



ANNUAL
REPORT

2017



Christian Health Association of Ghana (CHAG)

ANNUAL REPORT 2017

CONTENTS

LIST OF TABLES	v
LIST OF FIGURES	vi
Abbreviations	vii
Chairperson’s Letter	
A Note of Gratitude	
CHAG in a Nutshell	1
Summary Outlook 2017	3
Performance Indicators	10
Input Indicators	12
Performance Outcome and Status for 2017	15
1.0 Service Delivery	16
1.1 Out-Patient and In-Patient Services	16
1.2 The Contribution of CHAG to National Outpatient and In-Patient Services	17
1.3 Contribution to OPD by Church Denomination	21
1.4 Contribution to CHAG OPD & IPD by Region	22
1.5 Bed Utilization and Average Length of Stay	24
1.6 Reproductive and Sexual Health Services	24
1.7 Family Planning	27
1.8 Child Health Services	30
1.9 HIV/AIDS Services	30
1.10 Outreach Health Services	33
1.11 School Health Programme	34
1.12 Summary Burden of Disease (Epidemiology)	36
1.12.1 Morbidity	36
1.12.2 Admissions	39
1.12.3 Mortality	41
1.12.4 Maternal Mortality	43
1.13 Key Health Outcome Indicators	44
1.14 Mental Health Services	51
1.14.1 Achievements for 2016	51
1.14.2 Mental Ill Clients seen at OPD and IPD	52
1.14.3 Mental health conditions seen in 2017	55
1.14.4 Facilities in the Spotlight	56
2.0 HEALTH INFORMATION	57
3.0 LEADERSHIP AND GOVERNANCE	60
4.0 HUMAN RESOURCES	62
4.1 Staffing Situation	
4.2 Ratio of Professional to Auxiliary Nurses	
4.3 Doctor to patient ratio	

4.4	Summary of Key HR Performance Indicators 5-Year Trend defined.	
4.5	Promotions And Upgrades	
4.6	Separations	
4.7	Inter-Agency Transfers	
4.8	Staff Turn-Over Rate	
4.9	HEALTH TRAINING INSTITUTIONS	
4.9.1	Student Intake	
4.9.2	Student Pass rate	
5.0	HEALTH TECHNOLOGY	74
6.0	HEALTH FINANCING	77
7.0	PARTNERSHIPS FOR HEALTH	80
8.0	RESEARCH FOR HEALTH	81
8.1	CHAG'S CORPORATE MONITORING AND EVALUATION (M&E) SYSTEM	81
9.0	POINTERS FOR ACTION	84
	Annex 1: CHAG Member Institutions by Type	86

LIST OF TABLES

Table	Page
1: CORE VALUES OF CHAG	2
2: OBJECTIVES OF CHAG	2
3: KEY HEALTH INDICATORS: 2012 - 2017	5
4: PERFORMANCE INDICATORS.	11
5: INPUT INDICATORS: 2012-2016	13
6: OPD, IPD SERVICE OUTPUTS AND INSURANCE STATUS OF CLIENTS: 2012 - 2016	16
7: CHAG PERCENTAGE REGIONAL CONTRIBUTION TO NATIONAL OPD AND IPD SERVICES, 2016	19
8: REPRODUCTIVE AND SEXUAL HEALTH SERVICE OUTPUTS, 2012-2017	26
10: TREND OF FAMILY PLANNING UPTAKE BY TYPE, 2013-2017	29
11: HIV/AIDS SERVICE OUTPUT 2012 - 2017	32
12: TOP-10 CAUSES OPD MORBIDITY: 2012 - 2017	38
13: TOP-10 CONDITIONS FOR ADMISSIONS: 2012 - 2017	40
14: TOP-10 CAUSES OF MORTALITY: 2010 - 2017	42
16: KEY HEALTH OUTCOME INDICATORS: 2012 - 2017	45
17: MENTAL HEALTH OPD AND IPD DATA	54
19: HEALTH INFORMATION PRECARIOUS CHALLENGES	57
20: REPORT SUBMISSION RATE BY FACILITIES (2012 -2016)	58
21: LEADERSHIP AND GOVERNANCE: CRITICAL CHALLENGES	60
22: NUMBER OF STAFF AND CORRESPONDING SALARIES BY INSTITUTION	
24: KEY HR PERFORMANCE INDICATORS	
25: INTER-AGENCY TRANSFERS 2016	
26: STAFF TURN-OVER RATE, 2016	
27: CRITICAL NETWORK CHALLENGES: HEALTH TECHNOLOGY	74
29: CRITICAL NETWORK CHALLENGES: PARTNERSHIP FOR HEALTH	80
30: CRITICAL NETWORK CHALLENGES: HEALTH RESEARCH	81
31: HEALTH FACILITY PERFORMANCE: ORGANIZATIONAL CAPACITY INDICATORS AND MEASURES	82
32: HEALTH FACILITY OUTCOMES AND IMPACTS	83

LIST OF FIGURES

Figure	Page	
1	TREND OF DOCTORS AND NURSES/OPD CLIENTS RATIO 2012 - 2016	14
2:	TREND OF PERCENTAGE CHAG CONTRIBUTION TO NATIONAL OPD & IPD	18
3:	OPD CONTRIBUTION BY DENOMINATION, 2016	21
4:	IPD CONTRIBUTION BY DENOMINATION, 2016	22
5:	PROPORTION OF 2016 ANNUAL OPD CLIENTS CONTRIBUTED BY REGION	23
6:	PROPORTION OF 2016 ANNUAL ADMISSIONS CONTRIBUTED BY REGION	23
7:	TREND OF BED OCCUPANCY RATE AND AVERAGE LENGTH OF STAY, 2012 - 2016	24
8:	CHAG'S CONTRIBUTION TO REGIONAL DELIVERIES, 2016	25
9:	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI) 2012-2016	30
10:	CHILD WELFARE OUTREACH SERVICES FROM 2012 - 2016	33
11:	OUTREACH IMMUNIZATION COVERAGE AND VITAMIN- A SUPPLEMENTATION: 2012 - 2016	34
12:	SCHOOL HEALTH PROGRAMME FROM 2012 - 2016	34
13:	STUDENT ENROLLED IN SCHOOL HEALTH PROGRAM FROM 2012 - 2015	35
14:	SCHOOL HEALTH PROGRAMME DIAGNOSED CONDITIONS FROM 2012 - 2016	35
15:	CHAG TOP TEN (10) CAUSES OF MORBIDITY FOR THE YEAR ENDING DECEMBER 31, 2016	37
16:	CHAG TOP TEN (10) CAUSES OF ADMISSION 2016	39
17:	CHAG TOP TEN (10) CAUSES OF MORTALITY FOR 2016	41
18:	CHAG TOP TEN (10) CAUSES OF MATERNAL MORTALITY: 2016 ANNUAL	43
19:	TREND OF MATERNAL MORTALITY RATIO: 2012 - 2016	46
20:	TREND OF STILL BIRTHS RATE: 2012 - 2016	47
21:	TREND OF NEONATAL MORTALITY RATE: 2010 - 2015	48
22:	TREND OF INFANT MORTALITY RATE: 2012 - 2016	49
23:	TREND OF UNDER 5 MORTALITY RATE (U5MR): 2010 - 2015	49
24:	TREND OF CRUDE MORTALITY RATE: 2010 - 2015	50
25:	2016 CAESAREAN SECTION DELIVERY RATE (%) BY INSTITUTION	.
26:	2016 STILLBIRTH RATE (PER 1,000 DELIVERIES) BY INSTITUTION	.
27:	2016 INFANTS MORTALITY RATE BY INSTITUTION	.
28:	UNDER 5 MORTALITY RATE: 2016	.
29:	2016 MATERNAL MORTALITY RATIO BY INSTITUTION	.
30:	MENTAL HEALTH CASES REPORTED IN 2016	55
31:	RELAPSED, DEFAULTERS AND SPECIAL MENTALLY ILL PERSONS SEEN IN CHAG INSTITUTIONS IN 2016	.
32:	ADMISSIONS, DISCHARGES AND DEATHS FOR MENTALLY ILL PERSONS SEEN IN 2016	.
33:	ANNUAL 2016 MINIMUM SERVICE DATA SET SUBMISSION RATE BY FACILITY TYPE	58

34:	DENOMINATIONAL MINIMUM SERVICE DATA SUBMISSION RATES CHART	58
35:	CHAG NETWORK CAPACITY IN 2016	
36:	PERCENTAGE DISTRIBUTION OF STAFF BY CHCU AND ANNUAL BASIC SALARY	
37:	FOUR YEAR TREND OF GOG STAFF ON NOMINAL ROLL	
38:	PROPORTION OF GOG & IGF STAFF	
39:	PROFESSIONAL TO AUXILIARY NURSE	
40:	NO. OF STAFF IN CADRES	
41:	PROMOTIONS AND UPGRADES	
42:	EMPLOYEE SEPARATIONS 2015 AND 2016	
43:	TREND OF STUDENT ENROLMENT IN TRAINING INSTITUTIONS, 2011-2016	
44:	TREND OF STUDENT PASS RATE IN CHAG TRAINING INSTITUTIONS, 2011-2016E	
45:	PERCENTAGE DISTRIBUTION OF CHAG FACILITIES BY REGION	75
46:	CHAG FACILITIES BY TYPE, 2016	75
47:	OWNERSHIP OF CHAG FACILITIES BY DENOMINATIONS, 2016	76



ABBREVIATIONS

AC	Annual Conference
ANC	Ante Natal Care
ARI	Acute Respiratory infections
ARV	Anti-Retroviral Vaccine
BLS	Basic Life Support
C4C	Connect for Change
CCG	Christian Council of Ghana
CHAG	Christian Health Association of Ghana
CHC	Church Health Coordinators
CHCU	Church Health Coordinating Units
CHPS	Community Health Planning and Services
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CSS	Community System Strengthening
DANIDA	Danish international Development Agency
DFID	Department for International Development
DPs	Development Partners
DHMIS	District Health Management Information System
EMS	Emergency Medical Services
ENBC	Essential New Born Care
ES	Executive Secretariat
FAME	Fellowship and Associates Medical Evangelism
FP	Family Planning
GHS	Ghana Health Service
GOG	Government of Ghana
GPCC	Ghana Pentecostal and Charismatic Council
	HEFRA Health Facilities Regulatory Agency
HR	Human Resources
HSS	Health Systems Strengthening
IGF	Income Generating Funds
IMCI	Integrated Management of Childhood Illness
IPD	In-Patient Department
MAF	MDG Accelerated Framework
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MHS	Mental Health Service
MIs	Member Institutions
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSDS	Minimum Service Data Set
NCHS	National Catholic Health Secretariat
NHIA	National Health Insurance Authority
OPD	Out-Patient Department
OPAT	Organizational Performance Assessment Tool
PHC	Primary Health Care
PLHIV	Patients Living with HIV and AIDS
TBA	Traditional Birth Attendant
UTI	Uterine Tract Infection
URTI	Upper Respiratory Tract Infection

Chairperson's Letter

Dear Friends,

We fought a good fight, yet we have not finished the race. By God's grace and with your support over the years, we celebrated our 50 years of coming together and providing distinguished health services to Ghanaians. Amidst all challenges that we have encountered over the past 50 years, you have been with us and supported us in diverse ways. You, the good people of this country, reposed your confidence and trust in us and we have served you well especially in 2017. The commitment, endurance and tenacity of our able Christian health workers contributed immensely to the successes we chalked in 2017. On behalf of the CHAG Board of Trustees, let me thank you all; those who had the privilege to render Christ-like health services and those clients that received services from CHAG in 2017.

Our mandate is to provide healing to all manner of people in fulfillment of Christ's mandate to heal the sick. In the light of this mandate, we sought to improve the lives of people living with mental illnesses and mothers who give birth in our institutions. We achieved a lot by engaging different non-formal sectors/actors to improve mental health services delivery. The lives of many mentally ill persons were touched. CHAG Member Institutions (CMIs) contributed immensely in reducing institutional maternal mortalities. Furthermore, our committed staff upheld our Christian identity and witness in all circumstances. And for this commitment to the cause of CHAG, we are most grateful.

In spite of these achievements in 2017 and over the past 50 years, CHAG is still confronted with evolving challenges in the health sector. We experienced significant cuts in funding during 2017 owing to the exit of our core Development Partner, DANIDA, whose exit was predicated by Ghana's assumed status of a Lower Middle Country. There were still delays in reimbursement of validated claims from the National Health Insurance Authority. This situation adversely affected our capacity to deliver quality health services for the poor and needy people in 2017, and the situation continues to threaten CHAG's potential to render quality services. In many ways, the financial and organizational sustainability of CHAG health services remain a major concern. Consequently, the far-reaching transformation process that begun about 4 years ago is being pursued with several objectives: *to strengthen our position as the most reliable partner in the health sector, to drive our ability to innovate and to successfully position CHAG for the long term in the face of emerging challenges. Ultimately, we aim at evolving and becoming technologically compliant operationally and structurally in order to promote the development and sustainability of Christian health service delivery.*

I hope you benefit from this 2017 Annual Report as it highlights the role, contributions and impact CHAG has made on the lives and livelihoods of our cherished clients and the Ghanaian public as a whole. We uphold unity in diversity and co-operation and partnership as our cherished core values. Together, we are transforming health care and meeting the needs of our clients now and will do so in the future. Your support is highly valued!

With gratitude,

Dame Dr. Mrs. Agatha A. Bonney
Board Chairperson
Christian Health Association of Ghana (CHAG)

A Note of Gratitude

Dear Colleagues,

In pursuit of our core value of holistic healthcare provision, CHAG continued to render curative, preventive, promotive and rehabilitative health services to our cherished clients in the year 2017. Consistent with our mission, we maintained our commitment to providing quality training of health professionals across our network of 302 Member Institutions.

Being a Golden Jubilee Year, we celebrated our collective role and contributions in the Ghanaian health sector with sense of fulfillment. We also recognized the changes and challenges confronting the entire CHAG network, conscious of our timeless mandate. As faithful stewards and servants of the Lord's healing ministry, we explored opportunities for growth and development of the CHAG fraternity, and for achieving universal health coverage in the next 50 years.

For the year under review– 2017, CHAG contributed 27.8% of national in-patient care/admissions and 18.7% of national OPD services with barely 7.4% of health infrastructure. Specifically, we handled 5,261,683 Outpatient visits, 447,950 admissions, 110,109 supervised deliveries and admitted 2,878 students in the 18 pre-service CHAG Training Colleges. These gains, with limited resources, were an affirmation and demonstration of CHAG's efficiency niche in the Health Sector. We owe these significant contributions to our dedicated Front-Line Staff, Senior Leadership and Board of Trustees for their commitment to the values and ideals of CHAG. Consistent with core value of cooperation and partnerships, CHAG collaboratively worked with Agencies, Providers, and Organizations to improve equitable and convenient access to affordable quality health services. In particular, we enjoyed the support of the Government of Ghana through the Ministry of Health, DANIDA, EU, UKAID/DFID, UNFPA, amongst others.

On behalf of my Management Colleagues, I wish to thank the Board of Trustees for their guidance, direction and support in many ways, and our CHAG Secretariat Staff for their dedicated efforts and for the way they continued to uphold the culture of excellence and creativity.

As a Christian Not-For-Profit Organization, our aspiration is to provide extraordinary health services, in all its dimensions, to those we serve. Hence, we would continue to explore innovative interventions and strive to promote health and healing for those who depend on us in the times ahead.

Dear Friends, this 2017 annual performance report highlights the details of our collective achievements, common challenges and pointers for our future growth prospects and potentials as Christian Health Service Provider. The report represents our renewed promise and pledge to promote Jesus Christ's healing ministry everywhere, to everybody, and at all times!

Sincerely,



Peter Kwame Yeboah

Executive Director

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Christian Health Association of Ghana (CHAG) in a Nutshell

CHAG is a Network Organisation of 302 Health Facilities and Health Training Institutions owned by 25 different Christian Church Denominations. CHAG provides health care to the most vulnerable, deprived, marginalized and underprivileged population groups in all 10 Regions of Ghana, particularly in the most remote areas.

The larger 7 Church denominations operate autonomous coordinating offices either at Presbytery, Diocesan or National level. They provide technical, logistical and program support to their corresponding Health Facilities. To some extent, they also mobilize funding for their members. Majority of these offices have longer-term strategic plans, policies and administrative guidelines.

At the National level, CHAG is spearheaded by the Secretariat providing stewardship for the CHAG network, developing strategic partnerships in support of capacity development of the network and its members, and articulating the Network's position and interest in the policy discourse of the Health Sector.

CHAG is a recognised Implementing Partner/Agency of the Ministry of Health (MOH) and works within the policies, guidelines and strategies of the MOH. Nonetheless, CHAG is autonomous and takes an independent position to advocate and promote improvements in the Health Sector and promotes the interest of its members and target beneficiaries.

CHAG is directed by a Strategic Framework outlining aspirations and approaches inspired by Christian identity, purpose and values.

For more information, kindly visit CHAG website: www.chag.org.gh

Table 1: Core Values of CHAG

- Pro poor; assist the most vulnerable and less privileged in society.
 - Respect the dignity and equal rights of each person irrespective of gender, sexual orientation, race, age, religion, political orientation and societal status.
 - Act in the spirit of love, service, justice, compassion, forgiveness and truthfulness.
 - Holistic health care, address psychological, physical, spiritual and social needs of clients.
 - Respect autonomy of members of the Association and their own unique contribution to shared vision, mission and objectives.
 - Critical reflection on performance for continuous quality improvement.
 - Honest, open and transparent and working towards joint action for results.
-

The overall objective of CHAG is to contribute to national health sector objectives and outcomes. Specific objectives of CHAG relate to representation and partnership

Table 2: Objectives of CHAG

- Foster effective partnerships between Church health services.
 - Improve dialogue and partnerships within the health sector.
 - Promote improvements in the health sector.
 - Advocate and promote Christian values and ethics in health care policy and services delivery.
 - Promote the interests and sustainability of Church health services in Ghana.
-

CHAG is governed by a Board of Trustees and directed by a Strategic Framework that outlines the medium-term aspirations and approaches. At the National level, CHAG operates a Secretariat, which provides stewardship, develops strategic partnerships, builds capacity and articulates the interest of the Association through lobbying, advocacy and policy dialogue. The larger Church denominations operate coordinating offices at various levels providing financial, technical, logistical and programme support to their respective health facilities. CHAG works closely with the Ministry of Health (MOH) and its Agencies at policy and implementing levels based on performance agreements, mutuality and reciprocity.

¹ CHAG Strategic Framework 2014-2016, Unity in Diversity, December 2013.

² Memorandum of Understanding between MOH and CHAG, 2006. Memorandum of Understanding between GHS and CHAG, December 2013.

Summary Outlook 2016

The year 2017 was when the Christian Health Association of Ghana (CHAG), formerly Church Hospitals Association of Ghana (CHAG) attained 50 years. Consequently, the Golden Jubilee was celebrated with lots of activities. It was a time of reflection on CHAG's past performance, relevance and planning for the next 50 years.

As CHAG is noted for and in fulfillment of its mission, CHAG provided compassionate health care to many Ghanaians in 2017 particularly in remote areas. Thus, CHAG consolidated its role in the Ghanaian health sector by improving access to quality health services and professional training through its Network of 302 Hospitals, Health Centres, Clinics and Training Schools.

On leadership and governance, CHAG sought to strengthen health facility systems and to improve outcomes within the Network by increasing access to the use of organizational performance and assessment tool (OPAT). CHAG thus adopted OPAT as a performance management tool to monitor performance in the nine health system blocks within the network.

To improve efficiency and effectiveness of work at the CHAG Secretariat, the Board of Trustees restructured the Secretariat's functional portfolio by realigning duties and introduced one new key position.

Consistent with CHAG's objective to support the achievement of national health outcomes, CHAG initiated processes to partner the Ministry of Health toward the implementation of the CHPS policy.

Without any relief, CHAG continued to bear the debilitating consequences of NHIS' mounting indebtedness as a result of delays in reimbursement of NHIS validated claims. This adversely impacted on our capacity to fulfil our core mandate of providing quality health services to our cherished clients. Towards sustainability and optimization of health services, CHAG initiated steps to assist member institutions set up Centres of Excellence that will expand the skill and knowledge of specialists in remote areas. Specifically, seven specialized Mental Health centres were set up in the Northern, Brong Ahafo, Ashanti, Volta and Central regions to provide care for adolescents and people of all age groups who suffer mental illness.

In spite of the mounting challenges in service provision exacerbated mostly by the NHIS indebtedness, CHAG proved to be a reliable partner in the health sector. Overall, CHAG increased its contribution to the national health sector objectives as indicated by a selected number of outcomes, performance and input indicators. In particular, there were improvements in key health sector outcome indicators from the year 2012 to 2017. These indicators include maternal mortality, still births and crude mortality rates.

There was an increase in maternal mortality ratio from 109 to 152 deaths per 100,000 live births in the year under review. This represents 39% increase of the ratio (109/100,000 live births) recorded in 2016. However, over a five-year period, there has been 3.8% reduction in institutional maternal mortality and 33.6% reduction in Under-5 mortality within the CHAG network (refer table 3 below). A number of factors could have accounted for the 1-year rise in maternal mortality. The lack of funding to support the activities of the MDG Accelerated Framework (MAF) program for maternal health and late referrals of complicated cases from lower level facilities to our facilities might have accounted for this. A study will be conducted into the causes of the rise in the mortality to inform decision making on the issue. There was also a rise in Caesarean Section (CS) rates as shown below. Concerted efforts aimed at reducing avoidable child deaths within the CHAG network over the period, contributed to the reduction in the under-5 mortality. Stillbirths and crude mortality rates reduced by 26.9% and 17.4% respectively, compared to 2012. These are indications of improvement in the quality of health service delivery within the Network. However, Neonatal and Infant Mortality Rates worsened over the said period. Table 3 on the next page provides details on the key outcome indicators for CHAG over a five-year period.

Table 3: Key Health Indicators: 2012 – 2016

Outcome Indicator	2012	2013	2014	2015	2016	2017	% Change 2016 - 2017	One-year Performance 2016 - 2017	% Change 2012 - 2017	5-Year performance 2012 - 2016	National 2016	Developing Countries 2016
Maternal Mortality Rate	158	168	167	145	109	152	39.4	Worsened	-3.8	Improved	151 ¹	239 ⁴
Neonatal Mortality Rate	5.5	7.1	9.8	6.5	13	9	-3.7	Improved	63.6	Worsened	28 ²	52 ²
Infant Mortality Rate	6.6	7.9	10.9	8.6	12.9	10.1	-2.6	Improved	53.0	Worsened	43 ²	107 ²
Under 5 Mortality Rate	21.1	19.5	17.3	15.1	18.3	14	-3.9	Improved	-33.6	Improved	62 ²	177 ²
Still Births Rate	26	24	21	21	20	19	-5.0	Improved	-26.9	Improved	29 ³	18.4 ⁵
Crude Mortality Rate	23	23	21	22	19	19	0%	Improved	-17.4	Improved	9 ²	16 ²

¹ Institutional Maternal Mortality ratio, DHIMS 2, 2016

² The World Bank, Data, 2014, 2015

³ World Health Organization: Maternal, newborn, Child and adolescent health, stillbirths 2015

⁴ World Health Organization: Maternal Mortality Key facts 2015

⁵ 2015 worldwide estimates: WHO neglected tragedy of stillbirths

Christian Health Association of Ghana (CHAG) Golden Jubilee Celebration



Figure 1: Ghana's Former Ministers of Health awarded during CHAG's Golden Jubilee Celebration

Background

The year 2017 as a Golden Jubilee Year was celebrated with a focus on CHAG's role, achievements and contributions in the Ghanaian health sector. This was consistent with the theme "50 years of Christian Health Service Delivery; Improving and Sustaining Innovations". In order to consolidate the past gains and chart a feasible pathway towards achieving Universal Health Coverage (UHC), the occasion was used to identify changes and challenges confronting the CHAG network and the health sector. To ensure the sustainability of Christian health services, the occasion was also used to explore prospects and potentials for the growth and development of CHAG at all levels.

Climax for the Golden Jubilee

Pursuant to the spirit of the Golden Jubilee Year, a series of celebratory themes and activities were earmarked to climax the occasion, which included the following:

Documentaries

Documentaries on the historic growth and development of the Ghanaian health sector; the role/contributions of CHAG were developed and aired. Two documentary episodes were to demonstrate CHAG's historic contributions over the years through tell-tale imageries of selected CHAG member institutions. These segments profiled CHAG's rural reach, pro-poor services, role played by the missionaries, clergy and churches, and the evolving partnerships between CHAG and Government since 1967.

Reflections on “50 years of Christian Health Services, lessons and pointers” by Rev. Dr Frederick Deegbe highlighted CHAG's 50-year privileged position as stewards and servants of Jesus Christ's healing ministry and the fact that the Christian identity and values that drives the compassionate service delivery remains timeless. Therefore, the pro-poor, rural reach targeting the needy, neglected and marginalized continue to serve as model for Universal Health Coverage.

Changes and Challenges

Financial sustainability of CHAG at all levels was identified as a major issue confronting Christian health services delivery in the next 50 years. Consequently, amongst the myriad of changes and challenges identified were:

- Government's withdrawal of utility subsidies from CHAG facilities
- High utility bills of commercial rates being charged to CHAG facilities, which are non-profit
- The NHIS chronic delays in reimbursements, uneconomic tariff structure and other operational challenges impeding service delivery
- The unintended consequences of Ghana's re-designation as lower middle-income country leading to drastic reductions in Development Partner support for CHAG.

Recommendations

Towards “Exploring innovations for the sustainability of Christian Health Service” moderated by Prof. Stephen Addai, adopted the following recommendations:

The need for attitudinal change in CHAG health professionals to reflect Christian values in order to attract and retain clients in an increasing competitive environment.

Establishment of a medical school for the organizational and institutional sustainability of CHAG

Developing / setting up an alternative Mutual Health Insurance schemes (private and run by CHAG) to support the NHIS

Serving as lead public health advocates by reorienting CHAG service delivery package to include disease (communicable and non-communicable) prevention and health promotion in the next 50 years.

Forge a closer partnership with government/MOH towards achieving UHC and the related SDGs



Figure 2: Rev Sr. Rose Sumah(OLA) and others Srs. being awarded by Most Rev. Joseph Kwaku Afrifah-Agyekum(immediate past Episcopal Chairman for Health-GCBC) during the CHAG Golden Jubilee Conference

Awards Ceremony

The Golden Jubilee Celebration was climaxed with an awards ceremony, which amongst others, sought to recognize distinguished individuals and organizations whose significant and varied contributions enhanced CHAG's 50-year contributions in the Ghanaian health sector. The awards were conferred in the following categories;

1. Category A - Distinguished services to past CHAG Board Chairs
2. Category B - Exemplary Ministerial Partnership with CHAG as Ministers
3. Category C - Special Advocacy and Excellent Partnership
4. Category D - Past Executive Directors & Distinguished Past Members of CHAG Board of Trustees
5. Category E - Distinguished services to CHAG

The prospective impact (and probative value) of the awards scheme were to:

1. Promote CHAG's visibility and relevance in the health sector
2. Enlist champions and advocates for CHAG's cause at both policy and operational levels of CHAG
3. Serve as the lead Agency for distinguished services in the health sector using the awards to stimulate standard setting for professionalism, partnership and performance.

Institutionalize a platform for harnessing past exemplary experiences towards restructuring the health sector



Figure 3: Hon. Kwaku Agyeman-Manu, Minister of Health receiving an award from Most Rev. Joseph Afrifah-Agyekum and Dr. (Mrs) Agatha Akua Bonney (Chairperson, CHAG Board of Trustees)

Performance Indicators

Performance indicators showed mixed performance in 2017 compared to previous years. Total number of outpatient attendance was 5,261,683, a decline of 13.3% over that of 2016 and 7.6% over a 6-year period (2012-2017). Total hospital admissions declined by 3.5% in the year under review. However, over a 6-year period there has been 12.8% increase in admissions. The decline in OPD and admissions may be attributed to the numerous Community Health Planning Services CHPS compounds that were established in communities where CHAG facilities operate.

Total deliveries in 2017 was 110,109, a decline of 19.4% compared to 2016. Of this, the number of Caesarian Sections (CS) was 23,894, which represents a decrease of 6.7% over that of that of 2016. Although the absolute number of CS cases in 2017 was lower than in 2016, the proportion of CS cases to total delivery was 21.7%, much higher compared to 2016 and way beyond the WHO recommended rate of 6-10%.

The number of children vaccinated for BCG increased by 6.3% over the period, while the bed-occupancy rate which has been declining since 2013 stood at 49.2% in 2017. Over the last five years there has been an improvement in students pass rate from 61% in 2012 to 84% in 2017. However, this shows a drop from 95% in 2016 to the current 84%.

