Ghana Harmonized Health Facility Assessment 2022-2023

Snapshot 6

Management and governance

July 2023

Table of contents

Introduction

Health systems strengthening in Ghana

The government of Ghana strives to strengthen and improve health care delivery and ensure equitable access to quality basic health care for the population. Ghana's "National Health Policy: Achieving Universal Health Coverage (UHC) (2019-2030)" and "The UHC Roadmap (2020 – 2030)" both emphasize equitable access to quality primary care services for the population. Primary Health Care (PHC) is the foundation of the country's UHC Roadmap, which aims to improve the delivery and quality of primary health care services, with a focus on improving access to essential services for the poor and vulnerable while protecting households from the risk of impoverishment due to out-of-pocket spending on health care.

Over the years, data from the health and other sectors have been used to measure the availability and access to health care, and the health status of Ghanaians. The typical sources of data include routine health management information systems, civil registration and vital statistics, health system data, rapid health facility assessments, household surveys and censuses. The data from these sources have informed policy decisions and interventions to further strengthen health delivery. Nonetheless, there is still a need for innovative methods of data collection to provide more comprehensive data to assess health service delivery inputs and outputs in Ghana.

Health facility assessment is often used to generate information on service availability, readiness and quality of care. Ghana has conducted three landmark assessments of its primary healthcare system (Vital Signs Profile Assessment, 2018; Community Health Planning and Services (CHPS) Verification Survey, 2018; and EmONC survey, 2020). The data from these surveys provided valuable information on the status of health facilities in the country. However, these assessments were not comprehensive enough (in terms of coverage and content) to inform - ongoing innovations in healthcare delivery such as the Networks of Practice (NoPs). As the government rolls out NoPs, it is necessary to put systems in place to collect, analyse and use data for decision-making across levels of the health sector. A comprehensive service availability and readiness survey at all levels of health delivery in the country will help determine the status of health facilities and identify gaps in service availability and readiness in the country for improvement.

The Harmonized Health Facility Assessment

In 2022, Ghana adopted the WHO Harmonized Health Facility Assessment (HHFA), which provides an approach for conducting a comprehensive assessment of health service availability, readiness and quality of care to further strengthen its efforts towards achieving UHC. The HHFA is a comprehensive, standardised health facility survey that provides reliable and objective information on the availability of health services and the capacities of facilities to deliver the services at the required standards of quality.

Availability and quality of health services are integral to achieving UHC and the health-related Sustainable Development Goals (SDGs). HHFA data can support health sector reviews and evidence-based decision-making for strengthening country health services. The HHFA builds on previous and existing global facility survey instruments and uses standardised indicators, questionnaires, data collection methodologies and data analysis tools through multi-stakeholder collaboration.

The HHFA covers all key facility services and facility-level management systems. Its content is organised into four modules: service availability; service readiness; quality of care; and management and finance. Each HHFA module includes a set of stand-alone questionnaires that may be designated Core, Core + Additional and/or Supplementary. The combined questionnaire contains questions from multiple modules, integrated and organised to facilitate data collection. The questionnaire was adapted to the country's needs.

Methodology

Study design

The Ghana HHFA is the collective effort of a multi-partner group that has included The Global Fund, The World Bank, USAID, GAVI, PEPFAR/CDC, UNICEF, UNFPA, UN MDG Health Envoy and WHO. The data collection methodology used for this HHFA was a facility audit with key informants and observation for availability, readiness, management and finance. As part of this harmonized approach, efforts were made to bring together existing indicators with a standard set of indicator definitions, questionnaires and recommended assessment/measurement methods. For this assessment, the HHFA questions were organized into three main topic areas: service availability, service readiness, and management and finance.

The HHFA was a cross-sectional survey and covered all regions and health facility levels in Ghana, using a sampling frame of 9,505 facilities listed in the DHIMS database. The latest WHO HHFA tool was used to ensure the deployment of a standardized and tested tool. Ghana implemented the availability, readiness, management and finance modules using the facility audit methodology. These modules were used to collect information on the physical presence of facilities, resources, services, capacity to provide specific services, and management practices to support continuous service availability and quality. Data collection used interviews and observations as required in the specific modules of the questionnaire.

Sampling

The survey population encompassed all approved/licensed health facilities across Ghana, both government (fully or partly), faith-based and privately owned, including secondary and primary hospitals, health centres, polyclinics, clinics, maternity homes, and CHPS compounds. The sampling methodology prescribed by the HHFA protocol was adapted to arrive at the survey sample and involved both purposive and random sampling procedures. All designated regional and district hospitals and polyclinics were purposively included. The remaining facilities (other general hospitals, health centres, clinics, maternity homes, and CHPS) were randomly sampled. A total of 1,487 facilities were included in the sample, out of which 1,421 facilities were successfully interviewed and included in the analysis. Table 1 shows the distribution of the final 1,421 interviewed facilities by region and facility type.

Table 1. Distribution of interviewed facilities by region and facility type

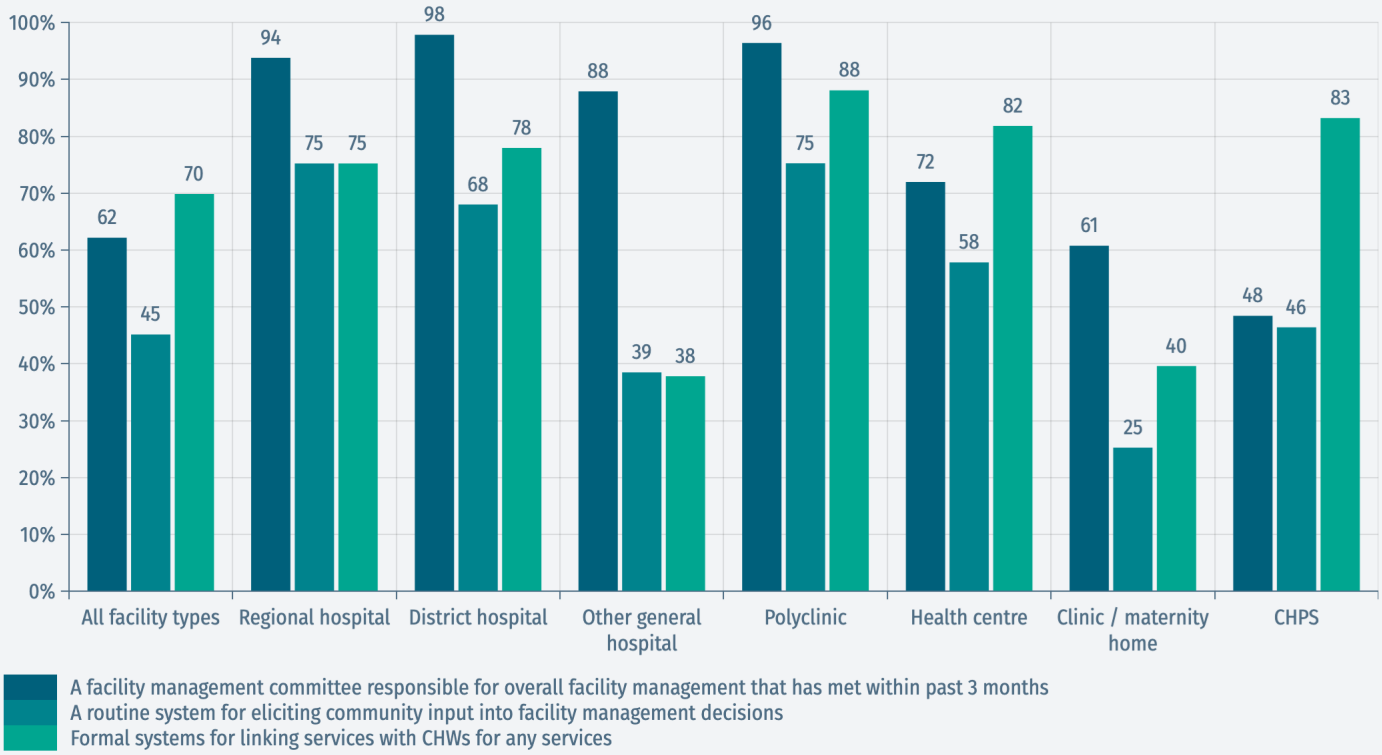
	Regional hospital	District hospital	Other general hospital	Polyclinic	Health centre	Maternity home	Clinic	CHPS	Total
Ahafo	1	6	1	0	7	1	5	5	26
Ashanti	1	27	18	8	54	18	30	17	173
Bono	1	12	4	1	31	3	9	11	72
Bono East	1	4	13	1	23	1	4	11	58
Central	1	11	11	14	28	8	21	34	128
Eastern	1	18	15	2	41	1	15	57	150
Greater Accra	1	11	33	23	23	25	83	6	205
North East	1	2	1	1	13	0	3	9	30
Northern	1	8	13	3	25	1	10	26	87
Oti	1	5	2	1	20	0	2	14	45
Savannah	1	4	2	3	15	0	3	12	40
Upper East	1	6	12	0	24	1	6	27	77
Upper West	1	6	6	5	27	2	3	28	78
Volta	1	9	15	3	37	2	9	21	97
Western	1	5	12	0	24	6	23	31	102
Western North	1	4	5	0	12	3	9	19	53
Total	16	138	163	65	404	72	235	328	1421

