CHAG

CHRISTIAN HEALTH ASSOCIATION OF GHANA

Health in Body, Mind and Soul

ANNUAL REPORT 2018

Christian Health Association of Ghana (CHAG)

ANNUAL REPORT 2018

CONTENTS

LIST OF TABLES

LIST OF FIGURES

Figure	Page

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-Based 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
MAFMDG	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 Service
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
OPAT	Organizational Performance Assessment Tool
PHC	Primary Health Care
PLHIV	Patients Living with HIV and AIDS
PMTCT	Prevention of Mother To Child Transmission
TBA	Traditional Birth Attendant
UTI	Urinary Tract Infection
URTI	Upper Respiratory Tract Infection

Chairperson's Letter

Dear Friends,

With sense of gratitude, the year 2018 proved successful for CHAG. In fulfillment of our mission of promoting the healing ministry of our Lord Jesus Christ, virtually all the key health service indicators witnessed significant improvements. In particular, both Out-Patient visits and In-Patient admissions increased. There were also appreciable reductions in Maternal, Under-five and Neo-natal mortalities.

Friends, in many ways, these modest achievements demonstrate patients' confidence in health services offered in the CHAG network. As a corollary to the improved service utilization, we are pleased to recognize the commitment, endurance and tenacity of our able frontline health workers in ensuring the provision of quality health services to our cherished clients, irrespective of the changes and challenges confronting CHAG Member Institutions (CMI). Indeed, these positive developments inspire the entire CHAG network to intensify efforts towards attaining Universal Health Coverage.

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 2018. In the years ahead, we would strengthen our position as the most reliable partner in the health sector. Ultimately, we aim at evolving and becoming better, bigger and influential Christian network focused on promoting the growth, development and sustainability of Christian health services in Ghana.

I hope you benefit from this 2018 Annual Report, which highlights the role, contributions and impact CHAG made in the lives and livelihoods of our cherished clients and the Ghanaian public as a whole.

With gratitude,

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

A Note of Gratitude

Dear Partners and Colleagues,

With our resolve to become better, bigger, and influential Christian Health Service Network, CHAG continued to render curative, preventive, promotive, rehabilitative and palliative health services to our cherished clients in the year 2018. Consistent with our mission of becoming the most reliable partner in Ghana's health sector, we maintained our commitment to providing quality training of middle level health professionals across our network of 345 Member Institutions.

Our Strategic Orientation

We fulfilled our collective role and contributions in the Ghanaian health sector by providing health services aligned with Ministry of Health objectives and policy goals. The year 2018 marked the second year of operationalizing the CHAG 2017-2021 strategic plan aimed at building a resilient network that addresses emerging health issues promptly. Therefore, in the course of the year, we recognized the changes and challenges confronting the entire CHAG network. Hence, as faithful stewards and servants of Jesus Christ's healing ministry, we explored opportunities for growth and development of the CHAG fraternity, and for achieving universal health coverage.

Our Role and Contributions to Health Sector Goals/Targets

For the year under review– 2018, all the key health indicators improved between 7.9% and 53.6%. Institutional maternal mortality declined by 18.4%; from 152 to 124 per 100,000 live births. There were also significant reductions in under-5 mortality, which reduced by 53.6%, infant mortality by 11.9%, neonatal mortality by 8.9%, and Crude Mortality by 7.9%. It is noteworthy to emphasize that in two years, under-5 mortality has reduced by 64.5% (from 18.3 in 2016 to 6.5% in 2018).

HIV counseling services increased by 95%, whilst the proportion of new cases that were put on ARVs increased by 72.1% compared to those that were put on treatment in 2017. Prevention of Mother To Child Transmission (PMTCT) activities also increased in CHAG facilities in 2018. There was over three-fold rise in the number of pregnant women who were tested through the PMTCT programme. The proportion of pregnant women tested for HIV in 2018 was 318.2% more than those tested in 2017. These are by no means small achievements.

Ultimately, CHAG's role and relevance as a reliable partner in the health sector was affirmed in 2018. Accordingly, CHAG contributed 32.1% of national in-patient care/admissions and 22.0% of national OPD services with barely 6% of national health infrastructure. Specifically, we handled 6,785,233 Outpatient visits, 542,689 Admissions, 143,242 supervised deliveries, and admitted 1,789 students in the 19 pre-service CHAG Health Training Colleges. These gains, with limited resources, were an affirmation and demonstration of CHAG's efficiency niche and distinctive competencies in the health sector.

Appreciation

Friends, we owe these significant contributions to our dedicated front-line staff, committed Management Teams and diligent Board of Trustees for upholding the values and ideals of CHAG. In consonance with our core values of cooperation and partnerships, CHAG collaborated 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, UKAID/DFID, PharmAccess, 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.

Affirmation and Conclusion

As a Christian Not-For-Profit Organization, our aspiration is to ensure equitable inclusion in society by improving access to quality health services in all its dimensions, to those we serve especially the poor, needy, marginalized and neglected segments of the society. Hence, we would continue to explore innovative interventions and strive to promote holistic health and healing, in all circumstance, for those whose lives and livelihoods depend on us. Indeed, re-igniting Primary Health Care towards attaining Universal Health Coverage shall remain our passion in the years ahead.

Dear Friends, this 2018 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 Providers. In many ways, 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
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Christian Health Association of Ghana (CHAG) in a Nutshell

The Christian Health Association of Ghana (CHAG) is a network organization of 345 Health Facilities and Health Training Institutions owned by 33 different Christian Church denominations. It is the second largest provider of health services in Ghana and contributes about 30-40% of national health service provision. Over the past fifty-one (51) years, the contributions of CHAG continue to deepen particularly in remote and urban poor areas. Although CHAG continues to provide health care to the most vulnerable and underprivileged population groups particularly in the most remote areas of Ghana, where the Government of Ghana had no facilities, the network recognizes the need to meet the health needs of the urban poor, where necessary.

CHAG is an implementing partner/recognized agency of the Ministry of Health and works within the policies, guidelines and strategies of the Ministry of Health (MOH). Nonetheless, CHAG is autonomous and takes an independent position to advocate and promote improvements in the health sector and to promote the interest of its Members and its 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 development (Table 2).

Table 2: Objectives of CHAG

- Foster effective partnerships amongst 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 2018

The year 2018 was when CHAG sought to develop structures towards achieving financial sustainability as contained in the Programme of Work. The year also offered a time for reflection on how to position CHAG to become bigger, better and influential. Hence, 2018 was adjudged to be the best performing year with the network witnessing an all-time improvement in all the key health service indicators.

In 2018, CHAG provided compassionate health care to many Ghanaians particularly in remote and urban poor 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 345 Hospitals, Health Centres, Clinics, PHCs and Health Training Schools.

On leadership and governance, CHAG sought to facilitate the development of policies, regulatory framework and to strengthen institutional leadership and governance capacities at all levels to promote financial sustainability for the network. Again, CHAG realized the need to strengthen institutional, organizational and employee performance management systems. To improve outcomes within the Network, CHAG increased access to the use of organizational performance and assessment tool (OPAT) by training new members who were admitted to the network. CHAG thus adopted OPAT as a performance management tool to monitor performance in the nine health system building blocks within the network.

