CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)

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THE STATE OF OUR HOSPITALS

PEER AND PARTICIPATORY HEALTH APPRAISAL FOR ACTION OF CHAG HOSPITALS (2006)

NOVEMBER 2006

TABLE OF CONTENTS

TABLE OF CONTENTS **2**

ACRONYMS **3**

EXECUTIVE SUMMARY **4**

BACKGROUND **7**

OBJECTIVES AND METHODOLOGY **9**

- BROAD OBJECTIVES 9
- METHODOLOGY: 9
  - *Planning And Organization* *9*
  - *Preparations For Training And Training:* *9*
  - *The Assement* *10*
  - *Regional Summits/ Feedback:* *10*
  - *National Collation And Report Writing:* *10*
  - *Feedback at National CHAG Congress* *10*
- CHALLENGES 11

FINDINGS **12**

- A.PATIENT CARE & MANAGEMENT 12
- B.COMPARATIVE ANALYSIS OF THE OUTPUTS OF CHAG AND GHS 2004/2005 15
- C.INTERNAL HOSPITAL MANAGEMENT & EXTERNAL LINKAGES 21
- D.HOSPITAL EXTERNAL LINKAGES & RELATIONS 23
- E.EQUIPMENT AND INFRASTRUCTURE 24
- F.FINANCE & ACCOUNTING 25
- G. CLIENT AND COMMUNITY VIEWS 27
- H.SITES FOR GOOD/BEST PRACTICE 29

RECOMMENDATIONS **29**

- *PATIENT CARE & MANAGEMENT* *29*
- *SERVICE OUTPUT* *30*
- *INTERNAL HOSPITAL MANAGEMENT & EXTERNAL LINKAGES* *30*
- *HOSPITAL EXTERNAL LINKAGES & RELATIONS* *30*
- *HOSPITAL EQUIPMENT AND INFRASTRUCTURE* *30*
- *CLIENT and Community Views* *30*

THE WAY FORWARD **30**

ACKNOWLEDGEMENTS **31**

ANNEX 1: LIST OF HOSPITALS APPRAISED 33

ACRONYMS

ALOS	Average length of stay
ATF	Accounting Treasury and Financial Regulations
BMC	Budget Management Centre
BOR	Bed Occupancy Rate
BPEMS	Budget and Public Expenditure & Management Systems
CEO	Chief Executive Officer
CHAG	Christian Health Association of Ghana
CHIM	Centre for Health Information Management
DANIDA HSSO	Danish International Development Agency Health Support Service Office
DHA	District Health Administration
DHMT	District Health Management Team
DOTS	Directly Observed Treatment Services
GES	Ghana education Service
GHS	Ghana Health Services
GRNA	Ghana Registered Nurses Association
HRD	Human Resource Development
HSWU	Health Services Workers Union
KATH	Konfo Anokye Teaching Hospital
MoH	Ministry of Health
NGO	Non Governmental Organisations
NID	National Immunization Day
OPD	Out Patient Department
PDE	Patient Day Equivalent
PPM	Planned preventive maintenance
PPRHAA	Peer and Participatory Health Appraisal for Action
RHMT	Regional Health Management Team
SDA	Seventh Day Adventist
TUC	Trade Union Congress
VCT	Voluntary Counselling & Testing

EXECUTIVE SUMMARY

The Danish International Development Agency (DANIDA) has been supporting the Christian Health Association of Ghana (CHAG) to conduct Peer and Participatory Rapid Hospital Appraisal (PPRHAA) of the CHAG member hospitals for the past three years as part of the CHAG five year strategic plan. The appraisal covers patient care management, internal hospital management, external linkages and relations of the hospitals, finance and accounting, equipment and infrastructure, service output, and client and community views.

- For this year (2006) the decision was taken to appraise all the 58 hospitals and to organize the appraisal on regional/zonal basis to build regional capacity for sustainability in the absence of donor support. Also it was to make a comparative analysis of the service performance output of CHAG and GHS Ghana Health Service hospitals.

Some of the key findings of the appraisal are:

Patient Care Management

- Many hospitals do not have full 24 hour coverage by all categories of staff due to shortage of professional health workers.
- Hospitals do not have systems for monitoring clinical adverse incidents
  in the light of increasing medico-legal awareness
- A good number of clinical protocols are available but their use needs to be improved.
- Regular clinical meetings need to be increased
- Management of hospital wastes has to be improved but infection control practices are good.

Internal Hospital Management

- All hospitals are now engaged in planning but are limited in scope and degree of implementation and monitoring
- Organizational structures differ from one church denomination to another and is not always clear to staff. Management is too

centralized around the head of the hospital in a few hospitals. In these hospitals, middle level managers have little authority to get their work done

- Structured support and supervision is universally weak
- Although hospitals have mechanisms for assisting the poor, deferral and Exemption practices are not well organized and clients are not well informed about D&E policies where they exist
- Drug availability is high in all hospitals but only Presbyterian hospitals and a few others have very strong drug revolving funds.
- Relations of CHAG hospitals with district health management teams have improved but CHAG hospitals need to strengthen their links with district assemblies.

Equipment and Infrastructure are generally adequate in most hospitals, although a few have obsolete equipment. Systems for ensuring adequate maintenance are however a problem in many facilities. There was virtually no hospital that has made any investment to raise capital funding for medical equipment.

Accounting and financial management practices are quire satisfactory in most hospitals. While all hospitals plan and draw up annual budgets according to government guidelines, only very few had any strategic plan. Internal control systems are fairly good but hospitals need to put in place internal audit mechanisms.

Interviews with communities that use the hospitals revealed the following key issues:

- Waiting time had improved at the OPD until the introduction of National Health Insurance (NHI)
- Friendly staff in most hospitals except in few where Ward Aids, maternity and security staff need to be more respectful
- Communities said inpatient care is generally too expensive and prices are not displayed or understood
- Communities do not participate in the management of hospitals

- There is favouritism and lack of confidentiality in some hospitals
- Hospitals are mostly very clean but waste disposal needs to be improved.

Comparison of CHAG and GHS Hospital Service output showed:

- That CHAG hospitals make substantial input into national hospital indicators, especially that of in-patient care.
- Bed use indicators of CHAG are higher than those of GHS
- The workload in mission hospital for nurses and doctors is twice that of GHS hospitals but nearly the same for the two organizations for all other staff.

Recommendations

The appraisers recommended a review and improvement in some of the patient care practices such as monitoring of adverse incidents, ward rounds and maternal audits. The comparative analysis of service out put indicates that CHAG makes substantial input into national health indicators therefore CHAG needs to use this information for more advocacy with government. All hospitals have to increase community participation in the management of their facilities as well as improve planned preventive maintenance in the hospitals.

BACKGROUND

As part of its central policy strengthening support to the health sector, DANIDA HSSO assisted the Christian Health Association of Ghana (CHAG) to develop a five-year strategic health plan aimed at improving the quality, efficiency and coverage of the considerable services CHAG provides in the health sector in Ghana. The strategic plan was completed in 2003 and since then, the CHAG secretariat has, among other things in her strategic plan, been conducting annual Peer and Participatory Health Appraisal for Action (PPRHAA) in the hospitals run by members of the association.