Key findings

- A majority of facilities (62%) had a management committee responsible for overall facility management.
- Routine systems for eliciting community input in facility management decisions are uncommon, with only 45% of facilities having such systems. However, 7 out of 10 facilities had in place formal systems for linking services with CHWs (except in other general hospitals and clinics/maternity homes).
- About a quarter of the facilities surveyed (23%) had an annual budgeted work plan.
- Over 90% of regional hospitals, district hospitals and polyclinics had received an external financial audit.
- Most facilities charged user fees for any OPD services. However, these user fees or the written guidelines for user fees were not visibly posted in most facilities.
- Overall, one out of ten facilities (11%) had a written fire safety plan. Three out of ten facilities had a strategy to meet staffing needs in an emergency. Availability of emergency preparedness systems is more common in hospitals and polyclinics than the lower level facilities.
- On average, 29% of facilities have a system and guidelines to monitor adverse events (ranging from 33% in other general hospitals to 57% in regional hospitals). Systems and guidelines to monitor nosocomial infections are less common (17%), ranging from 19% in polyclinics to 50% in regional hospitals.
- Nationally, management systems for IPC were absent in most of the facilities surveyed; national scores were below 30% for each of the IPC indicators.
- At least half of the facilities had external assessment against standards except for the NEQA certification system for any services.
- Nationally, 54% of facilities reported having a routine quality assurance process for any service area.
- Sixteen percent of facilities had an established routine external quality assessment mechanism for at least one laboratory test. This was mostly reported by the hospitals, especially regional hospitals (74%) and district hospitals (68%).
- Majority of facilities (74%) have a routine system for checking the quality of data compiled for reports, but only 17% of facilities had a written policy for data quality checking.
- Most facilities assessed had unique patient identifiers for curative OPD services and individual patient records for outpatients. However, 82% of facilities (especially CHPS, clinics/maternity homes and health centres) use only standardized paper individual patient records for outpatients. Four out of ten facilities (hospitals and clinics/maternity homes) used only standardized electronic individual patient records for outpatients.
- At least 9 out of 10 facilities had unique identifiers and individual patient records for inpatient and individual patient records for all categories of facilities. The use of paper individual patient records for inpatients was non-existent in the regional hospitals but very high (100%) at the CHPS level.

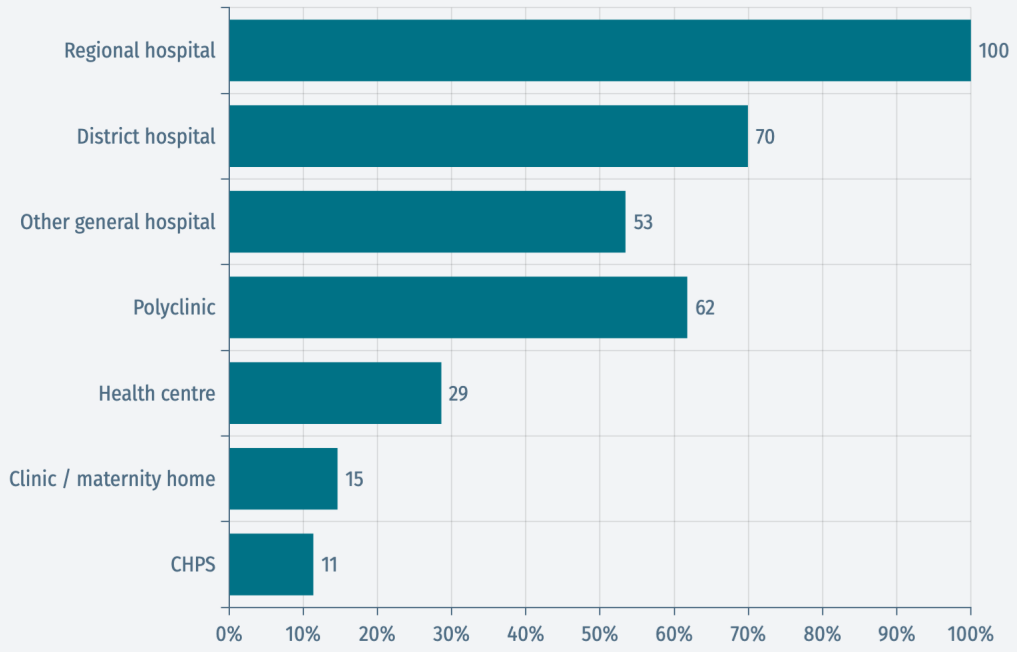
Management and governance

Figure 1. Percentage of facilities with management and governance



A majority of facilities (62%) had a management committee responsible for overall facility management. Such management committees were less common in clinics/maternity homes and CHPS. Routine systems for eliciting community input in facility management decisions are uncommon, with only 45% of facilities having such systems. However, 7 out of 10 facilities had in place formal systems for linking services with CHWs (except in other general hospitals and clinics/maternity homes.

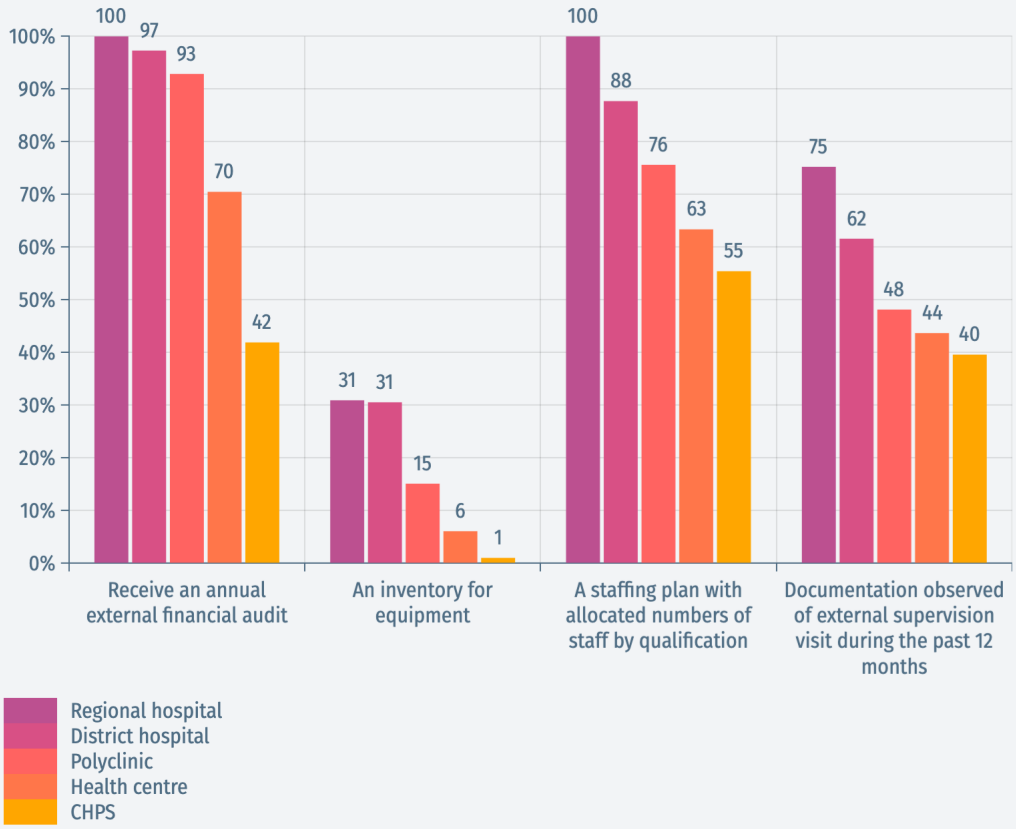
Figure 2. Percentage of facilities with budgeted annual work plan for current financial year



About a quarter of the facilities surveyed (23%) had an annual budgeted work plan. All regional hospitals had an annual budgeted work plan. However most lower level facilities such as health centres, clinic/ maternity homes and CHPS did not have annual budgeted work plans.

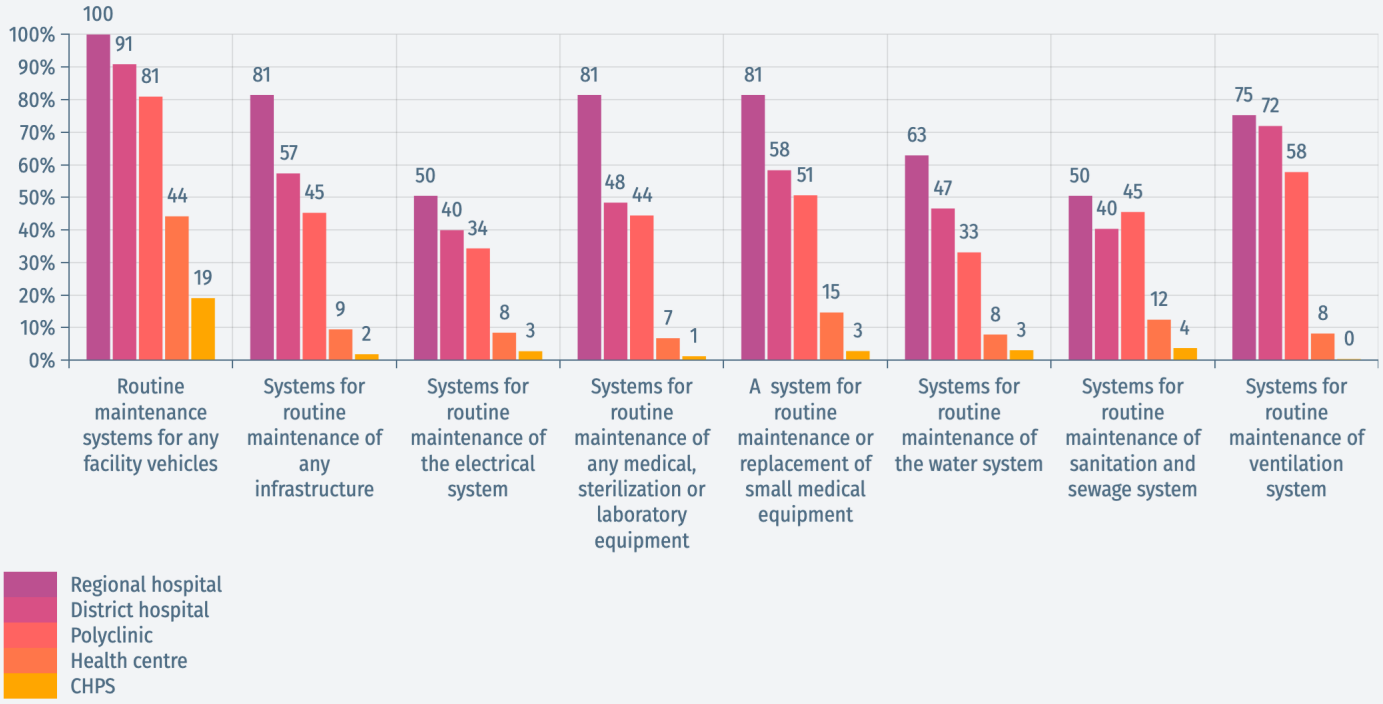
Over 90% of regional hospitals, district hospitals and polyclinics had received an external financial audit. About two-thirds of all facilities (65%) had a staffing plan with allocated numbers of staff. However, equipment inventory was not available in most facilities. Similarly, majority of facilities did not have any documentation of external supervision visits during the past 12 months.