Consistent with CHAG's objective to support the achievement of national health outcomes, CHAG actively participated in all the Ministry of Health engagements on national health policy and practice towards the financial sustainability and optimization of CHAG health services, CHAG embarked on a journey to ensure that all CHAG Member Institutions (CMIs) submit their NHIS claims electronically. To this end, with support from PharmAccess Group, 273 claim officers from the network were trained on the use of CLAIM-IT software for prompt and accurate submission of NHIS claims.

In spite of the challenges associated with NHIS indebtedness, uneconomic tariff structure, and utility bills exacting a heavy toll on CMIs, 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. Significantly, all the key indicators improved (reduction in mortality rates) between 7.9% and 53.6%. These indicators include under 5 mortality (53.6%), maternal mortality (18.4%), infant mortality (11.9%), neonatal mortality (8.9%), and crude mortality (7.9%). Significantly, in two years, under-5 mortality has reduced by 64.5% from 18.3 per 1,000 LB in 2016 to 6.5 per 1000 LB in 2018.

Over a five-year period, there have been improvements (reduction in the various mortality rates) in the above indicators. The greatest improvements were seen in under-5 mortality (62.4%), followed by maternal mortality (25.7%), infant mortality (18.3%), crude mortality (16.7%), neonatal mortality (16.3%) and still birth rates (9.5%) as can be seen in table 3 below.

A number of contributory factors could have accounted for the notable improvements in all the key indicators. Awareness was created on poor performance on some of the indicators in the previous year. Over the past 3 years, the CHAG Annual Conferences highlighted the gaps, overlaps and legitimate concerns in service delivery across the CHAG network. Subsequently, CHAG provided recommendations and interventions to ensure efficiency and effectiveness in service delivery. Specifically, in addressing avoidable maternal mortality, over 100 midwives and several other staff were trained on the use of a mobile app called Safe Delivery App (SDA) in Eastern and Ashanti regions as well as at the 2018 CHAG Annual Conference. Consequently, the improved knowledge in the conduct of deliveries had direct impact on maternal and neonatal outcomes. It may, in part, also account for the notable reductions in maternal mortality and neonatal mortalities that were observed in the year under review. Again, it has been observed elsewhere that a rise in Caesarean deliveries contribute to reduction in maternal mortality as was observed in 2018. There was a rise in Caesarean Section (CS) rates as shown below. Under-5, infant, crude, neonatal mortalities and stillbirth rates all reduced by 62.5%, 25.7%, 18.3%, 16.7%, 16.3% and 9.5% respectively. 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 – 2018

OUTCOME INDICATOR	Year (CHAG)							% Change (CHAG)	One-year Performance	% Change	5-Year Performance	National	Developing Countries
	2012	2013	2014	2015	2016	2017	2018	2017 - 2018	2017 - 2018	2014 - 2018	2014 - 2018	2017	2016
Maternal Mortality Rate (per 100,000 LB)	158	168	167	145	109	152	124	-18.4	Improved	-25.7	Improved	147.3[1]	239[5]
Neonatal Mortality Rate (per 1000 LB)	5.5	7.1	9.8	6.5	13	9	8.2	-8.9	Improved	-16.3	Improved	25[2]	52[2]
Infant Mortality Rate (per 1000 LB)	6.6	7.9	10.9	8.6	12.9	10.1	8.9	-11.9	Improved	-18.3	Improved	37[2]	107[2]
Under 5 Mortality Rate (per 1000 LB)	21.1	19.5	17.3	15.1	18.3	14	6.5	-53.6	Improved	-62.4	Improved	52[2]	177[2]
Still Births Rate (per 1000 LB)	26	24	21	21	20	19	19	0.0	Stabilized	-9.5	Improved	29[3]	18.4[6]
Crude Mortality Rate (per 1000 Admissions)	23	23	21	22	19	19	17.5	-7.9	Improved	-16.7	Improved	9.4[4]	16[2]

[1] Ghana Health Service, FHD 2017
[2] GDHS & GMHS, 2017
[3] World Health Organization: Maternal, newborn, Child and adolescent health, stillbirths 2015
[4] GDHS, 2008
[5] World Health Organization: Maternal Mortality Key facts 2015p
[6] 2015 worldwide estimates: WHO neglected tragedy of stillbirths

CHAG 2018 ANNUAL CONFERENCE

Background

CHAG in its 2nd year of implementing its 2017-2021 strategic plan, seeks to "Build a Resilient Health Network towards achieving Universal Health Coverage(UHC)"". Hence, the theme for 2018 was to "build structures for financial sustainability of the CHAG network." Consequently, the 2018 Annual Conference held in Sunyani, explored feasible pathways towards achieving UHC through building a resilient health network. The Conference, which brought together 490 participants, was used to affirm CHAG's resolve to reach out and provide quality healthcare to all manner of persons irrespective of their socio-economic circumstances. To ensure the sustainability of Christian health services, the occasion was also used to explore prospects and potentials for making CHAG better, bigger, richer and influential in the health sector. The role of CHAG in nurturing key and important personalities serving in various important roles in the health sector nationally and globally, many of whom were present at the conference, was highlighted.

Changes and Challenges

Aside financial sustainability, which is a major issue confronting Christian health services delivery and the entire health sector, a myriad of challenges identified were:

- How to train, attract and retain the right number, quality and mix of staff to deliver quality health services at all times in the population that CHAG serves.
- Inadequate infrastructure.
- 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.
- Non-adherence to proper referral systems.
- Inappropriate staff attitude.

Recommendations

Towards "Building Resilient Health System towards Attaining Universal Health Coverage; the Role of CHAG, the conference adopted the following recommendations:

- ✓ The need to explore feasible funding mechanisms to finance CHAG operations.
- ✓ Establishing structures and mechanisms to support the CHAG Supply Chain.
- ✓ Putting in a place package of holistic health services.
- ✓ Repositioning CHAG to be friendlier and responsive to patients.
- ✓ Partnering with the people in the catchment areas in identifying relevant challenges for impactful services.
- ✓ Ensuring the embodiment of Jesus Christ in the healing ministry through compassionate and professional health service provision
- ✓ Invigorating health research within the network.

Launching of the CHAG Human Resource Policy Manual

The occasion was used to launch a Human Resource (HR) policy manual that had been prepared to harmonize the administration of HR within the network. The manual is the consolidated HR policies and practices of the various constituent Denominational Health Services in order to ensure uniformity in the administration of human resource across the CHAG network.

Admission of New CHAG Member Facilities

Towards the growth and development of CHAG, twenty-seven (27) new CHAG Member Institutions were admitted into the CHAG family at a ceremony that granted their certificate of membership. Figures 1-3 show pictures of some of the important aspects of the 2018 conference.

Figure 1:
SECTION OF DIGNATORIES THAT GRACED THE 2018 CHAG ANNUAL CONFERENCE IN SUNYANI

Figure 2:
CROSS-SECTION OF PARTICIPANTS AT THE 2018 CHAG ANNUAL CONFERENCE IN SUNYANI

Figure 3:
REPRESENTATIVES OF NEW CHAG MEMBER INSTITUTIONS BEING INDUCTED AT THE 2018 CHAG ANNUAL CONFERENCE IN SUNYANI

Performance Indicators

Performance indicators showed an overall improved performance in 2018 compared to previous years. There was a total of 6,785,233 outpatient visits, an increase of 28.9% over that of 2017. This represents a 13.5% average increase over a 5-year period (2014-2018). Total hospital admissions were 542,689, an increase of 17.5% compared with that of 2017, and an average increase of 9.6% over a 5-year period. These modest gains could be attributable to the fact the CHAG network acknowledged the need to improve care given the decline in both OPD and admissions in the previous years as highlighted during the 2018 annual conference in Sunyani. This awareness, in addition to a number of interventions, put in place by a number of facilities, partially accounts for the increase in OPD and admissions in 2018.