Table 4: Performance Indicators

Performance indicator	2012	2013	2014	2015	2016	2017	% Change 2016-2017	1-year Performance	% Change 2012-2017	6-year Performance	National 2016
Total Out-Patients	5,813,740	5,844,783	5,749,927	5,942,777	6,065,897	5,261,683	-13.5%	Declined	-9.5%	Worsened	29,948,878
Total Admissions	397,240	428,601	439,186	455,577	464,377	447,950	-3.6%	Declined	12.8%	Worsened	
No of Deliveries	114,205	117,313	119,141	110,228	136,669	110,109	-24.1%	Declined	-3.6%	Worsened	
Total Caesarian Sections	17,839	19,284	20,779	21,834	25,612	23,894	-7.9%	Declined	33.9%	Significantly increased	
Caesarian Rate	15.60%	16.40%	17.40%	19.8%	19.0%	21.70%	2.7%	Worsened	6.1%	Worsened	6.5%
Vaccination (BCG)	109,878	111,371	113,413	91,632	85,813	101,167	17.9%	Improved	-7.9%	Decreased	
HTC Clients counselled	31,451	36,946	50,238	40,161	62,291	66,664	7.0%	Significantly increased	111.9%	Decreased	
Bed Occupancy Rate	68.60%	64%	69%	39.7%	52%	49.20%	2.8%	Declined	-19.4%	Decline	
Student Enrollment	726	1,854	2,849	2,491	2,878	2,800	-2.7%	Declined	299.4%	Significantly increased	
Student Pass Rate	61.00%	65.00%	88.00%	98.00%	95.00%	84.00%	11.0%	Worsened	23.0%	Improved	

¹ World Health Organization - Trends in Caesarian delivery by Country and Wealth quintile: a cross sectional survey in Asia and sub-Saharan Africa

Input Indicators

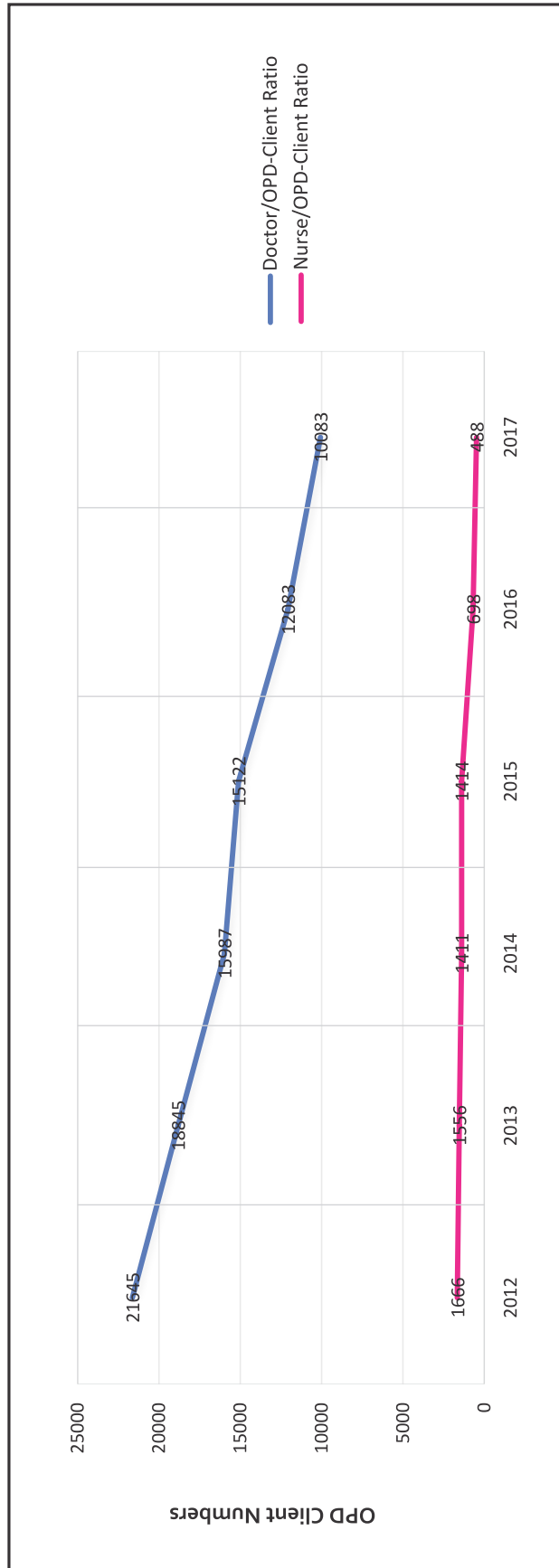
As depicted in Table 5 and Figure 1, selected *input indicators* showed a considerable improvement in the area of human resources with a noticeable increase of 126.8% in the total number of CHAG staff enrolled on GOG-payroll since 2012. The average proportion of *clinical staff* relative to the total staff establishment increased from 48% in 2012 to 64% in 2017, although distribution of clinical staff remained uneven. Doctor to client and nurse to client ratios have seen continuous improvements from 2012 to 2017 as shown in table 5 below. Every year there are nurses and doctors who accept posting into CHAG and this account for the improvement in the above ratios. The nurse/client ratio (1:488) at the moment is better than the national nurse / client ratio of 1:834.

Table 5: Input Indicators: 2012-2016

Input indicators	2012	2013	2014	2015	2016	2017	% Change 2016-2017	1-year performance	% Change 2012-2017	5-year performance	National (Ghana)	WHO Standard
Total Mechanized Staff	8,861	9,356	11,127	12,584	15,942	20,099	26.1%	Increased	126.8%	Significantly increased		-
% Clinical/non-clinical staff Ratio	48	64	73	53	60	64	4%	Improved	16.0%	Improved		-
Doctor/OPD-Client Ratio	1:21,645	1:18,845	1:15,987	1:15,122	1:12,083	1:10,080	-16.6%	Improved	53.4%	Improved	0.096:1,000 (1:10,416)	3.4/1,000
Nurse/OPD-Client Ratio	1:1,666	1:1,556	1:1,411	1:1,414	1:698	1:488	-30.1%	Significantly improved	70.7%	Significantly improved	1:834 ²	3.4/1,000 ³

¹WHO Global Health Observatory Data, 2010
² Holistic Assessment Report 2016, MOH

Figure 1: Trend of Doctors and Nurses/OPD Clients Ratio 2012 - 2017



³ Staff Access deficit indicator, 2010 World Health Report

Performance Outcome and Status for 2017

As an Implementing Partner, CHAG sought to contribute to the achievement of Ghana's Health Sector Medium-Term Development Plan (2014-2017) by adopting the Health System Strengthening approach. Hence, the focus areas comprised;

1. Health Service Delivery
2. Health Information
3. Leadership and Governance
4. Human Resource for Health
5. Health Financing
6. Health Technology
7. Community Ownership and Participation
8. Partnership
9. Health Research

This section provides information on the performance, outcome and status of CHAG during 2017. It is structured on the nine (9) health systems building blocks as adopted in 2010 by CHAG as its performance management framework.

1.0 Service Delivery

CHAG provides primary, secondary and tertiary health care as well as preventive, promotive, rehabilitative and palliative services. CHAG's health service provision hinges on core values such as Christian identity, purpose and values with much emphasis on protection of patient's rights and adherence to professional medical norms and ethics. Other important aspects are quality of care and patient safety, addressing the local disease burden and improving efficiency and effectiveness. Services provided by CHAG are aligned to national health sector priorities and in accordance with standard treatment guidelines.

1.1 Out-Patient and In-Patient Services

In 2017, a total of 5,261,683 out-patients (old and new) and 447,950 in-patients benefitted from health services provided by CHAG. There was 13.5% decline in Outpatients attendance and 3.5% in in-patient's admissions respectively compared with that of 2016. The decline in OPD may be attributed to the numerous Community Health Planning Services CHPS compounds that were established in communities where CHAG facilities operate. These compounds are beginning to manage cases beyond their scope and are referring to CHAG facilities late. This explains the increase in admissions.

Out of every 10,000 Out-patients, about 850 patients were admitted in CHAG hospitals with 18 beds per 1,000 population. Approximately 94% and 92% respectively of the OPD and IPD clients were insured. This represents 11% increase in OPD and 3.5% IPD insured clients respectively compared to 2016. Over a period of six years, outpatient attendance has seen 9.5% decline (2017 compared with that of 2012), while insured outpatients increased by 6.8%. General inpatients admissions increased by 12.8% whereas insured inpatient clients increased by 9.5% (Table 2) over the same period. Table 1 shows trend of OPD and IPD numbers from 2012 to 2017. In the coming year CHAG would build strong quality assurance teams within our facilities to ensure that clients have a better option.

Table 6: OPD, IPD Service Outputs and Health Insurance Status of clients: 2012 – 2016

Performance Indicator	2012	2013	2014	2015	2016	2017	6 Years Trend
OPD	5,692,640	5,766,567	5,979,124	5,942,777	6,065,897	5,261,683	Declined
OPD Insured	88%	94%	89%	87%	85%	94%	Increased
IPD	397,240	428,601	439,186	455,577	464,377	447,950	Declined
IPD Insured	84%	86%	86%	85%	82%	92%	Increased

1.2 The Contribution of CHAG to National Outpatient and In-Patient Services

In 2017, CHAG contributed 18.7% and 27.8% of National OPD and in-patient respectively as shown in figure 2 and table 7 below. CHAG has been contributing an average of 29% to National in-patient services since 2012 (refer to figure 5 below). Similarly, CHAG's contribution to National OPD care has been fairly constant over the past six years. The average contribution since 2012 is 19%. The number of clients seen at the inpatient and outpatient departments have not significantly changed since 2012 even though the number of CHAG Member Institutions (CMIs) have increased. The establishment of many CHPS and private health facilities in some of the areas where CMIs operate is creating competition for some of our clients.

The regional contribution of CHAG to IPD and OPD care is highest in the Ashanti region where CHAG contributes 75% and 44% to in-patients and out-patient care respectively. These figures exclude IPD and OPD clients attended to by the Komfo Anokye Teaching Hospital and private facilities in Kumasi (refer to table 8 below). The second region where CHAG makes significant contribution to OPD and in-patient care is in the Brong Ahafo with 58% and 42% respectively. The regions with the least OPD and inpatient recorded are the Greater Accra region with 7% and Upper East with 8%.

Figure 5: Trend of Percentage CHAG Contribution to National OPD & IPD

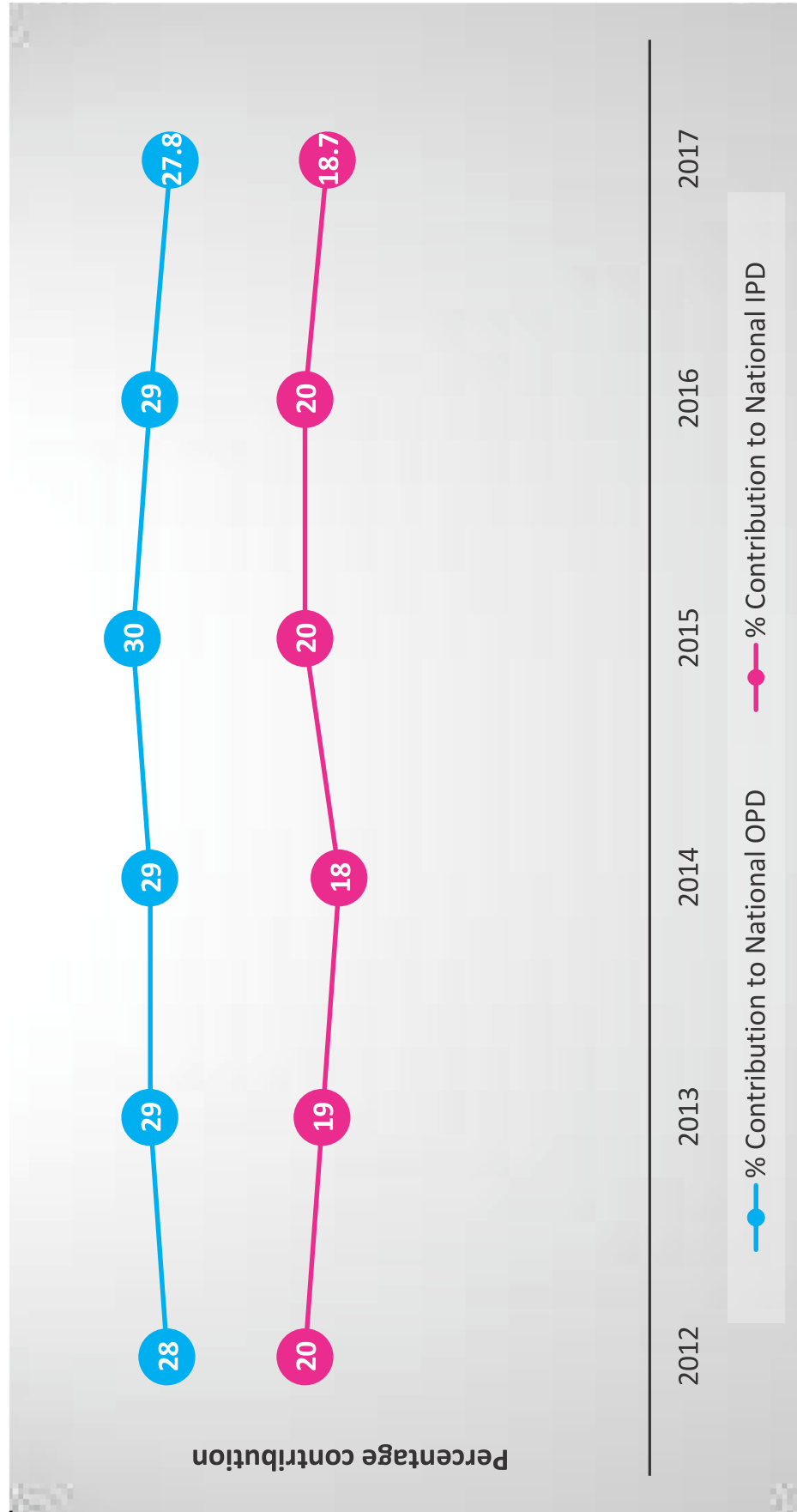


Table 7: CHAG percentage Regional Contribution to National OPD and IPD Services, 2016

Output	2012	2013	2014	2015	2016	2017	6-year Trend
National OPD	29,496,283	30,142,274	31,087,824	29,949,173	29,948,878	28,451,871	Fluctuating
CHAG OPD	5,813,740	5,749,927	5,749,927	5,942,777	6,065,897	5,261,683	Fluctuating
CHAG % Contr. to National OPD	20%	19%	18%	20%	20%	18.7%	Declining
National IPD	1,405,997	1,460,360	1,534,379	1,501,773	1,532,839	1,523,653	Fluctuating
CHAG IPD	397,240	428,601	439,186	455,577	464,377	447,950	Increasing
CHAG % Contr. to National. IPD	28%	29%	29%	30%	29%	27.8%	Declining

Table 8: CHAG's contribution to Regional and National OPD and IPD, 2016

Region	In-patients			Out-patients			Percentage (%) Contribution CHAG		
	National In-patients	Contribution by CHAG	National Out-patients	Contribution by CHAG	IPD	OPD			
Ashanti	115,446	86,453	2,719,849	1,207,168	75	44			
Brong Ahafo	167,635	97,813	3,415,961	1,291,657	58	38			
Central	187,824	40,026	3,591,370	573,827	21	16			
Eastern	190,752	37,433	4,130,672	702,316	20	17			
Greater Accra	127,207	16,846	3,639,881	269,827	13	7			
Northern	171,412	56,316	942,999	395,691	33	42			
Upper East	156,701	12,903	2,373,324	310,717	8	13			
Upper West	85,236	25,184	2,086,391	235,157	30	11			
Volta	292,129	49,638	4,866,360	610,880	17	13			
Western	193,708	41,765	1,974,714	468,659	22	24			
National	1,588,050	464,377	29,741,521	6,065,897	29	20			

Source: DHIMS 2 (accessed 12th April 2018)

1.3 Contribution to OPD by Church Denomination

The National Catholic Health Service (NCHS) because of the large number of facilities they own, continues to contribute more to both OPD and IPD care since the formation of CHAG compared to the other Church Health Services. From 2013 to 2017, NCHS has seen a steady rise in contribution to the overall OPD care for CHAG from 59.1% and 61.2% respectively. Presbyterian health service is the second followed by SDA and Methodist. Figures 4 & 5 show 2017 percentage contribution to OPD and IPD by denomination respectively.

Figure 3: OPD Contribution by Denomination, 2016

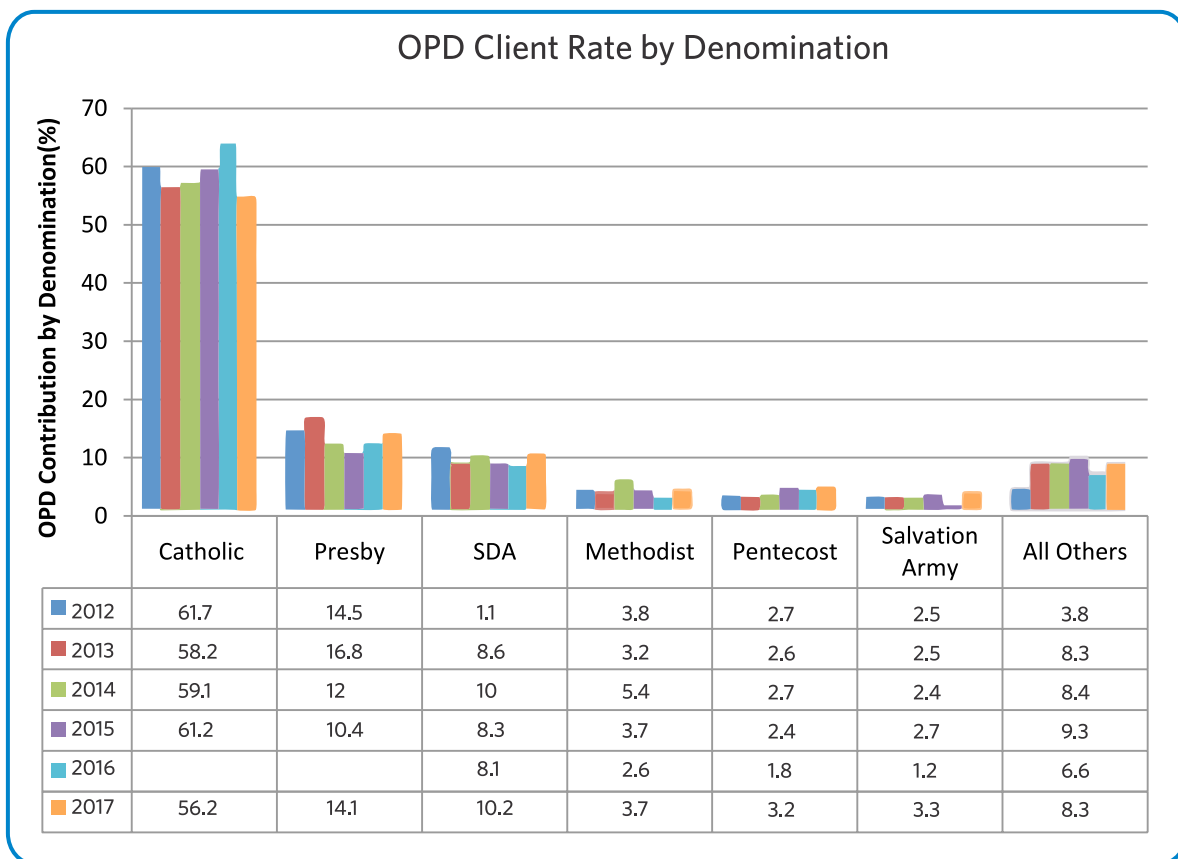
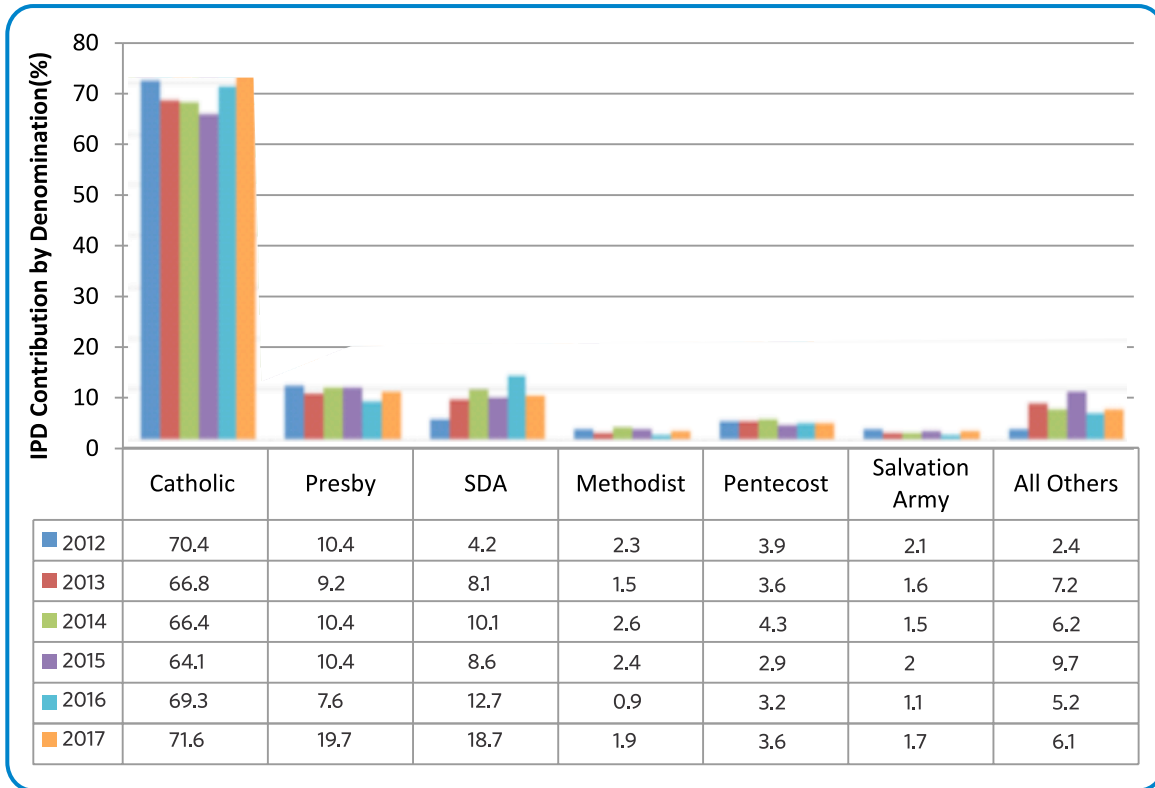


Figure 7: IPD Contribution by Denomination, 2017



For the inpatients care, the National Catholic Health Service contributed approximately 71.6% to the CHAG IPD Client attendance compared to other Denominational Health Services. Compared to 2012 this year's contribution represents a 1.2% increase in NCHS contribution to CHAG's IPD as shown in figure 4.

1.4 Contribution to CHAG OPD & IPD by Region

CHAG has higher number of Member Institutions in the Ashanti Region than any other region in the country. The region has the highest population and by extension, the highest number of health facilities. Consequently, in 2017, Ashanti region contributed 21.3% to OPD clients within the Network (refer to figure 5) while Brong Ahafo Region contributed 18.4% of OPD Client attendance with Eastern Region coming third with 12.7%.

Figure 8: Proportion of 2017 Annual OPD Clients contributed by Region

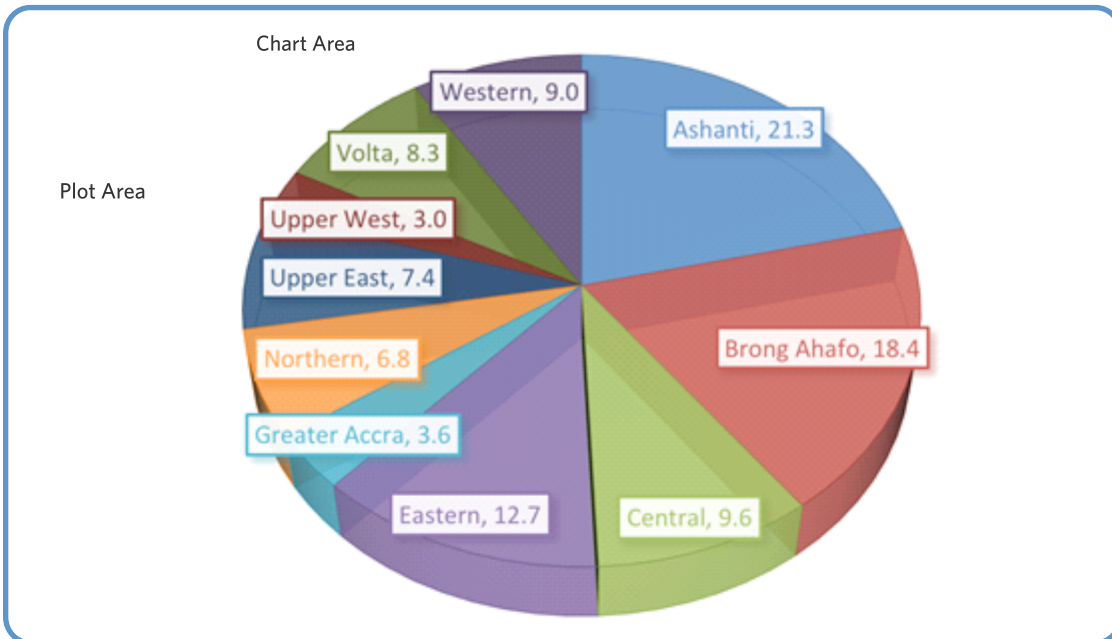
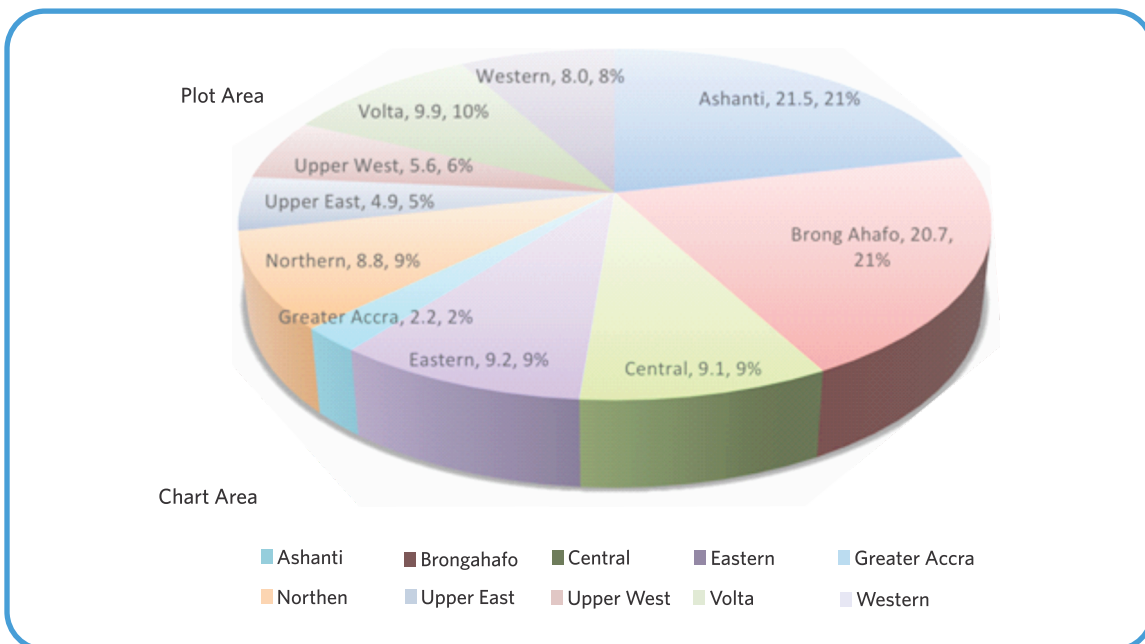


Figure 9: Proportion of 2017 Annual Admissions Contributed by Region

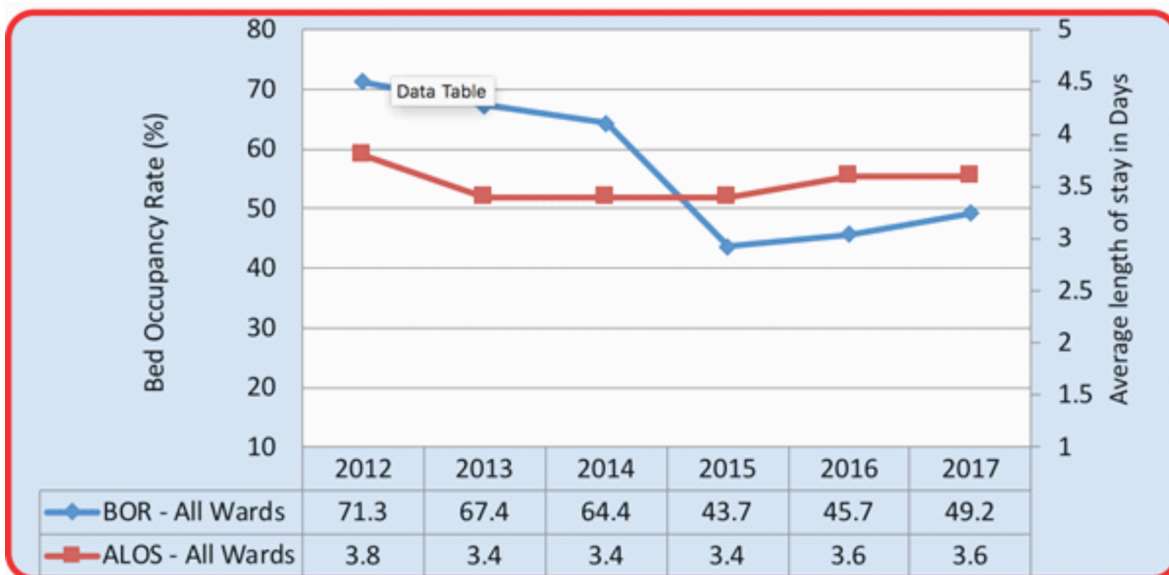


Again, with regards to in-patient care, Ashanti Region contributed a higher proportion of 21.5% inpatient admissions followed by Brong Ahafo region with 20.7% and the Greater Accra region with the least of 2%. Greater Accra contributes the least because it has limited number of facilities. Figure 6 highlights regional contribution to IPD data.