PPRHAA is a rapid but comprehensive appraisal methodology developed in the Upper West Region for assessing the effectiveness of health systems and service performance in facilities. PPRHAA involves bringing together a multi-disciplinary team from the facilities to be appraised, giving them a standard orientation and getting them to work as a team to appraise their own facilities as well as those managed by their peers. The field appraisal is rapid, lasting only half a day, but covers the following key areas:

A. Patient Care Management
B. Internal Management, External Linkages and Relations
C. Finance, Accounting, Equipment and Infrastructure
D. Service Output
E. Client and Community views of services provided to them by the health facilities.

After the appraisal in each facility, the appraisers provide an immediate feedback to the facility, elicit the identification of major priority problems and assist the institution to develop plans to solve and improve the systems issues identified by the appraisers and the health staff of the appraised facility.

CHAG's annual appraisals has so far covered only hospitals since this is the area that CHAG makes the most contribution of health care in the country. The appraisals covered 10 in 2003, 7 in 2004 and 10 in 2005. These appraisals were conducted as sample of all the regions and the different church denominations that make up CHAG.

The results of the appraisal in 2005 were presented at the annual CHAG Congress, a meeting of the representatives of all the members of the association. The congress was very happy with the report and demanded that the appraisal in 2006 should cover all the 57 CHAG hospitals in the country and that the appraisal system should be decentralized as much as possible to build local capacity and provide regional pictures of the health services. The congress also asked the CHAG secretariat to use the appraisal system to estimate the contribution being made by member institutions to health care in the country so the information can be used for advocacy for resources for member institutions.

When members of the appraisal teams were asked for the result of the previous PPRHAAs in their institutions, the following were identified:

1. PPRHAA created awareness for the need to improve systems as opposed to just staff development. (systems and practices)
2. Hospitals are now more particular on documentation (protocols, guidelines etc)
3. Directional signs in facilities have improved and information desks introduced.
4. Hospitals have identified and filled basic equipment needs.
5. Used the findings to prepare project plans and to mobilise founds
6. More efforts have been made to reduce waiting time for clients
7. PPRHAA has created awareness that community and client views have to be taken into account especially those creating inconvenience to clients.
8. It has pushed up computerisation of accounts in the hospitals in Ashanti Region
9. Lead to a drive for new constructions (laundries, mortuaries and the painting of walls in some hospitals in Ashanti Region)
10. Has led mission hospitals to start employing more professional administrative staff.
11. Many have used PPRHAA to enrich Quality Assurance Teams in Western and Central Regions.
12. Has improved quick implementation of plans in institutions
13. The PPRHAA teams had less difficulty in obtaining information this time round due to early dissemination.

OBJECTIVES AND METHODOLOGY

BROAD OBJECTIVES

The main objective for this year's PPHRAA exercise was to initiate a process that will ensure the building of a PPHRAA system within CHAG that can be sustained into the future with little or no support from Donors/Development partners.

SPECIFIC OBJECTIVES

- To conduct a comprehensive PPRHAA assessment of all CHAG member hospitals
- Decentralize the conduct of PPRHAA by creating regional PPRHAA teams
- Conduct a comparative analysis of CHAG and GHS outputs

METHODOLOGY

Planning And Organization

CHAG Management met with the Lead Consultants to review the previous PPRHAA exercises and to undertake the initial planning for 2006 PPRHAA process. At this meeting, as a measure to decentralise the process, the 10 regions of the country were grouped into six zones. Anchor persons for the exercise in the zones were also identified. The anchor persons were to identify and form the regional teams, organise and coordinate the process in their zones, ensure collation of regional reports for the compilation of the national composite report. The thematic areas were also reviewed and collapsed from the original seven to five as a measure to cutting down personnel cost.

The planning process was taken further with the meeting of CHAG Secretariat and Lead Consultants with National and Regional Coordinators. The coordinators were briefed by the lead consultants on the suggested processes and methods to be adopted for the 2006 CHAG PPRHAA. The briefing included planning for logistics support for the exercise. Views were invited, followed by discussions.

Preparations For Training And Training:

The consultants met to discuss training needs for the Regional Teams. The Consultants then organized training sessions concurrently for six regions/zones at the various regional/zonal levels. The training sessions involved taking the 48 team members through all the thematic areas and what to look out for. This also included report writing and collation.

The Assessment

Each Regional Team drew up an itinerary for their appraisals. Information was relayed to the facilities to be appraised after which the appraisals started with their visits. The teams spent a day in each facility and went through the process of briefing the management team. Members of the teams were assigned thematic areas to appraise. They visited various departments, interviewed and collected and reviewed information. While doing these appraisals, managers and other key staffs were requested to identify problems and suggest solutions which were later used for the development of action plans. After the appraisals, Management and Supervisors were debriefed by the teams on their findings. Together, action plans were drawn up and the Spider-web diagrams were explained.

Regional Summits/ Feedback:

Regional Workshops were supposed to be organised to discuss findings, cross-cutting issues and plans. Unfortunately, only one region, Ashanti, was able to hold the regional workshop. Sixteen out of the eighteen hospitals were represented and they felt the exercise was useful but complained that the notice was too short and they could not prepare properly for the visit of the appraisal teams. The other Regions were unable to organise the summits this was due to financial and time constraints. There are plans to organise these feedback meetings later.

National Collation And Report Writing:

Regional Coordinators reconvened in Accra on the 11th May 2006 for the collation and writing of the National Report.

Feedback at National CHAG Congress

The PPRHAA team was given a slot at the National Congress of CHAG to present the report. Power Point presentations were made covering;

- Background, Objectives and Methodology
- Patient Care
- Internal Hospital Management and Linkages
- Finance and Equipment
- Community views
- Comparative Analysis
- Recommendations
- Best Practises
- Way forward

The presentation on comparative analysis generated a lot of debate when it showed that CHAG hospitals were contributing or providing a much bigger part of the health services in the country than was previously estimated. It also came out that human resources were much more efficiently used in the CHAG institutions judging from the Average Monthly Admissions per Doctor and Average Patient Day Equivalent per Nurse.

CHALLENGES

- Notice sent out to Regions for preparation for PPRHAA was too short
- Preparation in the regions was inadequate
- Inadequate budget for logistics
- The exercise covered more facilities within the short period
- Staff of the hospitals could relate with members of the appraisal teams

FINDINGS

A.PATIENT CARE & MANAGEMENT

QUALITY CARE

All hospitals were examined for 24hours service and found out that except for three Hospitals St Dominic, Akwatia, Alfa Medical Centre, Madina, Accra and SDA Hospital Kwadaso, most other facilities did not provide 24 hour service in the context of having a medical officer, pharmacist/dispenser and laboratory technician physically present and on duty in the facility at all times. At best, most had duty teams who were on duty, living on the hospital compound and called from home when their services were required. Shortage of professional staff was cited as reasons for facilities inability to provide 24 hour service. There was no hospital which had an anaesthetist physically present 24hours in the hospitals because invariably there was only one or being shared between two hospitals (Bryan Hospital Obuasi)

The issue of monitoring and management of clinical adverse incidents are not being taken seriously. This is because there are no systems for dealing with them, for example, not a single hospital was found to keep a register of adverse events.

In general, many of the hospitals do not have emergency wards but have systems for admitting patients into the wards. It appears health providers discourage patients from coming to hospital whenever they like.

CLINICAL RECORDS/REGISTERS

Clinical notes on OPD cards were scanty, very few indicated the diagnosis and treatment although this has improved because of the requirements for insurance. Charts for medication by nurses were well kept but this was not the same for fluids input/output charts. Inpatient notes including theatre notes are still very scanty and these have medico-legal and insurance implications.