Total deliveries in 2018 were 143,242, an increase of 30.1% over that of 2017, and 20.2% over that of 2014. Of this, the number of Caesarian Sections (CS) were 33,232, which represents an increase of 6.9% over that of 2017 and 32.1% increase over a 5-year period. The proportion of CS cases to total delivery in 2018 was 23.2%, compared to 21.7% in 2017. These are both beyond the WHO recommended rate of 6-10%.

The number of children vaccinated for BCG increased by 12.2% over the period, while the bed-occupancy rate, which had been declining since 2013, increased from 49.2% in 2017 to 57.9%.

Over the last five years there has been an improvement in students pass rate from 61% in 2012 to 84% in 2018. Compared to 2016, however, this shows a drop from 95% to the current 84%.

Table 4: Performance Indicators.

Performance indicator	2014	2015	2016	2017	2018	% Change 2017-2018	1-year Performance	% Change 2014-2018	-year Performance	National 2018	Sub-Saharan Africa
Total Out-Patients	5,749,927	5,942,777	6,065,897	5,261,683	6,785,233	**28.9%**	mproved	13.5%	Improved	29,948,878	
Total Admissions	439,186	455,577	464,377	447,950	542,689	**17.5%**	Improved	9.6%	Improved		
No of Deliveries	119,141	110,228	136,669	110,109	143,242	**30.1%**	Improved	20.2%	Improved		
Total Caesarian Sections	20,779	21,834	25,612	23,894	33,232	**39.1%**	Increased	59.9%	Significantly increased		
Caesarian Rate	17.40%	19.8%	19.0%	21.70%	23.2%	**6.9%**	Worsened	33.3%	Worsened	6.5%[1]	2%[1]
Vaccination (BCG)	113,413	91,632	85,813	101167	113,513	**12.2%**	Improved	0.1%	Improved		
HTC Clients counselled	50,238	40,161	62,291	66,664	130,417	**95.6%**	Significantly increased	159.6%	Significantly improved		
Bed Occupancy Rate	69%	39.7%	52%	49.20%	57.9%	**17.7%**	Improved	-16.1%	Declined		
Student Enrollment	2,849	2,491	2,878	2,800	2684	**-4%**	Declined	-6%	Declined		
Student Pass Rate	88.00%	98.00%	95.00%	84.00%	84.5%	**-1%**	Declined	-4%	Declined		

[1] World Health Organization - Trends in Caesarean 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 4, selected input indicators showed a considerable improvement in the area of Human Resources with a significant increase of 82% in the total number of CHAG staff enrolled on GOG-payroll since 2014. The average proportion of clinical staff relative to the total staff establishment declined from 73% in 2014 to 69% in 2018.

Doctor to Client and Nurse to Client ratios have seen continuous improvements from 2014 to 2018 as shown in Table 5 and Figure 4 below. Every year, there are nurses and doctors who accept postings into the CHAG network, and this account for the improvements in the above ratios. The national Doctor to population ratio in 2018 was 1:7,196. Within the CHAG network, however, the ratio over the same period was 1:9,817, higher than the national average. Although the national average appears better, there are regions with worse ratios. In Upper East region, the Doctor to population ratio is 1:20,936. These remote areas are the places where CHAG health facilities operate hence, the relatively poor ratio for CHAG. On a positive note, the Nurse/Client ratio (1:618) in 2018 was better than the national Nurse / Client ratio of 1:839.

Table 5: Input Indicators: 2014-2018

Input indicators	2014	2015	2016	2017	2018	% Change 2017 -2018	1-year Performance	% Change 2014-2018	5-year erformance	National (Ghana)	WHO Standard
Total Mechanized Staff	11,127	12,584	15,942	20,099	20,344	1.2	Increased	82.8	Improved		-
% Clinical/non-Clinical Staff Ratio	73	53	60	64	69	5.0	Improved	-4.0	Declined		-
Doctor/OPD-Client Ratio	1:15,987	1:15,122	1:12,083	1:10,080	1:9,817	-2.6	Improved	-38.6	Improved	1:7,196[1]	1/1,000[2]
Nurse/OPD-Client Ratio	1:1,411	1:1414	1:698	1:488	1:618	9.0	Increased	-56.2	Improved	1:839[1]	3.4/1,000[2]

[1] Holistic Assessment Report, Ministry of Health Ghana, 2018
[2] WHO Global Health Observatory data, 2019

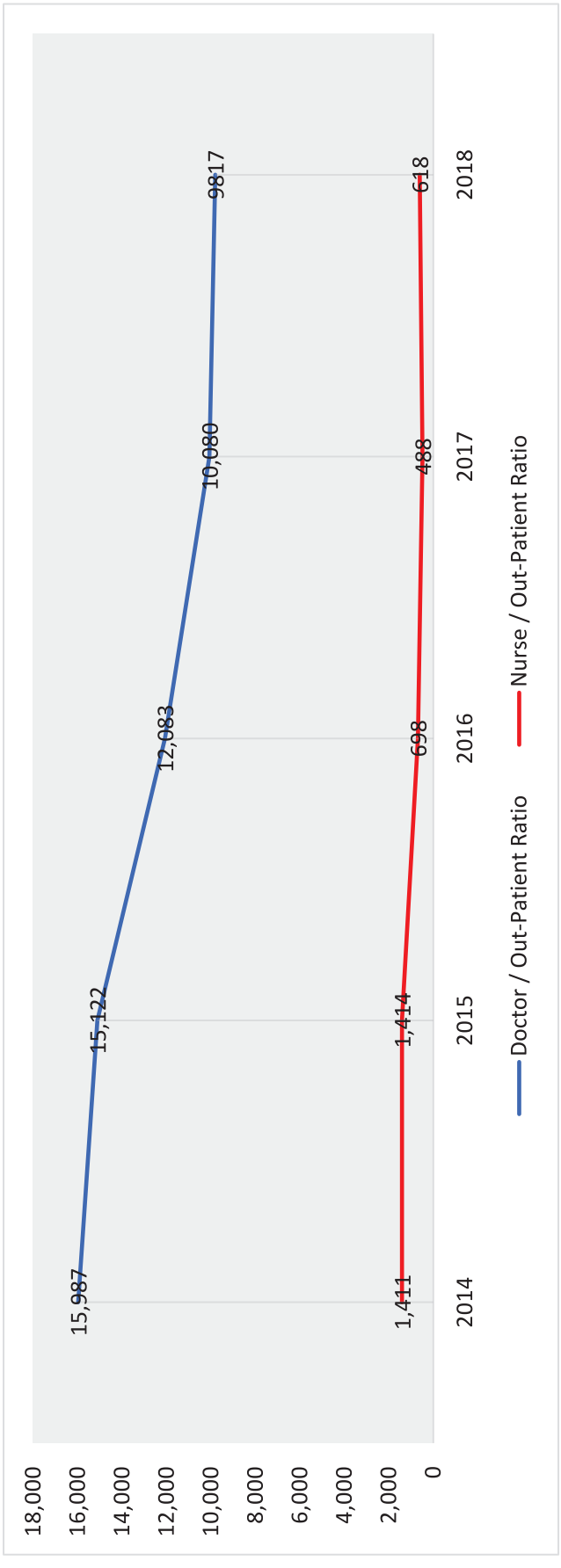


Figure 4: Trend of Doctors and Nurse /OPD Clients Ratio 2014 - 2018

Performance Outcome and Status for 2018

CHAG adopts the Health System Strengthening approach in its operations. These comprise:

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 2018. 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. The services of CHAG are characterized by quality and safety. We seek to address the local disease burden and improve efficiency and effectiveness. Therefore, in 2018, all the spectrum of health services was provided by the network. Services provided by CHAG were aligned to national health sector priorities and in accordance with standard treatment guidelines.