1.5 Bed Occupancy Rate (BOR) and Average Length of Stay (ALOS)

From 2012 to 2017, the proportion of beds utilized by inpatients per 100 beds in CHAG decreased from 70 to 49 beds. The progressive decline in bed utilization could be attributed to early diagnosis and treatment thus avoiding the need to be admitted. The decreasing trend means that the demand for hospital beds within CHAG facilities decreased and a pointer to the fact that going forward, it may not be necessary to keep many beds in a facility. Rather than focusing on building facilities with large number of hospital beds, it is instructive to rather focus on quality of service delivered to clients. Average days spent at all wards were 3.5 days and this has been so since 2014. Figure 7 below provides details.

Figure 10: Trend of Bed Occupancy Rate and Average Length of Stay, 2012 - 2016



1.6 Reproductive and Sexual Health Services

CHAG continues to prioritize Reproductive and Sexual Health. A total of 110,109 supervised deliveries were conducted in 2017. This was 19.4% less than that of 2016 and 3.6% less than that conducted six years ago (2012). About 22% of all deliveries were performed under Caesarian Sections (CS). This is 3% higher than that of 2016 and it higher than the WHO approved CS of 10-15%. Moreover, this is above that of Ghana national target of 6.5% and that of Sub-Saharan Africa of 2%. There is room for improvement. While the cause of CS is not so clear, it's could likely be attributed to delayed reporting and referrals from home and smaller facilities to the hospitals as well as some women opting for CS. Table 2 below shows the trend of Sexual and Reproductive Health outputs, 2012 – 2017.

A total of 132,284 pregnant women were registered at CHAG Reproductive and Child Health (RCH) units in 2017 for antenatal services (ANC). This is 22.4 % increase compared to that of 2016 and 6% increase over the last 6 years (2012-2017). Over 151,700 mothers were registered for Postnatal Care (PNC) and 94.0% of these PNC registrants, initiated breast feeding within one hour of delivery.

Figure 11: CHAG's Contribution to Regional Deliveries, 2017

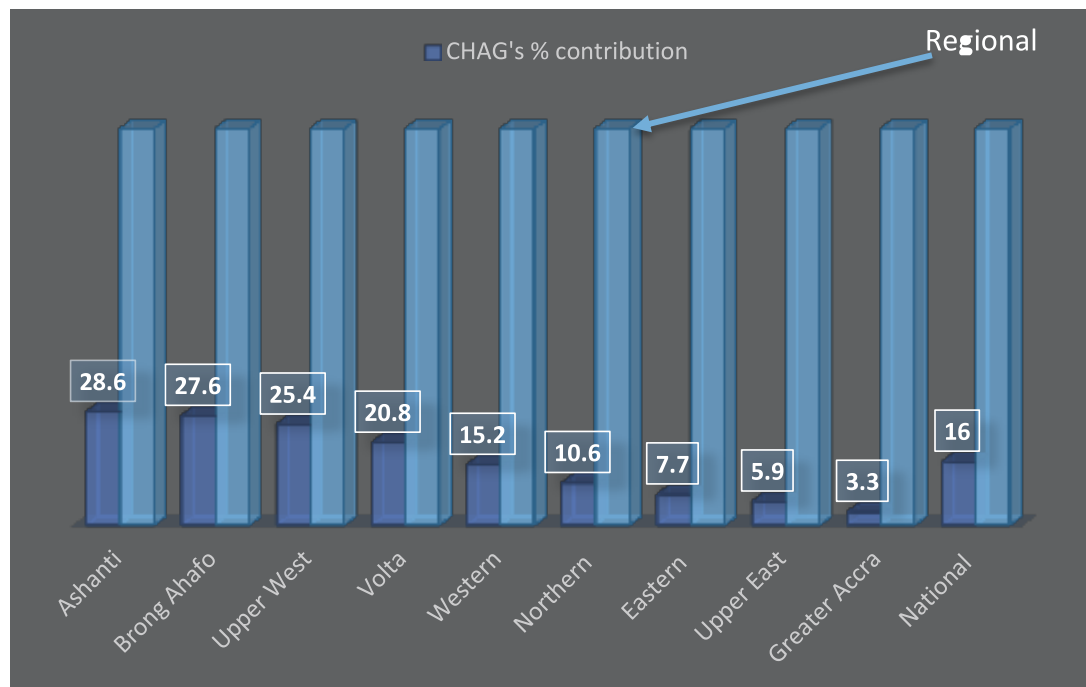


Table 8: Reproductive and Sexual Health service outputs, 2012-2017

Performance Indicator	2012	2013	2014	2015	2016	2017	6-Year Trend
Total Deliveries (Live/Still)	114,205	117,313	119,141	110,228	136,669	110,109	Decreased
Total C-S	17,839	19,284	20,779	21,834	25,612	23,894	Increased
-S Rate	15.60%	16.40%	17.40%	20%	19%	21.7%	Worsening
Total ANC Registrants	93,303	125,647	117,257	106,271	124,785	132,284	Increased
Total ANC Attendance	507,034	632,282	620,223	560,394	641,554	684,800	Increased
ANC 4th Visit Rate	105%	75%	92%	84%	81%	81.3%	Stabilized
Total PNC Registrants	81,149	87,177	91,551	122,924	142,704	151,707	Increased
MM Audit Rate	77%	92%	86%	86%	97%	87.5%	Improved

¹ World Health Organization - Trends in Caesarean delivery by Country and Wealth quintile: a cross sectional survey in Asia and sub-Saharan Africa

² WHO statement on Caesarean section rates; http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

1.7 Family Planning

During the year under review, CHAG provided family planning services under reproductive and child health. Number of couples accepting family planning methods were 2,544,226. This was 12.0% higher than the previous year. Out of this number, 909,558 (36%) were new couples who registered for family planning. In all, 3,253,598 visits were made to the family planning units within CHAG facilities for the year under reporting. However, this was about half of the total visits observed in 2016. Figure 7 below shows trend of family planning services 2012 - 2017

Figure 12: Family Planning Services: Registrants, acceptors and visits 2012-2017

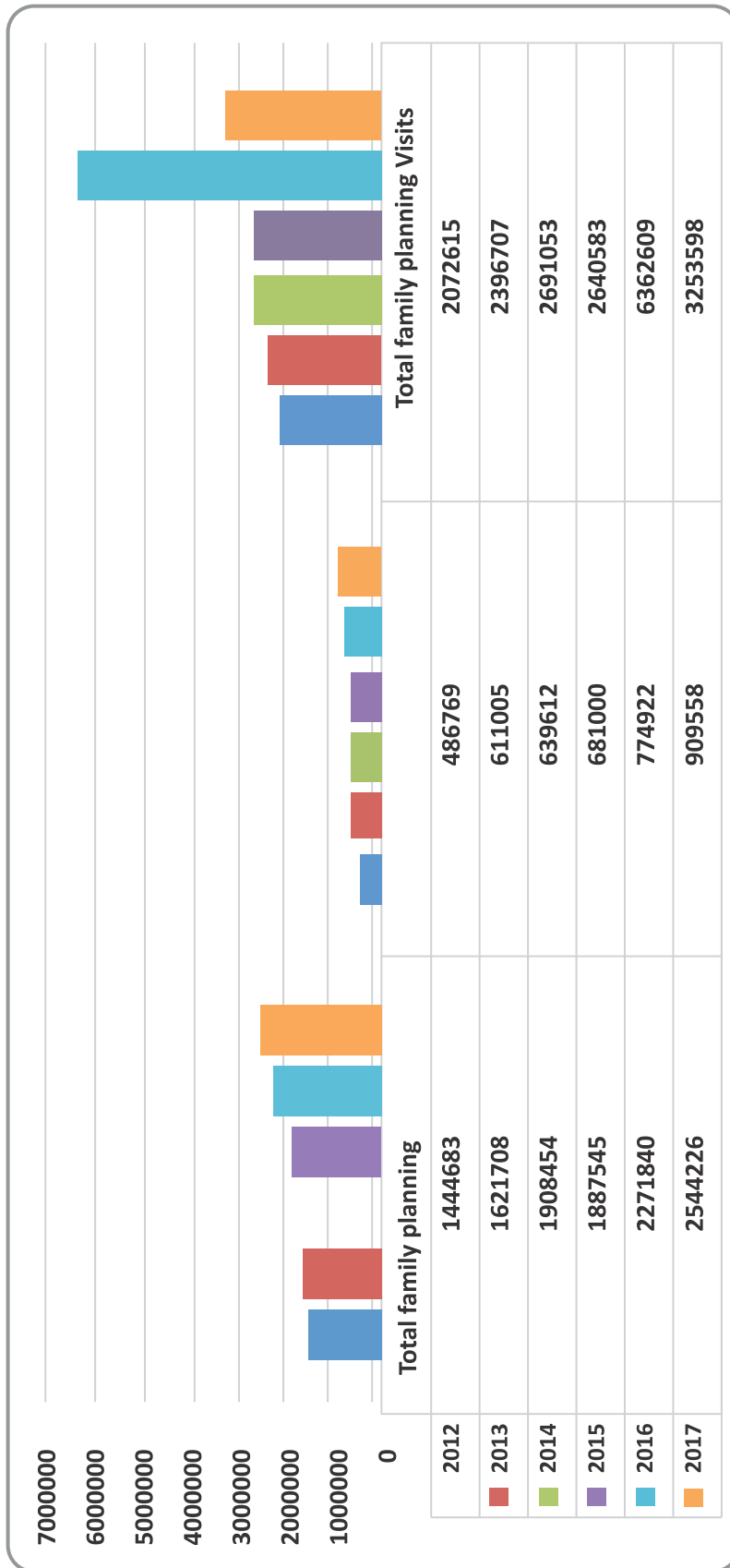


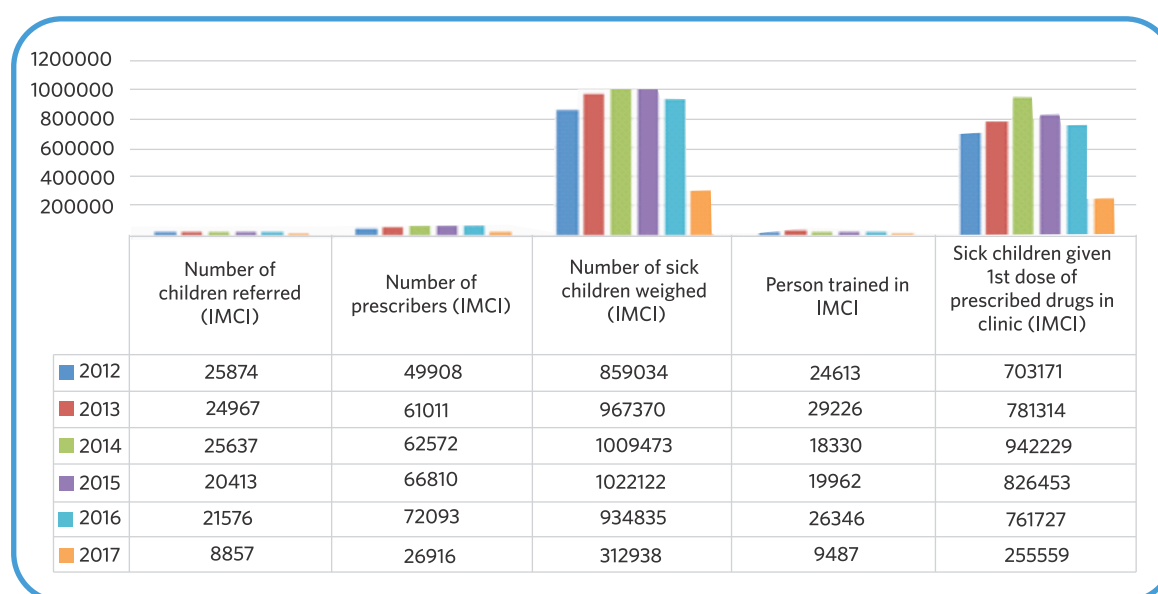
Table 9: Trend of Family Planning uptake by type, 2013-2017

Description	2013	2014	2015	2016	2017
Natural family planning	10,821	10,344	15,101	6,756	<u>11,738</u>
Male sterilization (vasectomy) acceptors	0	4	14	7	<u>31</u>
Female sterilization acceptors	463	455	807	695	<u>541</u>
Condom (male) acceptors	52,581	70,715	83,470	67,724	<u>2,721</u>
Condom (female) acceptors	81	162	108	261	<u>48</u>
Oral contraceptives acceptors	10,542	11,592	10,810	8,326	<u>1,380</u>
Implant acceptors	2,956	3,308	4,336	6,478	<u>4,811</u>
All other artificial methods acceptors	37,053	33,026	34,280	26,941	<u>11,689</u>

1.8 Child Health Services

About 8,857 children were seen and referred to the next level of care. For the health staff to provide quality services aside the provision of equipment/consumables, training is key to be abreast with current treatment regimens and others. However, the number of trained persons in Integrated Management of Childhood Illnesses (IMCI) over the past 6 years (2012 -2017) shows a decreasing pattern. Approximately 9,500 personnel from CHAG were trained in IMCI in the year 2017. There was 58.9% decline compared to the numbers trained in 2016. Over a 6-year period, there is a 65.8% decline. Figure 13 below shows trend of key information on Integrated Management of Childhood Illness

Figure 13: Integrated Management of Childhood Illnesses (IMCI) 2012-2017



1.9 HIV / AIDS SERVICES

CHAG facilities continued to render HIV /AIDS services in 2017, providing pre-test and post-test counselling, laboratory testing and home care services to clients. A total of 66,664 clients were counselled for HIV, which was 55% more than that in 2016. There was a 7% gap between those counselled and those who tested. One percent (1%) of the 93% who tested were positive. This is 12% less than that of 2016 and about 38% less than that of 2012. For HIV/AIDS Prevention of Mother to Child Transmission (PMTCT), 118,122 pregnant women were counselled for HIV testing, out of which 23,613 (20%) were tested. Out of those tested 8,104 of them (19%) were positive. Over a 6-year period the number of HIV positive tests has reduced from 5.2 to 2.0. Total number of clients who received Anti-Retroviral (ARV) treatment was 3,974. Testing rate is low, and it is worth investigating and putting interventions in place to improve the testing rate. Trend of HIV/AIDS output is shown in table 3 below.

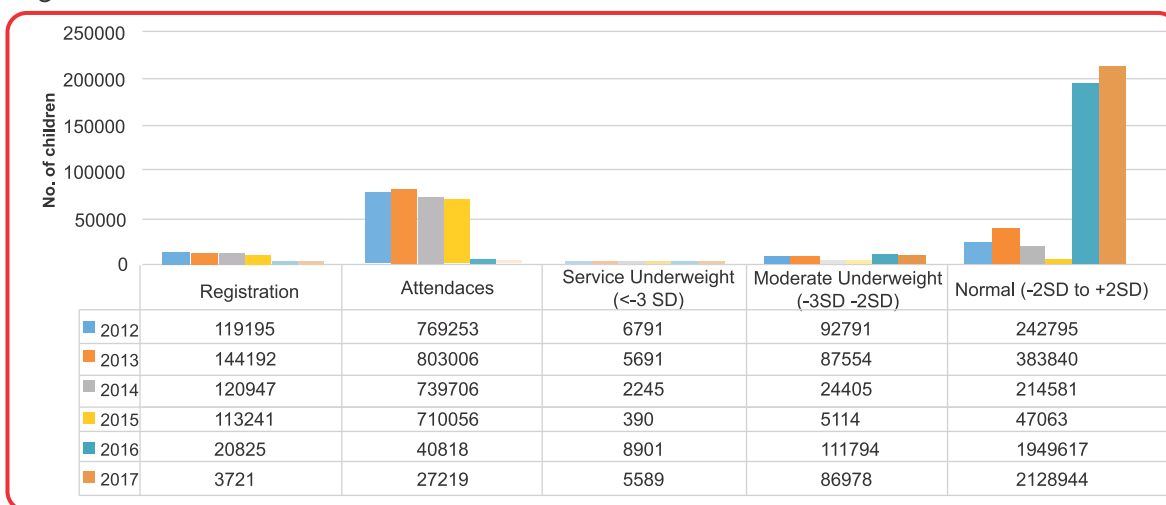
Table 10: HIV/AIDS Service Output 2012 - 2017

	2012	2013	2014	2015	2016	2017	% Change 2016-2017	One-year Performance	% Change 2012-2017	6-Year performance
HTC Client Counseled	31,451	36,946	50,238	40,161	62,291	66,664	7.0%	Increased	112.0%	Significantly increased
HTC Client Tested	29,330	32,269	38,593	39,008	58,067	65,721	13.2%	Increased	124.1%	Significantly increased
% HTC Tested +VE	24%	21%	18%	17%	15%	12%	3.0%	Improved	12.0%	Declined
PMTCT Clients Counseled	73,169	111,470	110,856	136,836	115,734	118,122	2.1%	Increased	61.4%	Increased
PMTCT Clients Tested	66,421	92,695	108,817	93,254	110,655	23,613	-78.7%	Increased	-64.4%	Declined
% PMTCT +VE	5.20%	2%	1.50%	2%	2.3%	2.00%	-0.3%	Worsened	-3.2%	Declined
All other HIV Tested +VE	8,296	6,459	5,325	4,072	2,947	8,104	175.0%	Improved	-2.3%	Declined
No of Clients ARV Treatment	4,096	5,360	5,325	4,520	3,800	3,974	-15.9%	Decline	-3.0%	Declined

1.10 Child welfare Outreach Health Services

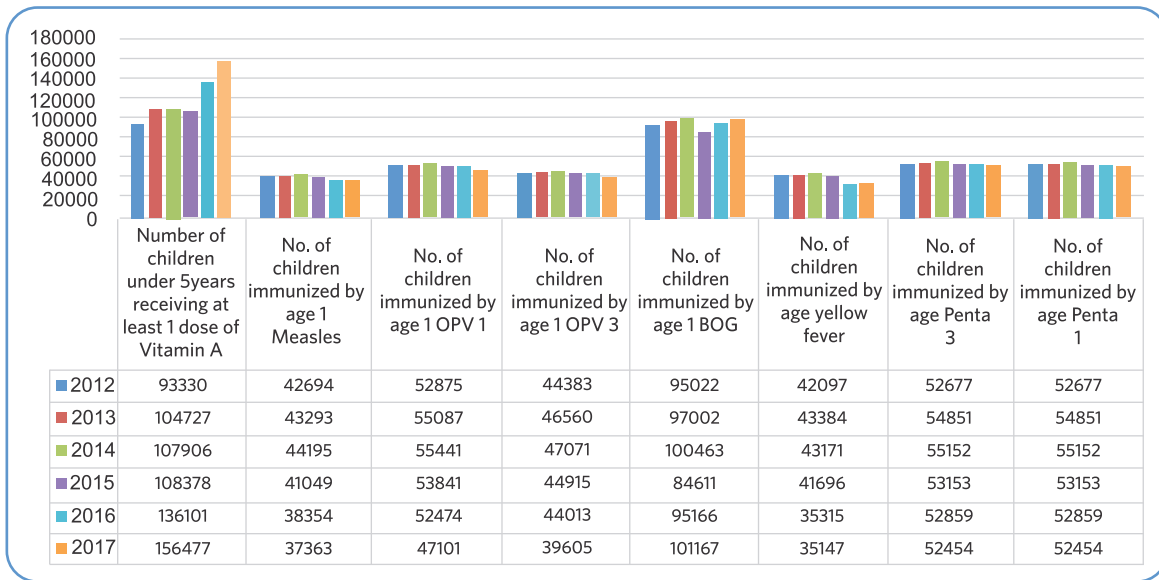
In 2017, a total number of 2,221,511 children were reached during outreach programmes. Over 3,700 children were newly registered. Out of those reached, 2,128,944 had normal (-2SD to +2SD) weight, 86,978 were moderately underweight (-3SD to -2SD), and 5,589 were severely underweight (<-3SD). (Figure 15)

Figure 14: Child Welfare Outreach Services From 2012 – 2017



During the year under review, 156,477 children under the age of 5 years were given at least one (1) dose of vitamin A with a total of 101,167 children under-1 year being immunized against Tuberculosis (given BCG Vaccines). Given the number of deliveries that occurred in the year under review, there is a gap of about 9,000 children who were not given BCG. About 37,363 were immunized against Measles and 35,147 for Yellow Fever. The most frequent vaccine given to children during outreaches over the past six years was Vitamin A whiles the least frequent vaccine given was Yellow Fever as shown in figure 11 below.

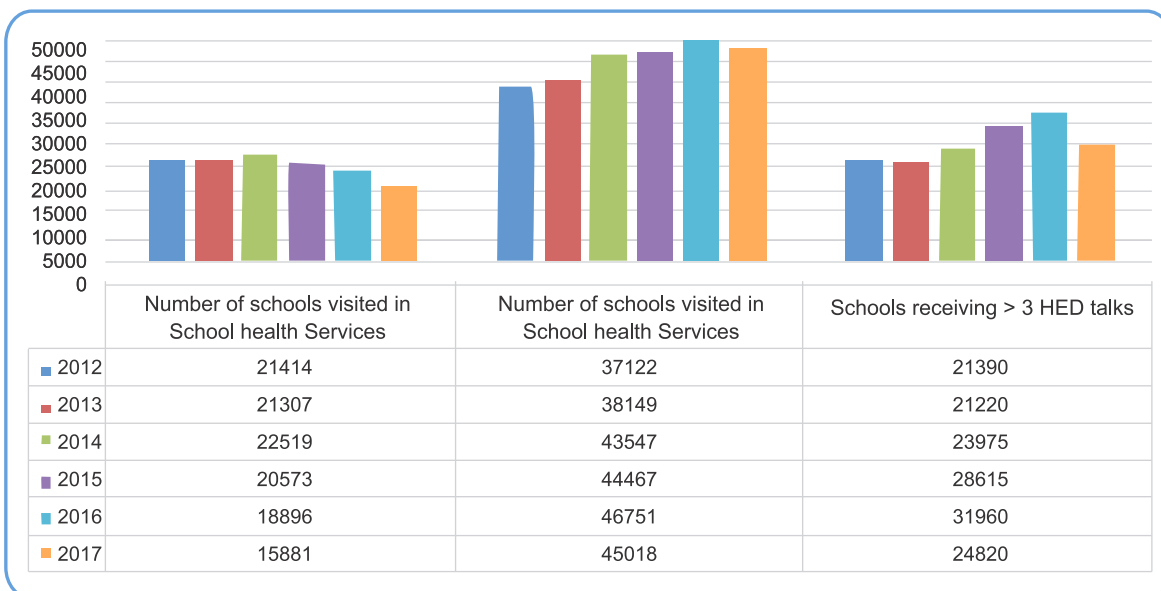
Figure 15: Outreach Immunization Coverage and Vitamin- A Supplementation: 2012 – 2



1.11 School Health Programme

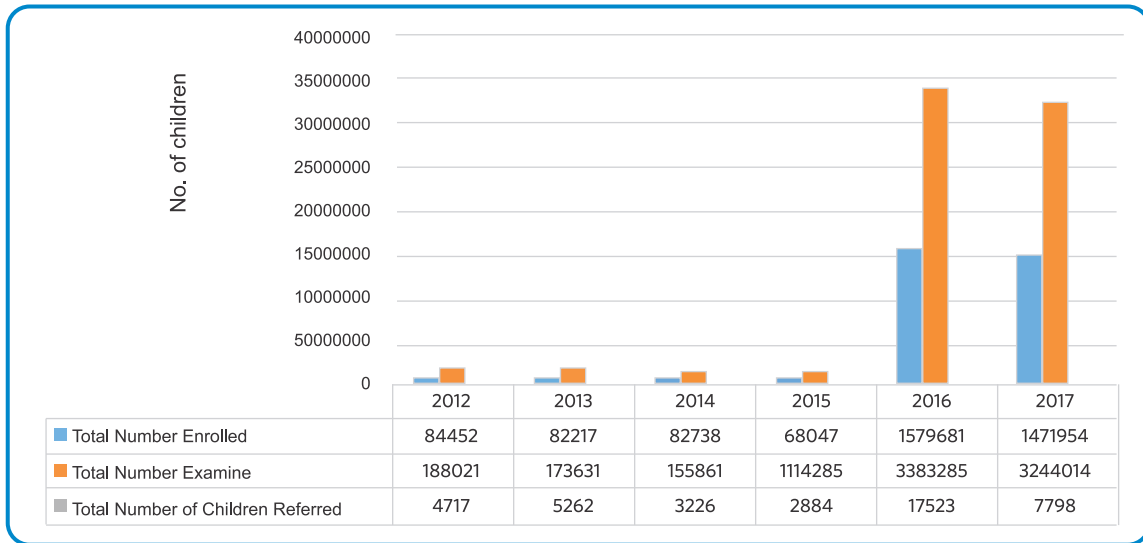
CHAG Health facilities visited 45,018 schools in 2017, which is 3.7% lower than the number of schools visited in 2016. However, over a period of 6 years, this represents a 21.3% increase. Close to 25,000 of the schools visited had more than three (3) health education talks in 2017, which is 20.9% decline compared by that of 2016 and 16% increase over that of 2012 as shown in figure 11.

Figure 16: School Health Programme From 2012 – 2017



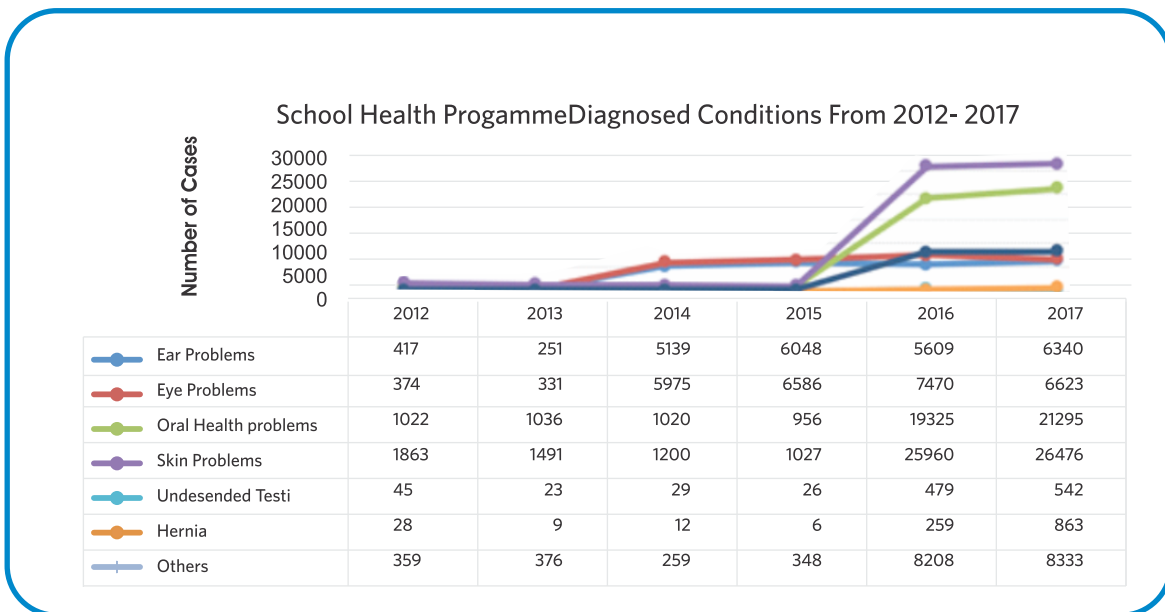
In 2017 CHAG enrolled 1,474,954 students under the school health programme. Over 3,244,014 tests for diseases were conducted on the students out of which 7,798 students were referred.

Figure 17: Student Enrolled in School Health Programme from 2012 - 2017



Students were diagnosed of various conditions during the school outreach services. The following top five diseases/conditions were recorded: Skin diseases (37.6%), Oral problems (30.2%), Eye problem (9.4%), Ear problems (9.0%), and Hernia (1.2%). The rest constituted 11.8% (8,875 conditions) of all diagnoses which was 4.8% increase over that of 2016 as shown in figure 14 below.