Most facilities store adequate and up to date records of patients/clients. Data in most hospitals are kept mainly in hard copy, and a few store them by use of computers. Data are easily retrievable. Health information management is basically the storage and retrieval of data; little use is however made of generated information for managerial decision making.

PROTOCOLS FOR CLINICAL/NURSING CARE

Treatment and diagnostic protocols were available in most facilities but very often not displayed. In the Brong Ahafo Region, most of the facilities have protocols displayed on the facility bulletin boards. In the Methodist Hospital at Wenchi in particular, the protocols were also displayed/posted on various wards. Assin Fosu had protocols in all its service points. Of note was the display of DOTS in almost all facilities. However, the extent to which the protocols are adhered to is questionable.

WARD ROUNDS
Daily ward rounds are held in all the facilities. Additionally, St. Dominic Hospital, Akwatia and St. Martin's Hospitals, Agomenya, undertake grand ward rounds at least once a week. This practice was generally found to be rare in all the other institutions visited. Where it exists, it is irregular and does not include the full complement of personnel required. Some teaching of participating staff is done on rare cases during the ward rounds.

CLINICAL MEETINGS
Clinical meetings are not a regular feature in the facilities. Conferences were mostly on maternal death audits, and rare on clinical issues. The need for clinical meetings cannot be over emphasised as they do not only serve as a clinical tool but are useful as management tools for improving quality of care which every institution aspire to achieve.

UNIVERSAL PRECAUTIONS [HYGIENE & SANITATION]
The observance of universal precautions is good in most of the institutions, except in one region where its observance was found to be inadequate. Most Hospitals visited are generally neat and well kept. Good waste disposal methods such as the use of incinerators were found to be poor. Sustainable improvements are required to make waste disposal acceptable. St. Martin de Porres Hospital, Eikwe has a "Shredding Machine" used for shredding sharps and other medical waste.

While all the hospitals had laundry facilities, disinfection of laundry before washing was not practiced. 50% of the hospitals have laundry machines. All hospitals have sterilization machines for instruments and linen.

ORGANISATION & MANAGEMENT OF OPD
Patient are attended to by doctors in some hospitals, this creates long waiting time when the doctors have to finish ward rounds before coming to the OPD. More hospitals such as Holy Family Hospital, Nkawkaw and St. Dominic Hospital, Akwatia in the Eastern Region are using non-doctors for screening patients at the OPDs, this reduces the work load of the few doctors. This is mainly because of staff shortages; Medical Officers are therefore requested to man Out Patients Department.

Privacy and confidentiality are maintained in the Hospitals assessed. Labelling and directional signs are found in the majority of facilities. Suggestion boxes even though available are not used because most of the clients are illiterate. Information desks are now becoming common in the hospitals assessed as a result of the recommendation of previous PPRHAA, but the information available at these desks are limited mainly directing first time visitors to different parts of the hospital.

PATIENT MEDICATION
All facilities have the National Essential Drug List, although many do not have their own institutional lists. Drugs are also well stocked, and stored by facilities. Most Hospitals have good rational drug use practices. A few though have drugs not stored under an air conditioned environment. Dormaa Presby Hospital was probably the only hospital that had costs of drugs and services displayed publicly for its clients.

Most appraised hospitals have an average number of items per prescription of 2.1 and prescribed drugs with their generic name between 90 to 92 percent. Prescriptions containing antibiotics constitute between 9.3 to 10.9 percent whilst those with injections ranged between 9.3 and 10%. No hospital had tracer drugs out of stock. This is a lot more improvement over the situation last year.

In the Northern Region, antibiotic usage was higher than the other regions. In Akomaa Memorial SDA Hospital, Kortwia-Abodom, and Methodist Hospital, Wenchi, there is a recommendable policy of not giving injection at the OPD. The patients who are sick enough to be given injection are sent to the ward.

DIAGNOSTIC SERVICES
Generally, the institutions offered adequate laboratory and x ray services, and ensured confidentiality of results. Only a few had either no X-ray or non functioning X-ray equipment. A good proportion of hospitals now use ultrasound scanners. There is no evidence that laboratory results were explained to patients by the consulting doctor. 58% of facilities operate blood transfusion services. The cost of laboratory services was not displayed in any of the hospitals. Previous PPRHAA exercises have not significantly increased the number of facilities displaying cost of services.

THEATRE & EMERGENCY CARE
Facilities have well functioning operating theatres, with emergency drugs fairly stocked. Theatre practices were good; a few have recovery wards although ill equipped. Most facilities have no Accident & Emergency Units. Equipment and methods for sterilising are adequate in all facilities.

LABOUR WARD & MATERNITY
Most Hospitals have midwives running a three shift duty. Partographs are generally not used as a routine tool. In the northern sector however staffs require training in life saving skills.

OUTREACH
Outreach services form part of the main Primary Health Care activities of the hospitals and not to provide technical support to clinics and Health Centres around the catchment's area. A few organise specialised outreach services;
Buruli ulcer; Global Evangelical Church Medical Centre, St Martins Agroyesum, Agogo Presby Hospital, Orthopaedics; 5, Eye care: 13 hospitals, Voluntary Counselling & Testing (VCT) 20

REFERRAL SYSTEM

Referrals are made by all facilities, but the support of the National ambulance system is weak and causes delays. Documentation of referrals into and out of the facilities is not always kept and feedback is also scanty. Records were available in Wenchi and Duayaw Nkwanta. There was a general complaint that when they carry patients to Regional/Teaching hospitals they do not get support from the staff of the receiving hospital

B.COMPARATIVE ANALYSIS OF THE OUTPUTS OF CHAG AND GHS 2004/2005

PURPOSE OF ANALYSIS

In previous PPRHAA exercises, the emphasis was in comparing service indicators across hospitals and analysing trends over the years. For this year, analysis was aimed at comparing CHAG and GHS hospitals for advocacy and for identifying low service outputs for strengthening.

Data and Analysis

Service Output data were collected from the following sources:

- Data from CHIM & Human resource data from HRD of the GHS.
- Data from CHAG hospitals during the PPRHAA exercise.
- Population data from the 2000 Population Census

Analysis for the comparison between CHAG and GHS was done for hospitals only and did not include outputs from clinics, health centres and teaching hospitals. National and regional comparisons were made.

The output data from CHIM had a few problems. That from Volta Region was not complete and the Brong-Ahafo data has not been disaggregated by facility, thus making it difficult to sort out the data for hospitals only.

The following indicators were compared for CHAG & GHS:

- Indicators of Coverage
    - OPD Coverage per Capita
    - In-patient Coverage per 1000

- Efficiency Indicators
    - Average length of stay (ALOS)
    - Bed Occupancy Rate (BOR)
    - Recurrent cost per Patient Day Equivalent (PDE). One PDE is defined as one patient-day or 3 OPD attendances.

- Work Load Indicators compared were:
    - Admissions per Doctor per month
    - PDE per Nurse
    - PDE per Staff.