1.1 Out-Patient and In-Patient Services

In 2018, there was a total of 6,785,233 out-patient visits (old and new), and 542,689 admissions. The OPD visits in 2018 is the highest recorded in five years. Admissions increased by 17.5% in 2018, compared to 2017. Over a 5-year period, admissions increased by 9.6%. By inference, out of every 1,000 Out-patient visits, there were 80 admissions in CHAG Hospitals.

Regarding clients' National Health Insurance Scheme (NHIS) coverage, about 88.3 % OPD and 83.6% IPD clients were insured. These represented 5.7% OPD and 8.4% IPD decline in NHIS insured coverage as compared to 2017. The percentage NHIS coverage in Ghana is 35.8%. Impliedly, many of the areas where CHAG facilities operate are covered by NHIA. It is encouraging to observe that in spite of the challenges associated with the NHIS, the proportion of OPD visits in 2018 was reassuring, showing clients continued confidence in the NHIS as depicted in Table 6 below.

Table 6: OPD, IPD Service Outputs and Health Insurance Status of clients: 2014 – 2018

Performance Indicator	2014	2015	2016	2017	2018	5-Years Trend
OPD	5,979,124	5,942,777	6,065,897	**5,261,683**	6,785,233	Fluctuating
OPD Insured	89%	87%	85%	**94%**	88.3%	Declined
IPD	439,186	455,577	464,377	**447,950**	542,689	Increased
IPD Insured	86%	85%	82%	**92%**	83.6%	Declined

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

In 2018, CHAG contributed 22.0% and 32.1% of National OPD visits and Admissions respectively as shown in figure 5 and table 7 below. CHAG has been contributing an average of 30% to National in-patient services since 2014 (refer to figure 5 below). Similarly, CHAG's contribution to National OPD care has been fairly constant/consistent over the past five years. The average contribution since 2014 is 19.7%. The number of OPD visits and admissions have both increased over the past 5 years. Preliminary assessment shows that the establishment of many CHPS and private health facilities in some of the areas where CMIs operate might be creating competition for some of our clients. As at the end of 2018, there were 5,267 CHPS compounds in Ghana. Hence the increase in OPD visits indicates greater confidence of the people in the services provided by CHAG health facilities.

Again, although the number of CHAG Members health facilities has increased over the years, it is important to note that the service data of about 60 CMIs are not properly captured as CHAG owned facilities in the District Health Management Information System (DHIMS). Hence, CHAG's comparative national contributions may have been understated in this report.
Given the observed trend and pattern of fluctuating OPD visits & IPD admissions over the years, a pointer for research into the probable determinants of OPD and IPD service utilization across the CHAG network seem established.

CHAG Regional Contribution to National OPD and IPD Services
A review of the regional contributions of CHAG to IPD and OPD services, shows Ashanti Region with the highest prominence where CHAG contributes 88% and 51% 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 IPD is the Brong Ahafo with 68% and 39% respectively. The regions with the least OPD and IPD recorded are the Greater Accra region with 15% and 7% and Upper East with 10 and 17%% respectively.

[1] Holistic Assessment Report 2018

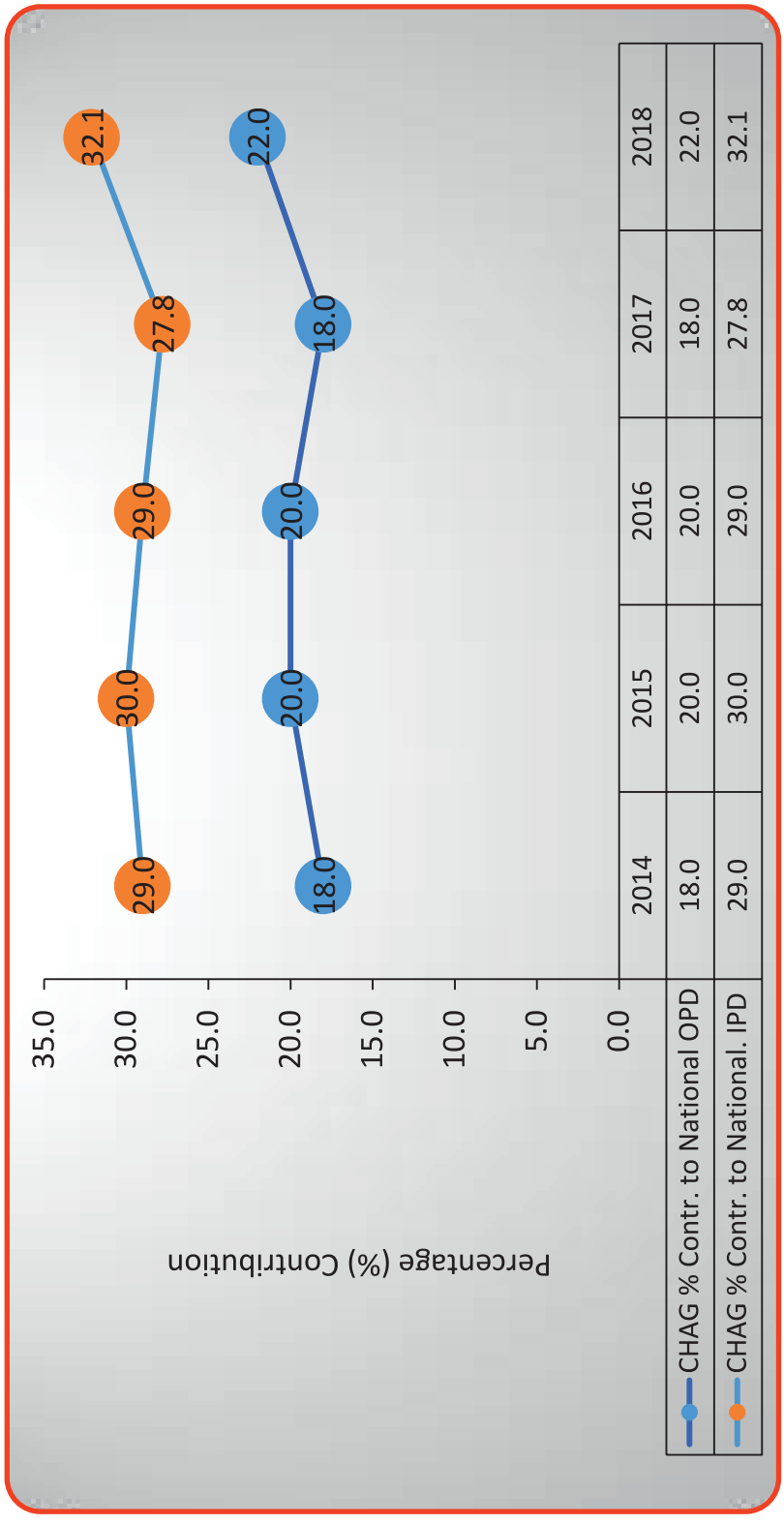


Figure 5: Trend of Percentage CHAG Contribution to National OPD & IPD, 2018

Table 7: CHAG percentage CHAG Contribution to National OPD and IPD Services, 2018