Figure 18: School Health Programme Diagnosed Conditions From 2012 - 2017



1.12 Summary Burden of Disease (Epidemiology)

The range of conditions that people presented to the various CHAG health facilities in 2017 did not change much compared to that in 2016. The top 10 common causes of OPD morbidity for the past six years (2012 to 2017) have remained the same. Malaria continues to be the commonest cause of OPD morbidity and admissions in CHAG Health facilities since 2012 as shown in Table 12 below. Over the past six years, there has been a steady decline in the proportion of malaria particularly in 2017. This is attributed to the efforts of Malaria Control Programme in ensuring that clinicians are treating actual malaria cases and not considering every fever as malaria. The extensive education and workshops on malaria case management and the policy of “test before you treat” is paying off. Over the past few years, several rapid test kits were distributed to the Network to ensure that cases were tested before treatment. Additionally, many prescribers, laboratory personnel and other paramedical staff were taken through malaria case management through various workshops in most of the regions. There were also massive campaigns on the use of Insecticide Treated Nets (ITNs) especially for pregnant mothers as well as indoor residual spraying against mosquitoes in some regions of Ghana. These activities have made huge impact on malaria. As seen in top ten conditions for 2016, majority of the conditions we dealt with were infections; malaria, respiratory and urinary tract infections among others. These have implications on pharmaceutical products being used. We are leaning more on antibiotics because of the conditions that are presenting at our health facilities. Rational use of medicines survey in selected CHAG institutions show that about 36-74% of all prescriptions are antibiotics above the WHO prescribed limit of 20%. Since antibiotics are comparatively expensive, health care cost is rising as a result. As prescription for antibiotics increase, so is the potential for antibiotic resistance to develop in the general population. With this trend, there will come a time when we will need to use highly effective but expensive antibiotics. In the end, a situation will arise where we will spend more on pharmaceutical products.

1.12.1 Morbidity

From 2012 to 2017, the top-10 morbidity statistics remained relatively similar. In 2017 Malaria accounted for 18.1% of OPD attendance compared to 38.8% in 2016. This was a drop of 53.4% over a period of one year. Since 2012, the proportion of OPD cases due to malaria has dropped by about 63.8%. Current measures regarding malaria case management should continue in order to sustain the gains made in the fight against malaria. Respiratory Tract Infections (13.8 %), Rheumatic/Joint Pains (10.0 %), and Diarrhea Diseases (6.7 %) were 2nd, 3rd, and 4th causes of OPD attendance respectively. Figure 19 shows the details with the other conditions and the proportions seen. Again, Table 12 shows a trend of top 10 causes of OPD 2012 to 2017.

Figure 19: CHAG Top Ten (10) Causes of Morbidity for the year ending December 31, 2017

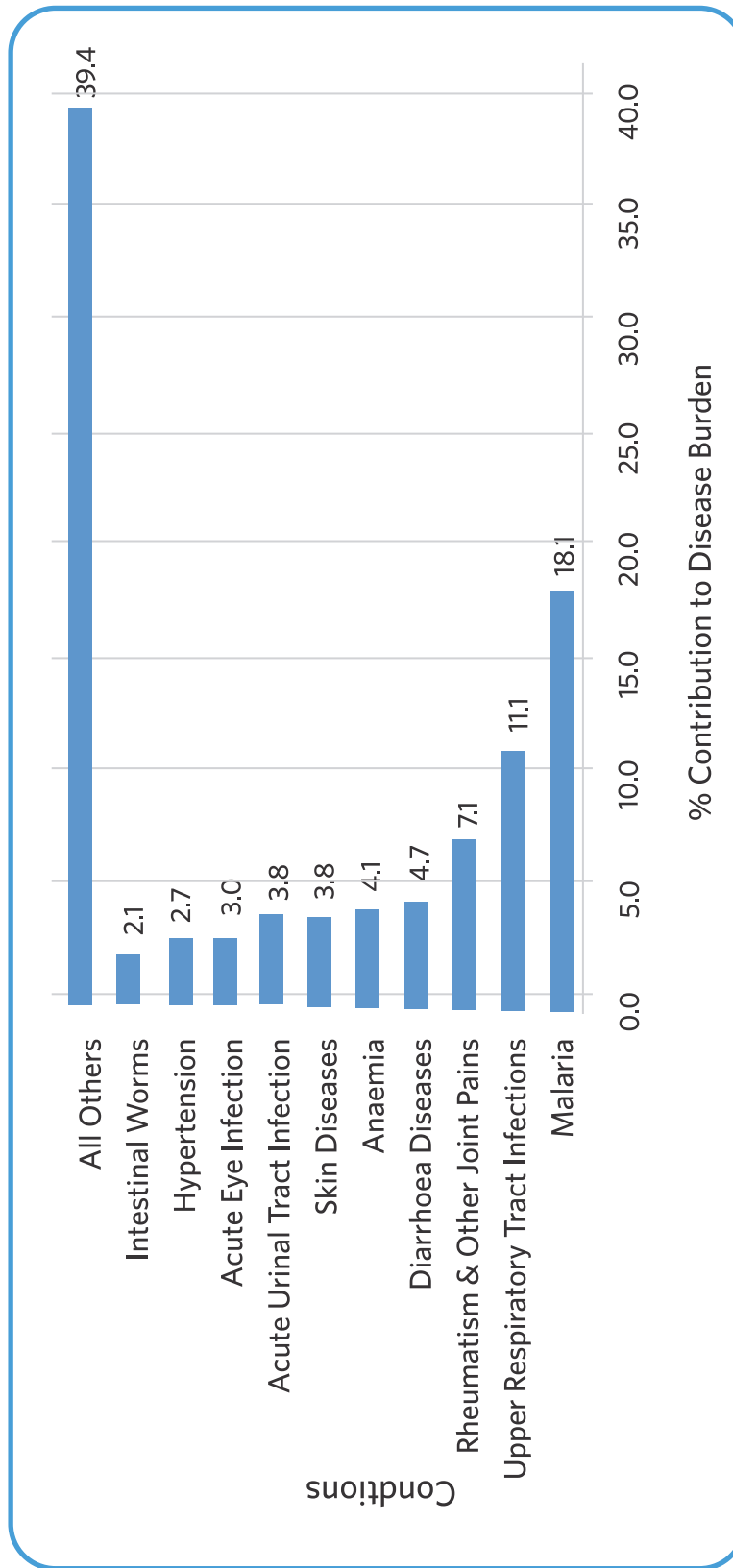


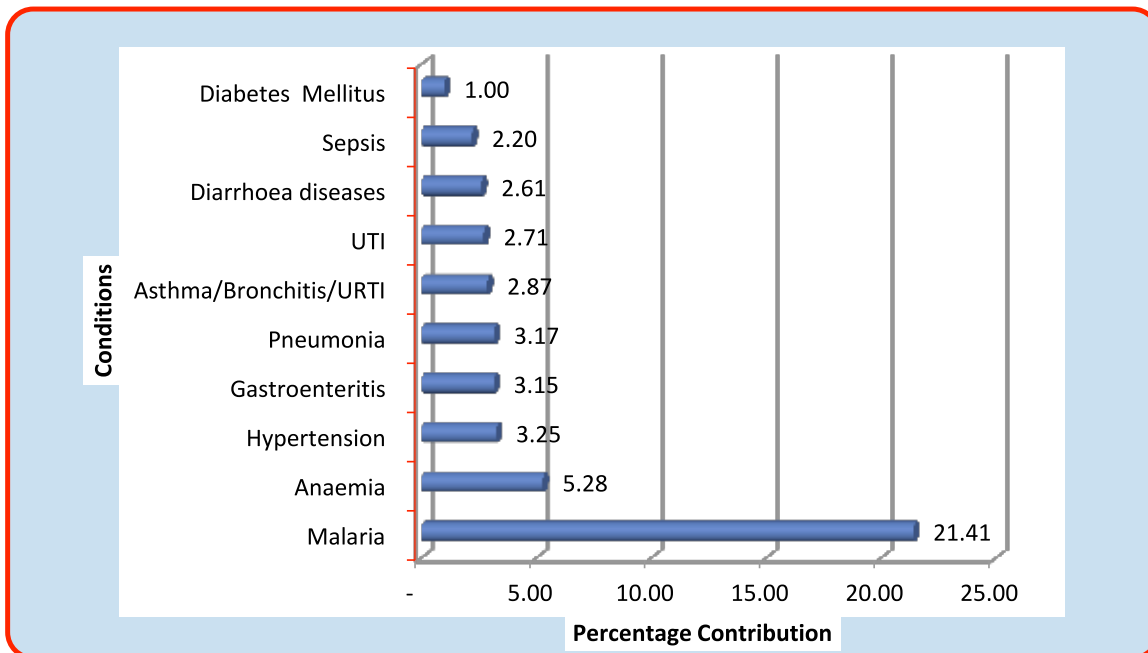
Table 12: Top-10 causes OPD Morbidity: 2012 – 2017

Condition	Percentage (%) Contribution by Condition										2012-2016 % Change	One-year performance	2012-2016 % Change	5-year performance
	2012	2013	2014	2015	2016	2017	2016-2017 % Change							
Malaria	50	45.8	44.9	22.9	38.8	18.1	-53.4%	Worsened	64%	Improved				
URTI	10.2	16.2	7	8.5	13.8	11.1	-19.6%	Worsened	-9%	Worsened				
Rheumatism / Joint Pains	5.8	6.6	8.3	5.2	10	7.1	4.8	Worsened	-22%	Worsened				
Skin Diseases & Ulcer	5.7	6.2	7.3	3.5	6.4	4.7	-29.0%	Worsened	18%	Worsened				
Anaemia	4	3.0	5.3	3.4	6.4	4.1	3.0	Worsened	-2%	Worsened				
Diarrhoeal Disease	4.5	4.7	5.3	3	6.7	3.8	-26.6%	Worsened	16%	Worsened				
Urinary Tract Infection	2.9	3.5	3.9	2.7	5.1	3.8	2.4	Worsened	-31%	Worsened				
Hypertension	6.0	4.9	4.2	2.2	3.9	2.7	-35.9%	Worsened	55%	Improved				
Intestinal Worms			-	1.7	2.8	2.1	1.1	Worsened	-24%					
Acute eye infections	-		-	-	-	3.0	0							
All Others			41	43.7	6.1	39.4								

1.2.2 Admissions

For the year under review, Malaria accounted for 17.7% of admissions followed by Anaemia (5.6%), Pneumonia (3.3%), and Hypertension (3.2%). Figure 20 shows details of top 10 causes of admission for 2017.

Figure 20: CHAG Top Ten (10) Causes of Admission 2017



Over a 6-year period, the proportions of malaria, Anaemia, hypertension and respiratory tract infections that account for the top 5 causes of admissions within CHAG facilities have reduced.

Noticeably, the proportion of admissions accounted for by malaria has reduced by over 31% since 2012 as shown in table 13 below. This is consistent with the downward trend of malaria as seen with the OPD cases. Anaemia has reduced by 7.7%. Typhoid fever which used to account for fairly significant amount of emergency surgeries due to perforations, has also decreased by over 2%. The reduction may be due to the availability and use of certain antibiotics such as ciprofloxacin.

Table 13: Top-10 Conditions for Admissions: 2012 – 2017

Condition	% Contribution by Condition						% Change 2016-2017	One-year performance	% Change 2012-2017	6 year Performance
	2012	2013	2014	2015	2016	2017				
Malaria	52.8	50.3	26	24	21.4	17.7	-17.3%	Improved	-66.5%	Significantly Improved
Anaemia	13	11	6	3.4	5.3	5.6	5.7%	Worsened	-56.9%	Significantly Improved
Asthma/Bronchitis/URTI	3.9	3.8	2	3.1	2.9	2.2	-24.1%	Improved	-43.6%	Significantly Improved
Hypertension	5.9	5.9	3	2.2	3.3	3.2	-3.0%	Improved	-45.8%	Significantly Improved
Pneumonia	4.5	4.7	2	2.9	3.2	3.3	3.1%	Worsened	-26.7%	Improved
Gastroenteritis	3.3	3.9	3	2.7	3.2	2.7	-15.6%	Improved	-18.2%	Improved
Diarrhoea Diseases	5.7	6.1	2	2.5	2.6	2.4	-7.7%	Improved	-57.9%	Improved
UTI	-	3.1	2	2.5	2.7	3.1	14.8%	worsened		
Sepsis	-	-	1	1.7	2.2	2.3	4.6%	Worsened		
Typhoid/Enteric Fever	3.5	2.6	1	1.5	1.0	1.0	0%	Improved	-71.4%	Improved
All Others	7.4	8.6	52	43.5	52.2	56.5		-29.1%		

1.12.3 Mortality

A total of 7,872 deaths occurred in 2017 in CHAG facilities. This was 3.4% increase over that of 2016 (7,612). Sepsis was the commonest cause of mortality and accounted for 6.6% of all deaths. Cerebro-Vascular Accident (CVA) was the second cause of mortality in CHAG institutions accounting for 5.3% of all adult deaths. The trend is an indication of changes in our social lifestyles that is negatively impacting on us, a situation that brings non-communicable diseases (NCDs) into focus. The situation calls for lifestyle modification to reduce the incidence of NCDs and hence CVAs. Severe Anaemia and Hypertension were the third and fourth highest cause of mortality accounting for 4.9% and 2.9% of mortalities. Malaria accounted for only 2.1% of mortalities. This highlights the improvement in malaria care. Figure 16 and table 14 give details of the mortality for 2017 and a trend from 2012. Refer to figure 21 and table 14 below

Figure 21: CHAG Top Ten (10) Causes of Mortality for 2017

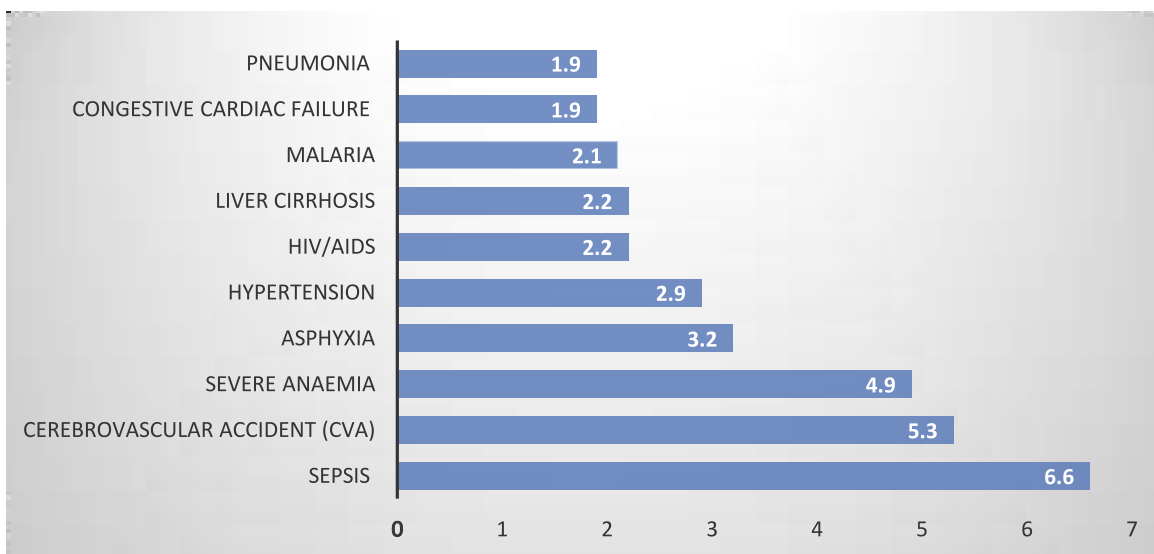


Table 14: Top-10 causes of Mortality: 2010 – 2017

Diagnosed Condition	2012	2013	2014	2015	2016	% Change 2015-2016	One-year performance	% Change 2012-2016	5-year performance
Severe Anaemia	12.8	10.1	15.1	6.7	4.8	-1.9%	Improved	-8	Worsened
Cerebro-Vascular Accident	15.8	14.5	14.7	5.7	5.6	-0.1%	Improved	-10.2	Improved
HIV/AIDS	15.9	16.6	13.7	4.3	4.1	-0.2%	Improved	-11.8	Improved
Septicaemia	15.3	14.9	14.3	4.0	3.9	-0.1%	Improved	-11.4	Improved
Asphyxia	-	5.9	6	3.5	2.8	-0.7%	Improved		
Malaria	13.5	12.8	13	3.3	2.9	-0.4%	Improved	-10.6	Improved
Hypertension	7.6	7.7	6.7	3.1	4.8	1.7%	Worsened	-2.8	Improved
Cirrhosis of Liver	4.5	6.7	6	2.5	5.6	3.1%	Worsened	1.1	Improved
Sepsis	5.3	5.3	5.5	5.3	4.1	-1.2%	Worsened	-1.2	Worsened
Prematurity	-	-	4.9	1.5	3.9	2.4%	Worsened		
All Others	-	-	61	60.1	57.	-2.6%	Improved		

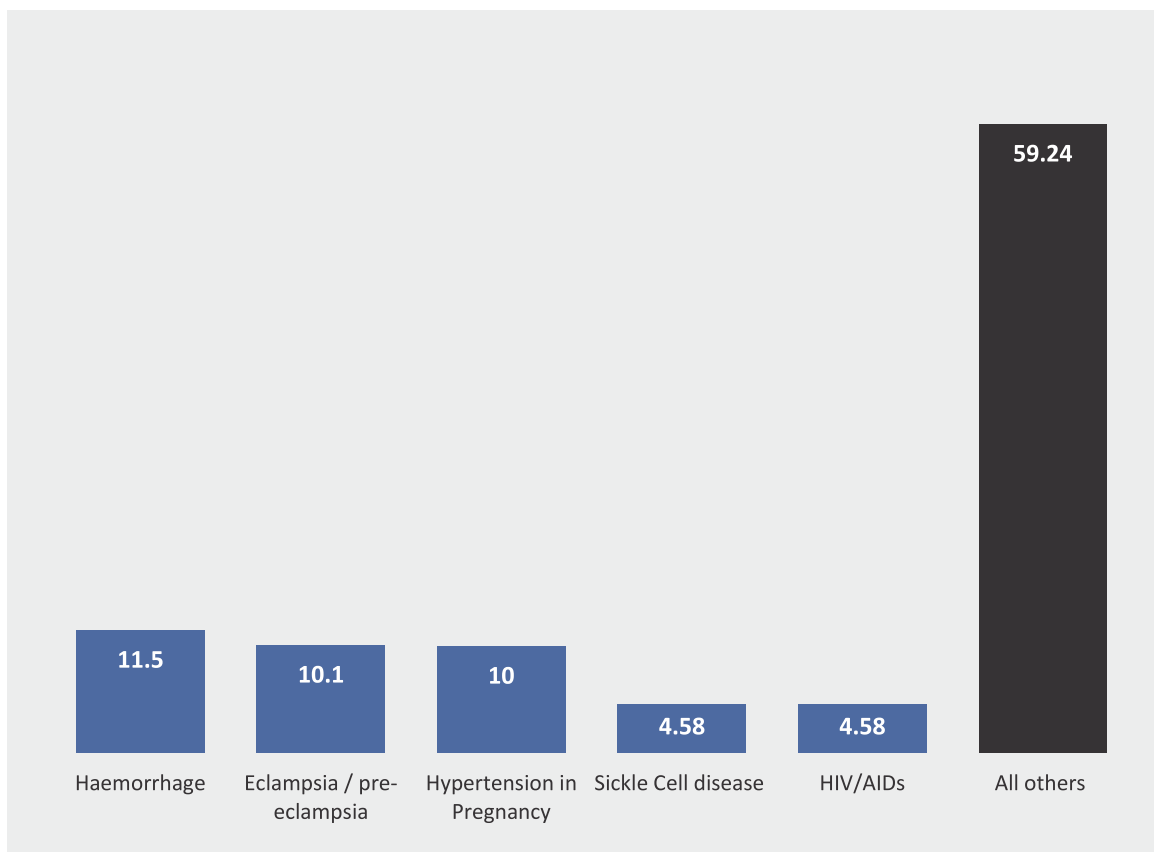
The proportions of deaths due to anaemia was higher compared to 2016 and significantly low compared to 2012. Over a 6-year period, the proportion of mortality from cerebro-vascular accidents, HIV/AIDS, septicaemia and malaria have significantly reduced as shown in table 14 above.

1.12.4 Maternal Mortality

Reducing maternal and neonatal mortalities were some of the key goals of CHAG in 2017. However, the MAF program which was implemented in 2015 & 2016 could not be continued due to funding challenges. Consequently, for the period under reporting, institutional maternal mortality ratio increased from 109/100,000 live births to **152/100,000** live births as shown in table 3 above.

From 2012 to 2017, there has been progressive reduction in the number of pregnancy related deaths per 100,000 live births within the CHAG network. Post-Partum Haemorrhages, Eclampsia, hypertensive disorders of pregnancy, Sickle Cell Disease and sepsis were the common causes of maternal deaths in CHAG Hospitals during 2017 as shown in Figure 22 below.

Figure 22: CHAG Top Five (5) Causes of Maternal Mortality for 2017



1.13 Key Health Outcome Indicators

There were improvements in three key health sector outcome indicators over a 6-year period (2012 to 2017). These indicators include maternal mortality, under-5 mortality, stillbirth and crude mortality rates. Specifically, from 2012 to 2017, institutional maternal mortality reduced by about 3.8%, under-5 mortality by 33.6%, stillbirth by 26.9% and crude mortality by about 17.4% as seen in table 15 below. These gains are as a result of concerted efforts from Member Institutions to improve these health outcomes.

Nonetheless, neonatal and infant mortality rates worsened over the same 6-year period with 63.6% and 53.0% increases respectively. New interventions are needed to address the neonatal and infant deaths.

Table 15: Key Health Outcome Indicators: 2012 – 2017

Outcome Indicator	Year							One-Year Performance 2016 - 2017	% Change 2016 -	6-Year performance 2012 - 2017	Formatted: Font: Developing Countries	
	2012	2013	2014	2015	2016	2017	2016 -				2016	2016
Maternal Mortality Rate	158	168	167	145	109	152	39.4	Worsened	-3.8	Improved	151 ¹	239 ⁴
Neonatal Mortality Rate	5.5	7.1	9.8	6.5	13	9	-3.7	Improved	63.6	Worsened	28 ²	52 ²
Infant Mortality Rate	6.6	7.9	10.9	8.6	12.9	10.1	-2.6	Improved	53.0	Worsened	43 ²	107 ²
Under 5 Mortality Rate	21.1	19.5	17.3	15.1	18.3	14	-3.9	Improved	-33.6	Improved	62 ²	177 ²
Still Births Rate	26	24	21	21	20	19	-5.0	Improved	-26.9	Improved	29 ³	18.4 ⁵
Crude Mortality Rate	23	23	21	22	19	19	0%	Improved	17.4	Improved	9 ²	16 ²

¹ Institutional Maternal Mortality, DHIMS 2, 2016² The World Bank, Data, 2014, 2015³ World Health Organization: Maternal, newborn, Child and adolescent health, stillbirths 2015⁴ World Health Organization: Maternal Mortality Key facts 2015⁵ 2015 worldwide estimates: WHO neglected tragedy of stillbirths

As depicted in table 16, maternal deaths have decreased over the last 6 years with significant reduction from 2014 to 2016. There was a reduction of about 3.8% in maternal mortality in 2017 compared to 2012. This is below both the national average of 319 per 100,000 live births and that for developing countries of 239 per 100,000 live births as seen in table 16 above. Stillbirth and under-5 mortalities were also improved in 2017 compared to 2016. These are all below the national averages. There were various interventions at the institutional level including training in IMCI and neonatal resuscitation, some of which were conducted by Systems for Health in selected regions. That may have contributed to the improvements seen in 2017. A trend of maternal mortality as depicted in figure 23 below.

Figure 23: Trend of Maternal Mortality Ratio: 2012 – 2017

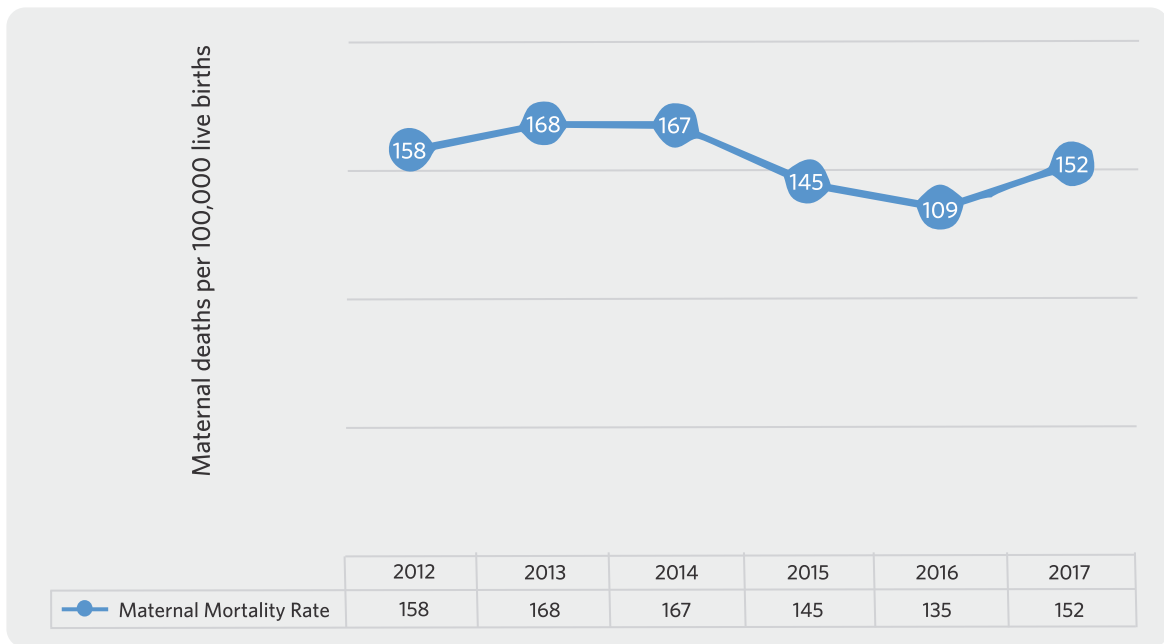
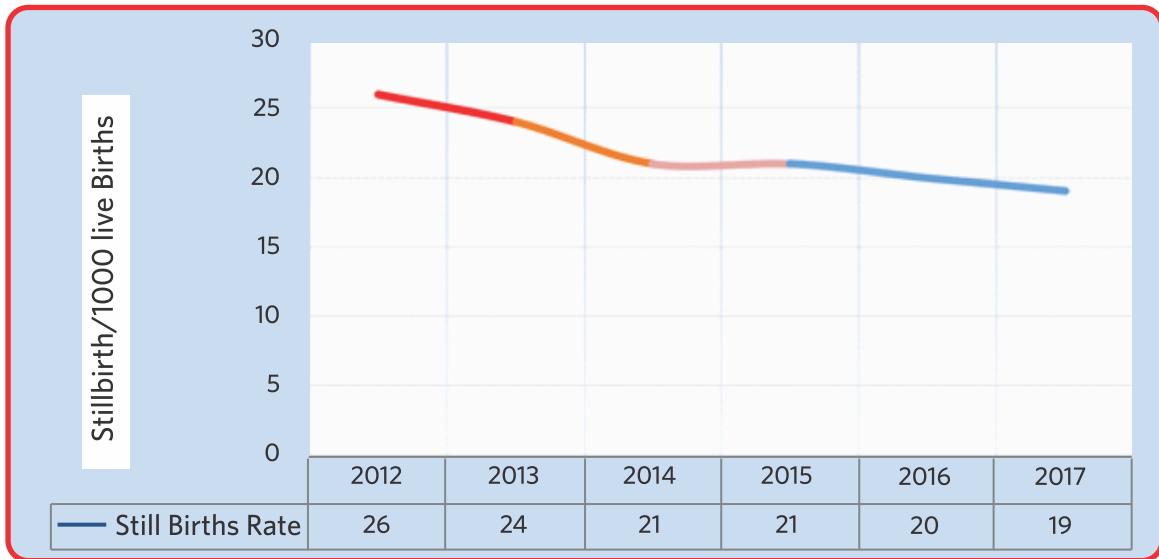
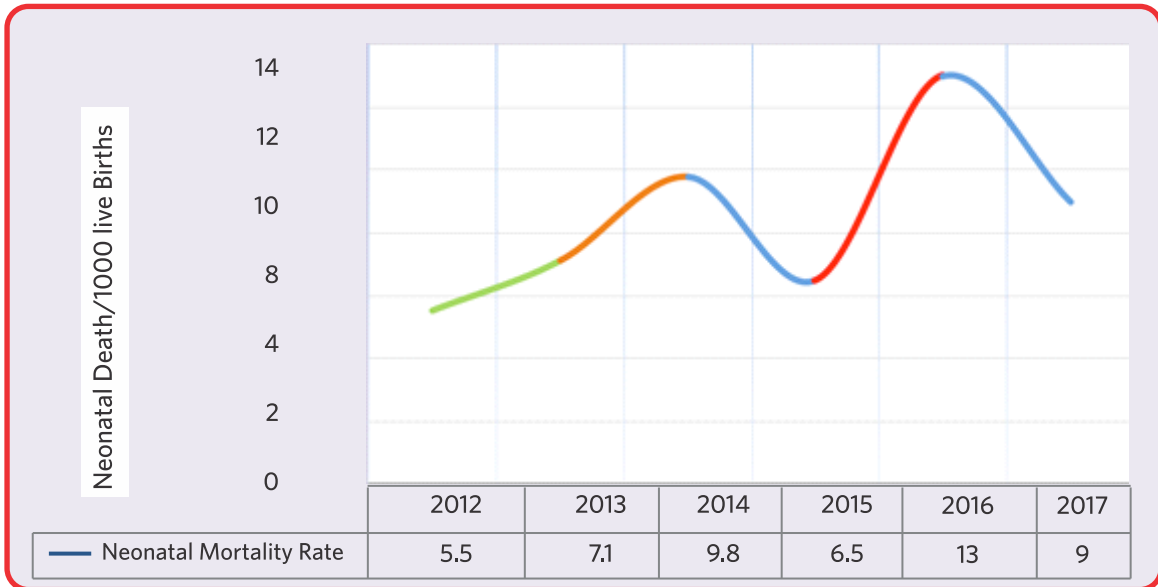


Figure 24: Trend of Still Births Rate: 2012 – 2017



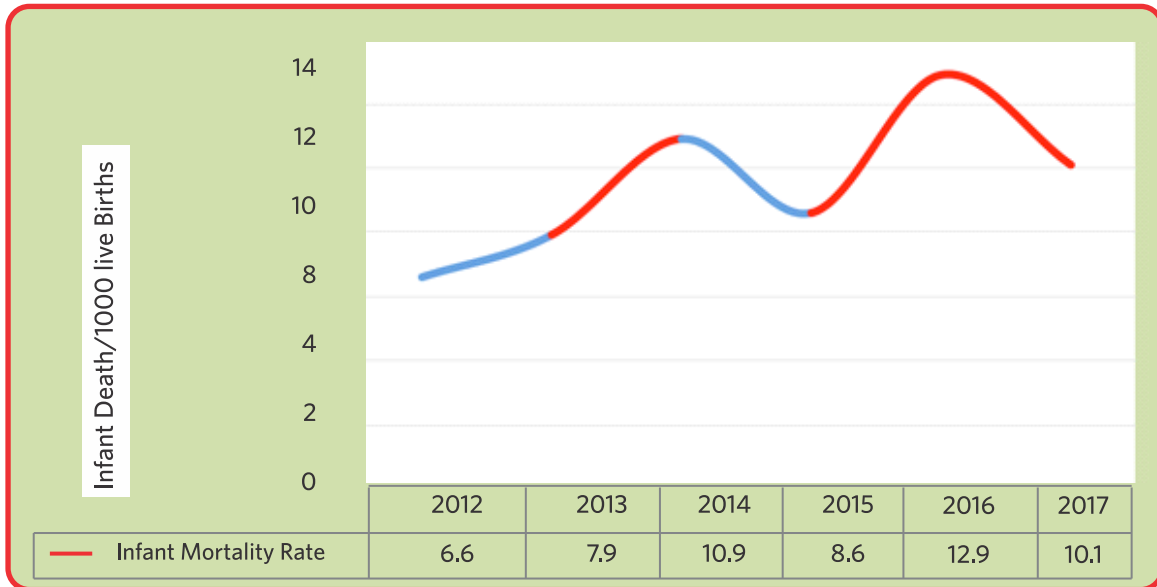
There has been continuous improvement in stillbirth rate since 2012. The highest decline was recorded between 2013 and 2014. Thereafter, the decline has been gradual. These may be attributed to continuing professional development activities in the various districts particularly the essential new-born care training being carried out nationwide. There are programmes like helping babies' breath, lifesaving skills etc. that are being carried out by Ghana Health Service, Systems for Health (USAID) that involve some CHAG facilities, albeit uncoordinated by CHAG Secretariat to ensure effective harmonization of interventions at the peripheral level. Nevertheless, these trainings are essential and need to continue in order to sustain the gains made in reducing stillbirth rate.