Figure 3. Percentage of facilities reporting they do financial audit



Infrastructure maintenance

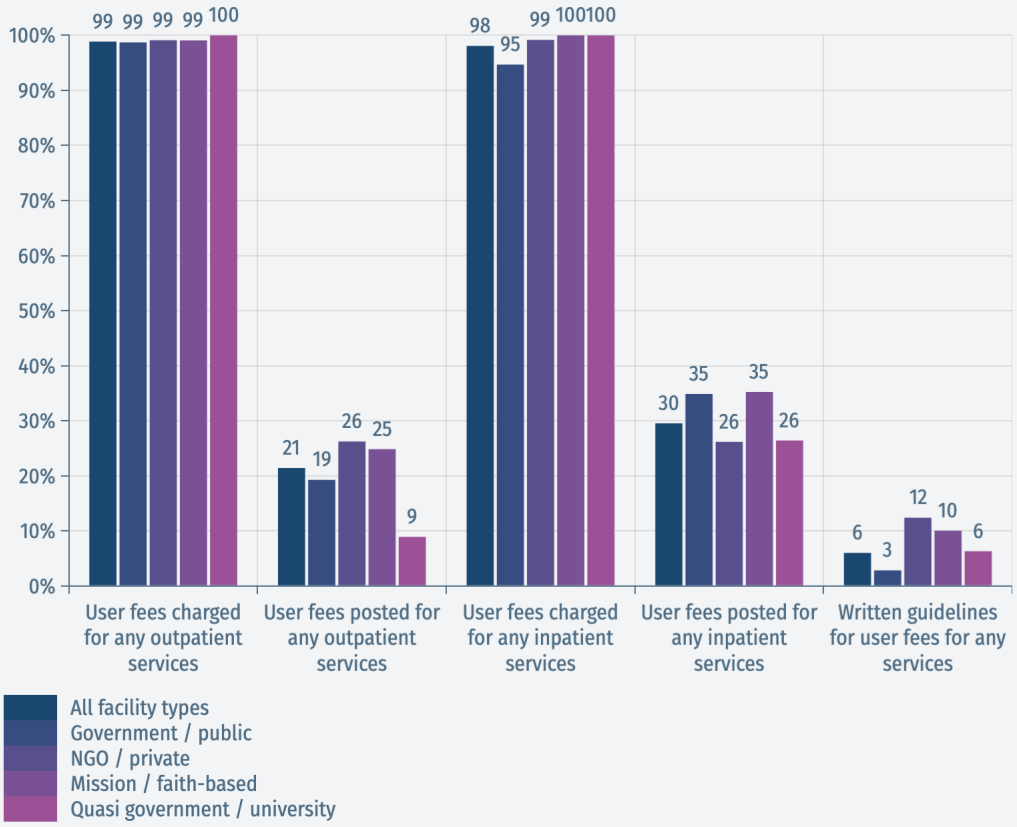
Figure 4. Percentage of facilities with routine maintenance systems for infrastructure and vehicles and equipment



Slightly more than half of the facilities surveyed (55%) had routine maintenance systems for facility vehicles. Such maintenance systems are more common in hospitals and polyclinics. Other maintenance systems appear to be rare (21% or lower nationally) and tend to be found in hospitals and polyclinics.

User fees

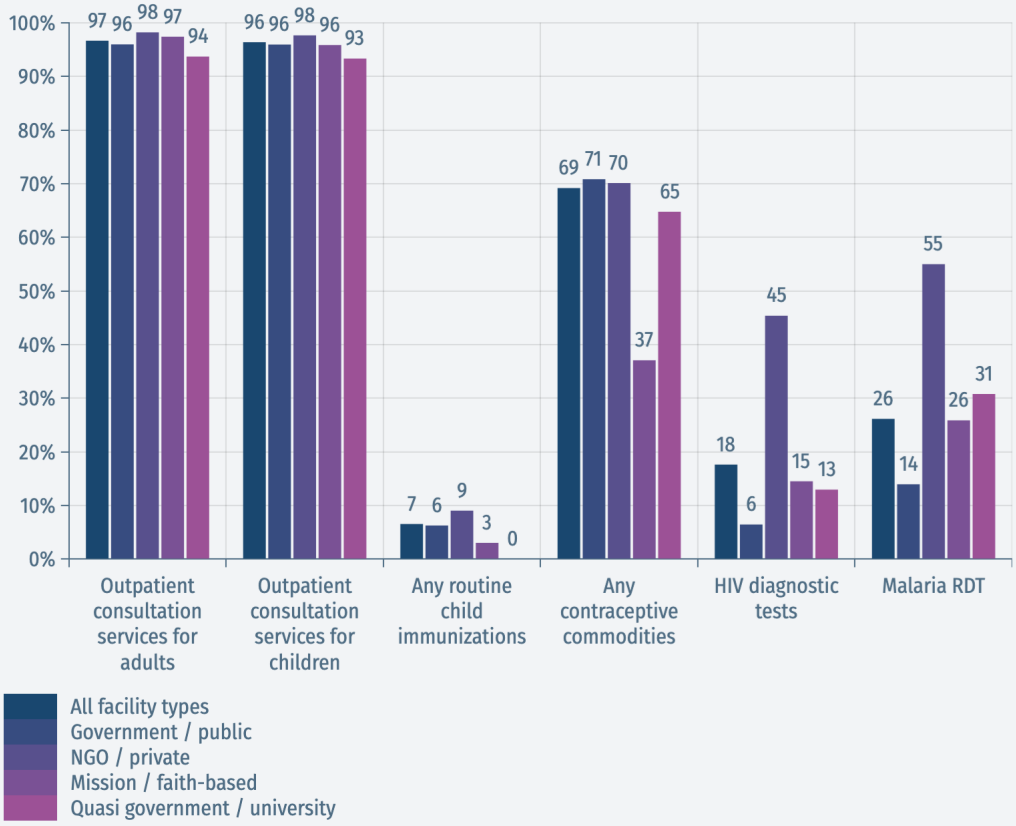
Figure 5. Percentage of facilities with user fees



Most facilities charged user fees for any OPD services. However, these user fees or the written guidelines for user fees were not visibly posted in most facilities. Similarly, almost all health facilities charged user fees for inpatient services. Less than ten percent (6%) of facilities had any written guidelines for user fees for any services.

User fees charges were mainly on OPD consultation services for adults and children and contraceptive commodities. Charges for child immunisation services and HIV diagnostics were less common.

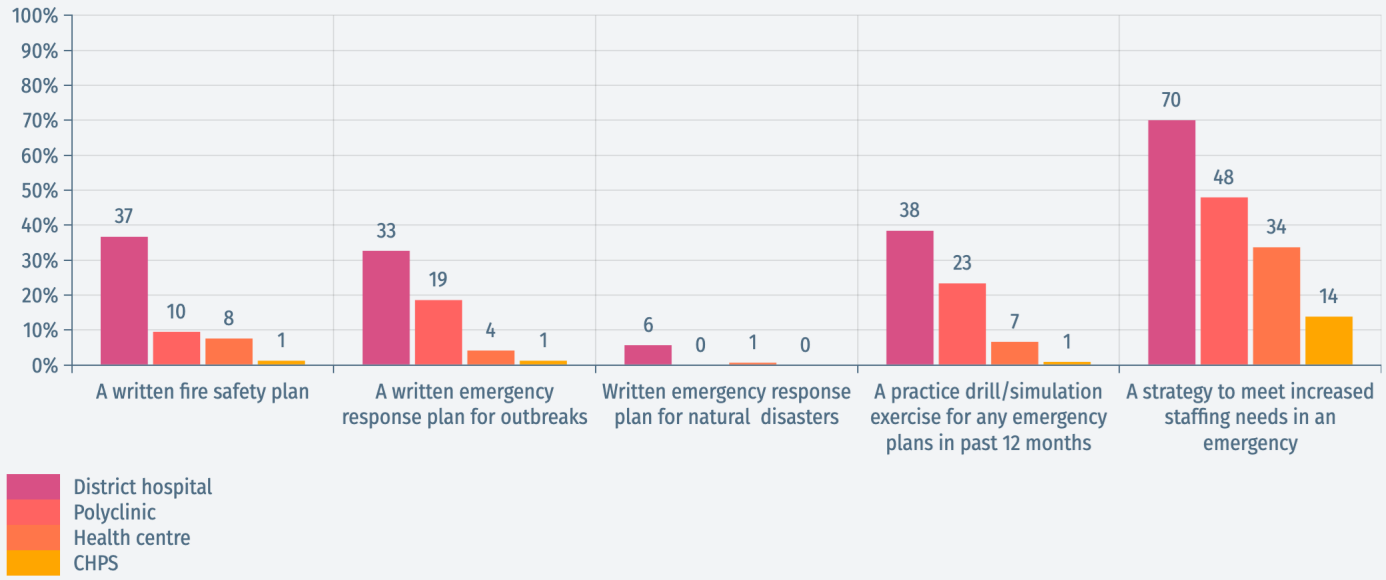
Figure 6. Percentage of facilities reporting they charge user fees for primary care services