Coverage Indicators

GHS owns about 58% of the total hospitals in the country, followed by CHAG with 33%, quasi-government hospitals own 5%; Private self-financing 3% and the teaching hospital 1%. (Figure 1)

Figure 1: Hospitals by Ownership

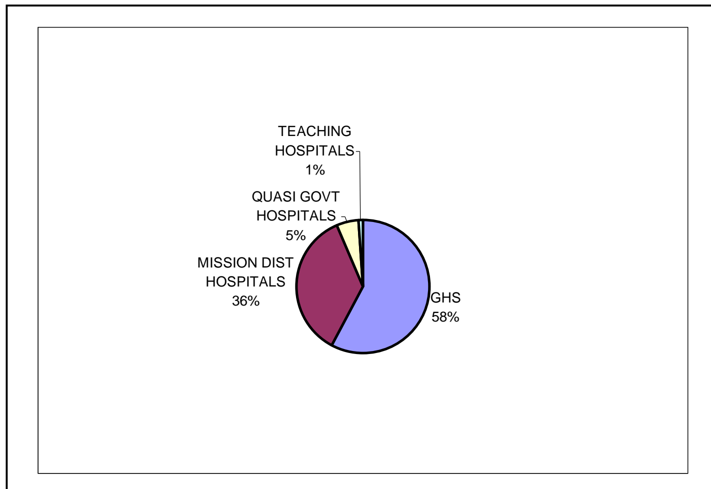
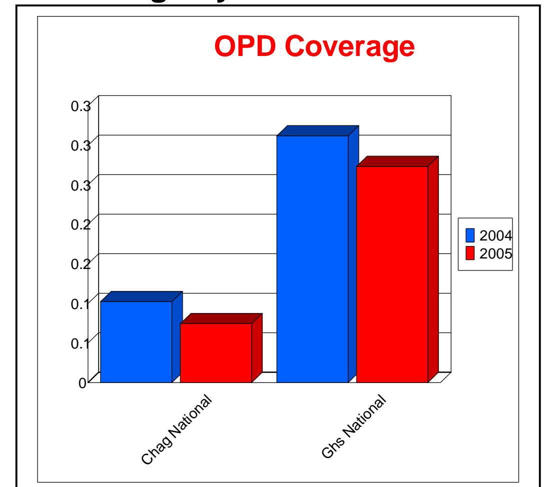


Figure 2: OPD Coverage by

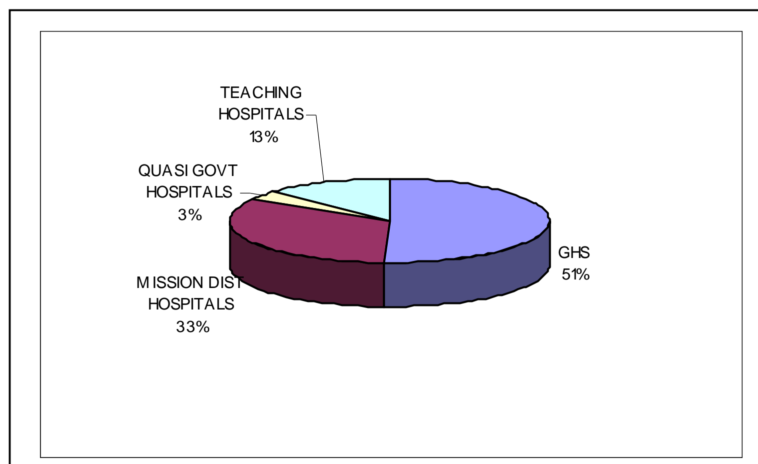


In 2004 and 2005 the national OPD coverage per capita (Figure 2) was 0.10 and 0.07 for CHAG hospitals as compared with 0.31 and 0.27 for GHS. The coverages for CHAG in the years 2004 and 2005 were about 25% of the national OPD coverage by hospitals.

In-patient coverage

_Of all the 17,670 (excluding psychiatric hospitals) hospital beds in the country, CHAG hospital beds form 33% as against 51% for GHS, 3% for quasi-government, Private self-financing ? and 13% for teaching hospitals in 2005. See figure 3.

Figure 3: % of Beds by Ownership (National)



In-patient coverage (Figure 4) for CHAG hospitals were 11.2 and 11.62 for 2004 and 2005 respectively. GHS contributions were 18.62 and 16.88 per 1,000 respectively. CHAG hospitals contributed about 60% of the contribution by GHS at national level. At the regional level, CHAG contributed a little more than half the coverage of the GHS

Figure 4: In-patient Coverage (National)

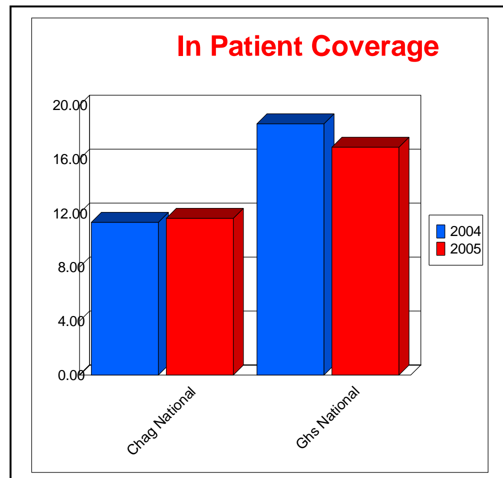
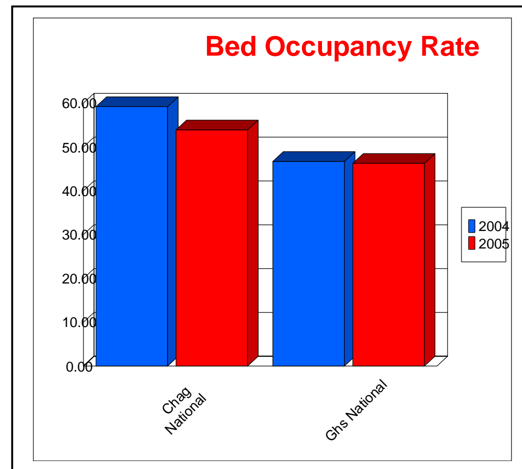


Figure 5: Bed Occupancy Rate (National)



Indicators of Bed use Efficiency

The average Bed Occupancy Rates for both CHAG and GHS declined between 2004 and 2005. In 2004, the bed occupancy rate for CHAG hospitals were 59.2% and 46.7% while in 2005 the figures were 53.89 for CHAG and 46.3% GHS.

Bed occupancy rate for both CHAG and GHS showed a slight decrease in the year 2005 compared to 2004, however CHAG hospitals scored almost 60% and GHS below 50% for the years under review. Both CHAG and GHS on average, do not use hospitals beds optimally (that is, an occupancy of 75%) but the figures indicate that CHAG hospital beds are far better utilized than those of the GHS. See figure 5.

Nationally, CHAG figures are closer to the norm of 5-7 days than those of the GHS. (See figure 6).

The regional picture mirrors the national one except in the northern region where bed occupancy rates are nearly the same for both CHAG and GHS hospitals. See figure 7

Figure 6: Average length of Stay (National)

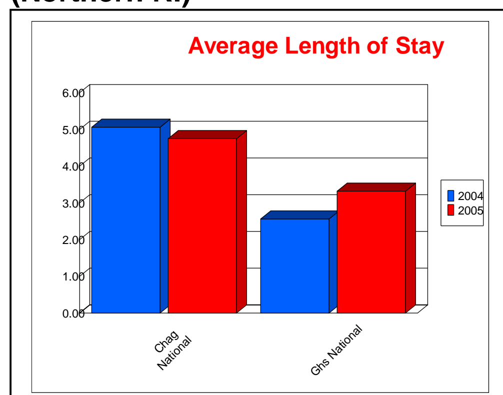
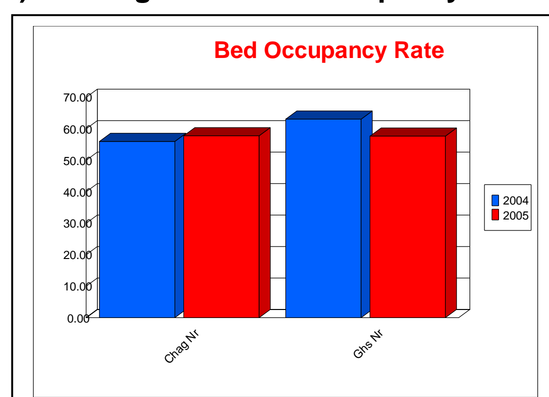


Figure 7: Bed Occupancy Rate (Northern R.)