Figure 25: Trend of Neonatal Mortality Rate: 2010 – 2017



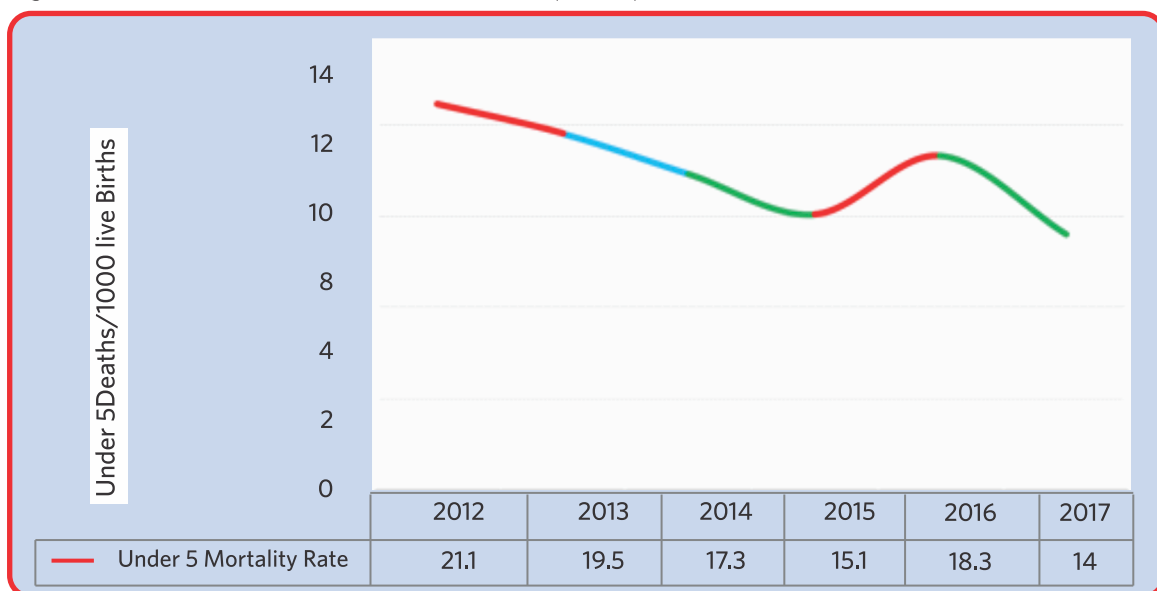
Neonatal mortality has been fluctuating since 2012. There was a sharp decline between 2014 and 2015 and again between 2016 and 2017. Consistent efforts are needed to keep neonatal rates low. Figure 25 above shows a trend of Neonatal mortality, 2012 – 2017. New-born training conducted for a number of staff began to yield results in 2017

Figure 26: Trend of Infant Mortality Rate: 2012 – 2017



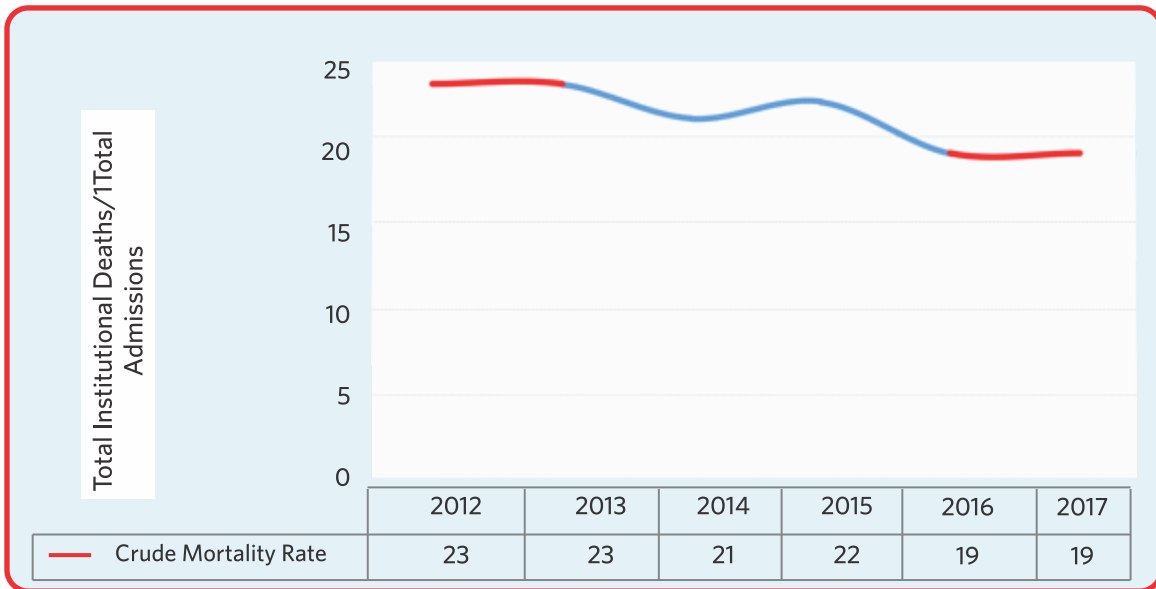
Infant deaths per 1000 live births had been fluctuating from 2012 to 2017 as shown in figure 26 above. For two years since 2012 there was an increase in the number of infant deaths. This declined from 2014 to 2015, rose again in 2016, declining again in 2017. Attempts should be made by healthcare managers in the various institutions to ensure that the declining trend continues.

Figure 27: Trend of Under 5 Mortality Rate (U5MR): 2010 – 2017



In 2017 there was reduction in Under 5 mortality of 13.6% compared to 2016. As shown in Figure 27 above, there has been an improvement in reducing the deaths of children under 5 years. Particularly for the period between 2012 and 2015, a noticeable decline was observed. For every 1,000 live births that occurred in CHAG institutions, about 14 children under the age of 5 years died compared to 18 in the previous year.

Figure 28: Trend of Crude Mortality Rate: 2010 – 2017



As shown in Figure 28 above, institutional deaths in CHAG have been between 19-25 per 1,000 admissions over the last 6 years with 2012 and 2013 recording the highest. The general trend over the past six years is a reduction (improvement) in the mortalities.

1.14 Mental Health Services

Since 2013, CHAG with funding support from the Department for International Development (DFID-UK), has embarked on a number of activities to improve the quality of life of persons living with mental illness. CHAG's Mental Health programme has 3 objectives, which are to: (1) reduce the incidence of and stigma towards persons with mental illness; (2) Increase access to treatment, care and support for persons suffering from mental illness; and (3) Re-integrate treated mentally ill persons back into their communities and support them. In 2017, CHAG Scaled up the program to involve important aspect of mental services including training professionals in newly WHO approved programmes (MhGAP), engaging Muslim Clerics, Training of Traditional healers and pastors.

Furthermore, 46 students were sponsored for a 2-year mental health programme at the Kintampo College of Well-Being in Community Mental Health and Community Medicine and Clinical Psychiatry. Furthermore, about 560 community health workers and prescribers were given refresher trainings in mental health to make mental health services accessible to all people in Ghana. To this end, mental health services got integrated with OPD services in about 172 facilities with 92 CHAG institutions having their staff trained in 2015. **Achievements**

for 2017

Specialized Mental Health centres were set up in the Brong Ahafo, Volta, Northern, Central and Ashanti regions to address the special needs of children, adolescents and working families who live with mentally ill persons. About 4 Day-Care and 3 adolescent centres were set up. These centres are in Jejemiraja, Dzemeni, Kumbungu, Bremang Asikuma, Agogo and Essieninpong.

About 172 CHAG institutions have set up and operating mental health units

CHAG with funding from DFID refurbished 106 facilities for MH services

A number of staff have received formal training to deliver mental health services. These include

1. 45 CPOs trained (11 females)
2. 77 CMHOs trained (26 females)
3. One psychiatrist trained, 1 to start Ghana College this year (2018)
4. 71 facilities collaborating with fetish priests and a number of them with pastors

5. 280 staff trained on the MhGap
6. 800 copies of guidelines in MH have been produced and distributed
7. About 3000 traditional healers and pastors were engaged to collaborate in the provision of mental health services at the community level

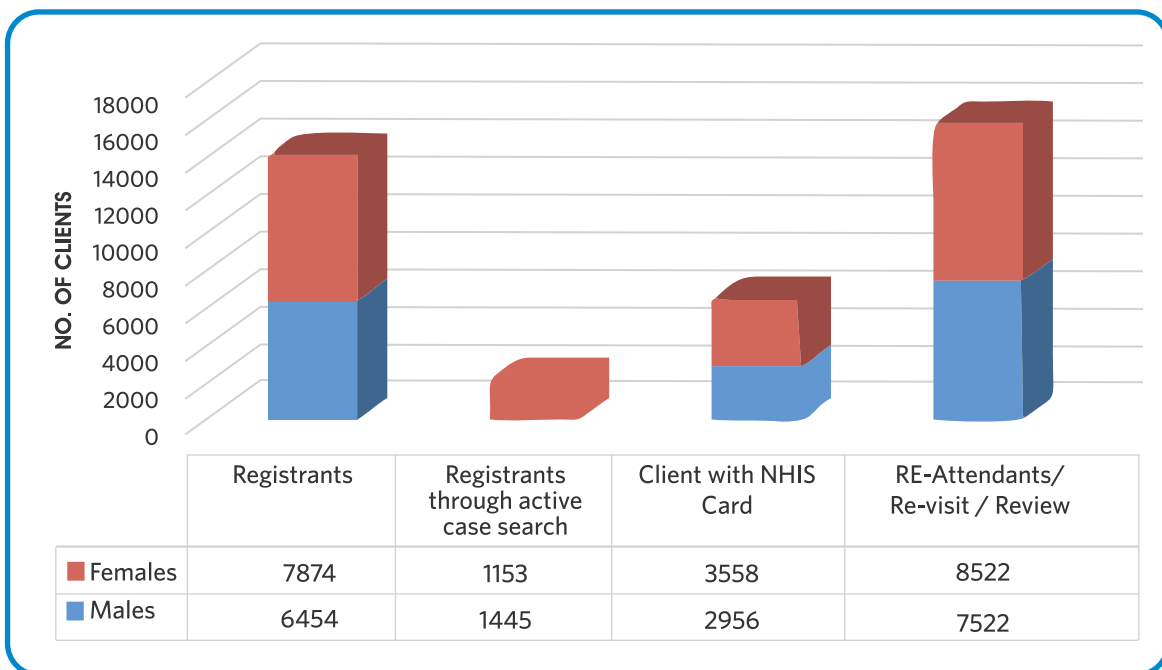
The Secretariat trained about 300 traditional healers and over 2000 pastors in Brong Ahafo and Ashanti regions of Ghana. Collaboration network is being developed between these groups at the community level to see clients.

1.14.1 Mental-Ill Clients seen at OPD and IPD

In 2017 CHAG Mental Health Units conducted 17,497 Mental Health durbars and campaigns across Ghana.

Close to 15,000 mentally ill patients were seen in CHAG Mental Health Units throughout 2017. About 45% of the clients seen were males while 55% were females as shown in figure 25. About 2,000 new patients were registered for mental care. About 1,882 (94.1%) of the new registrants were NHIS Clients.

Figure 29: CHAG 2017 Mental Clients - Registrants, Attendance and admissions



1.14.2 Impact of Mental Health

There have been several cases that have been cleared from the street and prayer camps and restored to their families.

In the Volta region, a 29-year-old lady who had been chained in one prayer camp since 2014 after unsuccessful attempts to stabilize her at the hospital was spotted by CHAG Mental Health staff at Nkwanta. Two things were difficult – convincing the family and prayer camp managers to allow the patient to be put on medication and removing the rusty chains on her legs. After follow-ups and being put on regular medications, the lady can now take care of herself, sing in church, cook for herself and her entire family. Her ambition now is to be able to go to school (Story by: **Bliss Christian Takyi, St Joseph's Hospital Nkwanta**)

In the Ashanti region, a 43-year-old epileptic and a single mother, fell into fire during one episode of her seizure while cooking. She sustained severe burns and got deformed to the extent that people would not buy from her as a result of her deformity. She was picked up by one Community Mental Health Officer who put her on treatment until her epileptic fits stopped. She was supported by CHAG with GHC 1,000 and this has positively impacted and transformed the otherwise doomed life. She is now an entrepreneur, selling food stuffs and vegetables. Her turnover is encouraging and has greatly improved her condition such that she can now buy her drugs on her own. Moreover, she is able to pay her children's school fees (story by: **Millicent Owusuwaa, CMHO, Methodist Clinic Brodekwan**).

At Dzemini in the Volta region, an 11-year old boy had been having seizure disorder for a period of 7 years. Parents say he used to have seizures about 6 times daily. During one mental health outreach programme, he was picked up by a registered Mental Health Nurse working at the EP Church Health Centre who started him on medication. His family was educated and got itself involved in the child's management. Thankfully, the boy does not experience seizures anymore. His parents are now planning to put him back in school (story by: **Emelia Kumi Tawiah, RMN, E.P H/C, Dzemeni**)



Figure 30: Pictures of 29-year-old lady who had been chained in a prayer camp since 2014. Pictures on right were taken after patient had been put on medication.

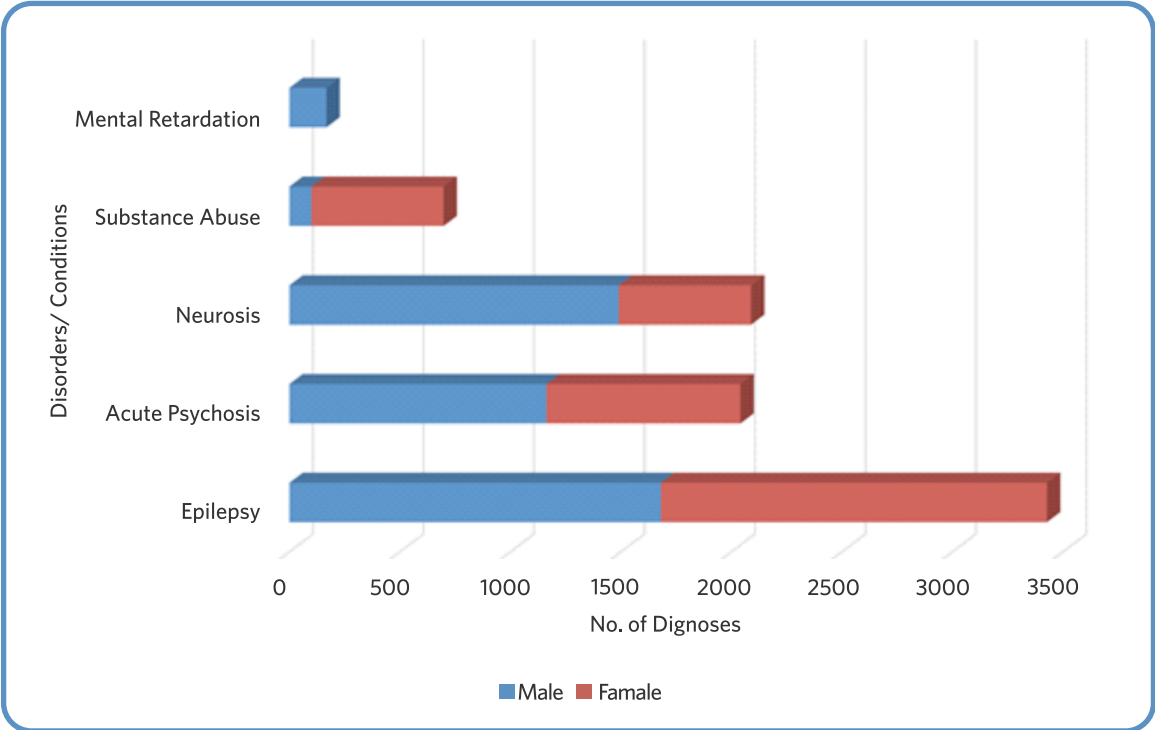
Table 14: Mental Health OPD and IPD data

	REGISTRANTS		RE-ATTENDANCES		ADMISSIONS		DEATHS		REFERRALS	
	Total registrants	NHIS	Revisits/reviews	Voluntary admissions	Involuntary admissions	Discharges	Deaths	Client referred in	Client referred out	
Male	6,454	2,956	7,522	374	7	346	7	73	21	
Female	7,874	3,558	8,522	339	10	357	21	66	35	
Total	1,4328	6,514	16,044	713	17	703	28	139	56	

1.14.3 Mental health conditions seen in 2017

Aside epilepsy and acute psychosis, neurotic, stress-related and somatoform disorders were the common conditions seen in 2017. About 3,500 epileptic cases were seen followed by acute psychosis as seen in Figure 26.

Figure 31: Top 5 Mental Health Cases reported in 2017



1.14.4 Facilities in the Spotlight

Our spotlight in 2017 fell on one institution that is leading the way in certain areas of care that is outstanding for our cherished clients. We focus on Richard Novati hospital, a Catholic facility at Sogakope in the Volta region.

Richard Novati Hospital, Sogakope (formerly known as Comboni Hospital): Giving hope to people with Parkinson's disease in Africa is part of a complex institution known as the Comboni Centre comprising of a technical and vocational school, primary and basic school, and a health institution. It was established in the year 1990 by Rev. Fr. Richard Novati – a Comboni Missionary in the Keta-Akatsi Diocese. The facility was initially run as a Mobile Clinic by the joint effort of Fr. Novati and Medicus Mundi – an NGO in Italy. In 1992, the clinic was fully passed on to the Catholic Diocese of Keta-Akatsi. The name Richard Novati Catholic Hospital was recently adopted in honour of the late Rev. Fr. Richard Novati. The Hospital is located at Fievie near Sogakope in the South Tongu District of the Volta Region off Accra-Aflao road. From a clinic, the facility grew steadily into a polyclinic and then a hospital in 2009. The hospital sees between 40,000 and 60,000 outpatients each year with between 3000 and 4000 inpatients. The hospital has not recorded a maternal death since October 2016 and performs about 500 surgeries annually. The hospital offers Ophthalmology, Dental, General Surgical and OBGYN services.

The hospital has started using local products in the area called *Mucuna pruriens* in treating patients with Parkinson's disease. Overall, the results of this project / study will be used to propose a low-cost alternative therapy to all individuals who cannot afford marketed levodopa therapy. A clinical trial study has thus begun. It is hoped that this study will change the course of treatment for patients with Parkinson's disease in West Africa.

2.0HEALTH INFORMATION

Health information encompasses all systems, procedures and staff targeted at the timely collection, analysis and dissemination of information to inform decision making; that is for planning, managing, monitoring and evaluation of health services. Integrity, Quality, Reliability and timeliness are key aspects in health information. These are relevant in making meaningful decisions in the health sector. All CHAG facilities are required to report to the CHAG Secretariat electronically using the CHAG Minimum Service Data Set (MSDS) bi-annually (January to June) and annually (January – December). Data obtained from the MSDS are validated, collated, analyzed and interpreted for reporting purposes to inform decision making at all levels within the CHAG Network.

The performance of Member Institutions is also monitored and evaluated through the District Health Information Management System (DHIMS–2). Below are listed challenges faced within CHAG Network is

Table 15: Health Information Precarious Challenges

-
- Inadequate data management and use of data for decision making at the health facility level
 - Inability of DHIMS-II to provide disaggregated data on CHAG at all levels;
 - Late and incomplete submission of CHAG minimum data set by members.
-

CHAG facilitates the submission of health service data to the government through DHIMS2 at the facility level. In 2016 completeness and timeliness of submitted data by CHAG Facilities on the DHIMS were 96.8% and 85.7% respectively. However, the submission rate of CHAG Annual (January to December) 2017 minimum service data (returns) to the CHAG Secretariat by CHAG Member Institutions(CMIs) comprising Hospitals, Polyclinics, Clinics, Health Centers, and Primary Health Centers) was 94.8%. Hospitals' reporting rate was 95.2% while all the others was 94.8%. This is a significant improvement of last year's performance.

Table 16 : Report Submission Rate by Facilities (2012 -2016)

Facility	2012	2013	2014	2015	2016	2017
Hospitals	90%	97%	97%	97%	85.3%	95.2%
All Others	81%	87%	89.0%	81%	75.0%	94.5%
Overall	84%	90%	93%	86.2%	77.3%	94.8%

Figure 32: Annual 2017 Minimum Service Data Set Submission Rate by Facility Type

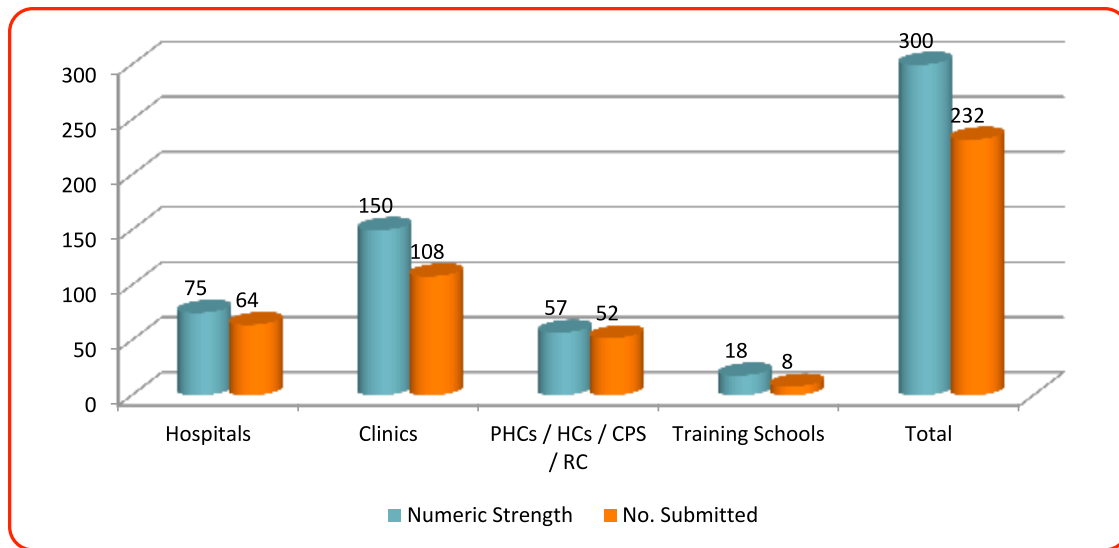
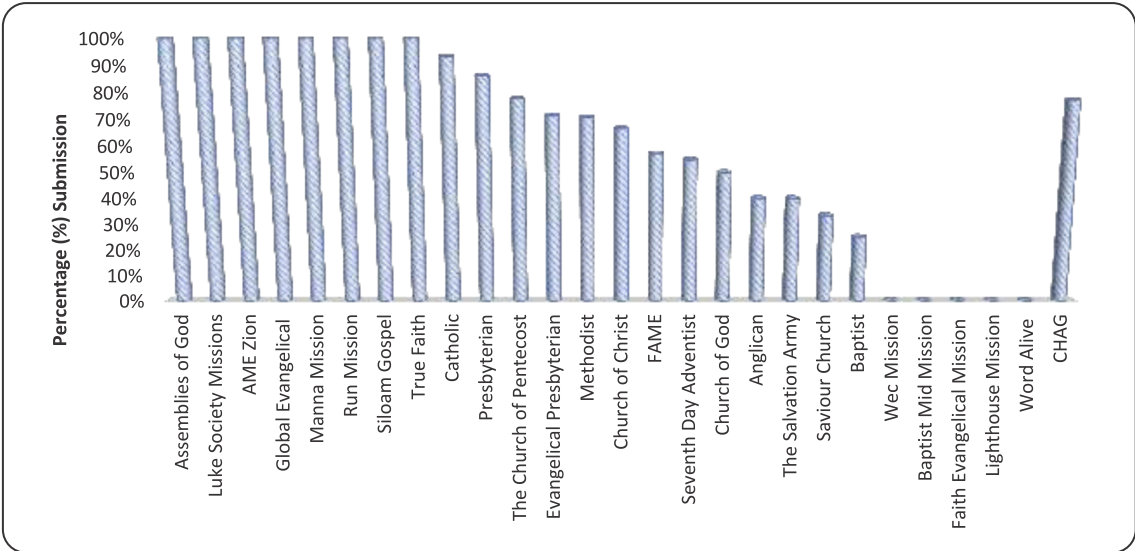


Figure 33: 2017 Denominational Minimum Service Data Submission Rates Chart



Delay in data submission is a regrettable challenge within the CHAG Network. The Secretariat is working on online data submission that will improve the submission as well as the timeliness and quality of data from CMIs. The capacity of managers will be built on how to use the web-based data reporting in the use of information for analysis and decision making. Health information officers and other frontline staff will be trained in data collection and management.

