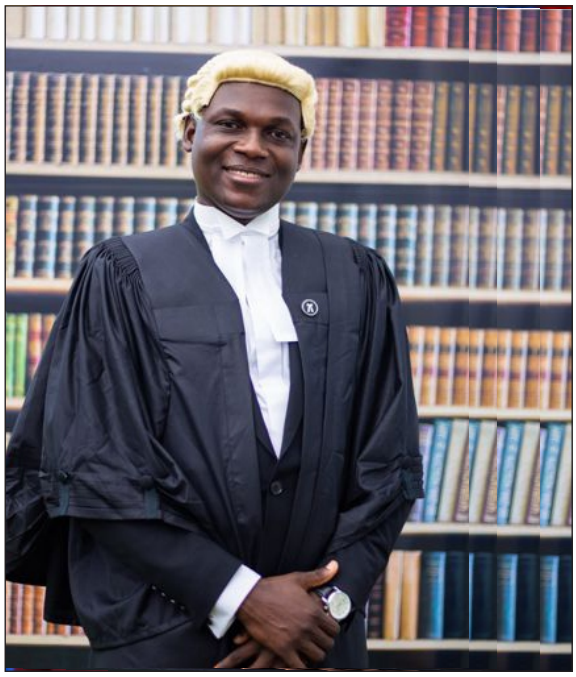
The National Council (NC), National Executive Committee (NEC) and the entire membership of AHSAG are very proud to be associated with him on the attainment of this great feat in his career.

We wish him the Almighty's guidance in his new position.

Abulais Yaro Haruna (Esq)

Congratulations to Abulais Yaro Haruna, Esq. for qualifying as a lawyer and being called to the Ghana Bar on 4th October, 2019. Abulais Yaro Haruna is the Head of Administration of New Tafo Government Hospital and the National Public Relations Officer of AHSAG. He is also the General Secretary of the Eastern Regional Caucus of AHSAG.

The National Council, National Executive Committee and the entire membership of AHSAG are proud to be associated with him on this great achievement of his life.



Nancy Waaley

Senior Health Service Administrator , Cape Coast Teaching Hospital

AHSAG congratulates our colleague, Nancy Waaley, a Senior Health Service Administrator of Cape Coast Teaching Hospital for graduating with an MBA in Human Resource Management from the University of Cape Coast in September, 2019. Nancy Waaley is also the Treasurer of the Central Regional Caucus of AHSAG.

AHSAG is proud to be associated with her on the attainment of this great academic success in her life.

Madam Georgina Yeboah

Deputy Director, HR - Komfo Anokye Teaching Hospital

Congratulations to Madam Georgina Yeboah, on the left side of the attached picture. She has been appointed by the National Labour Commission (NLC) to serve on a three-member Committee to oversee issues relating to labour and industrial disputes in the Northern Sector of Ghana.

Madam Georgina Yeboah is the Deputy Director, Human Resource Management of Komfo Anokye Teaching Hospital (KATH). She is a dedicated member of AHSAG and recently served on the Committee that worked on the establishment of the Capacity Building Centre of AHSAG.

The National Council, National Executive Committee and the entire membership of AHSAG salute her on this occasion. We wish her success and pray that she continues to make AHSAG proud.

COMMUNIQUÉ ISSUED BY THE ASSOCIATION OF HEALTH SERVICE ADMINISTRATORS, GHANA (AHSAG) AT THE END OF THEIR CPE PROGRAMME AND 42ND AGM HELD FROM 23RD - 27TH OCTOBER, 2018 AT SUNYANI, BRONG AHAFO REGION

Preamble

We, the Association of Health Service Administrators, Ghana (AHSAG) met at the 42nd Annual General Meeting and Continuing Professional Education (CPE) Programme in Sunyani in the Brong Ahafo Region of Ghana from 23rd - 27th October, 2018. And having deliberated extensively on the conference theme, **Achieving Universal Health Coverage – The Role of the Health Service Administrator** and related matters, we present below our comments and decisions for the consideration of Government and Stakeholders.

Achieving Universal Health Coverage

We recognise that Universal Health Coverage (UHC) is one of the components and a key strategy for attaining the Sustainable Development Goals (SDGs) and Ghana's development agenda. UHC emphasises that all communities should have uninhibited access to promotive, preventive, curative, rehabilitative, and palliative health services provided at sufficient quality that meet the desired level of client satisfaction without exposing the users of these services to financial hardship.

We note, however, that widening health infrastructure deficit especially at the district level and the weak ambulance situation across the country are major barriers to achieving UHC in Ghana. Indeed, about 50 per cent of districts in Ghana have no referral hospitals while less than 40 per cent of communities have basic health facilities such as Health Centres and CHPS Compounds. This situation is worsened by the fact that only 45 out of 133 ambulance stations across the country are functional with vehicle availability of about 50 per cent.

We urge the Ministry of Health to prioritise the rehabilitation of some existing health facilities and the construction of new facilities in deprived districts and communities.

'No Bed Syndrome'

We further note, with grave concern, the alarming reports of patients who are denied medical care even in emergency situations because some health workers at the health facilities they visited claim they cannot admit them because of lack of beds at the facility. This 'No Bed Syndrome', as it has become known, is a nonexistent monster in health facilities with dysfunctional clinical leadership. It is purely the case of inefficient bed management at such health facilities.

To eliminate this 'No Bed Syndrome', we will work together with other health professionals to provide effective leadership in the allocation and optimum utilisation of hospital beds in all health facilities. We will act to restore confidence in the health system by pursuing relevant customer care training programmes and orientation to inculcate in health workers acceptable norms and behaviours that promote quality health service delivery.