Output	2014	2015	2016	2017	2018	5-year Trend
National OPD	31,087,824	29,949,173	29,948,878	28,451,871	30,849,769	Fairly constant
CHAG OPD	5,749,927	5,942,777	6,065,897	5,261,683	6,785,233	Increasing
CHAG % Contr. to National OPD	18%	20%	20%	18.7%	22.0%	Increasing
National IPD	1,534,379	1,501,773	1,532,839	1,523,653	1,688,050	Fairly constant
CHAG IPD	439,186	455,577	464,377	447,950	542,689	Increasing
CHAG % Contr. to National. IPD	29%	30%	29%	27.8%	32.1%	Increasing

Table 8: CHAG's Contribution to Regional and National OPD and IPD, 2018

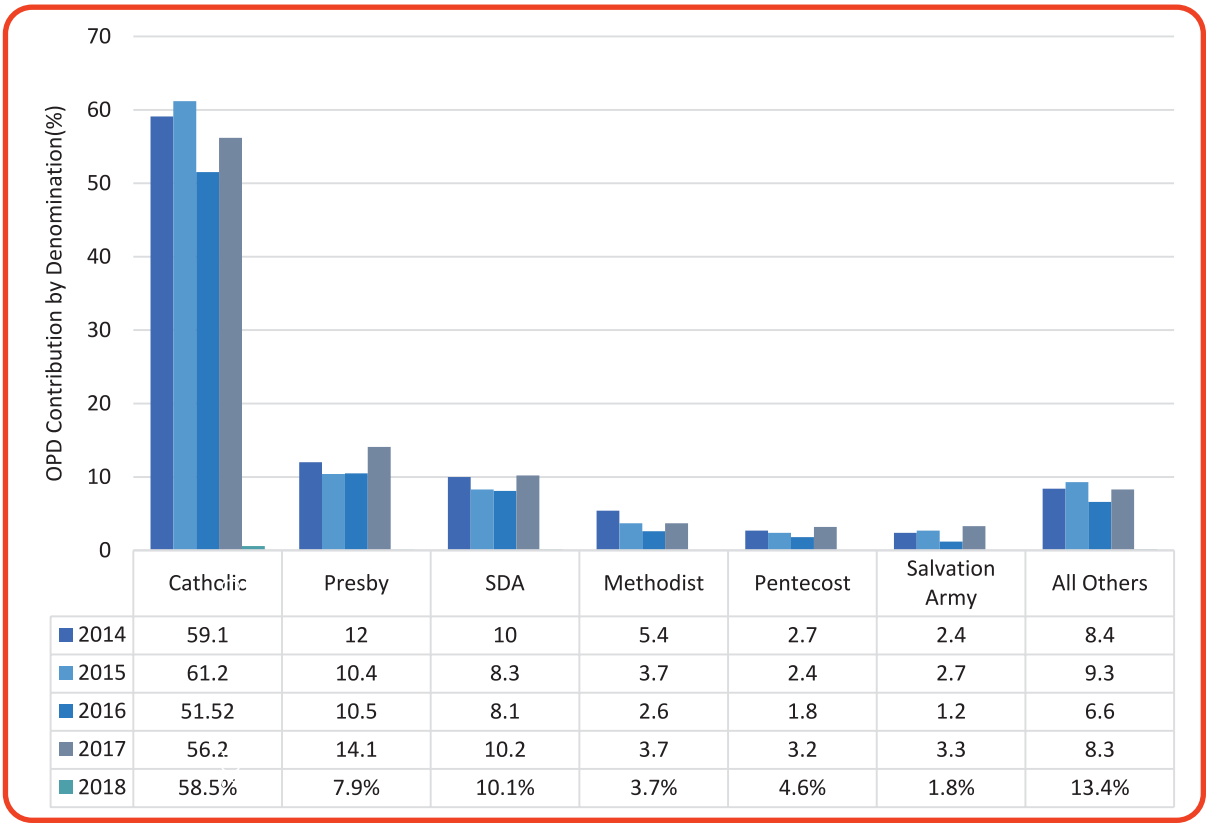
Region	In-patients		Out-patients		Percentage (%) Contribution CHAG	
	National In-patients	Contribution by CHAG	National Out-patients	Contribution by CHAG	IPD	OPD
Ashanti	115,446	101,032	2,821,198	1,445,467	88%	51%
Brong Ahafo	167,635	114,308	3,543,249	1,365,050	68%	39%
Central	187,824	46,776	3,725,194	678,415	25%	18%
Eastern	190,752	43,746	4,284,592	837,502	23%	20%
Greater Accra	127,207	19,687	3,775,513	274,792	15%	7%
Northern	171,412	65,813	978,138	436,566	38%	45%
Upper East	156,701	15,079	2,461,760	425,592	10%	17%
Upper West	85,236	29,431	2,164,135	211,996	35%	10%
Volta	292,129	58,009	5,047,693	522,983	20%	10%
Western	193,708	48,808	2,048,297	586,871	25%	29%
National	1,688,050	542,689	30,849,769	6,785,233	33.1%	22.0%

Source: DHIMS 2 (accessed 28th March 2019)

1.3 Contribution to OPD by Church Denominational Health Services

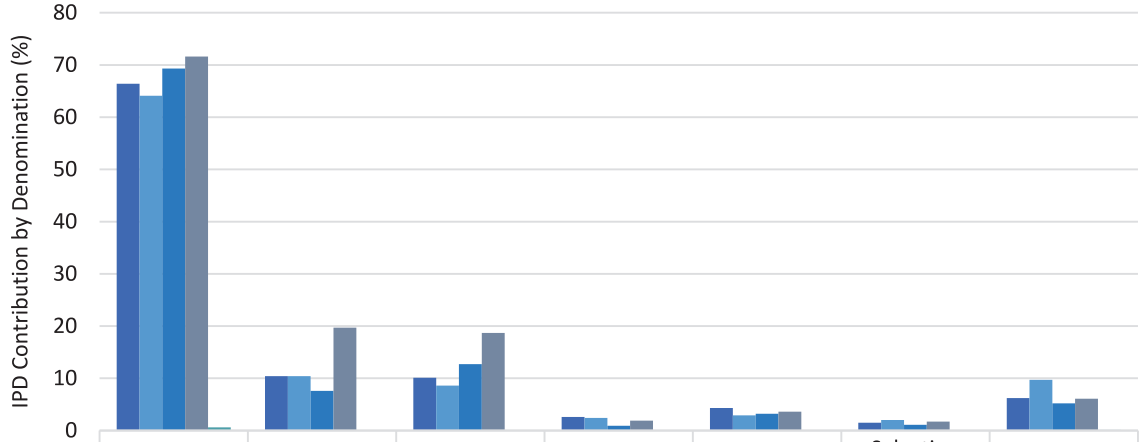
The National Catholic Health Service (NCHS) remain as the largest constituent member of CHAG with significant contributions in both OPD and IPD in comparison with other Church Health Services. NCHS contributed 58.5% to the overall CHAG OPD attendance in 2018 followed by Ghana Adventist Health Services (10.1%). Other Health Services that contributed more were the Presbyterian Health Service (7.9%), Pentecost (4.6%), Methodist (3.7%) and Salvation Army (1.8%). The rest of the Health Services contributed 13.4% to CHAG OPD attendance in the said year which is 5.1% over that of 2017. Figures 6 & 7 below show 2018 percentage contribution to OPD and IPD by denomination respectively.