Emergency preparedness

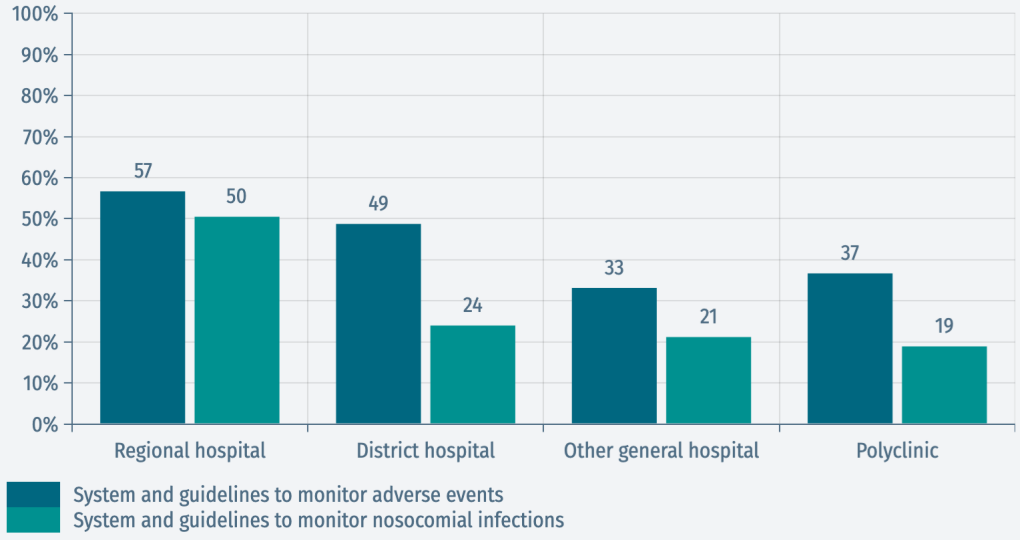
Overall, one out of ten facilities (11%) had a written fire safety plan. Three out of ten facilities had a strategy to meet staffing needs in an emergency. Availability of emergency preparedness systems is more common in hospitals and polyclinics than the lower level facilities.

Figure 7. Percentage of facilities with emergency preparedness system



Adverse events

Figure 8. Percentage of facilities with adverse event monitoring



On average, 29% of facilities have a system and guidelines to monitor adverse events (ranging from 33% in other general hospitals to 57% in regional hospitals). Systems and guidelines to monitor nosocomial infections are less common (17%), ranging from 19% in polyclinics to 50% in regional hospitals.

Nationally, 20% of facilities have systems and guidelines to monitor adverse events related to surgery. Such systems and guidelines are more common in regional hospitals (50%) and least available in polyclinics (15%).

Systems and guidelines for monitoring adverse reactions were rare. Nationally, about 12% of surveyed facilities had each of the four systems to monitor adverse reactions. Most regional hospitals (81%) had a system for monitoring adverse reactions to medicines.

Figure 9. Percentage of facilities with system and guidelines to monitor adverse events related surgery

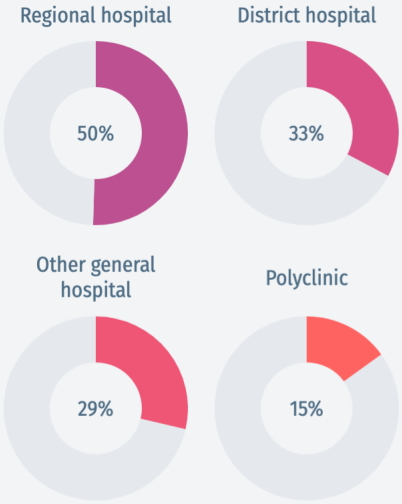
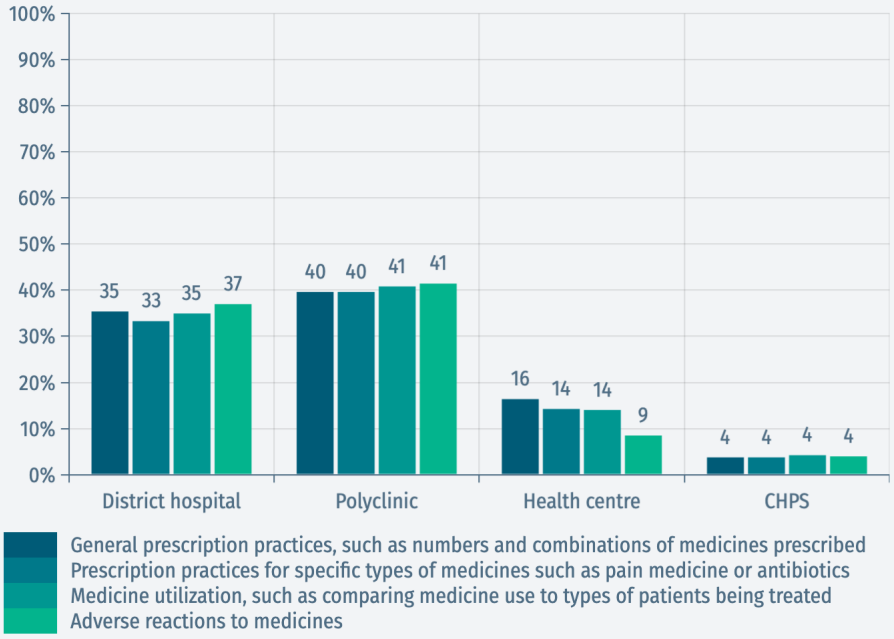
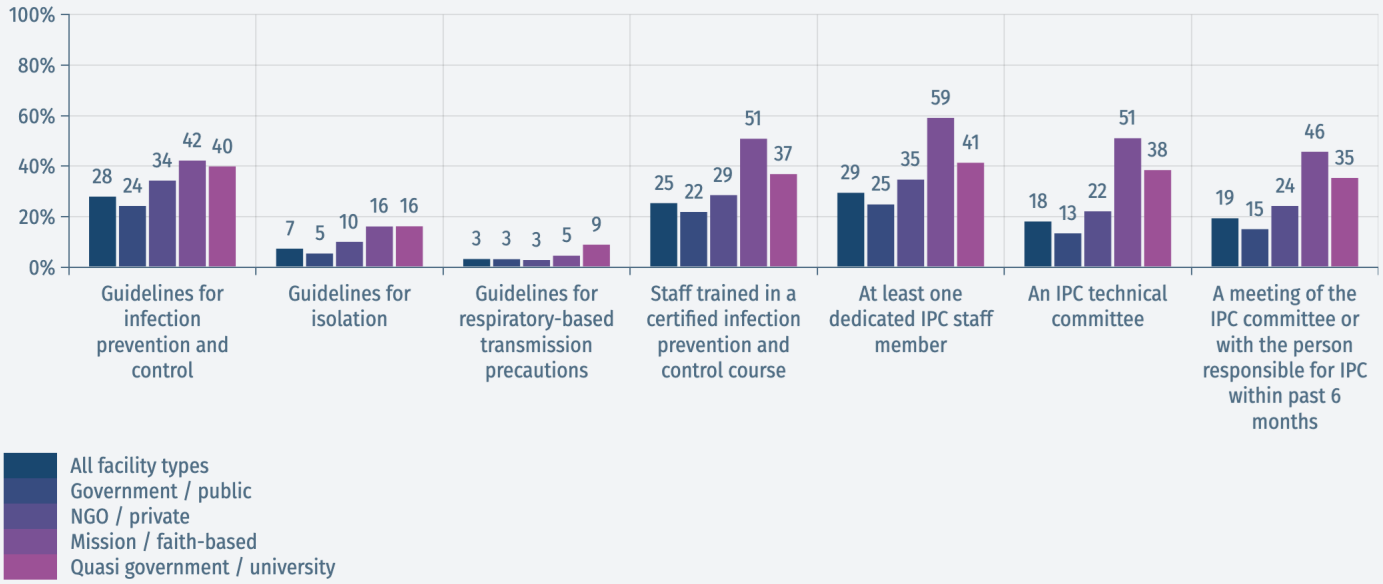


Figure 10. Percentage of facilities with system and guidelines to monitor adverse reactions



Infection prevention and control

Figure 11. Percentage of facilities with management systems for infection prevention and control (by managing authority)

