GHSA QUARTERLY REPORT – GHANA MCSP
PILLAR IV
PY18 Q1
October to December 2017

Introduction

The project aims to contribute to the reduction in the spread of diseases including Healthcare Associated Infections (HAIs) through the improvement of infection prevention and control practices in 56 health facilities (hospitals) in five regions of Ghana. To achieve this end, MCSP is supporting on-site training of 13,975 clinical and non- clinical frontline healthcare staff in the selected health facilities, which is 86% of the total number (16,225) of clinical and non-clinical staff at these facilities. The trainings started in December 2016 and due to end by 28th February, 2018.

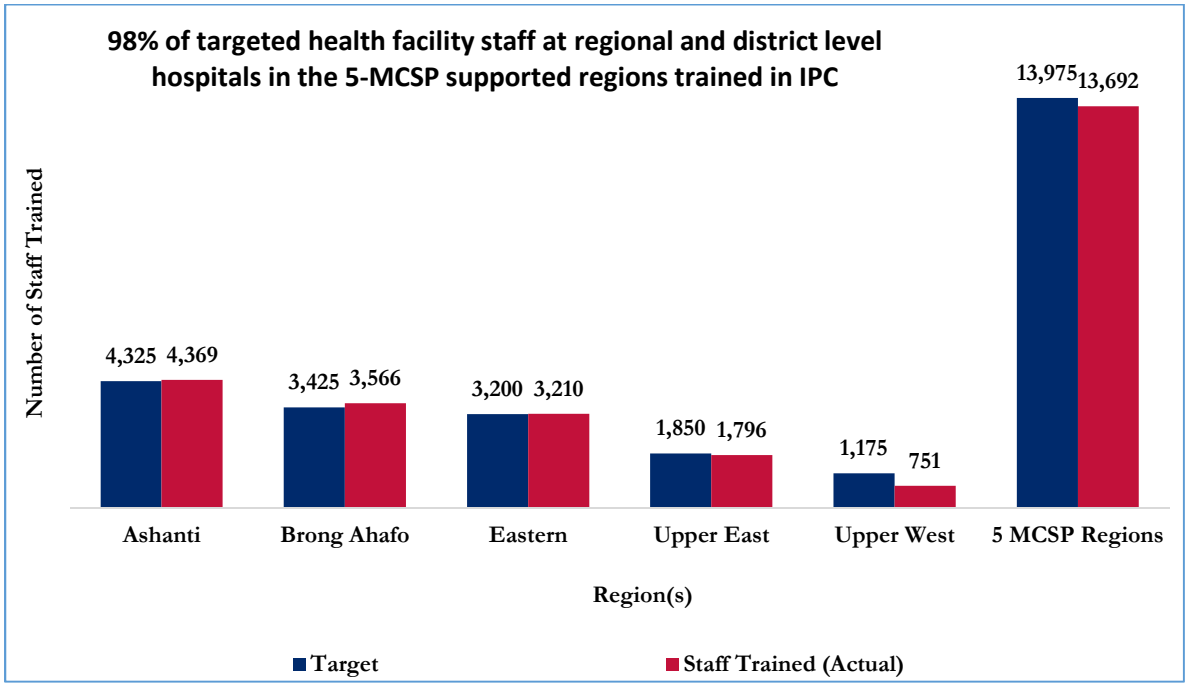
The project in collaboration with the Ghana Health Service designed a Competency Based Training strategy comprising of multiple essential components to train these large number of healthcare workers. The strategy included the development of a National IPC policy and guidelines as well as developing an IPC facilitator's guide which has training session plans, pre and post test questions and checklist for IPC procedures. In addition, national and regional IPC trainer of trainers were developed. Following the development of trainers a bespoke regional led strategy was used to roll out the trainings at the health facility level. This strategy comprised the administration of Fix amount awards with clear deliverables, deployment of health facility trainings, facility training reporting system to capture training data and scheduled monitoring and evaluation visits by MCSP.