Figure6: OPD Contribution by Denomination, 2018



	Catholic	Presby	SDA	Methodist	Pentecost	Salvation Army	All Others
2014	59.1	12	10	5.4	2.7	2.4	8.4
2015	61.2	10.4	8.3	3.7	2.4	2.7	9.3
2016	51.52	10.5	8.1	2.6	1.8	1.2	6.6
2017	56.2	14.1	10.2	3.7	3.2	3.3	8.3
2018	58.5%	7.9%	10.1%	3.7%	4.6%	1.8%	13.4%

Figure 7: IPD Contribution by Denomination, 2018



	Catholic	Presby	SDA	Methodist	Pentecost	Salvation Army	All Others
2014	66.4	10.4	10.1	2.6	4.3	1.5	6.2
2015	64.1	10.4	8.6	2.4	2.9	2	9.7
2016	69.3	7.6	12.7	0.9	3.2	1.1	5.2
2017	71.6	19.7	18.7	1.9	3.6	1.7	6.1
2018	61.1%	9.6%	9.3%	4.5%	2.5%	1%	12.2%

As shown above, whilst CHAG recorded an overall increase in Inpatient Admission in 2018, there were notable decline amongst various denominational Church Health Services. For inpatients' care, the National Catholic Health Service contributed approximately 61.1% of the CHAG IPD client admissions compared to other denominational Church Health Services. Yet there was 5.3% overall decline in NCHS' contribution to CHAG's IPD in 2018 compared to that in 2014 as shown in Figure 7. Similarly, whilst both the Presbyterian Health Services (PHS) and Ghana Adventist Health Services (GAHS) maintained their significant IPD contributions, there were also notable decline; GAHS IPD contribution reduced from 18.7% in 2017 to 9.3%, whilst PHS also reduced from 19.7% in 2017 to 9.6% in 2018

The contribution of Methodist Health Services (MHS) in 2018 (4.5%) was impressive compared to the previous year (1.9%). Whilst their OPD contribution remained same (3.7%), the IPD was improved by 2.6% compared to 2017. The increase in MHS contribution was due to expansion of two of their facilities; Ankaase and Wenchi. These facilities expanded their OPD and IPD units as well as the range of services including non-communicable disease clinics, and specialized urological services which is attracting national patronage. Again, these facilities train house officers, a situation that ensures constant presence of personnel and thus assures quality of health services.

1.4 Contribution to CHAG OPD & IPD by Region

CHAG has the highest 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 2018, Ashanti region contributed 21.3% of OPD clients within the Network (refer to figure 8) whilst Brong Ahafo Region contributed 20.1% of OPD client attendance with Eastern Region following with 12.3%.

Again, with regards to in-patient care, Brong Ahafo Region contributed a higher proportion of 21.2% admissions followed by Ashanti Region with 20.7%, Volta 10.2% and Greater Accra region with the least contribution of 1.8%. The Greater Accra contributed the least due to the limited number of CHAG facilities, which highlights CHAG's orientation towards the mostly rural and unreached areas in other 10 regions of Ghana. Figures 8 and 9 highlights regional OPD and IPD contributions respectively.

Figure 8: Percentage (%) OPD Visits Contribution by Region, 2018

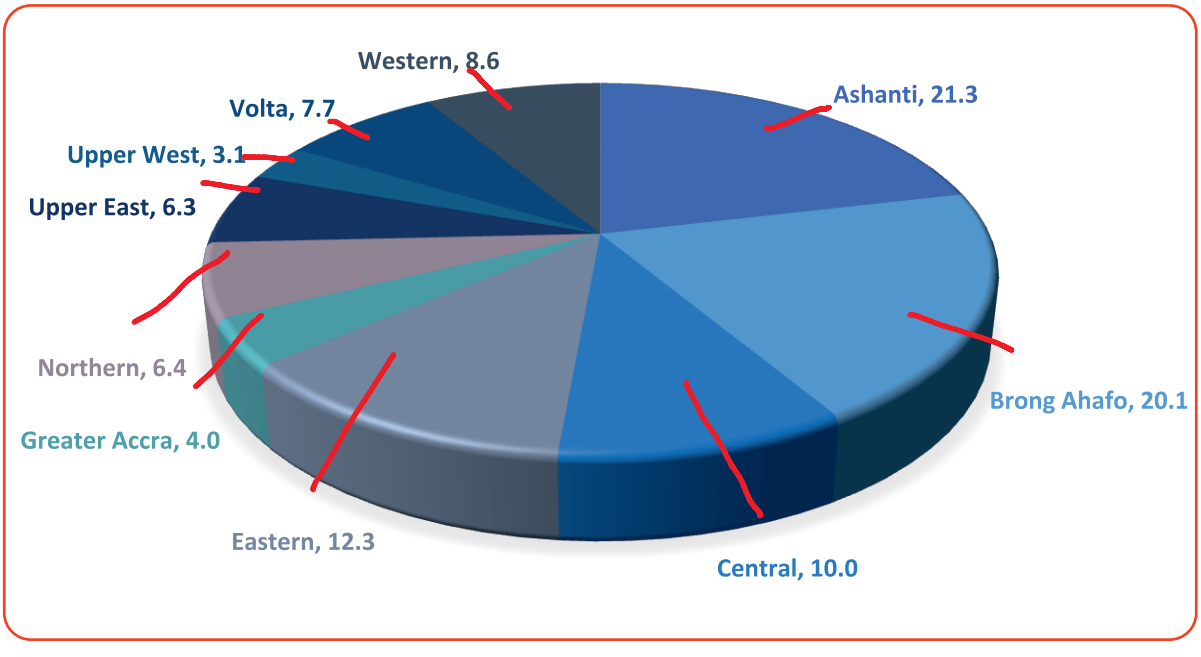
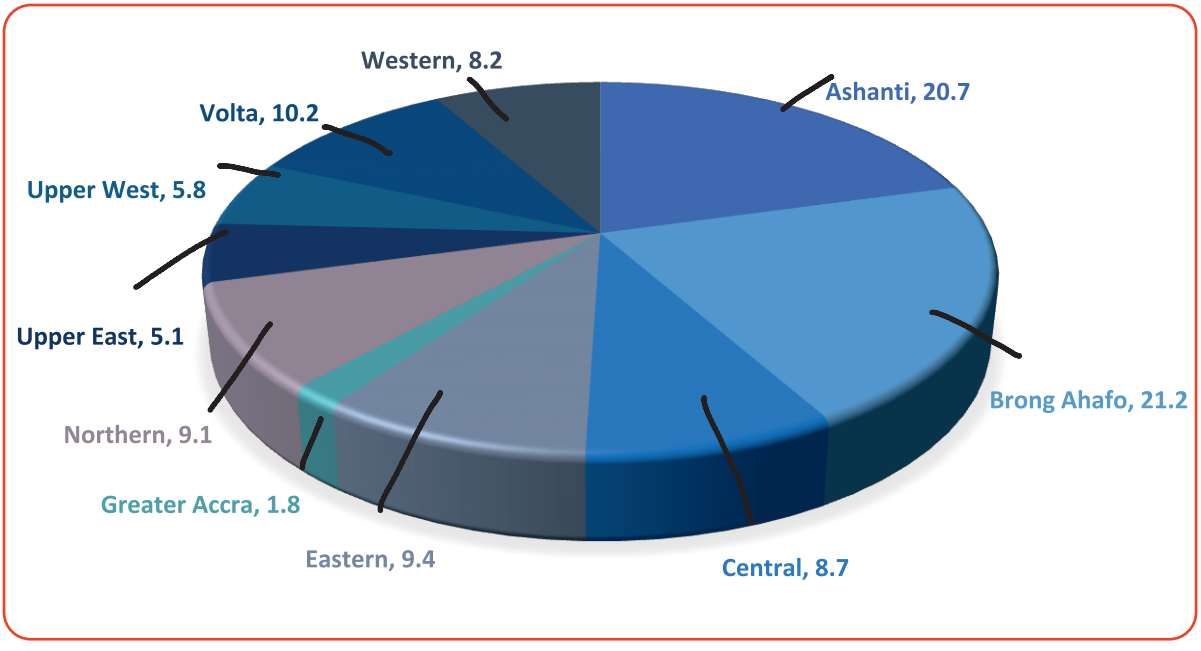