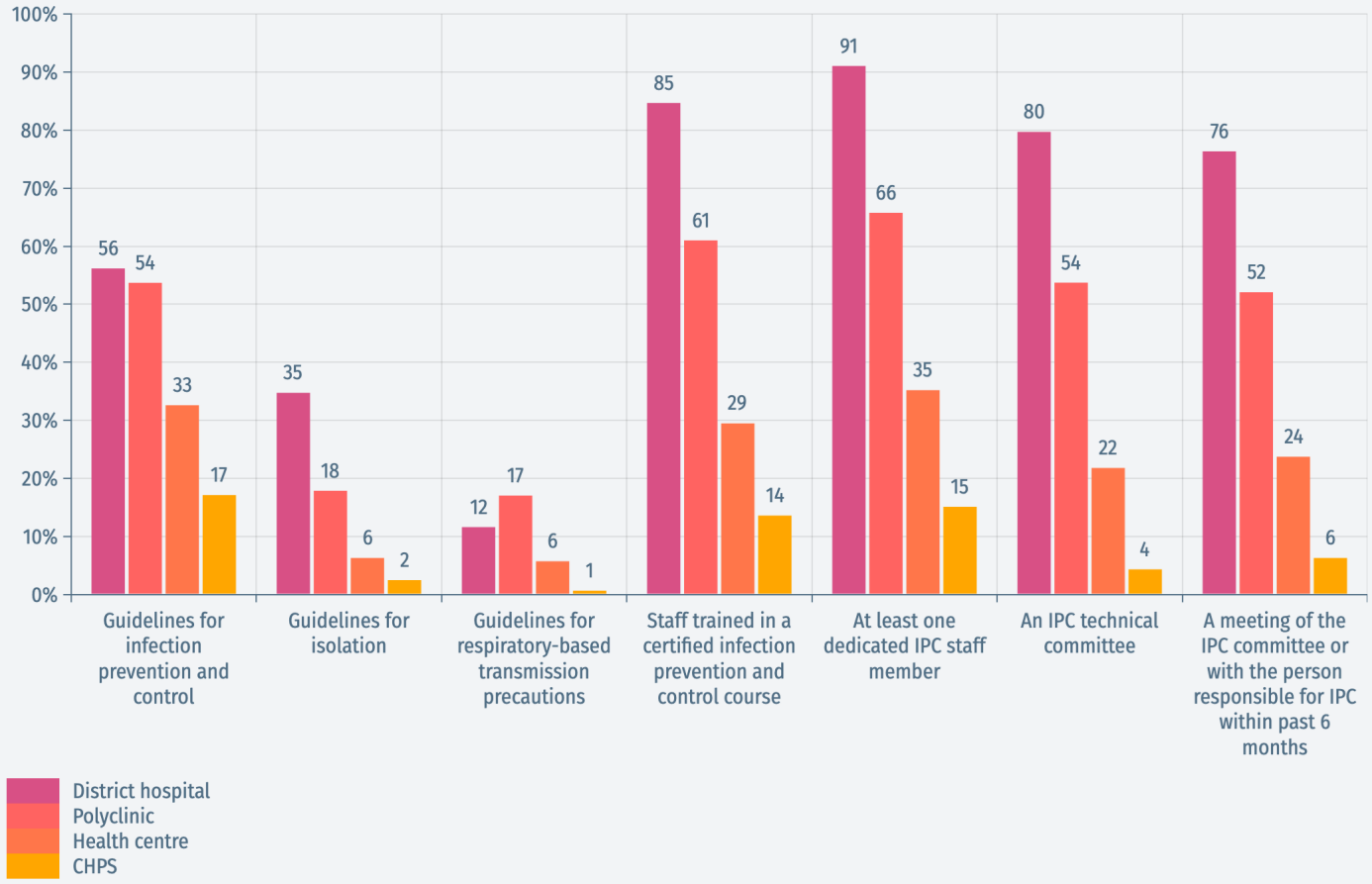


Nationally, management systems for IPC were absent in most of the facilities surveyed; national scores were below 30% for each of the IPC indicators.

Guidelines for IPC were available in about 3 out of 10 facilities (28%); however, guidelines for isolation and guidelines for respiratory-based transmission precautions were very rare (7% and 3% respectively). Generally, the IPC situation in the surveyed facilities was weak with only mission/faith-based facilities scoring above 50% in only three indicators.

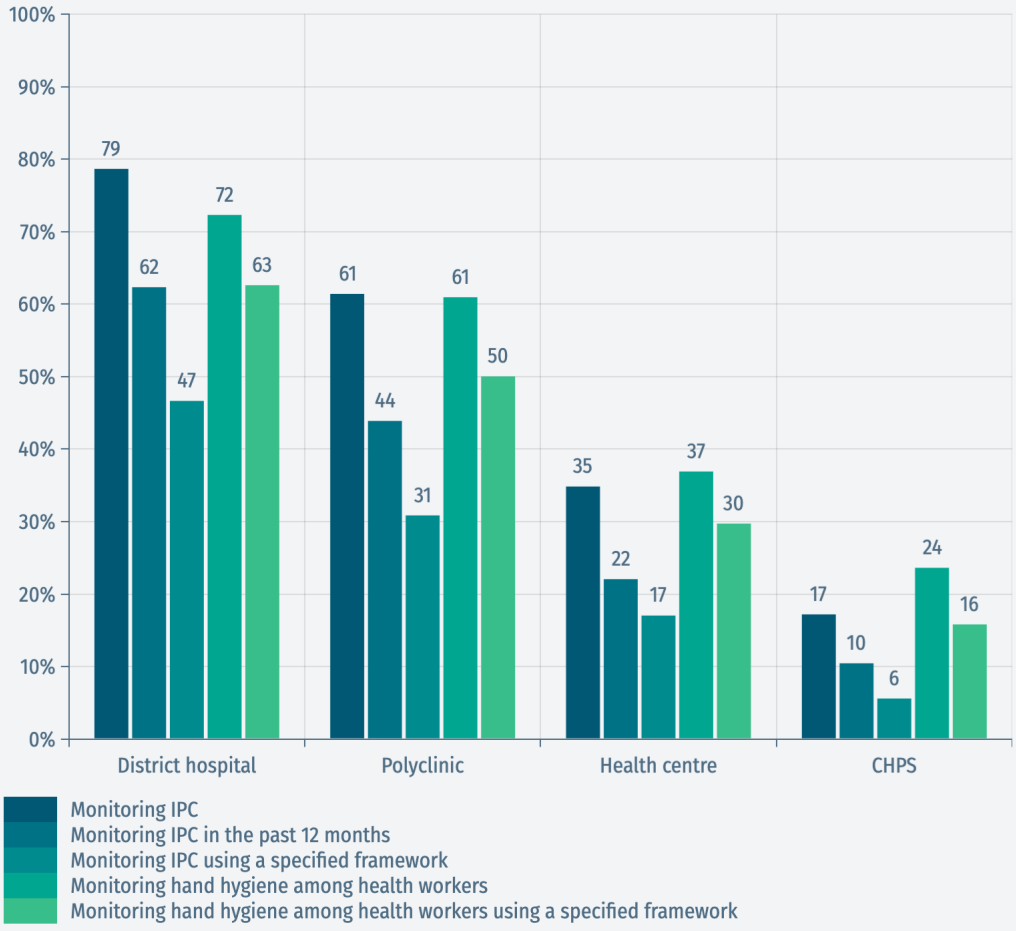
Regional and district hospitals scored above 60% on majority of the indicators.

Figure 12. Percentage of facilities with management systems for infection prevention and control (by facility type)



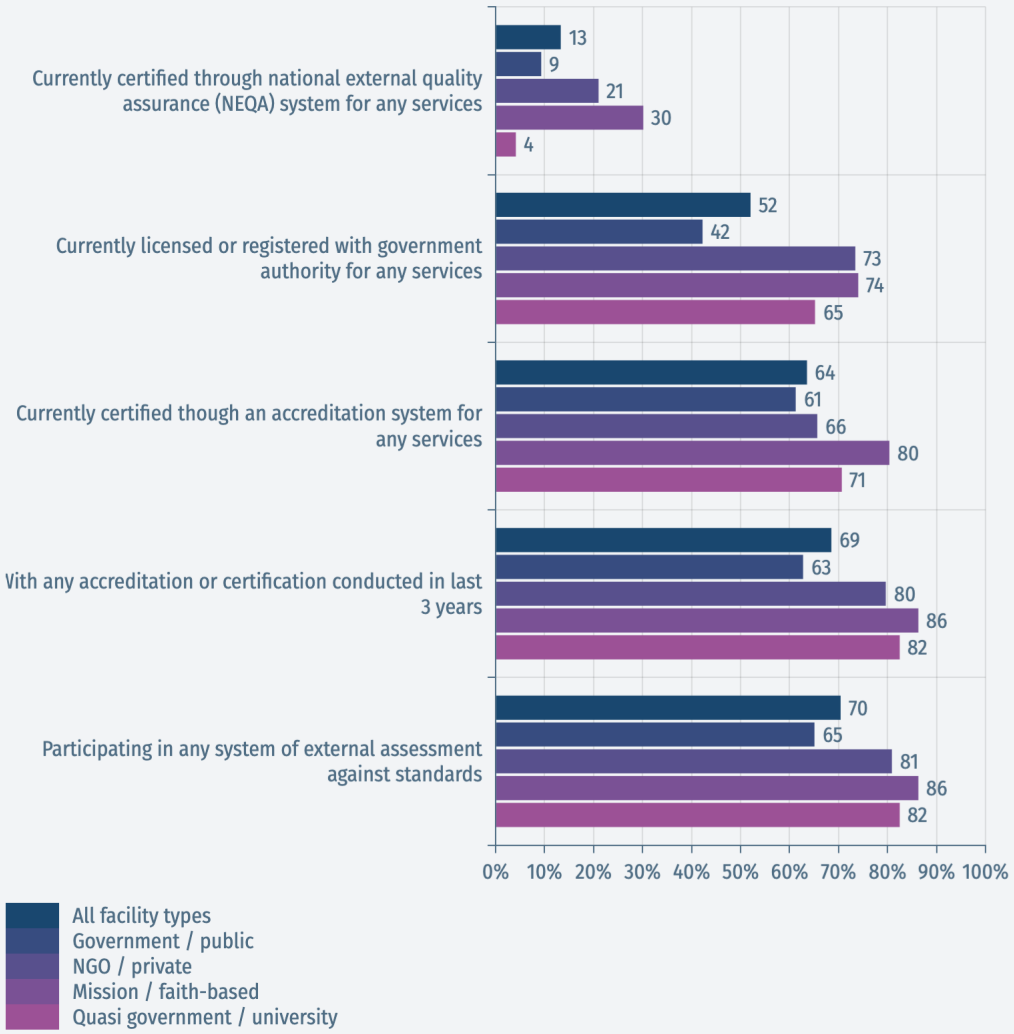
Nationally, 31% of facilities reported monitoring IPC, while 34% had a system for monitoring hand hygiene among health workers. Only 15% of facilities surveyed reported monitoring IPC using a specified framework. Systems for monitoring IPC and hand hygiene were more common in hospitals and polyclinics.