Activities & Results

PREVENTION

- Regional Health Directorate (RHD) in collaboration with MCSP conducted infection prevention and control (IPC) trainings in 4 regional and 53 district hospital across the five MCSP-supported regions namely Ashanti, Brong Ahafo, Eastern, Upper East and Upper West regions. This represents above 100% of the targeted number of health facilities (56 facilities).
- MCSP have trained 13,692 (98%) of targeted frontline health care workers on infection prevention practices and control (IPPC). See Figure 1 below.
- Of the number of healthcare workers trained, 10,059 were clinical staff and 3,633 were non-clinical staff.
- The overall pre-assessment average score was 45% whiles the post-assessment average score was 81% of the clinical staff trained. This indicates that, the change in knowledge scores of 36 percentage points. This implies clinical health workers had low level of knowledge in pre-training assessment, but gained knowledge on IPC practices at the facility level after the training.
- The team designed a dashboard for use by facilitators, which served as a guide to pinpoint problematic areas in participant comprehension and skills. This allowed the facilitators to know the specific topics that participants were scoring low in so that additional time and practice could be provided in these areas. This helped improve the post test scores as facilitators were able to focus on specific modules that participants found difficult to understand .

Figure 1: 98% of targeted health facility staff at regional and district level hospitals in the 5-MCSP supported regions trained in IPC in Ghana



*data from MCSP Ghana program records

Challenges

- Delays in implementing regional trainings in Upper West Region owing to administrative challenges at the RHD was a significant challenge and resulted in additional no cost extension request for the program so the Region could finalize trainings and meet their targets.
- Notwithstanding, MCSP engaged the new regional director who resolved the challenges, which has led to the start of the trainings in December, 2017. The trainings will be finalized by February 2018.

Lessons Learned, Proposed Course Changes, and Recommendations

- The project received approval for its request for a no cost extension to end the project on February 28, 2018. The request was required to help the Upper West Region complete their regional hospital training. The regional hospital is the only referral health facility for clinical care in the region hence the need to ensure their IPC training is completed.

ANNEX I: List of facilities completing IPC trainings through life of the project

ASHANTI REGION	Target	Number Trained
Regional Hospital	500	382
Bekwai Hospital	225	240
Effiduase Hospital	225	194
Ejisu Hospital	225	215
Ejura Hospital	225	152
Kokofu Hospital	225	123
Konongo Hospital	225	181
Mampong Hospital	225	212
Manhyia Hospital	225	302
Maternal Child Health Hospital	225	220
New Edubiase Hospital	225	155
Nkawie Hospital	225	227
Nkenkaasu Hospital	225	238
Nyinahin Hospital	225	120
Obuasi Hospital	225	176
Suntreso Government Hospital	225	371
Tafo Hospital	225	301
Tepa Hospital	225	168
Juabeng Hospital		235
Juaso Hospital		157
TOTAL	**4,325**	**4,369**

EASTERN REGION	Target	Number Trained
Regional Hospital	500	615
Akuse Hospital	225	111
Asamankese Hospital	225	237
Atua Hospital	225	231
Begoro Hospital	225	

BRONG AHAFO REGION	Target	Number Trained
Regional Hospital	500	512
Sampa Government Hospital	225	182
Atebubu Government Hospital	225	166
Bechem Government Hospital	225	280
Holy Family Hospital, Berekum	225	224
Holy Family Hospital, Techiman	225	384
Sene District Hospital, Kwame Danso	225	120
Methodist Hospital, Wenchi	225	227
Municipal Hospital, Goaso	225	177
Municipal Hospital, Kintampo	225	206
Municipal Hospital, Sunyani	225	373
Presby Hospital, Dormaa	225	301
St Elizabeth Hospital, Hwidiem	225	150
St Theresa's Hospital, Nkoranza	225	264
TOTAL	**3,425**	**3,566**

		201
Enyiresi Hospital	225	225
Kade Hospital	225	158
Kibi Hospital	225	228
Kwahu Government Hospital	225	272
Nsawam Hospital	225	227
Oda Hospital	225	230
Suhum Hospital	225	237
Tetteh Quashie Hospital	225	238
TOTAL	**3,200**	**3,210**