Figure 9: Percentage (%) Contribution to Hospital Admissions by Region, 2018

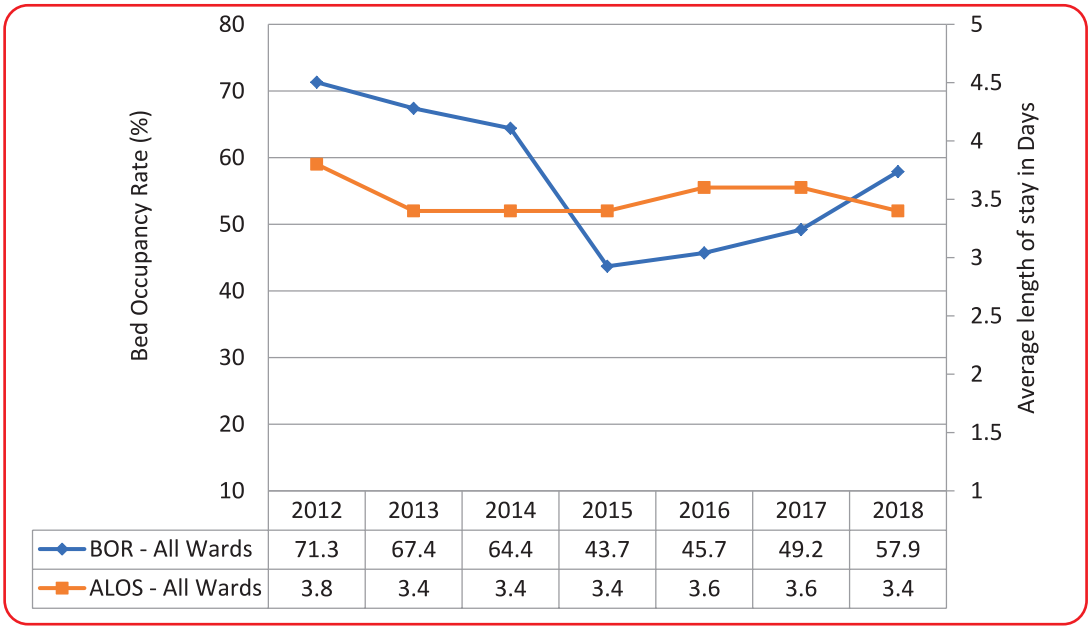


1.5 Bed Occupancy Rate (BOR) and Average Length of Stay (ALOS)

From 2014 to 2018, the proportion of beds utilized by inpatients per 100 beds in CHAG hospitals decreased from 71.3% to 58% beds. Compared to 2017, however, there was an increase in bed occupancy rate from 49.2% to 57.9% in 2018. At the national level, bed occupancy rate marginally increased from 58.0% to 58.3%. The 8.7% increase in the CHAG bed occupancy rate is attributable to a number of interventions some facilities put in place including improved customer relations, enhanced service package, community engagements, quality of care, amongst others. These interventions built clients' confidence and patronage of CMIs' health services. Hence the corresponding rise in both OPD visits and Hospital Admissions.

The average number of days spent at hospital wards for CHAG hospitals were 3.4 days in 2018, and this has remained fairly same since 2014. This is approximately same as the national average of 3.5. The international standard average length of hospital stays, ranges from 3.9 (Turkey) to 16.5 (Japan). Figure 10 below provides further details.

Figure 10: Trend of Bed Occupancy Rate and Average Length of Stay, 2012 - 2018



	2012	2013	2014	2015	2016	2017	2018
BOR - All Wards	71.3	67.4	64.4	43.7	45.7	49.2	57.9
ALOS - All Wards	3.8	3.4	3.4	3.4	3.6	3.6	3.4

1.6 Reproductive and Sexual Health Services

Reproductive and Sexual Health is one of the priority areas for CHAG. A total of 143,242 supervised deliveries were conducted in 2018. This was 30.1% increase over that of 2017 and 20.2% more than that conducted five years ago (2014). About 23.2% of all deliveries were performed under Caesarian Sections (CS). This is 1.5% higher than that of 2017, and also higher than the WHO approved CS rate of 10-15%. Moreover, the CHAG CS rate is above that of Ghana national target of 6.5% and that of Sub-Saharan Africa of 2%. The data seem suggestive of the need for an improvement. Whilst the cause of the rise in CS rate is not so clear, it could likely be attributed to delayed reporting and referrals from home, CHPS compounds and smaller facilities to the hospitals, which makes CS intervention unavoidable in such circumstance. It has also been noted that increasing number of women, especially the working class, are opting for CS in recent times. Nevertheless, the need for CHAG to establish the actual causes of the increasing CS rate cannot be overemphasized. Table 9 below shows the trend of Sexual and Reproductive Health outputs, 2014 – 2018.

From the table, a total of 122,200 pregnant women were registered at CHAG Reproductive and Child Health (RCH) units in 2018 for antenatal services (ANC), compared to 132,284 that registered in 2017. This represents a 7.6 % decline compared to that of 2017 and 4.2% increase over the last 5 years (2014-2018). Over 144,760 mothers were registered for Postnatal Care (PNC).