Financing UHC with NHIS

We welcome the on-going reforms by the National Health Insurance Authority (NHIA) to improve the sustainability of the National Health Insurance Scheme. We note, in particular, the introduction of a mobile renewal system and authentication devices. This pro-poor health financing scheme which ensures financial access to healthcare services is a key pillar to achieving UHC. We, therefore, urge the NHIA to deepen engagement with all stakeholders including health service providers to agree on realistic premium, tariffs, processing of claims, and timely re-imbursement to avoid any forms of out-of-pocket payments by NHIS card bearers.

Health Supplies Management for UHC

AHSAG recognises that the effective and efficient management of the supply chain of health

commodities is crucial to the attainment of UHC. However, in spite of efforts by various stakeholders including development partners, there are still significant challenges regarding the regular availability, affordability and quality of health commodities such as medicines and other critical logistics required for quality health service delivery. Key among these challenges are quality of health products, timely delivery of commodities, poor storage and security of commodities, and proper use of commodities in the treatment of cases or prevention of diseases.
It is the opinion of AHSAG that, the attainment of UHC in Ghana will be accelerated if stakeholders demonstrate commitment to addressing the bottlenecks in the supply chain of health commodities. In this regard, we urge the Ministry of Health and its agencies to speed up the development and deployment of the Ghana Integrated Logistics Management Information System (GILMIS) to promote the effective and efficient management of health commodities. We further urge the Ministry of Health and its agencies to strengthen the Central Medical Stores system and review the 'last mile distribution' project to eliminate shortage and expiry of health commodities at the Regional Medical Stores and health facilities.

We also note that the framework contract arrangements by the Ministry of Health for the 54 essential items has caused teething problems leading to a lot of stock outs in most hospitals. We therefore strongly recommend a review of the policy to include issuance of Non-Availability Certificates to facilities to procure those items from the Open Market anytime the Regional Medical Stores runs out. Again, the Ministry of Health should empower the various Regional Medical Stores to procure those items directly from Suppliers and stock same in order to ensure ready availability to hospitals.

Health Workforce Production, Distribution and Development

Health service delivery is a labour-intensive enterprise that requires the appropriate mix of health personnel who are motivated to provide quality health care at all levels of service delivery. We acknowledge that significant progress has been made in addressing the staffing gaps in public health facilities through various interventions by the Ministry of Health to increase production and retention of health workers. We note, in particular, that the essential health worker density more than doubled from 1.07 per 1000 population in 2005 to 2.65 per 1000 population in 2017. It is, however, important to stress that the recent staffing norms developed by the Ghana Health Service (GHS) and the Christian Health Association of Ghana (CHAG) reveal that the existing staff stock remains well below optimum and also inequitably distributed. For instance, about 58 per cent of the health workforce is concentrated mainly in Accra and Kumasi. We recommend that the GHS should hold broader stakeholder consultations to facilitate the smooth implementation of the staffing norm.

AHSAG welcomes the decision by the GHS to decentralize the recruitment and placement of staff instead of the current practice where staff are recruited and posted to health facilities from the national level. This shift in policy will undoubtedly contribute to bridging the inequity in staff distribution across the country. We urge Government to support this policy and issue financial clearance to GHS and CHAG to recruit the many unemployed health workers including Health Service Administrators to address the gaps in the staffing norms.

We strongly recommend that the Ministry of Health and its agencies should review the prevailing incentive packages and make it similar to that of CHAG to attract and retain adequate health personnel to health facilities in underserved communities. Government should consider reviewing the payment of market premium to health workers in favour of staff working in the rural, deprived and hard-to-reach communities. Moreover, the Ministry of Health and its agencies may consider posting staff to underserved communities on rotational basis so that staff who accept initial posting to such communities are not left in a particular area for a long time.

Effective Leadership and Governance

AHSAG appreciates that effective leadership at all levels is critical to achieving UHC. Health facilities are characterised by the preponderance of various

highly skilled health professionals who work very closely with other cadres of health workers to provide quality care to patients. The health sector, as dynamic as it is, requires leaders who are abreast with changing trends in health services and who can operate at both local and international levels. Recent global standards of leadership in health care demand inter-professional teams that can speak to and act on all aspects of the health facility's functions. Such leadership enjoins cooperation, collaboration, effective communication, and integration of care within and among teams to ensure continuum of care. Clinical care and functional management are integrated seamlessly for improved patient care.

AHSAG calls on Government, health service providers, policy makers and other stakeholders to provide effective leadership at all levels to improve geographic and financial access to health services as well as effective clinical governance at the health facility level. We further call for increased monitoring and supervision of policy implementation and accountability in the mobilisation and utilisation of health resources.

COMPUTERISATION OF HOSPITAL OPERATIONS

We note, with dissatisfaction, the poor state of ICT system in many public health facilities whose operations remain largely manually driven resulting in inefficiencies and delays in service delivery to clients. We are of the firm conviction that the networking of health facilities is long overdue and require bold initiatives to transform health service delivery in Ghana.

We welcome the efforts by the Management of the GHS and NHIA to computerise the operations of public health facilities to improve efficiency and quality of care. We pledge to take practical steps to support these initiatives, including facilitating the implementation of the computerisation programmes at various health facilities. We urge the Director-General of the GHS and the Chief Executive Officer of the NHIA to find sustainable ways to finance such initiatives, including the application of part of the Internally Generated Funds (IGF) of health facilities to implement the initiatives over an agreed period of time.

This, we believe, will ensure uniformity and integration of Healthcare ICT Systems across health facilities in the country. This will further modernise the operations of health facilities to respond to technological advancement and client expectations.

Signed:

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Signed:
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