3.0 LEADERSHIP AND GOVERNANCE

Leadership and governance relates to providing the direction, structure and stewardship to guide the organization to effectively achieve desired outcomes and impact. It involves the effective and transparent use of resources as well as competent performance management in an accountable, equitable and responsive manner. Important components of this system block are strategic planning, organizational and institutional development, general- and financial management, monitoring and evaluation, adherence to regulation and inter-sectorial and network advocacy. Critical challenges in leadership and governance that require sustained attention of CHAG are indicated in table 15 below:

Table 17 : Leadership and Governance: Critical Challenges

-
- Inadequate leadership and management skills
 - Weak governance, accountability and transparency
 - Selective compliance to policies and guidelines
 - Inadequate organisational development and institutional strengthening capacity
 - Difficulty in obtaining regulatory requirement
 - Non-compliance to regulatory requirement.
-

In 2017, CHAG as part of the Mental Health program supported by DFID, trained about 302 managers in certain aspect of leadership. Specific areas trained were; developing vision, mission and objectives for an organization; strategic leadership, resource mobilization among others. For the year under review, CHAG continued to participate in health sector meetings and technical sessions to promote member's interest, influence health sector policy and advocate for the advancement of the health sector.

National Committees on which CHAG served

Various Committees on which CHAG served at the National Level are the **Technical Working Group Committee on CHPS, Committee on Health Indicators for the SDGs, National Quality Strategy Technical Group, Health Sector Working Group, Ministerial Committee on Human Resources, Membership of the National AIDS Commission**, among others. Ultimately, CHAG's visibility, role and mandate as a major stakeholder and reliable partner in the health sector was recognized.

The leadership of the Secretariat supported member institutions particularly in the area of capacity building in key service provision areas including Mental Health, Essential Newborn Care, Lifesaving Skills for adults and children, Ultrasound scan/CTG machine training and obstetric surgeries.

4.0 HUMAN RESOURCES

Human Resources for Health (HRH) relate to all aspects of availability, functionality, performance and management of staff to attain optimum workforce productivity. The production, distribution, development, retention and utilization of a health workforce of the appropriate quantity, quality and the proper skill mix is essential to secure effective and quality health services. To this end, the Christian Health Association of Ghana (CHAG) regards human resource for health as central to achieving its mandate of contributing effectively to national health outcomes towards the achievement of universal health coverage and the sustainable development goal.

The staff strength of the CHAG Network stands at twenty-six thousand, eight hundred and five (26,805) as at December 31 2017, however, the number of CHAG employees on Government of Ghana payroll stands at nineteen thousand, five hundred and sixty eight (19,568).

The HRH situation for the year ended December 2017 across the CHAG network was fairly impressive. The staff strength grew from 15,927 to 19,568 (GoG staff) and from 4,792 to 7,237 (for those on IGF); representing staffing level growth of 23% for those on GoG payroll and 51% for those on IGF.

Other areas covered in this chapter of the report include: staffing situation, trend of professional to auxiliary nurses, inter agency transfer, and performance of CHAG Health Training Institutions during the period under review. Staffing Situation

The staff strength of the CHAG Network stood at twenty-six thousand, eight hundred and five (26,805) as at December 31 2017. However, the number of CHAG employees on Government of Ghana payroll stood at nineteen thousand, five hundred and sixty-eight (19,568). Table 22 below provides details of the staffing situation of CHAG employees on Government payroll.

Table 18: Trend of Number of Staff and Corresponding Salaries, 2013 - 2017

Year	2013	2014	2015	2016	2017
Salaries of CHAG staff on GoG payroll	118,084,128	135,812,280	154,883,462	218,886,709	306,668,966
% growth	-	15%	14%	41%	40%

Analysis of the past four years reveals that the number of CHAG employees on government payroll has been rising at an increasing rate until 2017; rising from over eleven thousand in 2013 to over twenty thousand in 2017 as shown in Figure 33 below.

Figure 34: Trend of CHAG Staff on GoG payroll

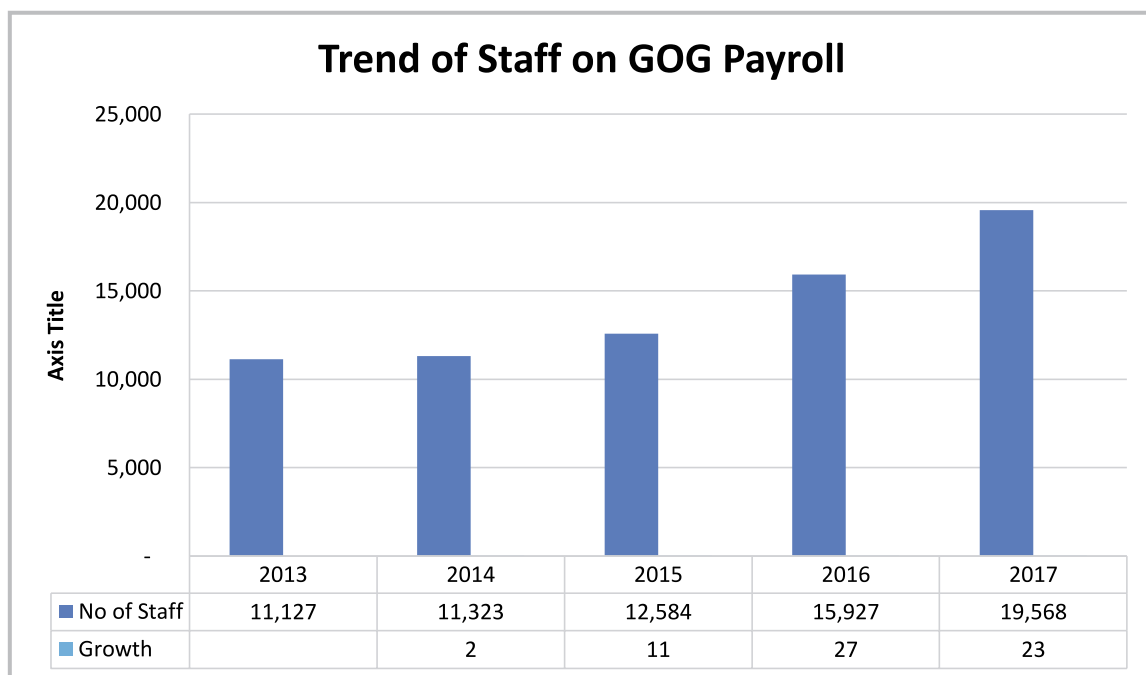
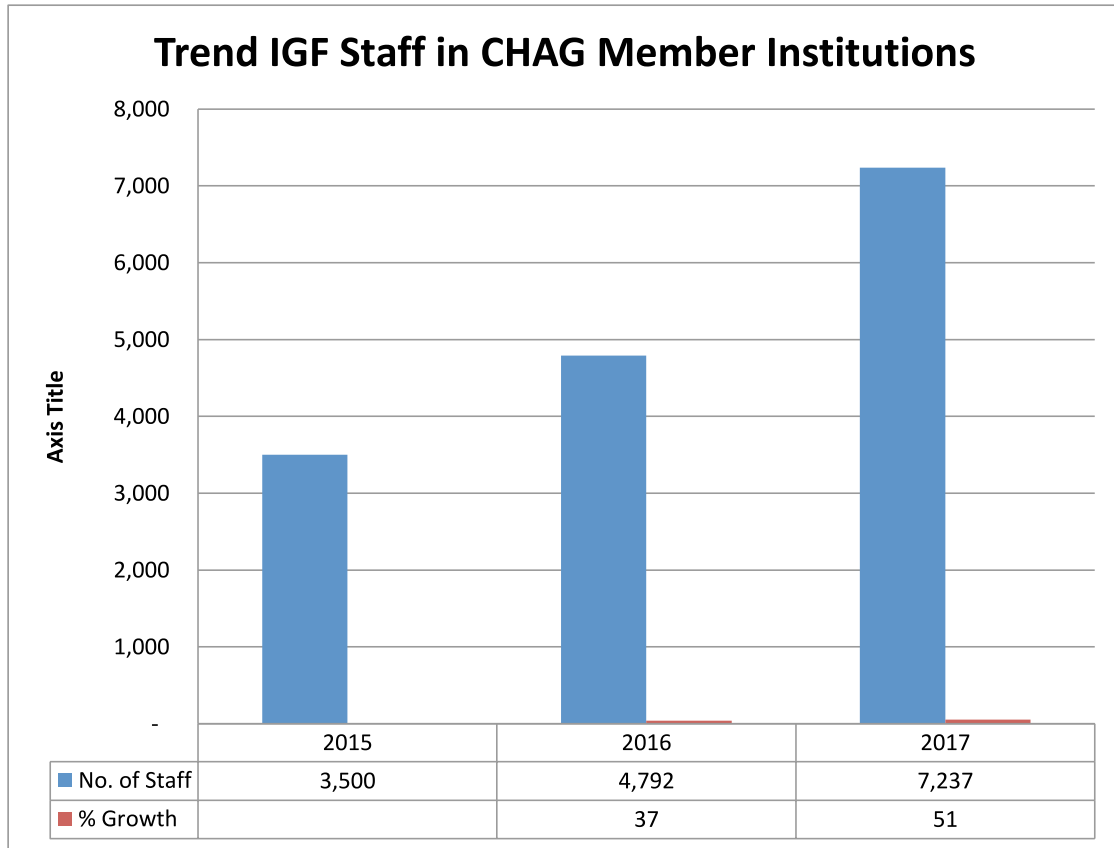


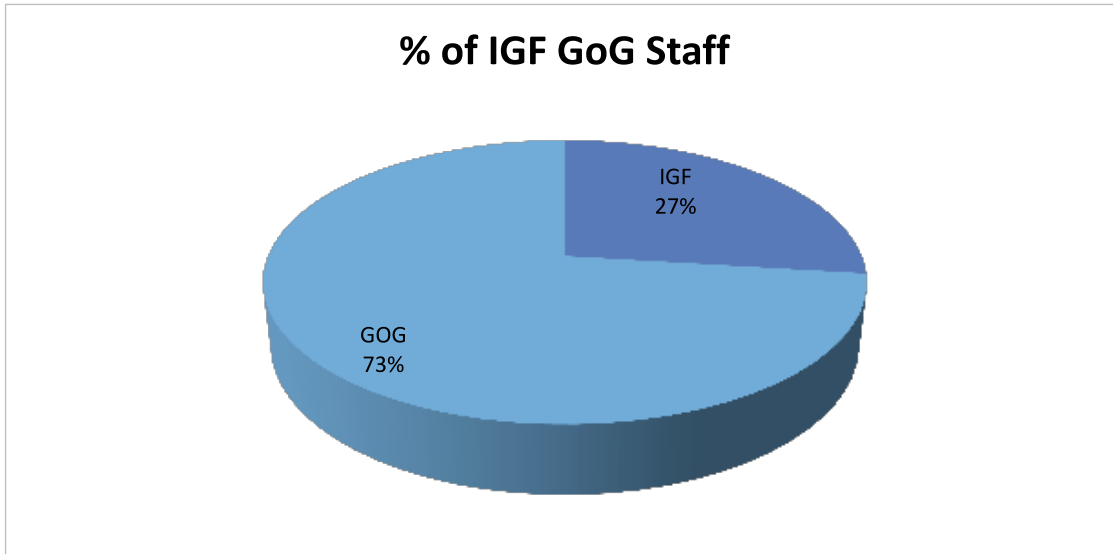
Figure 35: Trend of CHAG staff on IGF



From figure 34, number of staff on IGF increased by 51% compared to 23% for those on GoG payroll as indicated in figure 33. The rapid growth in IGF staff was anticipated and has been influenced by two factors as indicated below;

1. On hundred and sixteen (116) new facilities were admitted into CHAG membership in 2016, and these facilities came on board with staff who are not on GoG payroll.
2. Ministry of Finance has not given financial clearance to some key health professionals such as Pharmacists, Biomedical scientists, pharmacy technicians among others. Meanwhile, these professionals are very much required in the CHAG facilities for quality service provision, and also to satisfy credentialing and accreditation requirements by NHIA and HEFRA. Since the government has not given financial clearance to these cadres of health professional, CMIs had to recruit them in order to stay in business

Figure 36: Proportion of GoG & IGF Staff

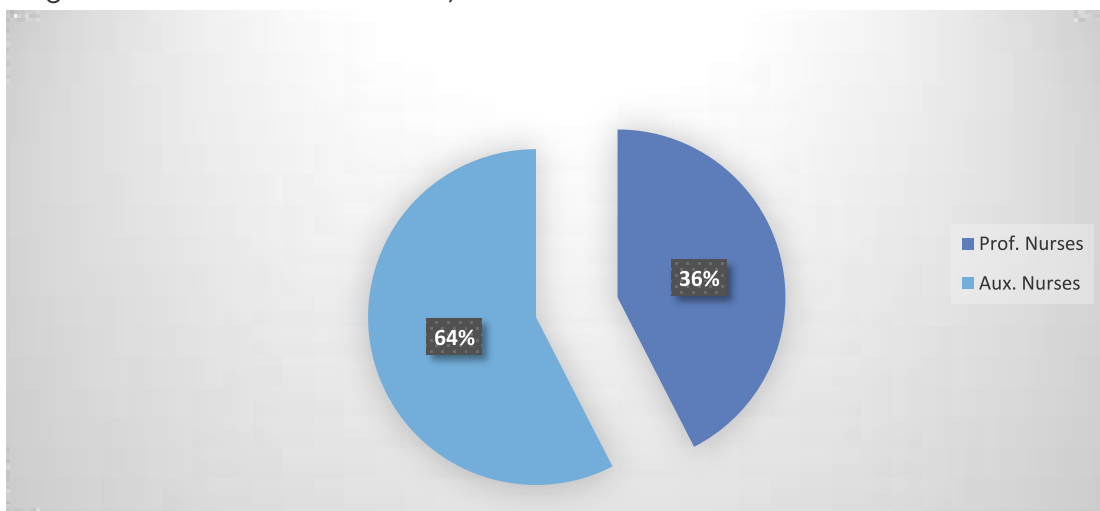


Source: CHAG 2017 HR Data.

4.1 Ratio of Professional to Auxiliary Nurses

The required proportion of professional and auxiliary nurses is 60% professional and 40% auxiliary. In 2016, the rate of professional nurses and their auxiliary counterparts was 58 and 42 respectively. However, in the year under review (2017), the rate stood at 64% to 36%. This indicates the CHAG network has the appropriate proportion of clinical to non-clinical staff proportions. However, care should be taken in order not to skew towards clinical staff as this can affect the required balance for effective health services delivery.

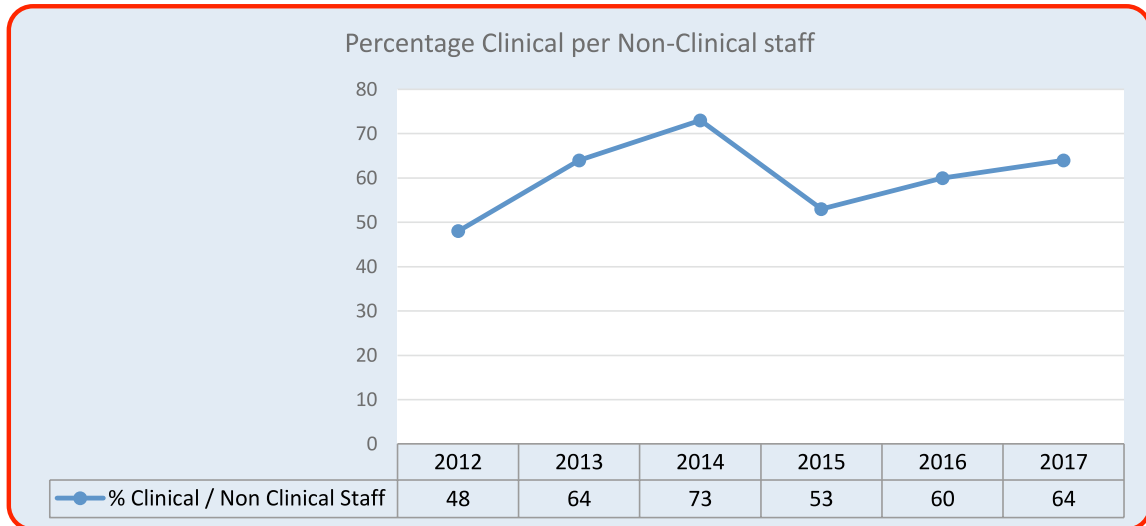
Figure 37: Professional to Auxiliary Nurses



Source: CHAG 2017 HR Data.

Figure 36 above shows the ratio of professional to auxiliary nurses. In numerical terms however, both categories had marginal increases.

Figure 38: Trend of Clinical to non-clinical staff, 2012 – 2017



From figure 37 above, 2014 was the year that the CHAG network had the highest ratio of clinical to non-clinical staff of 70%. A lot of clinical staff joined the network and at the same time the rate at which financial clearance was issued for non-clinical staff reduced. In the following year, there was a sharp drop. In 2016 and 2017 the situation has seen steady improvement.

4.2 Doctor to patient ratio

As at the end of 2017, there were five hundred and twenty-two (522) Medical Doctors including specialists within the CHAG network. Doctor out-patients' ratio recorded in CHAG in 2017 was 1:10,080. Each Medical Doctor saw 10,080 out-patients during 2017 with an average of 28 patients per day in CHAG. This performance is an improvement over the last six years (2012, 1: 1,645) when each doctor saw an average of 59 patients per day. The trend of Doctor to patient ratio is shown in figure 37 below. Nurse out-patient ratio declined from 1:698, in 2016 to 1:488 in 2017. CHAG Nurses saw more patients in the 2012 than in 2017.

Figure 39: Trend of Doctor: patient ratio 2012 – 2017

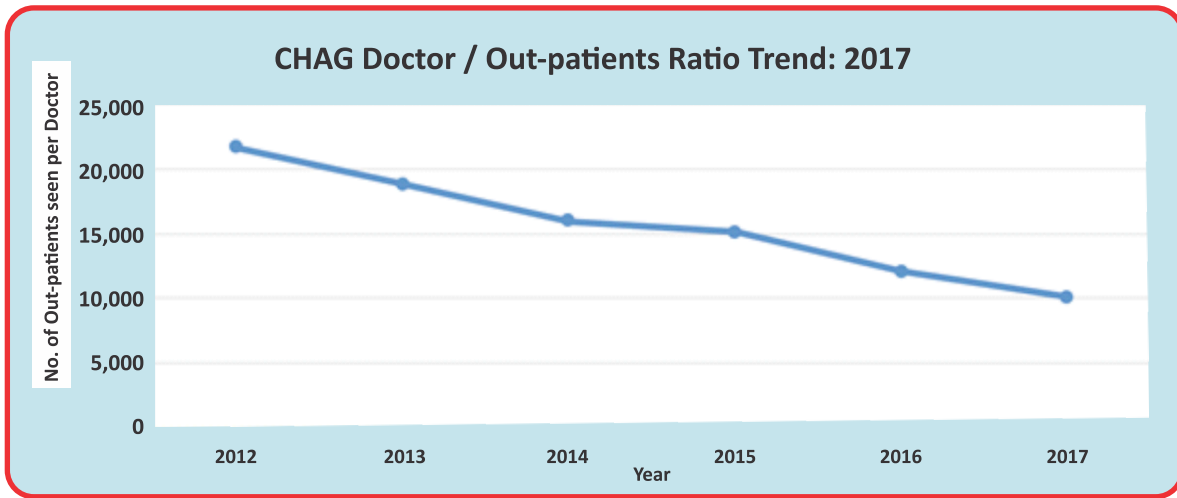
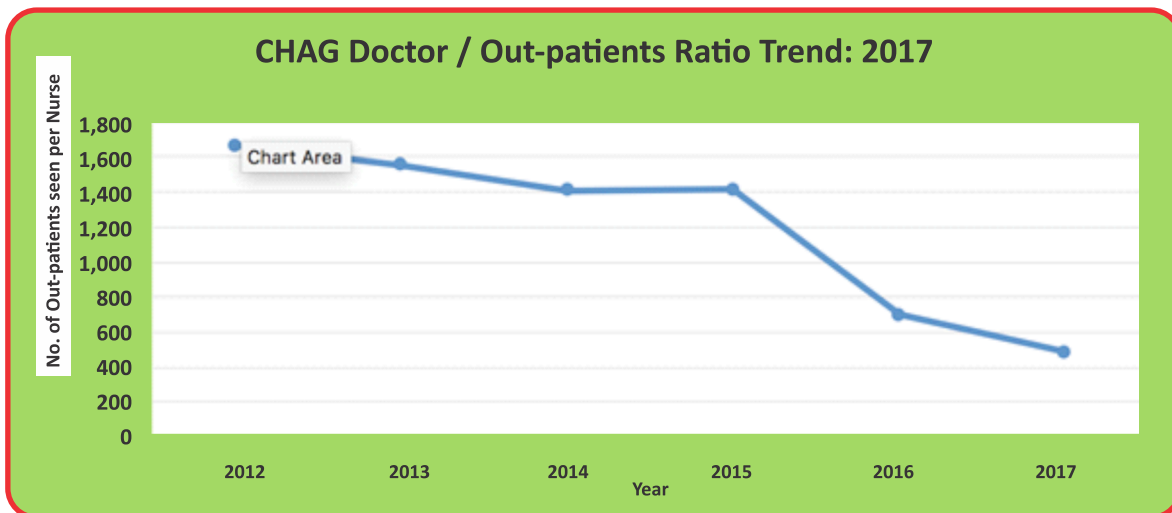


Figure 40: Trend of Nurse to outpatient ratio



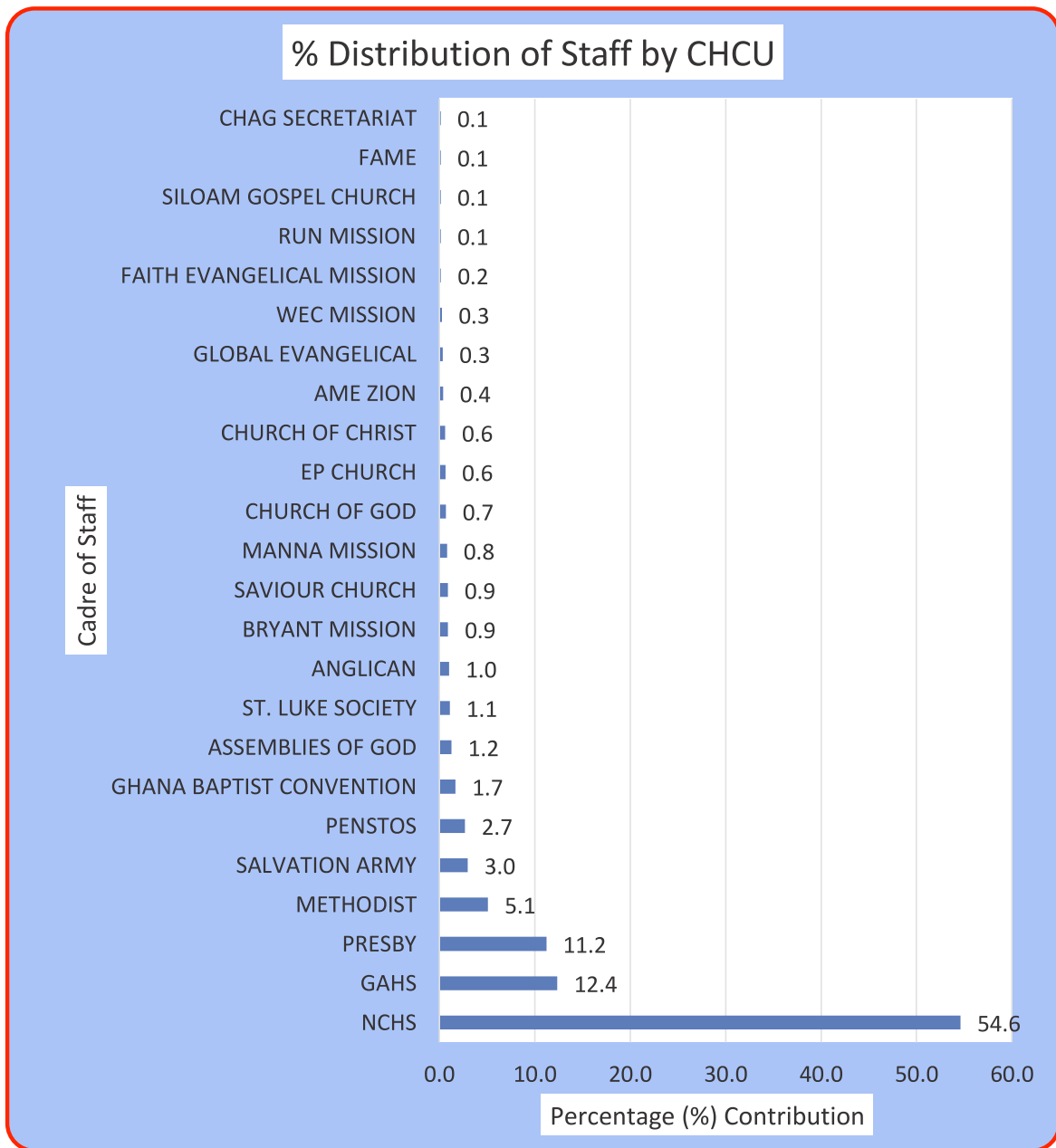
Nurse to outpatient ratio, just like doctor to outpatient ratio has been declining steadily since 2012. This is good for Ghana's health system as Nurses will give more attention to clients. A trend of Nurse to outpatient ratio is shown figure 38 above.

4.3 Distribution of Staff by Church Health Coordinating Units

The National Catholic Health Service (NCHS) continues to have the highest number of employees and salaries payments. This is consistent with the number of facilities as well as the proportion of contribution of the NCHS to health services delivery of the CHAG network. In the year under review (2017), the human resource strength of the NCHS stood at ten thousand, six hundred and eighty (10,680) employees on government payroll. This figure represents 54.63% of the total number of CHAG staff on GoG payroll. Ghana Adventist Health Service (GAHS) and the Presbyterian Health Service followed with 2,416 (12.36%) and 2,191 (11.21%) in number of employees on Government payroll, respectively. Figure

The lowest three of the distribution was Faith Evangelical Mission, Siloam Gospel Church, and FAME Health Services. The total staff strength of these three facilities constitute 0.42% of the total number of CHAG employees of government payroll.

Figure 41: Percentage Distribution of Staff by Church Health Coordinating Unit



4.4 Summary of Key HR Performance Indicators 6-Year Trend

Table 24 provides information on some key human resource performance indicators over a six- year period across the CHAG network. These include the total number of mechanized staff, and Doctor to Outpatient and nurse to out-patient ratios. This has seen continued improvement over the past 5 years.

Table 23: Key HR performance indicators

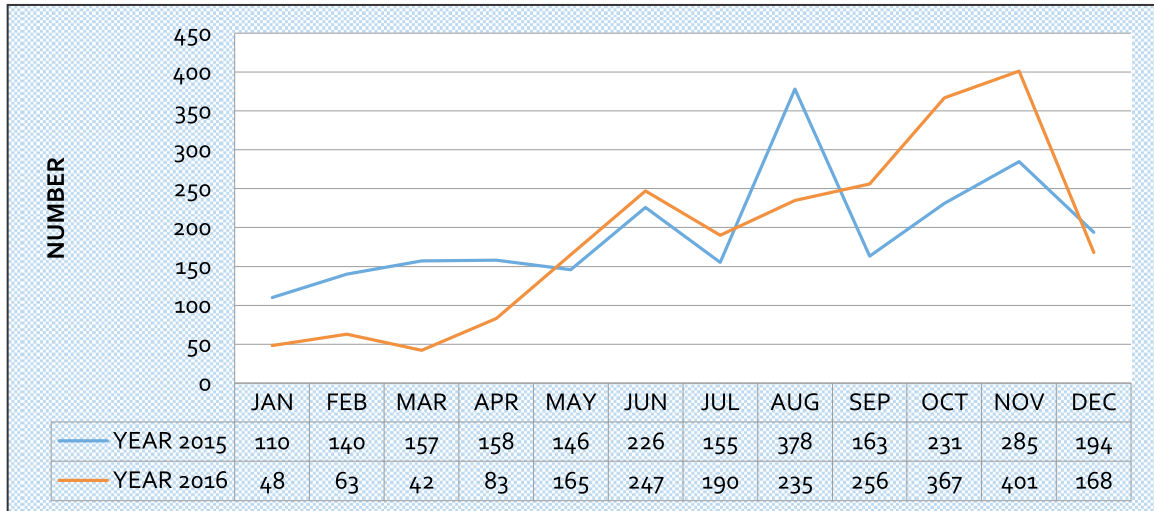
Input Performance Indicator	2012	2013	2014	2015	2016	2017	6-Year Trend
Total Mechanized Staff	8,861	9,356	11,127	12,584	15,942	20,099	Increasing
% Clinical /Non-Clinical Staff	48	64	73	53	60	64	Increasing
Doctor / Out-Patient Ratio	1:21,645	1:18,845	1:15,987	1:15,122	1:12,083	1:10,080	Improving
Nurse Out-Patient Ratio	1:1,666	1:1,556	1:1,411	1:1414	1:698	1:488	Improving

Source: CHAG 2016 HR data

4.5 Promotions And Upgrades

As part of efforts recognizing and motivating employees in their work, for improved performance and productivity, the Ministry of Health of Ghana and by extension CHAG promotes eligible employees who meet set criteria in the performance of their duties.