Figure 13. Percentage of facilities with system for IPC and hand hygiene



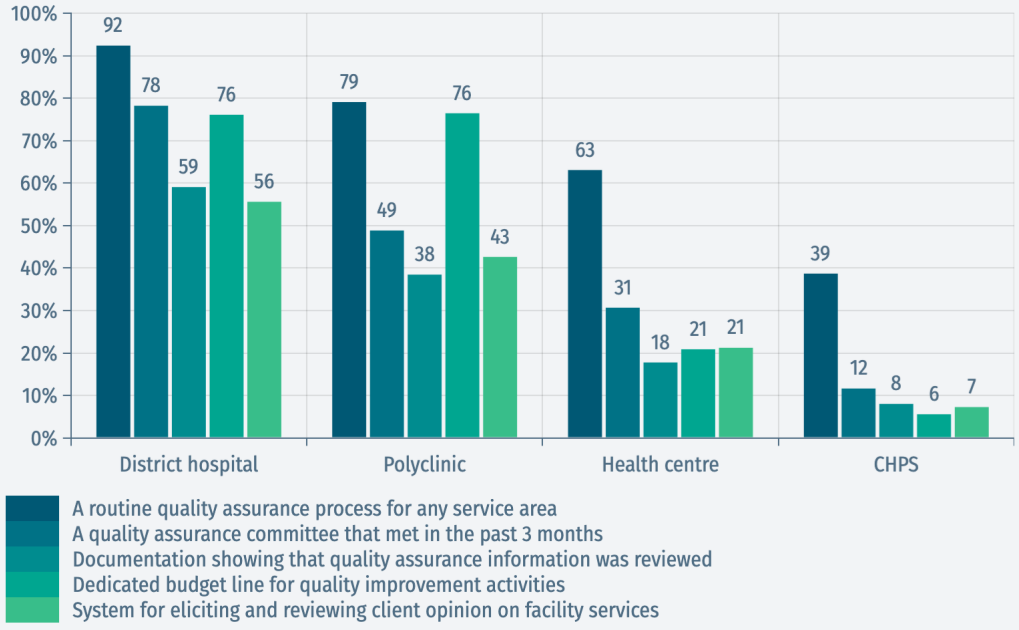
Quality assessment

Figure 14. Percentage of facilities with external assessment against standards



At least half of the facilities had external assessment against standards except for the NEQA certification system for any services. Mission/faith-based facilities reported higher levels for each of the indicators on being externally assessed against standards, while government/public facilities reported the lowest.

Figure 15. Percentage of facilities with internal assessment against standards



Nationally, 54% of facilities reported having a routine quality assurance process for any service area. Among the internal assessment against standards, documentation showing that quality assurance information was reviewed recorded lower percentages in all the facilities.

The percentage of facilities with case review systems was higher for the regional, district and other general hospitals and polyclinics. CHPS facilities had the least of facilities (17%) reporting on formal case review system. Death reviews are uncommon at health centres, clinic/ maternity homes and CHPS.

Figure 16. Percentage of facilities with case review systems

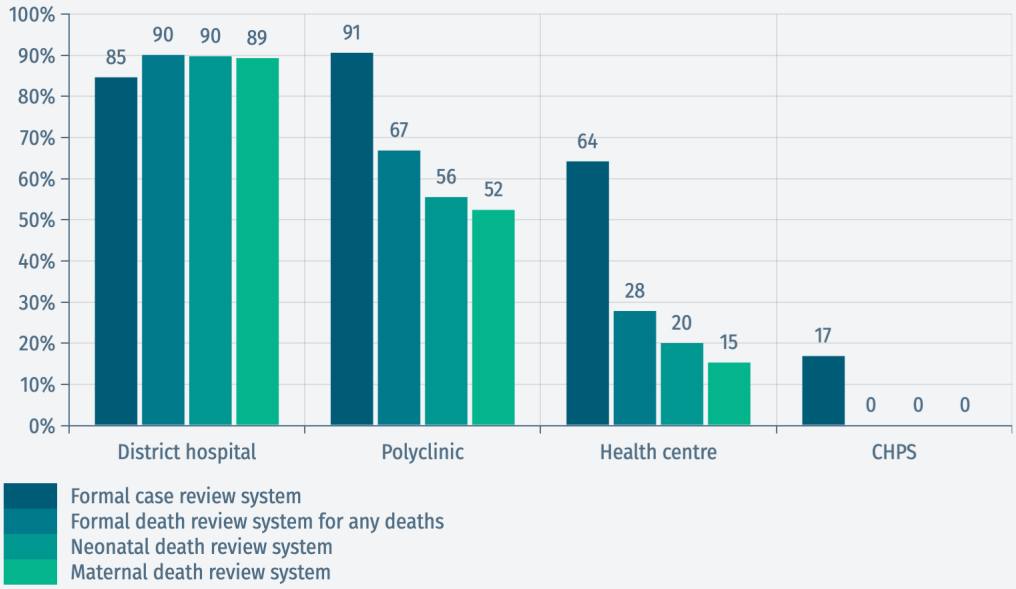
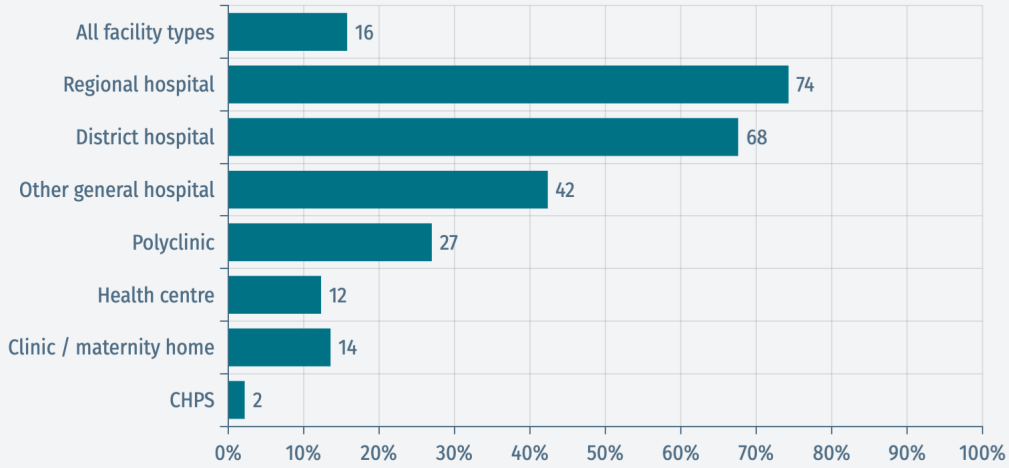
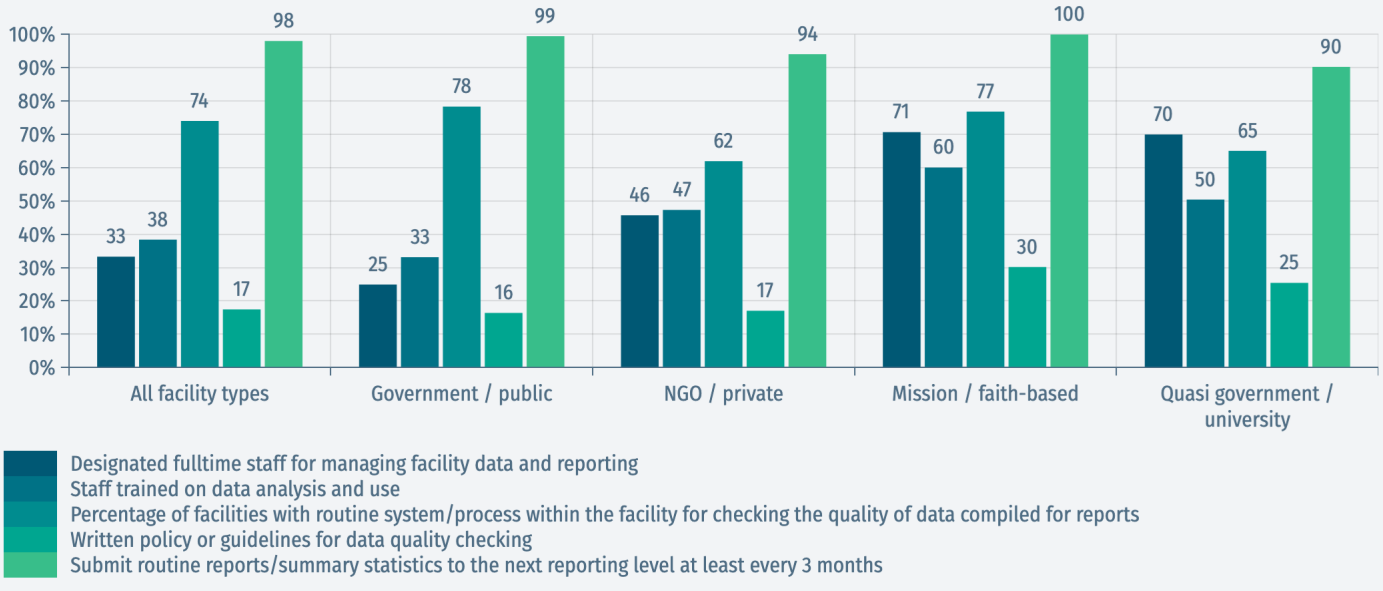


Figure 17. Percentage of facilities with an established routine external quality assessment mechanism for at least one laboratory test



Sixteen percent of facilities had an established routine external quality assessment mechanism for at least one laboratory test. This was mostly reported by the hospitals, especially regional hospitals (74%) and district hospitals (68%).