UPPER EAST	**Target**	**Number Trained**
Regional Hospital Bolgatanga	500	460
Bongo District Hospital	225	190
Presby Hospital,	225	293
Sandema District Hospital	225	175
Tongo District Hospital	225	56
War Memorial Hospital	225	234
Zebilla District Hospital	225	257
Paga Hospital		131
TOTAL	**1,850**	**1,796**

UPPER WEST REGION	**Target**	**Number Trained**
Wa Regional Hospital	500	193
Nadowli District Hospital	225	210
Nandom District Hospital	225	224
Tumu District Hospital	225	124
TOTAL	**1,175**	**751**

ANNEX II: Studies/Surveys Completed by Project

The project undertook a case study in September, 2017. The executive summary is shared in this report. The entire report will be attached to the final report.

Introduction

The purpose of this study was to understand how healthcare workers were able to translate their learning (knowledge) into practice; how the IPC trainings contributed to changes in clinical practice; learn from the innovative training approach (Competency-based); learn how the training contributed to reductions of infections on surgical wards; and how health facilities were adherent to IPC standards (i.e. WASH (hand hygiene), waste management, sharps containers, IPC focal person, IPC quality management committee and IPC supplies).

Methods

The study used a cross-sectional mixed methods design to evaluate the competency-based onsite training using both qualitative and quantitative methods. The case study used a sample of nine (9) trainers of trainers, nine (9) Clinical staff and six (6) non-clinical staff from eight hospitals in four out of the five MCSP focus regions. Key informant interviews were conducted with the selected participants, the WHO IPC standards assessment (health facilities IPC adherence standard protocol tool) was conducted at the eight hospitals and analysis was conducted of all staff pre-and-post assessments scores during training. The report includes the data collection instruments in the appendix.

Key Findings

During the course of the MCSP project, 13,137 (94% of the target number of 13,975) clinical and non-clinical staff were trained in IPC (whole site and On-site) as of the 30th November, 2017 in the 5-MCSP regions at 56 facilities in the 5 MCSP regions. There was an average increase in knowledge and competency from 45% to 81%, i.e., 36 percentage points in knowledge gain after the trainings. Clinical/nonclinical healthcare workers had low levels of knowledge at pre training assessment, but gained knowledge after the training. The IPC standards protocol assessment showed that the hospitals included in the sample adhere to some of the five major IPC standards. Facilities have focal persons in charge of IPC and a quality management (QM) Team in place for IPC and WASH activities, except for Eastern Region who have a dormant QM team and are in the process of reviving it. Water supply system, adequate, accessible and appropriate sanitation and waste management is well established, whereas hand hygiene (especially hand washing) seems to be a challenge for health workers.

Overall, respondents felt the competency based IPC training approach was acceptable, sustainable, and scalable because the competency-based training was onsite and enabled a whole-team approach to training and the development and deployment of a skilled cadre of Trainer of Trainers (TOTs). The current and future health workers who rotate through the facilities will be trained by facility-level ToTs that will improve ongoing IPC practices at the facility level.

Recommendations

Recommendations as a result of assessment findings include:

1. There should be adoption of the competency-based approach for in-service training for health workers to improve IPC standards and guidelines to protect health workers and improve health care by enhancing the quality of care in the health care settings.
2. The Hospital administration should provide copies of IPC and WASH policy Guidelines in all wards/units and ensure effective implementation through constant supervision and adequate supplies.
3. The hospital administration should re- activate the IPC and WASH committees and conduct regular audits to enhance compliance and implementation of infection prevention practices and control (IPPC).
4. The hospital administration needs to institute urgent and strict practice of hand washing at the hospitals, since there is availability of reliable water supply.

Conclusion

Health workers felt the competency-based training approach built their competency and confidence and improved the IPC practices by facilitating retention and translation of knowledge and skills into routine service delivery in their hospitals. Stakeholders (RHMT) felt that the competency-based approach would be sustainable because the highly skilled cadre of government ToTs could continue training and monitoring, and because there is less cost to continue the approach in existing sites.