A total of 1,487 employees of the network were promoted in 2017; indicating a 34.4% decline compared to the number (2,265) promoted in 2016. The decline is insignificant in the light of increasing number of health professionals within the network. A survey will be required to establish the reason for the drop.

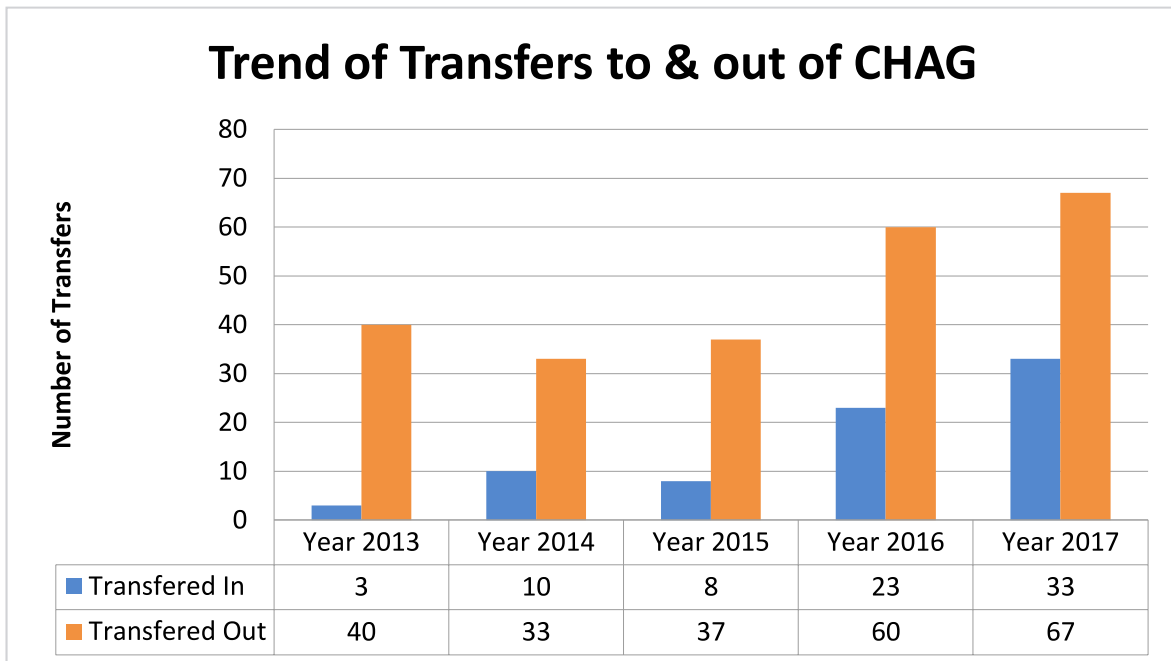


Source: CHAG HR data 2016

4.6 Inter-Agency Transfers

The Ministry of Health policy on transfer allows inter-agency transfer of staff. One major receiving agency of transfers from CHAG is the Ghana Health Service. Figure 41 below shows improvement in the net transfers between 2016 and 2017.

Table 43: Trend of Inter-agency transfers 2013 - 2017



Source: CHAG HR data 2017

Figure 41 above shows a consistent significant rise in the transfers out of CHAG relative to transfers to CHAG. Key among the possible reasons accounting for the movement of staff from CHAG to other agencies are the issues of location and management practices. Most of our facilities are located in hard-to-reach areas. Consequently, attracting and retaining critical staff has become a Herculean task. It is therefore imperative to develop strategies that will attract and retain critical health professionals within the network.

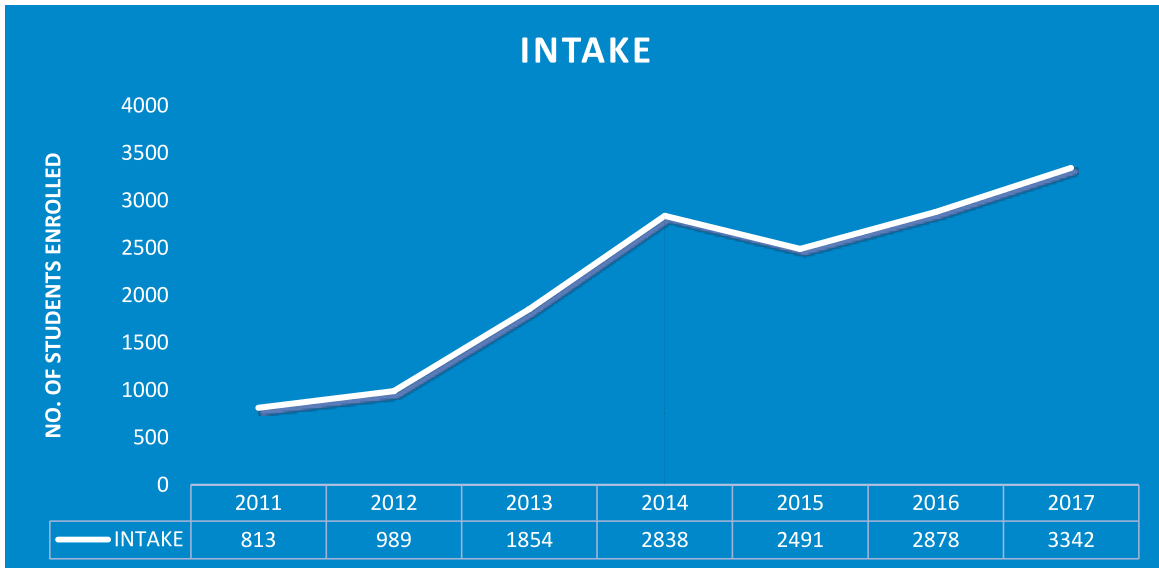
CHAG continued to invest in pre-service training in support of the Ministry of Health efforts to produce middle level cadres of health professionals to improve quality of health services for improved health outcomes. CHAG currently owns 19 Health Training Institutions, who have performed creditable over the years. The graph ... below give the trend of performance of CHAG facilities over the past seven years

4.9 HEALTH TRAINING INSTITUTIONS

Investment in pre-service training and continuous professional education of staff is a considerable measure for retaining staff to improve quality of services. CHAG therefore continued its investment in pre-service training during the period under review. The network has added three training institutions to its stock during the period, bringing the number of CHAG Health training institutions to nineteen (19). These Health Training Institutions have performed creditable over the years. The graphs ... below give the trend of intake and performance of CHAG facilities over the past seven years

The overall student intake at CHAG Health Training Colleges in 2017 was 3342, which represents 116.12% rise in students enrolment compared to that of 2016 enrolments as shown in figure The increase is largely attributable to the rise in the number of CHAG health institutions.

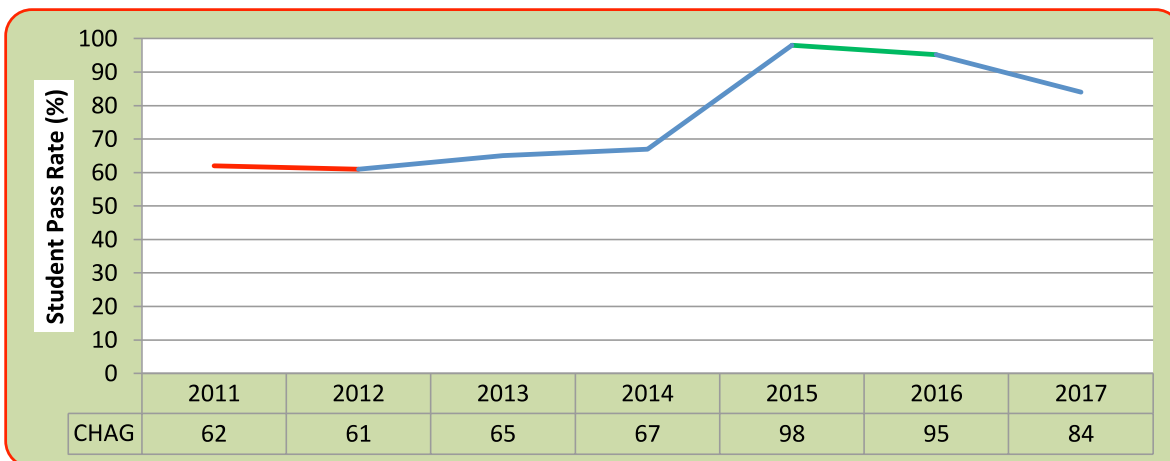
Figure 44: CHAG Student Enrolment Trend: 2011-2017



4.9.1 Student Pas rate

The average student pass rate has however seen consistent declined over the past two years; 2016 and 2017. It has declined from 98% in 2015 to 95% in 2017, and further to 84% in 2017; recording 14% decline over the two years. The lowest pass rate recorded by CHAG facilities in the year 2017 was 77.6% whilst the highest was 95%.

Figure 45: Trend of Student Pass Rate in CHAG Training Institutions, 2011-2017



5.0 HEALTH TECHNOLOGY

Health Technology relates to all aspects of infrastructures, medical equipment, amenities, medicines, vaccines, laboratory equipment and E-health applications. It furthermore relates to all procedures, systems and skills required to manage these items adequately to improve and maintain a high and uninterrupted level of service readiness by the health facility.

Critical network challenges related to health technology that require sustained attention are outlined in table 27.

Table 19: Critical Network Challenges: Health Technology

-
- Insufficient and obsolete health facility plant and equipment;
 - Poor diagnostic support services;
 - High cost of equipment and drugs.
 - Weak maintenance culture, budgeting and planning
 - Limited availability and inadequate use of ICT infrastructure and tools
-

Currently, the CHAG network comprises 302 health facilities and 19 Health-Training institutions. Of the 302 facilities 139 are clinics and 75 are hospitals. In all, the network accounts for 7.4% of the total health infrastructure in the health sector. CHAG Health Facilities are unevenly distributed in all ten regions, particularly in isolated areas and deprived districts (Figure 46).

Some CHAG Facilities have maintained the level and range of services since they were established many years ago. There is need to upgrade such facilities to respond to the expansion of the catchment communities and the growing needs of the clientele. This will help minimize the demands made by 'Chiefs and Opinion Leaders and politicians for 'government hospitals' in areas where CHAG facilities already exist.

Figure 46: Percentage Distribution of CHAG Facilities by Region

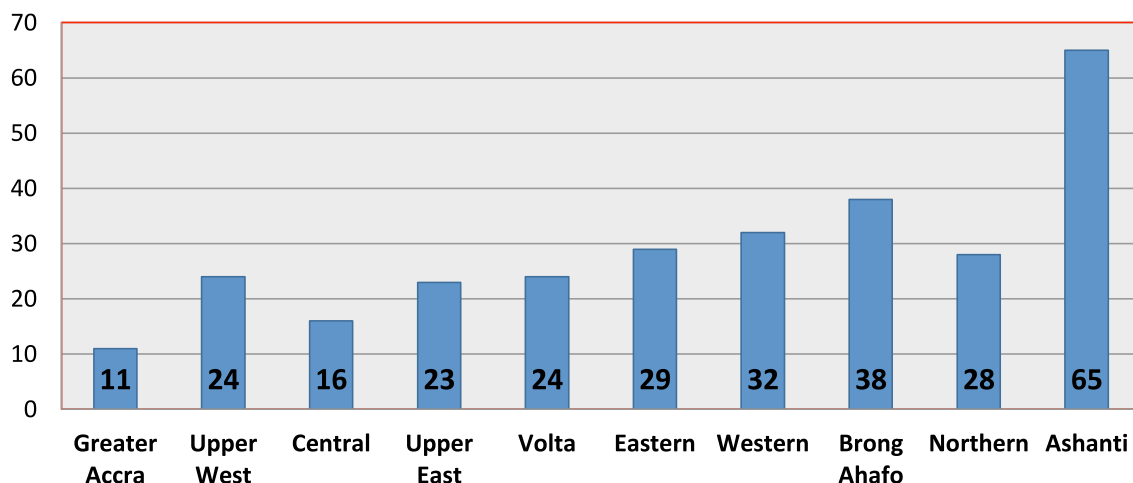
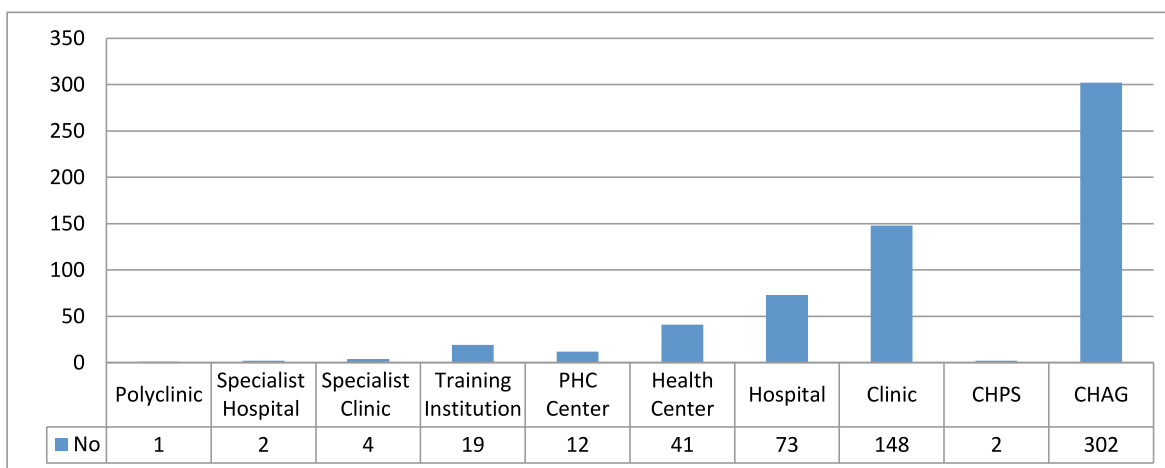


Figure 47: CHAG Facilities by Type, 2017



In 2017 CHAG Network health coordinating units increased to 26 from 21 in 2016. Majority of CHAG facilities is owned by the Catholic Church (43%) followed by the Presbyterian Church (16.5%) and the Seventh Day Adventist Church (9%). The Salvation Army, the Methodist and the Church of Pentecost each own about 4.5% of facilities. The remaining 14 other Church denominations each own less than 1% of CHAG facilities.

Development partners and other stakeholders continued to show interest in the operations of the Catholic Drug Centre, a system that ensured framework contracting of selected medicines under the NHIS medicines list for the Catholic facilities under CHAG.

Studies have revealed that middlemen, illegal trade, counterfeits and low-quality products underpin the medicines supply chain for many healthcare providers in Africa. Experts believe that counterfeit medicines constitute 25% of the medicines market in developing countries. The counterfeit trade is worth about \$700 billion a year and nearly 700,000 people are estimated to die from falsified and sub-standard medicines each year globally according to British Think Tank International Policy Network.

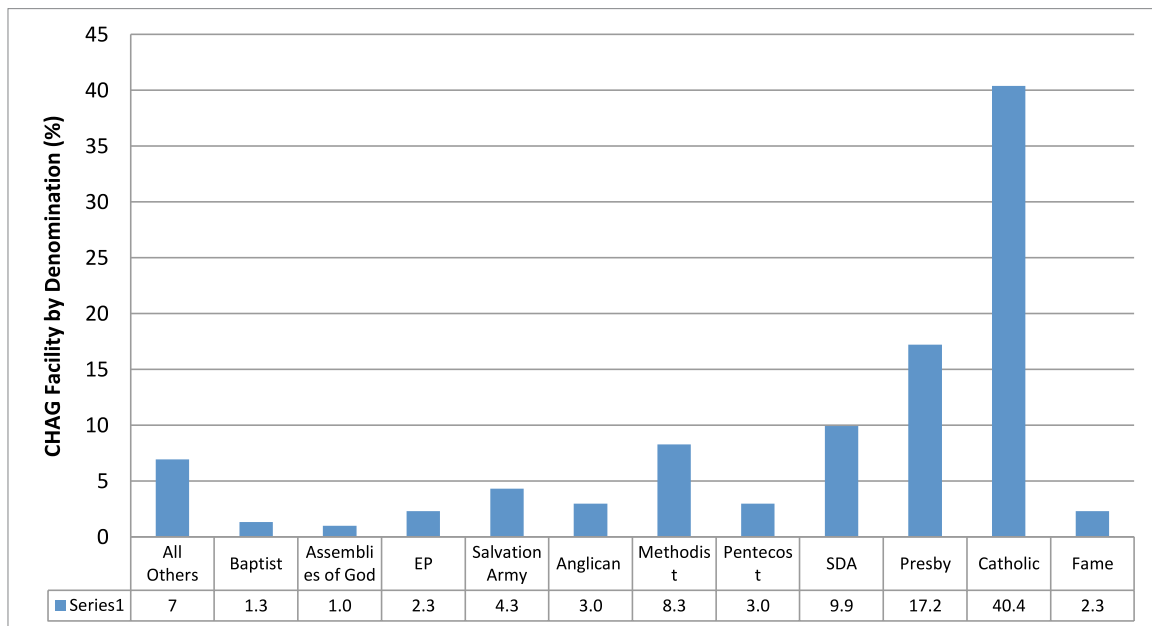
In Ghana, antimalarial medicines are among the most faked medicines on the market. The Country has been part of the Medicines Transparency Alliance (MeTA) since 2008; a multi stakeholder forum aimed at examining every aspect of the medicines supply chain. The Food and Drugs Authority (FDA) has occasionally arrested merchants of fake medicines and also destroyed fake medicines to serve as deterrent to others in Ghana.

A study to explore further the benefits of pooled procurement of medicines was undertaken in June 2017. The findings of the study suggest that most CHAG facilities expect the expansion of the scope of medicines covered under the CDC and the inclusion of more CHAG facilities in the pool or in a similar arrangement.

CHPS

CHAG was actively involved in the development of the CHPS implementation business plan. In 2017, CHAG operated ten CHPS Compounds in collaboration with the respective district health directorates. CHCU have been sensitized to improve their involvement in the implementation of CHPS in the years ahead to minimize the effect of reducing the share of outpatient coverage

Figure 48: Ownership of CHAG Facilities by Denominations, 2017



6.0 HEALTH FINANCING

CHAG Member Institutions are financed through government contribution, internally generated funds (mainly NHIS), direct funding support from development partners through projects and grants/donations. In the year under review, over 96% of government contribution went into staff compensation while the remaining 4% went into goods and services. Overall, government support accounted for 38% and 34% of income of CHAG member institutions (collectively) in 2015 and 2016 respectively.

Financing of CHAG was mainly through the government of Ghana (GOG) funds for salaries, internally generated funds (IGF), and support from development partners. Health insurance continues to be the single largest source of IGF income to health facilities. Over 87% of OPD income and 85.9% of income from inpatient care were financed through the NHIS.

Claims data also shows that CHAG, with about 7% health infrastructure contributed more than 19% of national claims data in 2017. Consequently, challenges with the NHIA have direct impact on the finances of the health institutions.

CHAG facilities continued to suffer from up to eight (8) months persistent delays in NHIS claim reimbursement in 2017. These delays affect the supply chain of medical and non-medical consumables and therefore have the tendency of compromising quality service delivered by our member institutions.

Of equal concern is the low tariffs paid for specialist services rendered by CHAG facilities. These services are provided at the door steps of the community, taking away the stress and cost of travelling to the cities, minimizing challenges associated with overcrowding at referral hospitals, and high cost of treatment for the poor clients at the secondary and tertiary levels. Yet, the NHIA refuses to adequately compensate CHAG hospitals for providing these services at the convenience of the clients. Providers are compelled to do balanced billing to make up for the difference between what the NHIA pays and what it costs them (the provider) to provide the care thereby perpetrating out of pocket payments (co-payment) and further impoverishing the poor clients.

Other cost containment measures were adopted by the NHIA such as clinical audit, biometric identification systems, electronic claims processing and centralized claims processing centers to cut down on the cost of providing health services to clients. 2017 saw a marked improvement in the management of claims by CHAG facilities following training and awareness creation on how to minimize losses due to avoidable errors.

Capitation

The capitation pilot in Ashanti and four other Regions was suspended in August 2017. This contributed to increased NHIA client attendance in smaller facilities that were adversely affected by the capitation policy.

Evaluation of the policy revealed unfavorable effect of the policy on health centres and clinics due to unfair practices in the preferred primary provider (PPP) selection and assignment by the NHIS staff, among other factors.

Table 25: Budget Execution 2017

	APPROVED BUDGET			TOTAL BUDGET			% ACTUAL EXPENDITURE			
	GOG	IGF	Donor	TOTAL BUDGET	GOG	IGF	Donor	TOTAL ACTUALS		
Compensation	277,187,743	38,672,793	-	315,860,536.00	261,991,596	77,545,203		339,536,799		
Goods and Service	-	166,974,047	5,492,117	172,466,164.00	-	161,920,263	5,872,806	167,793,069		
Investment		6,344,189.		6,344,189.00		22,997,161		22,997,161		
Total	277,187,743	211,991,029.00	5,492,117.	494,670,889.00	261,991,596	262,462,627	5,872,806	530,327,030		
% Cont. to budget	56.%	42.85%	1.%	100%	49.40%	49.49%	1.11%	100%		

7.0 PARTNERSHIPS FOR HEALTH

Effective partnerships are based on commitment, communication, cooperation and coordination. Important aspects and advantages of partnerships are: improving access to services; access to complementary resources; improved focus and coordination; and improved capacity, innovation and expertise. Critical network challenges related to partnerships for health that need sustained attention are (Table 29).

Table 20 : Critical Network Challenges: Partnership for Health

-
- Weak collaboration with GHS and local authorities at the region, district and sub-district levels;
 - The challenge of balancing the autonomy, diversity and unity of the network
 - Weak collaboration with NGOs and other partners.
-

CHAG continued to work at a decentralized structure that will meet the current demands of the health sector. This is required to improve representation and visibility of the Association at the regional and district levels, and to boost internal collaboration and partnerships.

In 2017, at the national level, CHAG deepened its partnership with the Ministry of Health and made visible contributions to health sector engagements. Partnership with DFID Ghana was also deepened in the course of the year. Aside DFID Ghana, CHAG partnered with Ecumenical Pharmaceutical Network (EPN) in starting a project on Anti-Microbial Resistance (AMR) and Non-Communicable Diseases.

8.0 RESEARCH FOR HEALTH

Critical challenges exist in the implementation of health services in member institution. The purpose of operational research is to promote contextual solutions and improve the quality and effectiveness of health services management and care. Critical network challenges related to health research that need sustained attention are (Table 30).

Table 21: Critical Network Challenges: Health Research

-
- Lack of health research agenda;
 - Limited research competence;
 - Weak documentation and dissemination of good practices across the network.
-

During the year under review, CHAG set up an Institutional Review Board (IRB). Members of the Board were drawn from the School of Public Health Legon, Private Medical Practitioners Association, experts in the field of research, Korle-Bu Teaching Hospital, the CHAG Secretariat and the CHAG Board. A new unit for research was also started to provide ambient space for research within the network. Partners will be sought in 2018 to collaborate for effective research.

8.1 CHAG'S CORPORATE MONITORING AND EVALUATION (M&E) SYSTEM

The Organizational Performance Assessment Tool (OPAT), the M&E tool is helping the health facilities to periodically assess their organizational capacity regarding the extent to which they deliver desired health outcomes. The OPAT provides a framework of indicators and measures to assess organizational performance and outcomes of CHAG health facilities in each of the 9 HSS blocks (Tables 31 and 32). CHAG uses the OPAT for consolidated reporting and strategic capacity development of the individual members and the network as a whole. For the year under review, no monitoring was done at the facility level due to funding issues. It is hoped that in the coming year, facilities will be assessed on the use of the OPAT.

Table 22: Health Facility Performance: Organizational Capacity Indicators and Measures

HSS Block	Indicator	Measure
Leadership & Governance	Regulatory Compliance	Validity of Registration
		Audited Financial Report
		MOH/CHAG Memorandum of Understanding
		CHAG Guidelines
	Strategic Management	Use of Strategic Plan
	Management Capacity	Preparation Annual Plan and Budget
Implementation Annual Plan		
Human Resources	Staff Coverage	Workforce Strength
	Staff Motivation	Staff Satisfaction
	Staff Competence	Staff Development
Service Delivery	Organization of Care	Availability Basic Health Services
		Accessibility Basic Health Services
		Availability Advanced Health Services
		Referral System and Practices
	Quality Assurance	Quality of Care
Finances	Financial Management	Financial Sustainability
		Financial Administration
		Budget Management
Technology	General Service Readiness	Basic Utilities
		Basic Diagnostic Equipment
		Infection Control Equipment and Amenities
		Laboratory Tests and Equipment
		Essential Medicines
Health Information	Data Management and Use	Timeliness Reporting
		Data Integrity
		Information Usage
Community Participation	Community Engagement	Community Collaboration
Partnership	Key Stakeholder Engagement	Collaboration with Health Sector Administration
Research	Operational Research	Research Agenda

Table 23: Health Facility Outcomes and Impacts

Indicator	No	Measure
1. Health Outcomes	1.1	Under-Five Mortality
	1.2	Neo-Natal Mortality
	1.3	Maternal Mortality
	1.4	Malaria Mortality
	1.5	Malaria Incidence
	1.6	HIV Prevalence
2. Responsiveness	2.1	Client Satisfaction
3. Financial Risk Protection	3.1	Health Insurance Coverage
4. Service Utilization	4.1	Out-Patient Ratio
	4.2	In-Patient Ratio
	4.3	Immunization Ratio
	4.4	Ante-Natal visits per client
	4.5	Referral Ratio
5. Quality and Safety	5.1	Fresh Still Births
	5.2	Compliance with Treatment Protocols
	5.3	Post-Surgical Wound Infection
6. Efficiency	6.1	Client-Cost Ratio
	6.2	Bed Occupancy Ratio

9.0 POINTERS FOR ACTION

The following are pointers for action in the ensuing years;

A. Service Delivery

- 1) Maternal mortality is still a challenge. The system can be upset with more maternal deaths if facilities become complacent in their efforts. Innovative approaches are needed to sustain reduction in maternal deaths. All facilities should aim at achieving institutional maternal mortality ratio of 70 per 100,000 live births as set out in the SDGs. Given the little rise in the maternal deaths for 2017 compared to 2016 it is important to bring back some of the activities that helped in reducing maternal deaths in 2016. These include the 100 days free maternal mortality campaign
- 2) Bed occupancy rate has been reducing over a couple of years now. It is time for facility managers to reflect whether they really need to keep many beds in the facility. Attention should be given to meeting customer needs to address the dwindling OPD attendance since the BOR and ALOS is also reducing.
- 3) There is the need for quality medicines supply to the CHAG network to ensure that clients are getting the right medicines. It is hoped that having quality and right medicines will ultimately lead to cost reduction to patients and the entire health system as well as lead to better health outcomes
- 4) Caesarean deliveries are still rising. It may be an attempt for health workers to avoid long periods of monitoring clients who go through labour or the choice of client to avoid going through the labour pains. Research is needed in this regard. Church Health Coordinating Units and Facility Managers should put measures in place to check the rising Caesarean deliveries. Facilities should aim at having Caesarean delivery rates within the WHO accepted range of 10-15%.

B. Human Resources

- 1) Weak governance systems have been identified in the network as leading to growing conflicts within institutions. In 2018 HR forum and training sessions will be organized to address some of these issues. Conflicts between employees and managers seen in 2017 would be addressed with the coming into force of the HR manual.
- 2) There is still the need to conduct research on the causes of attrition and retention within the network to address the growing trend of attrition to other agencies. In the long term this will help address retention issues not only in CHAG but also in the other MOH agencies.

- 3) Sponsorship for specialist training within the network is needed to ensure that Medical officers and other cadres who enter the CHAG network are motivated and retained. The issue of not promoting specialist to senior specialist position may in the long run lead to not having specialists in the network. A specialist who does not want to pursue academic work should be given the opportunity to work in the institutions and for that matter the Ghana College must resolve this issue in order not to deprive the rural areas of specialists.
- 4) Efforts and measures that have ensured the improvements in the doctor to patient and nurse to patient ratios since 2012 are commendable. These measures and effort should be sustained to ensure that the ratios get better in the coming years and that right staff mix is attained in the network. This will enhance quality of service within the network.

C. Health Financing

- 1) Innovative ways for addressing financial security of CHAG institutions are to be sought especially in the face of NHIS delays in reimbursements of claims to facilities. Additionally, measures that will improve NHIS claims management would be worth seeking in the next couple of years.
- 2) There is the need for review of NHIS charges/tariffs to take care of the rising utility bills. With the withdrawal of government subsidies on electricity and water, CMLs are paying high bills which the NHIS must take into consideration in their tariffs determination.

D. Community ownership and participation

- 1) Member facilities should learn to engage communities in which they operate effectively in order to sustainably address the key health indicators.

E. Research

- 1) There is the need to make operational research as part of strategic plans to generate evidence that could be used to address contextual problems. CHAG should institutionalize research and facilitate the setting up of a research agenda for the network.
- 2) Functional partnerships should be explored to consolidate past gains and embrace the changes and challenges in the health sector with sustainable and feasible interventions towards achieving the health-related SDGs.