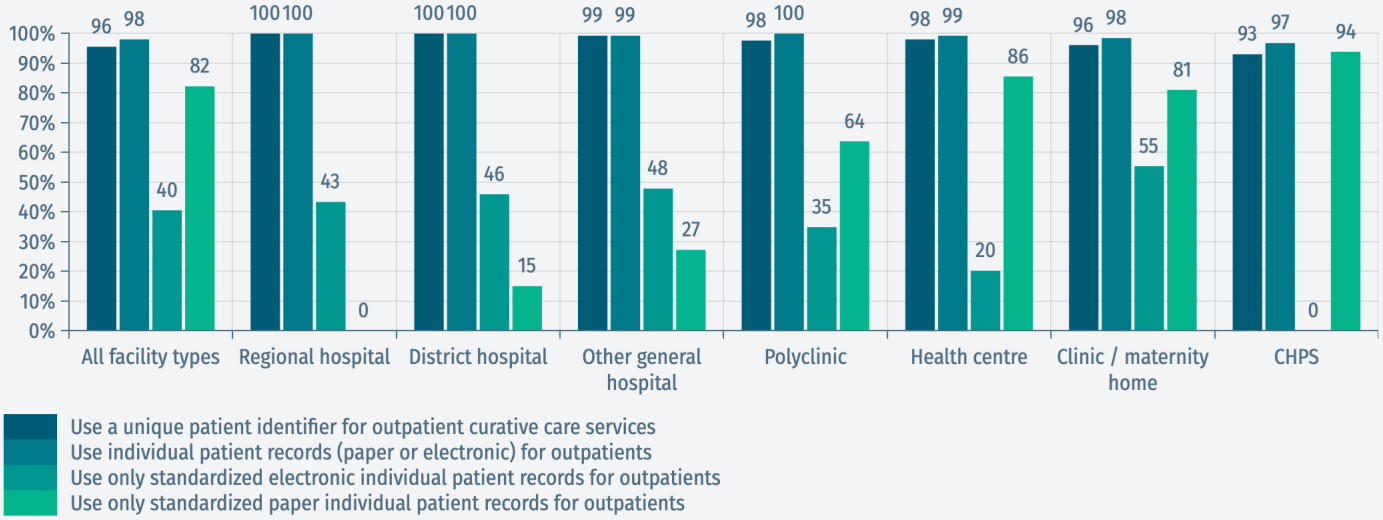
Figure 18. Percentage of facilities with health information staff and data quality processes



Virtually all facilities submit routine reports/summary statistics to the next level at least quarterly. Majority of facilities (74%) have a routine system for checking the quality of data compiled for reports. However, staff trained on data analysis and use, written policy or guidelines for data quality checking and designated full time staff for managing facility data and reporting were less common, especially in government/public facilities. Nationally, only 17% of facilities had a written policy for data quality checking.

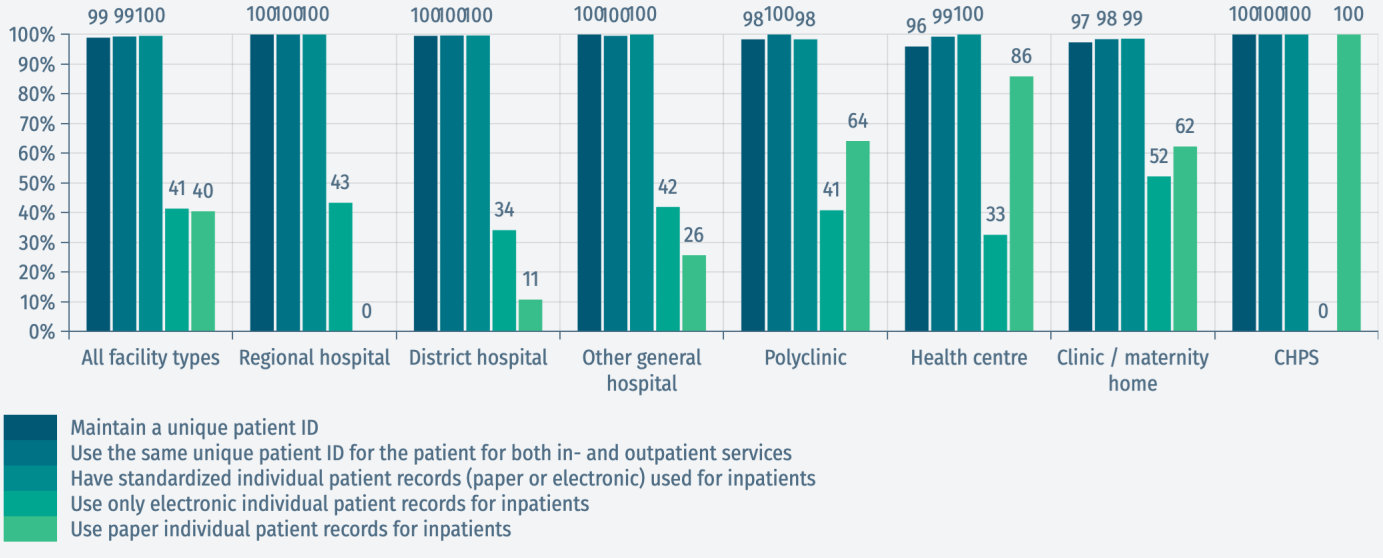
Patient records

Figure 19. Use of unique identifiers and individual patient records at facilities offering outpatient services



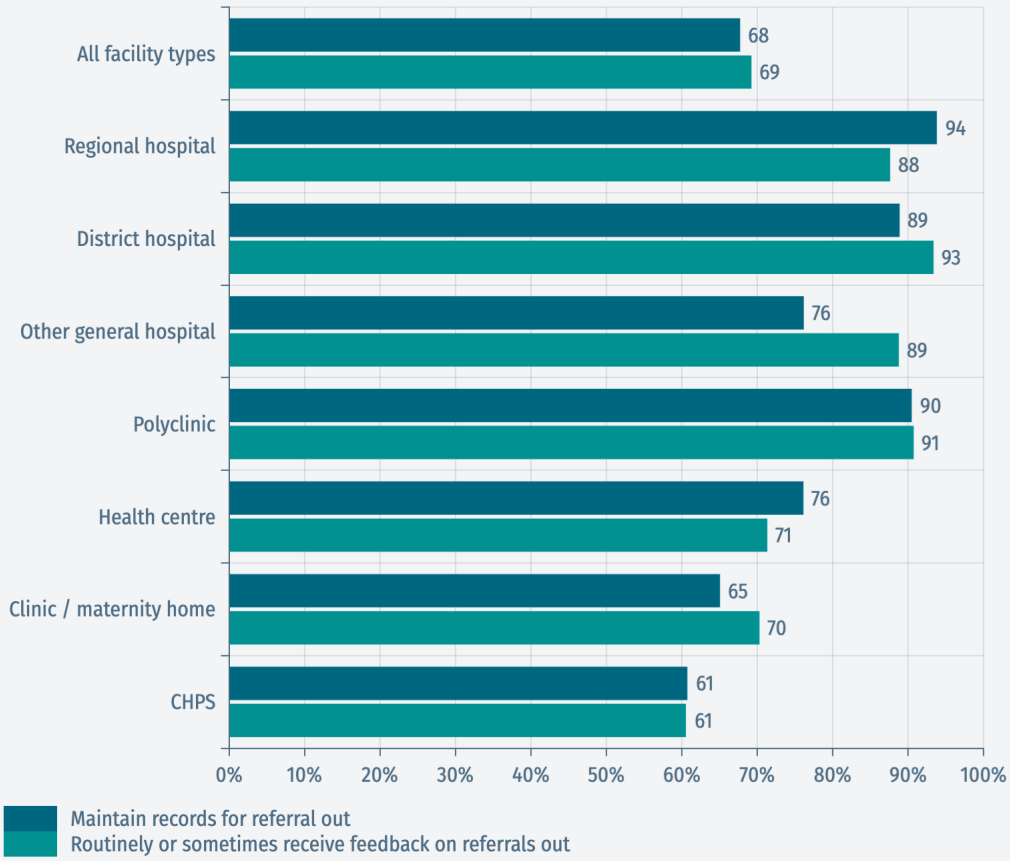
Most facilities assessed had unique patient identifiers for curative OPD services and individual patient records for outpatients. However, 82% of facilities (especially CHPS, clinics/maternity homes and health centres) use only standardized paper individual patient records for outpatients. Four out of ten facilities (hospitals and clinics/maternity homes) used only standardized electronic individual patient records for outpatients.

Figure 20. Use of unique identifiers and individual patient records at facilities offering inpatient services



At least 9 out of 10 facilities had unique identifiers and individual patient records for inpatient and individual patient records for all categories of facilities. The use of paper individual patient records for inpatients was non-existent in the regional hospitals but very high (100%) at the CHPS level.

Figure 21. Percentage of facilities with referral record



Nationally, about 7 out of 10 facilities maintained records for referrals out and routinely/sometimes receive feedback on referrals out. The percentage of facilities that maintain records for referral out ranged from 61% to 94% while facilities which routinely or sometimes receive feedback on referrals out ranged from 69% to 93%.