The following table shows the total numbers of health staff in the country by broad categories and ownership of hospitals

	Doctors		Nurses		Others		Total	
	2004	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**
CHAG	32	80	1331	1418	2873	4602	4236	6100
%	9.4%	18.2 %	20.8%	14.1	29%	38.4 %	25.5%	27.1%
GHS	307	359	5054	8653	7028	7390	12389	16402
%	90.6%	81.8 %	79.2%	85.9 %	71%	61.6 %	74.5%	72.9%
Total	339	439	10071	9901	9901	11992	16,625	22,502

Data Source: GHS Payroll

In 2005, out of the 22,302 persons on the payroll of the Ghana Health Service, 73% worked in the GHS while only 27% are mechanised staff of mission hospitals. CHAG doctors were only 18% of this number while GHS had 82% (figure 8). The distribution of nurses was similarly skewed -14% for CHAG as against 86% for GHS (figure 9). These calculations do not include the staffs that are directly paid by mission institutions but these numbers are very low and insignificant for all categories of staff except doctors.

Figure 8: No. of Doctors by Ownership

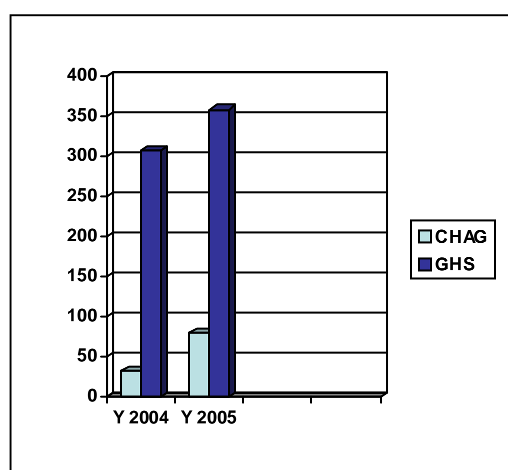
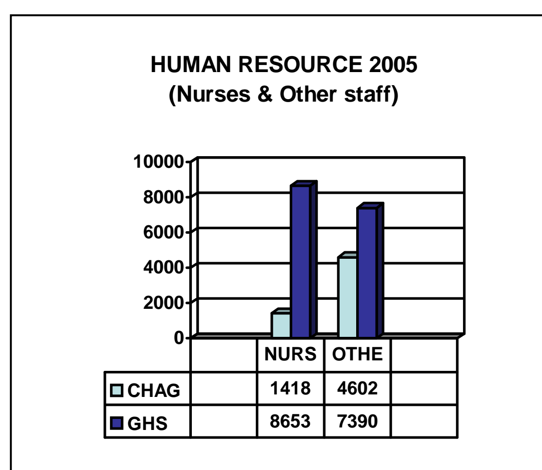
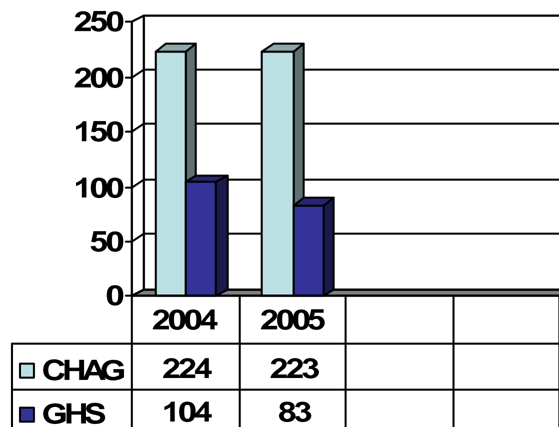


Figure 9: No. of Nurses & Other Staffs



Doctors in mission health facilities have a much heavier load of work (234 and 223 admission per doctor per month for 2004 and 2005 respectively) for CHAG doctors. The workloads for GHS doctors were 104 for 2004 and 83 for 2005. This includes CHAG doctors who are were not on the Government payroll. For the past two years these statistics indicate doctors in CHAG hospitals have 2 times more workload than their counterparts in the GHS (figure 10). **Note:**

Figure 10: Average Monthly Admissions per Doctor



The Patient-Day-Equivalent (PDE) per nurse per day nationally was 3.9 for 2004 and 3.3 in 2005 for CHAG nurses. Those of GHS were 1.7 and 1 for 2004 and 2005 respectively. It appears nurses in CHAG have about 2 times as much work as those in the GHS (see figure 11).

The figures for all other staff are 1.2 (2004) and 1 (2005) in CHAG while in the GHS the figures are 0.7 and 0.5 for 2004 and 2005 (figure12). This is the staff category that contains most of numbers of non-mechanized CHAG staff and is therefore probably over stated for CHAG.

Figure 11: Average PDE per Nurse

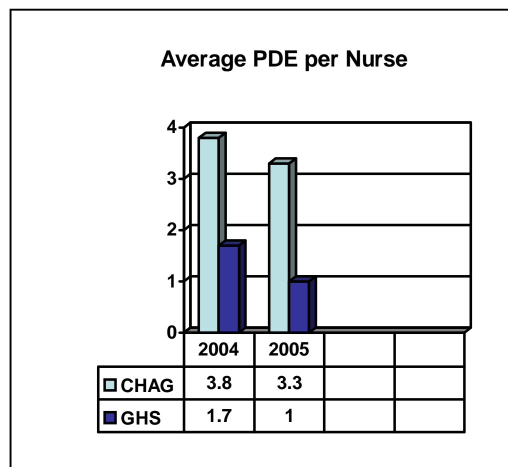
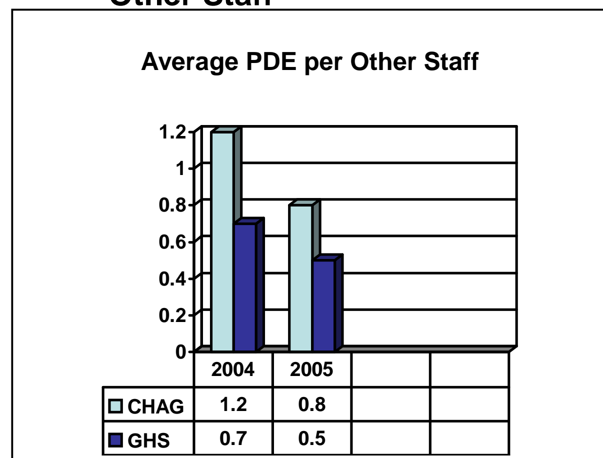


Figure 12: Average PDE per Other Staff



CONCLUSION

The data analysis seems to indicate the following:

- CHAG hospitals make substantial contribution to national health indicators
- Bed use is much higher in CHAG institutions as compared to GHS
- Workload for doctors and nurses is 2 times that of GHS.