Annex 1: CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
1	Salvation Army CHPS Centre, Anidasofie	CHPS	Ashanti	The Salvation Army
2	Presbyterian CHPS Centre, Tolla	CHPS	Upper East	Presbyterian
3	Anglican Eye Clinic, Jachie	Clinic	Ashanti	Anglican
4	Apagya Methodist Clinic, Apagya	Clinic	Ashanti	Methodist
5	Catholic Clinic, Esaase Bontefufuo	Clinic	Ashanti	Catholic
6	Catholic Clinic, Oku Ejura	Clinic	Ashanti	Catholic
7	Catholic Clinic, Sikaman	Clinic	Ashanti	Catholic
8	Church of Christ Mission Clinic, Bomso-Kumasi	Clinic	Ashanti	Church of Christ
9	Church of God Clinic Essienimpong	Clinic	Ashanti	Church of God
10	Church of God Clinic, Ahwerewa	Clinic	Ashanti	Church of God
11	Jesus Care Voluntary Clinic, Kumawu Besoro	Clinic	Ashanti	True Faith
12	Lake Bosumtwi Methodist Clinic, Amakom	Clinic	Ashanti	Methodist
13	Madonna Maternity Clinic, Besease	Clinic	Ashanti	Catholic
14	Methodist Clinic, Aburaso	Clinic	Ashanti	Methodist
15	Methodist Clinic, Bebu - Anyiaem	Clinic	Ashanti	Methodist
16	Methodist Clinic, Brodekwano	Clinic	Ashanti	Methodist
17	Methodist Clinic, Nyameani	Clinic	Ashanti	Methodist
18	Methodist Clinic, Senchi	Clinic	Ashanti	Methodist
19	Presbyterian Clinic, Abasua	Clinic	Ashanti	Presbyterian

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
20	Presbyterian Clinic, Mesewam	Clinic	Ashanti	Presbyterian
21	Saviour Church Clinic, Bonwire	Clinic	Ashanti	Saviour Church
22	Saviour Church Clinic, Subriso	Clinic	Ashanti	Saviour Church
23	SDA Clinic, Anyinasu	Clinic	Ashanti	Seventh Day Adventist
24	Seventh Day Adventist Clinic, Apaah	Clinic	Ashanti	Seventh Day Adventist
25	Seventh Day Adventist Clinic, Nobewam	Clinic	Ashanti	Seventh Day Adventist
26	St. Ann's Maternity Clinic, Donyina	Clinic	Ashanti	Catholic
27	St. Anthony's Clinic, Anyinasu	Clinic	Ashanti	Catholic
28	St. Edward's Hospital, Dwinyama	Clinic	Ashanti	Catholic
29	St. Joseph's Clinic, Abira	Clinic	Ashanti	Catholic
30	St. Mary Anglican Clinic, Apenkra	Clinic	Ashanti	Anglican
31	St. Mary's Clinic, Yapesa	Clinic	Ashanti	Catholic
32	St. Peter's Clinic/Maternity Home, Nitobroso	Clinic	Ashanti	Catholic
33	St. Theresa's Clinic, Nope, Nope - Obrayentoboase	Clinic	Ashanti	Catholic
34	St. Thomas Gen. & Maternity Clinic, Hiaa	Clinic	Ashanti	Catholic
35	St. Vincent's Clinic, Drobonso	Clinic	Ashanti	Catholic
36	Tafo Methodist Clinic, Tafo	Clinic	Ashanti	Methodist
37	The Salvation Army Clinic, Wiamaose	Clinic	Ashanti	The Salvation Army
38	Wesley Cathedral Methodist Clinic, Adum	Clinic	Ashanti	Methodist
39	Holy Spirit Clinic, Dantano	Clinic	Brong-Ahafo	Catholic
40	Kwakuanya Methodist Clinic, Kwakuanya	Clinic	Brong-Ahafo	Methodist
41	Methodist Asuakwaa Clinic, Asuakwaa	Clinic	Brong Ahafo	Methodist

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
42	Methodist Clinic, Dagyamem	Clinic	Brong-Ahafo	Methodist
43	Pentecost Clinic, Kasapin	Clinic	Brong-Ahafo	The Church of Pentecost
44	Presbyterian Clinic, Antwirifo	Clinic	Brong-Ahafo	Presbyterian
45	Presbyterian Clinic, Buokrukruwa	Clinic	Brong-Ahafo	Presbyterian
46	Presbyterian Clinic, Gyankufa	Clinic	Brong-Ahafo	Presbyterian
47	Presbyterian Clinic, Tanoboase	Clinic	Brong-Ahafo	Presbyterian
48	Presbyterian Clinic, Yaakrom	Clinic	Brong-Ahafo	Presbyterian
49	St. Alban's Clinic, Fetentaa	Clinic	Brong-Ahafo	Catholic
50	St. Anthony's clinic, Badu	Clinic	Brong-Ahafo	Catholic
51	St. Jame's Clinic, Abesim	Clinic	Brong-Ahafo	Catholic
52	St. Joseph's Clinic, Wenchikwaasi	Clinic	Brong-Ahafo	Catholic
53	St. Matthews Clinic, Ampenkro	Clinic	Brong-Ahafo	Catholic
54	St. Peter's Clinic, Donkorkrom	Clinic	Brong-Ahafo	Catholic
55	Yawsae Methodist Clinic, Yawsae	Clinic	Brong-Ahafo	Methodist
56	Calvary Baptist Micro-Clinic, Cape Coast	Clinic	Central	Baptist
57	Pentecost Clinic, Ayanfuri	Clinic	Central	The Church of Pentecost
58	Pentecost Community Clinic, Twifu Agona	Clinic	Central	The Church of Pentecost
59	Seventh Day Adventist Clinic, Dominase	Clinic	Central	Seventh Day Adventist
60	The Salvation Army Clinic, Agona-Duakwa	Clinic	Central	The Salvation Army
61	The Salvation Army Clinic, Baa	Clinic	Central	The Salvation Army
62	Methodist Mpraeso Clinic, Mpraeso	Clinic	Eastern	Methodist
63	Catholic Clinic and Maternity, Akim Swedru	Clinic	Eastern	Catholic
64	Holy Spirit Clinic & Maternity Home, Kwasi Fante	Clinic	Eastern	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
65	Hweehwee Methodist Clinic, Hweehwee	Clinic	Eastern	Methodist
66	Notre Dame Clinic, Nsawam	Clinic	Eastern	Catholic
67	St. John's Clinic/Maternity, Akim Ofoase	Clinic	Eastern	Catholic
68	St. Joseph Clinic & Maternity Home, Kwahu-Tafo	Clinic	Eastern	Catholic
69	St. Michael's Catholic Clinic/Maternity, Ntronang-Akim	Clinic	Eastern	Catholic
70	The Salvation Army Clinic, Akim-Wenchi	Clinic	Eastern	The Salvation Army
71	The Salvation Army Clinic, Anum	Clinic	Eastern	The Salvation Army
72	The Salvation Army Clinic, Begoro	Clinic	Eastern	The Salvation Army
73	Mpraeso Methodist Clinic, Mpraeso	Clinic	Eastern	Methodist
74	Osuben Methodist Clinic, Osuben	Clinic	Eastern	Methodist
75	St. Monica's Clinic and Maternity, Akim Sekyere	Clinic	Eastern	Catholic
76	Seventh Day Adventist Clinic, New Gbawe	Clinic	Greater_Accra	Seventh Day Adventist
77	Sight for Africa Eye Clinic, Darkuman	Clinic	Greater-Accra	Run Mission
78	St. Andrew's Clinic and Maternity, Kordiabe	Clinic	Greater-Accra	Catholic
79	St. John of God Clinic, Amrahia	Clinic	Greater-Accra	Catholic
80	Catholic Clinic/PHC, Salaga	Clinic	Northern	Catholic
81	E. P. Church Clinic, Wapuli	Clinic	Northern	Evangelical Presbyterian
82	St. Joseph Clinic & Mat Home, Chamba	Clinic	Northern	Catholic
83	Church of Christ Mission Clinic, Yendi	Clinic	Northern	Church of Christ
84	Fame Clinic, Ekumdi	Clinic	Northern	FAME Ghana
85	Fame Clinic, Loagri	Clinic	Northern	FAME Ghana
86	Fame Clinic, Makango	Clinic	Northern	FAME Ghana
87	Fame Clinic, Tobali/Tatindo	Clinic	Northern	FAME Ghana

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
88	Fame Clinic, Yezesi	Clinic	Northern	FAME Ghana
89	Holy Cross Maternity Home and Clinic, Sambuli	Clinic	Northern	Catholic
90	Presbyterian Clinic, Fooshegu	Clinic	Northern	Presbyterian
91	Zanzugu Yipala Methodist Clinic, Zanzugu Yipala	Clinic	Northern	Methodist
92	Anglican Clinic, Widnaba	Clinic	Upper East	Anglican
93	Anglican Clinic, Yelwoko	Clinic	Upper East	Anglican
94	Fame Clinic, Benwoko	Clinic	Upper East	FAME Ghana
95	Kayeresi Clinic, Kayeresi	Clinic	Upper East	Catholic
96	Presbyterian Clinic, Namolgo	Clinic	Upper East	Presbyterian
97	St. Martin's PHC/ Maternity Clinic, Biu	Clinic	Upper East	Catholic
98	All Saints Clinic, Piina	Clinic	Upper West	Catholic
99	Methodist Clinic, Lawra	Clinic	Upper West	Methodist
100	Nativity of Our Lady Health Centre, Ko	Clinic	Upper West	Catholic
101	Our Lady of Lourdes Clinic, Yagha	Clinic	Upper West	Catholic
102	Queen of Peace Clinic, Sabuli	Clinic	Upper West	Catholic
103	Samuel Seidu Memorial Clinic, Bayiri	Clinic	Upper West	Baptist Mid Mission
104	Seventh Day Adventist Clinic, Wa	Clinic	Upper West	Seventh Day Adventist
105	St. Christopher Clinic, Daputori	Clinic	Upper West	Catholic
106	St. Evarist Clinic, Ullo	Clinic	Upper West	Catholic
107	St. Gregory's Clinic, Nanvilli	Clinic	Upper West	Catholic
108	St. Ignatius Clinic, Lasia Tuolu	Clinic	Upper West	Catholic
109	St. John's Clinic, Funsu	Clinic	Upper West	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
110	St. Martin de Porres Clinic, Eremon	Clinic	Upper West	Catholic
111	St. Paul's Clinic, Kundungu	Clinic	Upper West	Catholic
112	St. Stella's Clinic, Karne	Clinic	Upper West	Catholic
113	E. P. Church Dan Moser Memo. Clinic, Dambai (Hohoe)	Clinic	Volta	Evangelical Presbyterian
114	E. P. Clinic, Hatorgodo	Clinic	Volta	Evangelical Presbyterian
115	E. P. Clinic, Jamani	Clinic	Volta	Evangelical Presbyterian
116	Fame Clinic, Akplale	Clinic	Volta	FAME Ghana
117	Fr. Cuniberto's Clinic, Lume	Clinic	Volta	Catholic
118	Mater Ecclesiae Clinic, Sokode	Clinic	Volta	Catholic
119	Nazareth Healing Complex, Vane Avatime	Clinic	Volta	Evangelical Presbyterian
120	Pentecost Clinic, Kpassa	Clinic	Volta	The Church of Pentecost
121	St. Anne's Clinic & Maternity Home, Tagadzi	Clinic	Volta	Catholic
122	St. Francis Clinic, Saviefe Agorkpo	Clinic	Volta	Catholic
123	St. George's Clinic, Liati	Clinic	Volta	Catholic
124	St. Luke's Clinic, Chinderi	Clinic	Volta	Catholic
125	The Salvation Army Clinic, Adaklu-Sofa	Clinic	Volta	The Salvation Army
126	Angela Memorial Catholic Clinic, Yawmatwa	Clinic	Western	Catholic
127	Anglican Clinic, Sefwi-Bonzain	Clinic	Western	Anglican
128	Bishop Anglonby Memorial Clinic, Sefwi-Bodi	Clinic	Western	Anglican
129	Holy Child Clinic, Egyam	Clinic	Western	Catholic
130	Holy Child Clinic, Fijai	Clinic	Western	Catholic
131	Kwawu Bethel Methodist Clinic Kwawu	Clinic	Western	Methodist

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
132	Mary Ekuba Ewoo Memorial Adventist Clinic, Akwidaa	Clinic	Western	Seventh Day Adventist
133	Nagel Memorial Clinic, Takoradi	Clinic	Western	Seventh Day Adventist
134	Nzulezu Methodist Clinic, Nzulezu	Clinic	Western	Methodist
135	Pentecost Clinic, Enchi	Clinic	Western	The Church of Pentecost
136	Pentecost Clinic, Tarkwa	Clinic	Western	The Church of Pentecost
137	Pentecost Clinic, Yawmatwa	Clinic	Western	The Church of Pentecost
138	Presbyterian Clinic, Papueso-Enchi	Clinic	Western	Presbyterian
139	Seventh Day Adventist Clinic and Maternity, Sefwi-Asawinso	Clinic	Western	Seventh Day Adventist
140	Seventh Day Adventist Clinic, Kofikrom	Clinic	Western	Seventh Day Adventist
141	Siloam Gospel Clinic, Bonyere	Clinic	Western	Siloam Gospel
142	St. John of God Clinic, Oseikojokrom	Clinic	Western	Catholic
143	St. Mark's Anglican Clinic, Subiri	Clinic	Western	Anglican
144	Gwira Eshiem Methodist Clinic, Gwira Eshiem	Clinic	Western	Methodist
145	Presbyterian Clinic, Ohiamatuo	Clinic	Western	Presbyterian
146	Seventh Day Adventist Clinic and Maternity, Sefwi Punikrom	Clinic	Western	Seventh Day Adventist
147	Seventh Day Adventist Clinic, Dadieso	Clinic	Western	Seventh Day Adventist
148	Seventh Day Adventist Clinic, Sefwi Amoaya	Clinic	Western	Seventh Day Adventist
149	Seventh Day Adventist Clinic, Wassa Nkran	Clinic	Western	Seventh Day Adventist
150	St Luke Methodist Clinic, Adwuofua	Clinic	Western	Methodist
151	Anglican Health Centre, Tano-Odumase	Health Centre	Ashanti	Anglican
152	Sacred Heart Health Centre, Bepoase	Health Centre	Ashanti	Catholic
153	St. John's Health Centre, Domeabra	Health Centre	Ashanti	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
154	St. Louis Health Centre, Bodwesango	Health Centre	Ashanti	Catholic
155	St. Luke's Health Centre, Seniagya	Health Centre	Ashanti	Catholic
156	Presbyterian Health Centre, Jenjemireja	Health Centre	Brong-Ahafo	Presbyterian
157	Presbyterian Health Centre, Kyeremasu	Health Centre	Brong-Ahafo	Presbyterian
158	Presbyterian Health Centre, Aboabo	Health Centre	Brong-Ahafo	Presbyterian
159	Presbyterian Health Centre, KwadwoKumikrom	Health Centre	Brong-Ahafo	Presbyterian
160	Presbyterian Health Centre, Kwamesua	Health Centre	Brong-Ahafo	Presbyterian
161	Presbyterian Health Centre, Suma Ahenkro	Health Centre	Brong-Ahafo	Presbyterian
162	Presbyterian Church Health Center, Assin-Praso	Health Centre	Central	Presbyterian
163	Presbyterian Health Centre, Assin Nsuta	Health Centre	Central	Presbyterian
164	The Salvation Army Health Centre, Ajumako-Ochiso	Health Centre	Central	The Salvation Army
165	Presbyterian Health Centre, Abetifi	Health Centre	Eastern	Presbyterian
166	Presbyterian Health Centre, Ekye	Health Centre	Eastern	Presbyterian
167	Presbyterian Health Centre, Kom- Aburi	Health Centre	Eastern	Presbyterian
168	Presbyterian Health Centre, Kwahu Praso	Health Centre	Eastern	Presbyterian
169	Tease Presby Health Centre, Afram Plains	Health Centre	Eastern	Presbyterian
170	Presbyterian Health Centre, Obregyima	Health Centre	Eastern	Presbyterian
171	Urban Aid Health Centre, Mamobi	Health Centre	Greater-Accra	The Salvation Army
172	Presbyterian Health Centre, Langbinsi-Gambaga	Health Centre	Northern	Presbyterian
173	Good Shepherd Health Centre, tuna	Health Centre	Northern	Catholic
174	Kuwani Health Centre, Kuwani	Health Centre	Northern	Presbyterian
175	Martyrs of Uganda Health Centre, Bole	Health Centre	Northern	Catholic
176	Nakpanduri Health Centre	Health Centre	Northern	Assemblies of God

CHAG Member Institutions by Type

177	Presbyterian Health Centre, Loloto	Health Centre	Northern	Presbyterian
178	Presbyterian Health Centre, Widana	Health Centre	Upper East	Presbyterian
179	Presbyterian Health Centre, Garu	Health Centre	Upper East	Presbyterian
180	Immaculate Conception Health Centre, Kongo	Health Centre	Upper East	Catholic
181	Martyrs of Uganda Health Centre, Sirigu	Health Centre	Upper East	Catholic
182	Presbyterian Health Centre, Siniensi	Health Centre	Upper East	Presbyterian
183	Presbyterian Health Centre, Sumaduri	Health Centre	Upper East	Presbyterian
184	St. Joseph Health Centre, Nakolo	Health Centre	Upper East	Catholic
185	St. Lucas Health Centre, Wiaga	Health Centre	Upper East	Catholic
186	St. Theresa Health Centre, Zorko	Health Centre	Upper East	Catholic
187	St. Catherine of Sienna Health Centre, Jirapa	Health Centre	Upper West	Catholic
188	St. Gerhardt Health Centre, Fielmuo	Health Centre	Upper West	Catholic
189	Koni Health Centre, Kpassa	Health Centre	Volta	Evangelical Church of Ghana
190	The Salvation Army Health Centre, Ziavi	Health Centre	Volta	The Salvation Army
191	Presbyterian CHPS Compound, Amonie	Health Centre	Western	Presbyterian
192	Presbyterian Health Centre, Kwamebikrom	Health Centre	Western	Presbyterian
193	Benito Menni Hospital, Dompoose	Hospital	Ashanti	Catholic
194	Adventist Hospital, Breman	Hospital	Ashanti	Seventh Day Adventist
195	Akoma Memorial SDA Hospital, Kortwia-Abodom	Hospital	Ashanti	Seventh Day Adventist
196	Baptist Medical Centre, Abuakwa	Hospital	Ashanti	Baptist
197	Bryant Mission Hospital, Obuasi-Adansi	Hospital	Ashanti	The Church of Pentecost
198	Global Evangelical Mission Hospital, Apromase	Hospital	Ashanti	Global Evangelical
199	HART Adventist Hospital, Ahinsan	Hospital	Ashanti	Seventh Day Adventist

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
200	Hopexchange Medical Centre, Christian Village - Kumasi	Hospital	Ashanti	Catholic
201	Janie Speaks A.M.E Zion Hospital, Afrancho	Hospital	Ashanti	AME ZION
202	Methodist Faith Healing Hospital, Ankaase	Hospital	Ashanti	Methodist
203	Pope John Paul II Medical Centre, Jamasi	Hospital	Ashanti	Catholic
204	Presbyterian Hospital, Agogo, Ashanti-Akim	Hospital	Ashanti	Presbyterian
205	Seventh Day Adventist Hospital, Asamang	Hospital	Ashanti	Seventh Day Adventist
206	Seventh Day Adventist Hospital, Dominase	Hospital	Ashanti	Seventh Day Adventist
207	Seventh Day Adventist Hospital, Kwadaso-Kumasi	Hospital	Ashanti	Seventh Day Adventist
208	Seventh Day Adventist Hospital, Namong	Hospital	Ashanti	Seventh Day Adventist
209	Seventh Day Adventist Hospital, Obuasi	Hospital	Ashanti	Seventh Day Adventist
210	Seventh Day Adventist Hospital, Wiamaoasi-Ashanti	Hospital	Ashanti	Seventh Day Adventist
211	St. Luke's Hospital, Kasei	Hospital	Ashanti	Luke Society Missions
212	St. Martin's Hospital, Agroyesum	Hospital	Ashanti	Catholic
213	St. Michael's Hospital, Pramso	Hospital	Ashanti	Catholic
214	St. Patrick's Hospital, Maase-Offinso	Hospital	Ashanti	Catholic
215	St. Peter's Hospital, Jacobu	Hospital	Ashanti	Catholic
216	Holy Family Hospital, Berekum	Hospital	Brong-Ahafo	Catholic
217	Holy Family Hospital, Techiman	Hospital	Brong-Ahafo	Catholic
218	Mathias Hospital, Yeji	Hospital	Brong-Ahafo	Catholic
219	Methodist Hospital, Wenchi	Hospital	Brong-Ahafo	Methodist
220	Presbyterian Hospital, Dormaa-Ahenkro	Hospital	Brong-Ahafo	Presbyterian
221	Seventh Day Adventist Hospital, Sunyani	Hospital	Brong-Ahafo	Seventh Day Adventist
222	St. Elizabeth Hospital, Hwidiem	Hospital	Brong-Ahafo	Catholic
223	St. John of God Hosp., Duayaw-Nkwanta	Hospital	Brong-Ahafo	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
224	St. Mary's Hospital, Drobo	Hospital	Brong-Ahafo	Catholic
225	St. Theresa's Hospital, Nkoranza	Hospital	Brong-Ahafo	Catholic
226	Coast for Christ Baptist Hospital, Winneba	Hospital	Central	Baptist
227	Hope Christian Hospital, Gomoa Feteh	Hospital	Central	Church of Christ
228	Mercy Women's Hospital, Mankessim	Hospital	Central	Catholic
229	Our Lady of Grace Hospital, Breaman-Asikuma	Hospital	Central	Catholic
230	St. Francis Xavier Hospital, Assin-Fosu	Hospital	Central	Catholic
231	St. Gregory Catholic Hospital, Gomoa Budumburam	Hospital	Central	Catholic
232	St. Luke Catholic Hospital, Apam	Hospital	Central	Catholic
233	Holy Family Hospital, Nkawkaw	Hospital	Eastern	Catholic
234	Presbyterian Hospital, Donkorkrom	Hospital	Eastern	Presbyterian
235	Seventh Day Adventist Hospital, Koforidua	Hospital	Eastern	Seventh Day Adventist
236	St. Dominic Hospital, Akwatia	Hospital	Eastern	Catholic
237	St. Joseph's Hospital, Koforidua	Hospital	Eastern	Catholic
238	St. Martin's de Porres Hospital, Agomanya	Hospital	Eastern	Catholic
239	Hawa Mem. Saviour Hospital, Akim-Osiem	Hospital	Eastern	Saviour Church
240	Faith Evangelical Mission Hospital, Bubuashie	Hospital	Greater-Accra	Faith Evangelical Mission
241	Manna Mission Hosp, Teshie-Nungua	Hospital	Greater-Accra	Manna Mission
242	Pentecost Hospital, Madina	Hospital	Greater-Accra	The Church of Pentecost
243	Baptist Medical Centre, Nalerigu	Hospital	Northern	Baptist
244	Saboba Medical Centre, Saboba	Hospital	Northern	Assemblies of God
245	West Gonja Hospital, Damango	Hospital	Northern	Catholic
246	Evangelical Church of Ghana Hospital, Kpandai	Hospital	Northern	Evangelical Church of Ghana
247	Seventh Day Adventist Hospital, Tamale	Hospital	Northern	Seventh Day Adventist

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
248	Tatale District Hospital, Tatale	Hospital	Northern	Catholic
249	The Kings Medical Centre, Bontanga	Hospital	Northern	Assemblies of God
250	Presbyterian Hospital, Bawku	Hospital	Upper East	Presbyterian
251	St. Joseph's Hospital, Jirapa	Hospital	Upper West	Catholic
252	St. Theresa's Hospital, Nandom	Hospital	Upper West	Catholic
253	Anfoega Catholic Hospital, Anfoega	Hospital	Volta	Catholic
254	Catholic Hospital, Battor	Hospital	Volta	Catholic
255	Comboni Hospital, Sogakope	Hospital	Volta	Catholic
256	Margaret Marquart Cath. Hosp, Kpando	Hospital	Volta	Catholic
257	Mary Theresa Hospital, Dodi-Papase	Hospital	Volta	Catholic
258	Sacred Heart Hospital, Weme-Abor	Hospital	Volta	Catholic
259	St. Anthony's Hospital, Dzodze	Hospital	Volta	Catholic
260	St. Joseph's Hospital, Nkwanta	Hospital	Volta	Catholic
261	Fr. Thomas Alan Rooney Memo. Hosp., Asankragwa	Hospital	Western	Catholic
262	St. John of God Hospital, Sefwi-Asafo	Hospital	Western	Catholic
263	St. Martin de Porres Hospital, Eikwe	Hospital	Western	Catholic
264	Valley View University Hospital, Techiman	Hospital	Brong-Ahafo	Seventh Day Adventist
265	St. Lucy Polyclinic, Tamale	Polyclinic	Northern	Catholic
266	Presbyterian PHC , Agogo, Ashanti-Akim	Primary Health Care	Ashanti	Presbyterian
267	Abease PHC Project, Prang/Abease	Primary Health Care	Brong-Ahafo	Catholic
268	Dormaa Presby PHC Project, Dormaa-Ahenkro	Primary Health Care	Brong-Ahafo	Presbyterian
269	Our Lady of Fatima Health Centre, Abease	Primary Health Care	Brong-Ahafo	Catholic
270	Presbyterian Primary Health Centre, Tease	Primary Health Care	Eastern	Presbyterian
271	Our Lady of Rocio PHC, Walewale	Primary Health Care	Northern	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
272	St. Joseph's PHC, Kalba	Primary Health Care	Northern	Catholic
273	Presbyterian Health Centre, Woriyanga	Primary Health Care	Upper East	Presbyterian
274	Presbyterian PHC, Bawku	Primary Health Care	Upper East	Presbyterian
275	Presbyterian PHC, Bolgatanga	Primary Health Care	Upper East	Presbyterian
276	Presbyterian PHC, Sandema	Primary Health Care	Upper East	Presbyterian
277	Wa Diocese PHC Project	Primary Health Care	Upper West	Catholic
278	E. P. Church Health Services, Ho	Primary Health Care	Volta	Evangelical Presbyterian
279	Presbyterian PHC, Enchi	Primary Health Care	Western	Presbyterian
280	The Salvation Army Rehabilitation Centre, Duakwa	Rehabilitation Centre	Central	The Salvation Army
281	The Salvation Army Rehabilitation Centre, Begoro	Rehabilitation Centre	Eastern	The Salvation Army
282	Christian Eye Centre, Abesim	Specialist Clinic	Brong-Ahafo	Anglican
283	Bishop Ackon Memorial Christian Eye Centre, Cape Coast	Specialist Clinic	Central	Anglican
284	Presbyterian Regional Eye Centre, Bolgatanga	Specialist Hospital	Upper East	Presbyterian
285	Emmanuel Eye/ Medical Centre, East Legon	Specialist Hospital	Greater-Accra	Luke Society Mission
286	Nursing & Midwifery Training College, Agogo	Training Institution	Ashanti	Presbyterian
287	Seventh Day Adventist Midwifery Training School, Asamang	Training Institution	Ashanti	Seventh Day Adventist
288	Seventh Day Adventist Nurses Training College, Kwadaso	Training Institution	Ashanti	Seventh Day Adventist
289	St. Patrick's Midwifery School, Maase-Offinso	Training Institution	Ashanti	Catholic
290	Holy Family Midwifery/Nurses Training College, Berekum	Training Institution	Brong-Ahafo	Catholic
291	Holy Family Nursing Training College, Techiman	Training Institution	Brong-Ahafo	Catholic
292	Physiotherapy & Orthotic Training School, Duayaw Nkwanta	Training Institution	Brong-Ahafo	Catholic
293	Presbyterian Midwifery Training School, Dormaa Ahenkro	Training Institution	Brong-Ahafo	Presbyterian
294	Presbyterian Midwifery Training School, Duayaw Nkwanta	Training Institution	Brong-Ahafo	Presbyterian
295	Holy Family Nurses Training College, Nkawkaw	Training Institution	Eastern	Catholic

CHAG Member Institutions by Type

	FACILITY NAME	TYPE	REGION	DENOMINATION
296	Presbyterian Nurses Training College, Bawku,	Training Institution	Upper East	Presbyterian
297	Jirapa Community Health Nursing Training School, Jirapa	Training Institution	Upper West	Catholic
298	St. Joseph's Nurses' Training College, Jirapa	Training Institution	Upper West	Catholic
299	Seventh Day Adventist Health Asst. Training School, Asanta	Training Institution	Western	Seventh Day Adventist
300	Word Alive Comm Health Nursing Training School, Esiama	Training Institution	Western	Word Alive
301	St. Joseph's Midwifery Training School, Jirapa	Training Institution	Upper West	Catholic
302	Bro. Tarcisus Prosthetics and Orthotics Training College, Nsawam	Training Institution	Eastern	Catholic



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