Services by health facility type

District hospitals

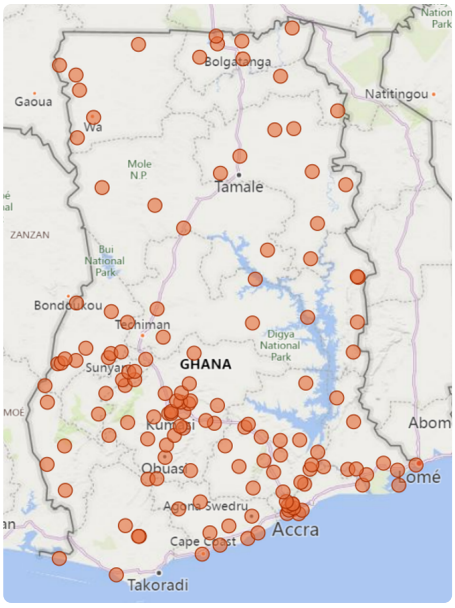
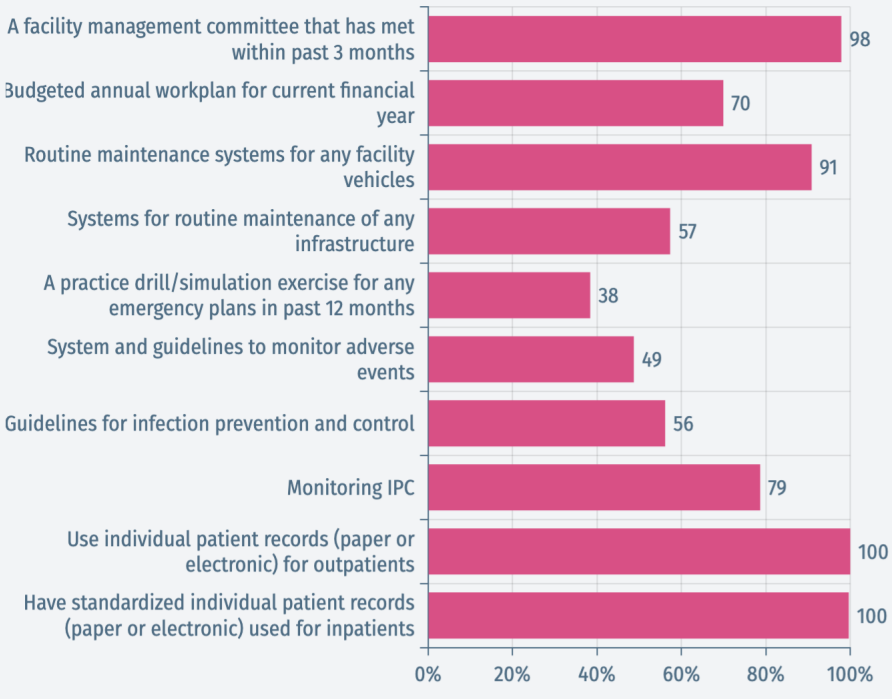


Figure 22. Percentage of district hospitals offering key services



Health centres

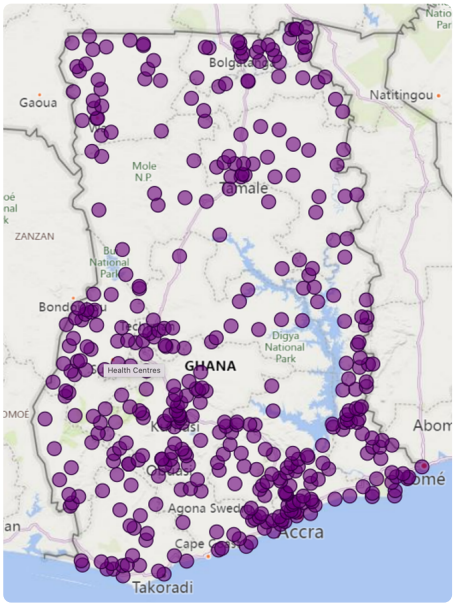
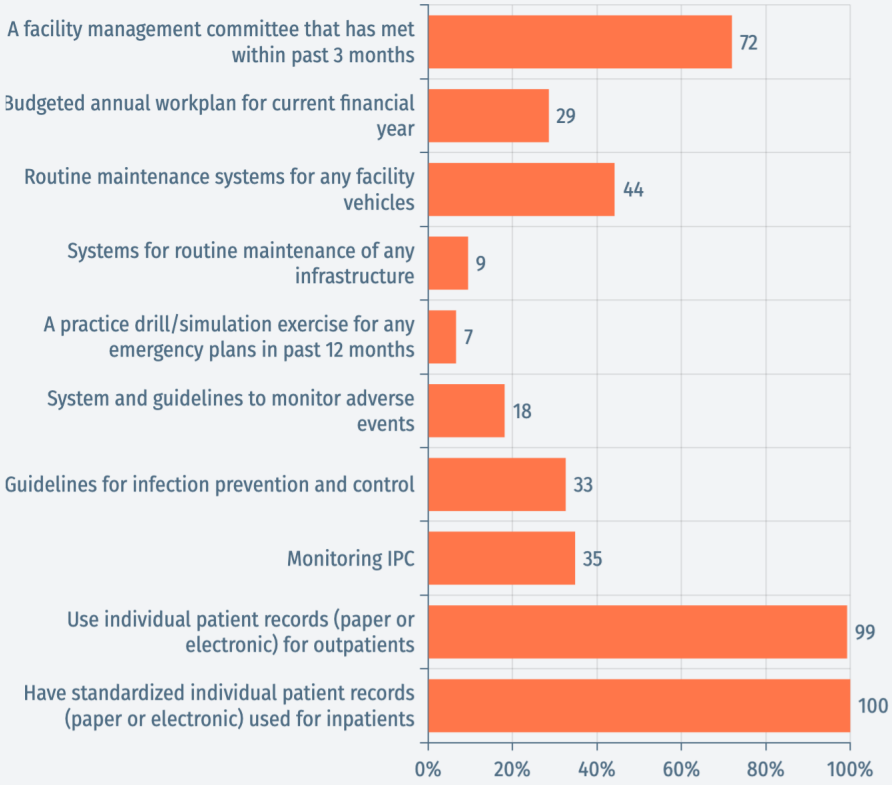


Figure 23. Percentage of health centres offering key services



CHPS

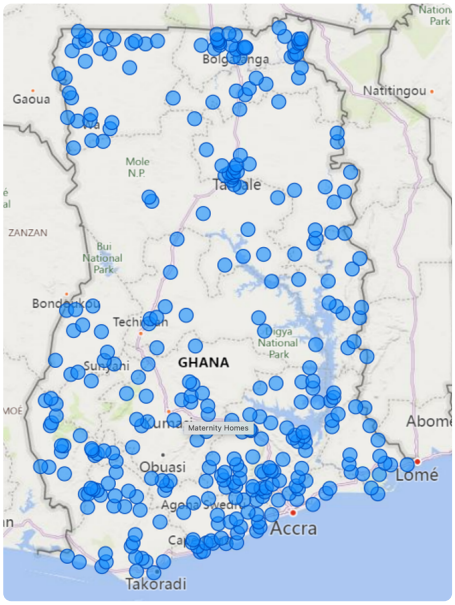
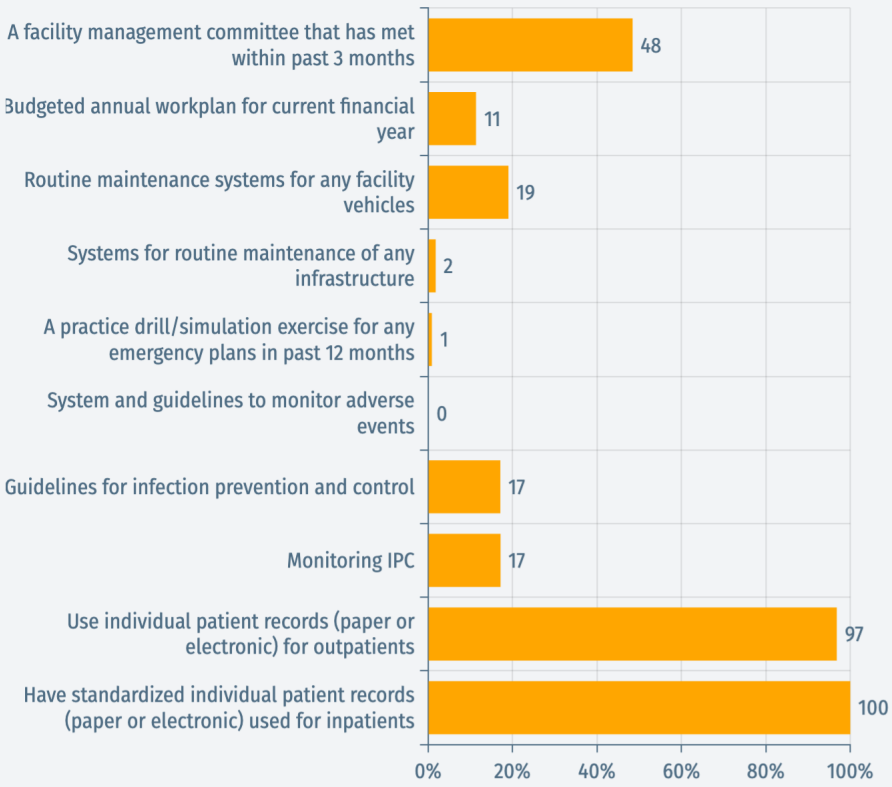


Figure 24. Percentage of CHPS offering key services



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