C.INTERNAL HOSPITAL MANAGEMENT & EXTERNAL LINKAGES

MANAGEMENT TEAM

All facilities have Management Teams whose composition varied in size and membership depending on church affiliation. Decision making in some cases are made at Hospital Board level but in a few cases the church has direct control. Most of the facilities meet to review plans and targets but others discuss just problems.

HOSPITAL PLANNING & MONITORING

All facilities are involved in the Ministry of Health Budget and Public Expenditure & Management Systems [BPEMS] planning process as well as their regional and/or diocesan budget planning. Even though they are involved, they seem to concentrate on personal emoluments. Written plans and budgets were not found in about half of the facilities. Planning in a few of the hospitals involved other departments. But budget control is centralised to top management.

ORGANISATIONAL STRUCTURE

Organisational structure depends on Church affiliation. Organisational structure is not clear to some staff in few facilities, while command and control is still too strong in the hospitals and evolves around the Heads of the facilities. For example, the team could not get access to information because of the absence of the Head of the facility.
Written and displayed organograms for the hospitals were not very common despite the previous PPRHAA exercise recommendations.

SUPPORT & SUPERVISION AT ALL LEVELS

Systems for support and supervision is generally weak or non-existent and management staff lacked the knowledge and skills to undertake structured supervision and to support the staff improve their performance. For instance none of the facilities appraised could produce a structured supervisory checklist.

AUTHORITY OF MIDDLE LEVEL MANAGERS

Middle level managers lacked the authority to take decisions and to discipline the staffs who are under their supervision. They also have limited level of authority and cannot be held accountable for low outputs and/or poor performance of staff. It is only in the Upper West Region where there are functional sub-BMCs that the mid-level managers are part of the decision-making process and wield some authority in the hospital.

LEADERSHIP

A Few hospitals have specific mission statements suited to their speciality. Visions and missions of facilities are adopted from their Churches. It became clear that managements have not been very strong in promoting their institutional Missions and Visions among their staff. Strategic plans to achieve goals of the Church and the health facilities therefore become blurred and left

undeveloped or unachieved. Dissemination of the strategic plans where they existed was found to be weak among the staff.

COMMUNICATION; JOINT PLANNING & DECISION MAKING

In a few institutions communication between management and staff was found to be poor because there are no clearly defined lines of reporting. In a few of the facilities staffs were reluctant to express their views because of fear of victimization.

Communication between management and staff in most of the institutions was found to be basically through circulars, memos, and staff durbars. Communication between the staff and management was also through Heads of Department meetings. In all Presbyterian and Methodist facilities as well as the Catholic hospital at Damongo there are staff representation on the management team.

CAPACITY BUILDING

In-service training is undertaken in the facilities but these are not usually based on individual staff or facility pressing needs. Staff development plans were non-existent in most facilities. Duayaw Nkwanta and Nkoranza hospitals had well documented staff development plans that were being followed. Staffs are however allowed to participate in training programmes organised by MOH or CHAG and also the Catholic Health Service in the case of Catholic Health Institutions. Staff appraisal systems exist and are generally used for staff promotions but are never based on performance targets set for the year.

HOSPITAL POLICIES & GUIDELINES

All facilities rely on the CHAG/HSWU of TUC Collective Bargaining Agreement but the latest Agreement was found to have lapsed. Most of the facilities have written institutional policies and guidelines. Newly employed staff had little knowledge of the CHAG/HSWU of TUC agreement.

The deferral, discount and exemption payment arrangements are not well developed with clearly defined guidelines and procedures. Patients are not aware of the mechanisms though the very poor are given access to health care services.

DRUG MANAGEMENT

Drug revolving fund/account was mostly part of the general account for the hospital. The Presbyterian and Methodist hospitals as well as Asankragwa and Damongo operate very strict Drug Revolving Fund with the Pharmacists (where available) as major signatories. However, in all facilities drug availability was assured though the inventory control methods were not well developed in some of the facilities.

D.HOSPITAL EXTERNAL LINKAGES & RELATIONS

HEALTH FACILITY PLANNING

Generally, most hospitals are involved in some form of planning both at their own level, as well as the district and regional levels. Community involvement in hospital planning is however very limited.

External linkage with DHMTs and District Assemblies was fast improving since the last review in a number of facilities (e.g. Asankragwa, Kpando, Onwe, Duayaw Nkwanta, Dormaa et al.) though in some of the regions, facility managers were not proactive in exploring the opportunities at the District Assemblies. Most of the hospital managers underestimate their potential to influence and advocate for improvement in services at their facilities.

HEALTH SERVICE LINKS

Primary Health Care services are offered by almost all the Hospitals. They also provide immunization on routine basis and take part in the National Immunization exercises. Several of the facilities receive personnel on posting from the Ministry of Health. A few have links with institutions and partners overseas from where they receive nursing and medical students for Tropical orientation. Others receive qualified personnel who come to assist for short periods from the same sources.

REFERRAL SYSTEMS

Although all facilities make referrals to other institutions, there are no clear guidelines, and the mechanism for feedback is also virtually non existent. Not all the hospitals have ambulances for referrals and thus use public transport, a situation which does not auger well for the safety of the patients.

DEFERRALS AND EXEMPTIONS

Almost all hospitals have stopped implementing the government exemption services for non payment. Institutional arrangements, although not properly defined, exist for deferring and/or exempting patients who cannot settle their bills. Nalerigu has a unique system where patients who cannot pay for services could be requested to “work and pay” for these services. Dormaa Presby Hospital has put in place a scheme to identify paupers in her catchment area so as to pay their premiums to the Insurance Schemes to save the hospital the troubles of unpaid bills when they seek services. A few have social workers who assist in determining paupers and retrieving unpaid bills.

LINKAGES AND ACCOUNTABILITY TO COMMUNITIES

There are no mechanisms in place to ensure accountability to the communities on services rendered, even though the communities are major stakeholders of the facilities. However, in some facilities suggestion boxes placed at vantage service points are rarely used and their impact on services as well as management decision making remains unclear.

INTERSECTORAL COLLABORATION

Except for one region, there is, to a varying degree, collaboration between facilities and other sectors. Several have very good relations with their District Health Directorates [DHA], Ghana Water Company, Ghana Education Service [GES] etc. Some have links to Non Governmental Organisations [NGO] within and outside the country.

E.EQUIPMENT AND INFRASTRUCTURE

Wards Equipment and Furniture

Most wards in all facilities visited have adequate furniture and beds with clean sheets in terms of quality and quantity. Mosquito nettings on windows and doors were universal, in addition treated bed nets were provided in some of the pediatric and maternity wards. Facilities appraised in one of the regions had old and weak equipment that need replacement. Both St. Elizabeth at Hwidiem and Battor Catholic Hospital have installed Oxygen flow meters in all the wards.

Clinical Support Service Equipments and furniture

All facilities visited had adequate equipment and furniture at the OPD, laboratory, and the dispensary which are functioning. While six facilities had modern theatres and x-ray departments, twenty five facilities do not provide theatre and x-ray services. Two facilities have more comfortable seats at their OPD. Most facilities had modern theatre equipment while five had old surgical equipment that need urgent replacement.

Other Support service equipment & Furniture

Thirty facilities provide adequate and satisfactory mechanized laundry and transport services. Twenty facilities provide adequate refrigerated mortuary services while the others had no mortuaries but provided transit rooms for corpses. Most facilities practice good safety precautions but the disposal of biological wastes were not satisfactory for lack of incinerators. Some of the facilities visited did not have maintenance staff at all and where available some lacked the capacity to repair medical equipment and hence there is over reliance on hired technical hands from outside.

Hospital Buildings, Staff Accommodation and Plant

In all the hospitals, buildings were generally available and adequate for their basic service delivery. Whilst five had adequate staff accommodation a few do not have at all whilst others provided rented houses to staff. Generally the state of repairs, security and upkeep of the buildings are quite good. Twenty of the hospitals visited had bigger standby generators; fourteen facilities had none while twenty three hospitals had smaller generators.

The water system in the wards and the residential areas was good. The system is mostly supported by water pumped to reservoirs for distribution. Some have adopted waste disposal methods like the use of incinerators and central refuse collection to keep the environment clean. Some facilities dump their refuse in dug out holes which are well covered but a few use shallow pits.

Maintenance of Equipment and Building

A few of the hospitals visited have functioning maintenance departments with qualified technical staff and yet a lot more facilities either do not have these departments or lack qualified staff to run them.

Most facilities visited have no maintenance plan budgets. The Presby and Catholic institutions have mobile maintenance teams which visit sister facilities to service their equipment.

Capital Funding

Most facilities seek assistance from Donors for the purchasing of equipment and starting new projects to complement local and government efforts. In recent times government supports have covered construction of new buildings under its investment budget while others have received vehicles and computers.

F.FINANCE & ACCOUNTING

Planning and Budgeting

In all the hospitals visited thirty six budgets are prepared with inputs from lower level managers and are generally linked to the MOH composite budgeting process. Apart from the BPEMS a few of the facilities do not have activity based budgets. The delay in the refund from the Insurance Schemes was found to be hampering the smooth running of the hospitals. It also became clear that the implementation of all other exemption schemes have been suspended due to non-refund.

Most of the facilities do not have strategic plans even though they actively participate in the annual MOH/CHAG planning and budgeting meetings.

Financial Reporting and Monitoring

In thirty two facilities financial statement are prepared on quarterly basis. These are discussed at management level and at board or Diocesan levels. Statements are compared to budgets for monitoring expenditure. Reconciliations are prepared on monthly basis except some facilities that do not prepare financial statements and have no independent bank accounts. All facilities visited prepare regular Donor Pooled Fund returns.

Accounting system and procedures

Twenty six facilities visited use accounting manuals which are mostly the MoH Accounting Treasury and Financial Regulations (ATF) and Church Accounting Policy guidelines. Some use computerized accounting Software like ACCPAC and SUN. In addition three have networked all the departments to a server, i.e. SDA Hospital Kwadaso, Holy Family Hospital, Nkawkaw and St Elizabeth Hospital, Hwidiem. The necessary ledgers are in use and bank reconciliation statements are prepared regularly. Except for a few facilities that do not have standard accounting manuals in place, all other facilities follow laid down accounting procedures in preparing their books.

Staff Capacity

The staff strengths in the account departments vary from hospital to hospital. Their qualifications range from University degree, CA, ACCA to HND. Almost all the revenue collectors are trained on the job. Most accounting staff are not computer literate and there would be the need for training in this direction, as was highlighted in last year's report.

Financial Checks and Controls

In all facilities standard financial safeguards and procedures are followed with checks and controls by management. Value books are kept under lock and key varying from proper safes to desk drawers. All facilities have external auditors visiting every year and none have internal audit departments, a situation which has not changed since the last exercise. There are periodic checks from the churches controlling offices. All facilities operate bank accounts except two.

Internally generated funds

Out of the fifty seven facilities visited fifty were able to meet their revenue targets. Low revenue generation was common to hospitals with no doctors at OPD. Supervision and control of funds was found to be very good. Some few hospitals have entered into other activities to increase their revenue, such as the production of Sachet water (Dormaa Presby Hospital) and hiring of plastic chairs (St John of God Hospital, Duayaw Nkwanta).

Budget and use of Internally Generated Revenue

In all the facilities visited, there is adequate authorization of expenditure. Revenue generation and expenditure guidelines include MTEF/BPEMS budgeting systems and other policy guidelines on expenditure. Budgetary allocation is generally according to priorities of the facilities and in all cases of disbursement, evidence of approval and validation exists. The high priorities of expenditure are on drugs and consumables

Stores and Purchasing

Thirty hospitals had purchasing committees many of which were not functional. In twenty eight others the accountant doubles as the purchasing officer.

Most stores in the facilities are well organized with stock levels monitored. Twenty had assets registers; fifty had inventory of assets while ten had not labeled their assets.

G. CLIENT AND COMMUNITY VIEWS

Waiting Time

The community members interviewed in some of the sites felt that waiting time at the OPDs were short and there were no long queues for drugs at the dispensary. (*This is an improvement over last years when 6 out of the 10 were judged as long waiting hospitals)* However, there were some complaints that the NHIS has increased the waiting time by virtue of the numerous documentations associated with the scheme. Clients and relatives said hospital staff are quite friendly and willing to guide them around the facility for the services they required. Some clients were satisfied with the visiting hours while others could not understand why there should be restrictions on when they can see their relatives on admission.

Costs and Affordability

Generally clients said, cost of services were high especially for inpatient services. *(Same as last year)* They admitted that the National Health Insurance Scheme could reduce the burden on them. They wanted facilities to reduce the costs and display prices of drugs and services at various points in the hospitals.

Information Provided

Clients said they got adequate information from staff including scheduled days for some special services, and reviews. Information on pharmaceuticals including side effects was usually lacking. Price lists were not displayed (except Dormaa) and clients did not understand the charging system. Many clients were not aware of schemes to support the needy but some hospitals allowed payment of hospital bills by installment with a guarantor. (*These have not changed)*

Community Participation

Most of the interviewees were not aware of any representation of the community on hospital management. Most communities receive no feedback even if there is a community representative. Clients in all the facilities said they had no means of influencing the affairs of the hospital but a few hospitals had suggestion boxes at vantage points. (*Not much change from last year).* Most communities have no health committees or any structures for discussing health issues except at Ankaase. Some hospitals have “open days” when they interact with the communities but this is infrequent. Damongo community organizes clean up campaigns from time to time in the hospital.

Privacy and Confidentiality
Clients were generally satisfied with privacy in the consulting rooms because one patient is seen at a time but not happy with the confidentiality at the history taking desk at the OPD. Some community members felt that the presence of the consulting room nurse did not give them the assurance of confidentiality.

Satisfaction with Care and Accountability
The community was generally satisfied with the services provided by the hospitals. Drugs were generally available except in a few facilities where patients had to buy their drugs outside the hospital which in some cases tend to be fake or expired drugs.

Staff Attitudes and Behaviour
While some communities were generally satisfied with the attitude and behavior of staff, others felt the Ward Assistants and some Maternity staff were disrespectful towards clients at the hospitals. They also had problems with non health staff especially the security personnel.

Barriers to Access
According to the community members, lack of money to pay for services was a barrier. They also complained that in some hospitals staff exhibited favoritism based on religious affiliation and social class when handling patients at the OPD. Distance and availability of transport from the community to the hospital was barrier in some places. *(No change)*

Environment and Hygiene
The hospitals were generally clean. Toilets were clean but inadequate in some OPDs. The hospital floors were mopped regularly with water and disinfectants. The grasses around the hospitals were mowed regularly. The community was however not satisfied with waste disposal in most of the hospitals, especially where they had no incinerators.

Overall Satisfaction with care and accountability;
Overall the communities and clients were satisfied with the services of the hospitals.

H.SITES FOR GOOD/BEST PRACTICE

Good/Best Practice	Site/Institution
Display of protocols at all levels of service delivery	Methodist Hospital, Wenchi
Grand Ward Rounds	St. Dominic's Hospital, AkwatiaSt. Martin's Hospital, Agomenya
Shredding equipment for some medical waste	St. Martin de Porres Hospital, Eikwe
Staff representatives on management	Presby and Methodist Hospitals
Well documented staff development plan	Duayaw Nkwanta and Nkoranza
Revolving Drug Fund	Presby & Methodist hospitals, Damongo & Asankragwa Catho
Well displayed directional signs	Methodist Hospital
Specific institutional mission statements	Duayaw Nkwanta, Dodze
Payment of premiums for declared paupers to avoid unpaid bills	Dormaa Presby Hospital
Networked accounting system	St Elizabeth- Hwidiem, Holy Family – Nkawkaw, SDA Hospital – Kwadaso,
Sustainable ambulance Services	SDA Hospital – Kwadaso
Cost of services and drugs displayed	Presbyterian Hospital Dormaa
Alternative revenue generation	Sachet water- Dormaa, Presby,Hiring of plastic chairs – St Elizabeth, Hwidiem

I. RECOMMENDATIONS

PATIENT CARE & MANAGEMENT

- Hospitals should strive to have standardised diagnosis and treatment protocols and adhere to them, this ensures quality of care throughout CHAG facilities. We recommend the MOH/GHS treatment guidelines be used.
- Grand ward rounds and clinical review meetings should be cultivated as a practice and used as a medium for staff education on particular cases and effective patient care. e.g. it is unacceptable to have maternal deaths not audited
- Facilities should adhere to plans prepared for staff in service training programmes as a means to enhance capacity building
- Monitoring and management of clinical adverse incidents should be instituted in all hospitals with registers to record all events. This is necessary in this era of health insurance and frequent litigations.
- Clinicians should be encouraged to write detail notes, case history, findings, operation notes, diagnosis, treatment etc, these will facilitate reviews should the need arise.

SERVICE OUTPUT

The data analysis seems to indicate that CHAG hospitals make substantial contribution to national health indicators. The data should be used by CHAG for advocacy and MOH/GHS should consider them when making resource allocation.

INTERNAL HOSPITAL MANAGEMENT & EXTERNAL LINKAGES

- CHAG should increase the role of local staff unions such as GRNA and TUC in educating and disseminating information on Hospital policies.
- CHAG hospitals should institutionalise the development of work plans and their implementation as a key medium for monitoring progress.
- Facilities should be encouraged to institute and/or strengthen Drug Revolving Funds

HOSPITAL EXTERNAL LINKAGES & RELATIONS

- Institutions should actively participate in the education of the public on the need to register with local Health Insurance Schemes
- CHAG health facilities should develop ways of involving communities they serve in their activities

HOSPITAL EQUIPMENT AND INFRASTRUCTURE

- CHAG facilities should endeavour to improve the disposal of biological waste by building incinerators.
- Planned preventive maintenance (PPM) should be budgeted and maintenance units established in all hospitals.

CLIENT and Community Views

- It is recommended that cost of services and the modalities for costing should be displayed in all facilities. This will forestall the common perception of clients of the cost of services and drugs being too high.
- Confidentiality of patient information should be reinforces through staff education and enforcement of rules and regulations on oaths of secrecy.
- It is recommended that the hospitals review their policies and include community representation on Advisory Boards of the hospitals. It will also be necessary to establish regular durbars with the communities to exchange views on hospital and health issues.

J. THE WAY FORWARD

The DANIDA support to this program would soon come to an end. For the annual appraisals, which member institutions find useful to continue, the following are some of the decisions that have to be made:

1. CHAG has to budget for the annual appraisal since the appraisal report forms a useful background document for the annual health national health sector review done by MOH and partners.
2. Each hospital could also form a PPRHAA team which can perform internal appraisal within their own hospital. The teams could also exchange hospitals each year and appraise other hospitals
3. Another option is for participating hospitals to contribute to the cost of the annual appraisal. Cost can be minimized through regional PPRHAAs.
4. It has also been suggested that PPRHAA be done by denominations but that seems to be a more expensive option because of the spread of some denomination hospitals such as those of the Catholics and the Presbys.

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Annex :List of Hospitals Appraised

	Ashanti Zone A
1	Seventh-Day Adventist Hospital, Asamang
2	Seventh-Day Adventist Hospital, Wiamoasi-Ashanti
3	Global Evangelical Hospital
4	Methodist Faith Healing Hospital, Ankaase
5	Seventh-Day Adventist Hospital, Kwadaso-Kumasi
6	St. Patrick's Hospital, Maase-Ofinso
7	St. Luke's Hospital, Kasei
8	Mathias Hospital, Yeji
9	Janie Speaks AME. Hospital, Afrancho
	Ashanti Zone B
1	Akormaaa Memorial SDA Hospital, Kortwia-Abodom
2	Bryant Hospital, Obuasi-Adansi
3	St. Peter's Hospital, Jacobu
4	St. Louis Gen. Hospital, Bodwesango
5	St. Martin's Hospital, Agroyesum
6	Seventh-Day Adventist Hospital, Dominase
7	Seventh-Day Adventist Hospital, Onwe
8	Presbyterian Hospital, Agogo, Ashanti-Akim
9	St. Patrick's Hospital, Maase-Ofinso
	Brong Ahafo Zone
1	St John of God Hospital
2	Holy Family Hospital, Techiman
3	Holy Family Hospital, Berekum
4	Hwidiem (St Elizabeth’s Hospital)
5	St Theresa’s Hospital, Nkoranza
6	Wenchi (Methodist Hospital)
7	Presby hospital, Dormaa Ahenkro
8	Drobo (St Mary’s Hospital)
	Central & Western Regions
1	Nagel Memorial Clinic, Takoradi
2	St. Martin de Porres Hospital, Eikwe
3	Fr. Thomas Alan Rooney Mem. Hospital,
4	St. John of God, Sefwi Asafo
5	St. Francis Xavier Hospital, Assin Fosu
7	Our Lady of Grace Hospital, Bremen Asikuma
8	Apam Catholic Hospital
9	Fr. Thomas Rooney Memo. Hosp., Asankragwa
	Volta/ Zone:
1	Anfoega Catholic Hospital, Anfoega
2	Catholic Hospital, Battor, Bator
3	Margaret Marquart Cath. Hosp, Kpando
4	Mary Theresa Hospital, Dodi-Papase

5	Sacred Heart Hospital, Weme-Abor
6	St. Anthony Hospital, Dzodze
7	St. Joseph's Hospital, Nkwanta
	Northern Zone
1	Baptist Medical Centre, Nalerigu
2	Catholic Hospital, Binde
3	Saboba Medical Centre, Saboba
4	Seventh-Day Adventist Hospital, Tamale.
5	West Gonja Hospital, Damango
6	Presbyterian Hospital, Bawku
7	Catholic Hospital, Nandom
8	St. Joseph's Hospital, Jirapa
	Eastern /Greater Accra Zone
1	Salvation Army Clinic, Begoro
2	Alpha Medical Centre, Madina
3	Manna Mission Hosp, Teshie-Nungua
4	Holy Family Hospital, Nkawkaw
5	Presbyterian Hospital, Donkorkrom
6	St. Dominic's Hospital, Akwatia
7	St. Joseph's Hospital, Koforidua
8	St. Martin's Hospital, Agomanya
57	**Total Hospitals Appraised**