[1] Ghana Health Service, DHIMS2
[2] Average length of stay in hospitals, Health at glance 2017© OECD 2017

Table 9: Reproductive and Sexual Health service outputs, 2014-2018

Performance Indicator	2014	2015	2016	2017	2018	% change 2017 2018	year Performance	% change 2014-2018	5-Year performance
Total Deliveries (Live/Still)	119,141	110,228	136,669	110,109	143,242	30.1	Improved	20.2	Increased
Total C-S	20,779	21,834	25,612	23,894	33,232	39.1	Increased	59.9	Increased
C-S Rate	17.40%	20%	19%	21.7%	23.2%	1.5	Worsened	33.3	Worsed
Total ANC Registrants	117,257	106,271	124,785	132,284	122,200	-7.6	Declined	4.2	Increased
Total ANC Attendance	620,223	560,394	641,554	684,800	748,657	9.3	Increased	20.7	Increased
ANC 4th Visit Rate	92%	84%	81%	81.3%	94.3%	13.0	Improved	2.3	Improved
Total PNC Registrants	91,551	122,924	142,704	151,707	144,760	-4.6	worsened	58.1	Increased
MM Audit Rate	86%	86%	97%	87.5%	99.3%	11.8	Improved	13.3	Significantly 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 services. Number of couples accepting family planning methods were 110,432. Since 2012, CHAG's contribution to national family planning has been declining. Even with the Natural Family Planning method, which is largely viewed to be the accepted and supported method of most Churches, acceptor rate seems very limited. For other CHAG network members, very few of them had commodities and the requisite training to promote the other artificial methods. Apart from the National Catholic Health Service that ran a programme in the past on Natural Family Planning, no Church Health Service had any plan drawn to actively promote uptake. Consequently, the general public of which Christians form about 71.2% do not have a coordinated voice from the Church on Family Planning. They are left to the mercy of what they read on printed materials and newspapers or what they hear on radio and on TV.

Against this background and given the low uptake of natural both Natural and Artificial family planning within the network, the Christian Health Association of Zambia (CHAZ) supported CHAG to improve the policy and fund environment for FP in Ghana by engaging trained faith-based organization representatives and Religious leaders as advocates. Consequently, a 7-member local committee was formed with membership from the various Church Health Coordinating Units (CHCU). The major CHCUs were engaged on how to improve FP within the network. The views of the various Churches on FP have been well documented in position papers through the committee. Figure 12 below shows some participants during the high impact advocacy training organized by CHAZ in Zambia in 2018.

Ghana Health Service was also engaged to extend and improve FP commodities to CHAG facilities particularly Natural FP commodities. Consequently, the GHS donated 500 pieces of Cycle beads to CHAG to support training and provision of Natural Family Planning.

To establish the FP situation within the CHAG network, ten (10) facilities were visited in the Eastern and Central regions of Ghana. Findings showed that out of the 10 facilities visited, only two had family planning commodities. Only one Catholic facility had Cycle Beads. About 90% of the facilities were not involved in FP decisions at the district level. Only two staff from Catholic institutions had been trained on Natural Family Planning whilst two staff from GAHS had been trained in all the artificial methods. All the Health Facilities indicated their need for training on FP and the need to improve FP services. The Catholic institutions specifically called for collaboration with Ghana Health Service (GHS) on matters of natural FP. They also called on CHAG to have a comprehensive programme on natural FP for all its institutions.

Again, CHAG collaborated with National Population Council (NPC) and distributed the new National Adolescent Reproductive Health and Rights Policy to its members including the CHAG Health Training Institutions. Figure 11 and table 10 below give details of some FP indicators within the network from 2012 to 2018.

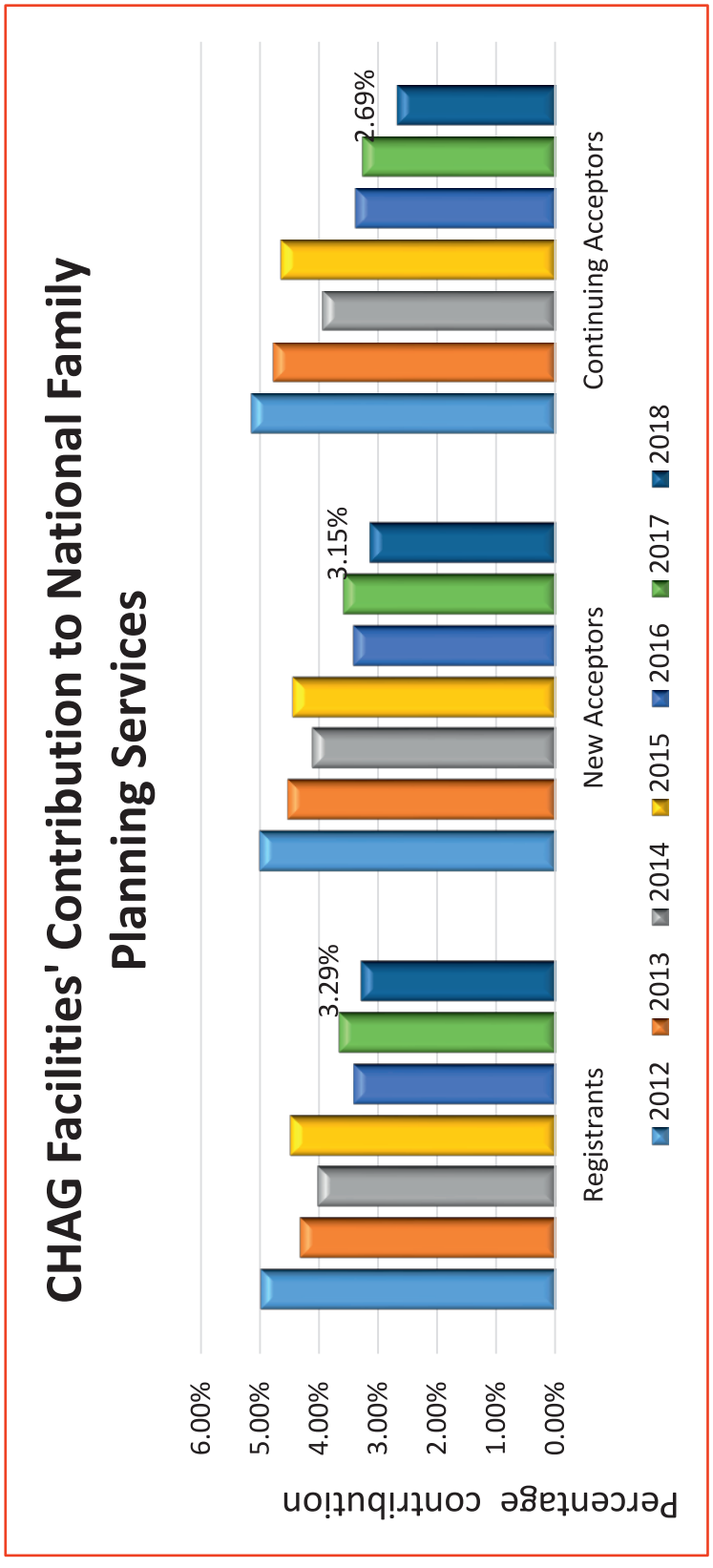


Figure 11: Family Planning Services: Registrants, acceptors and visits 2014-2018

Table 10: Trend of Family Planning uptake by type, 2013-2018

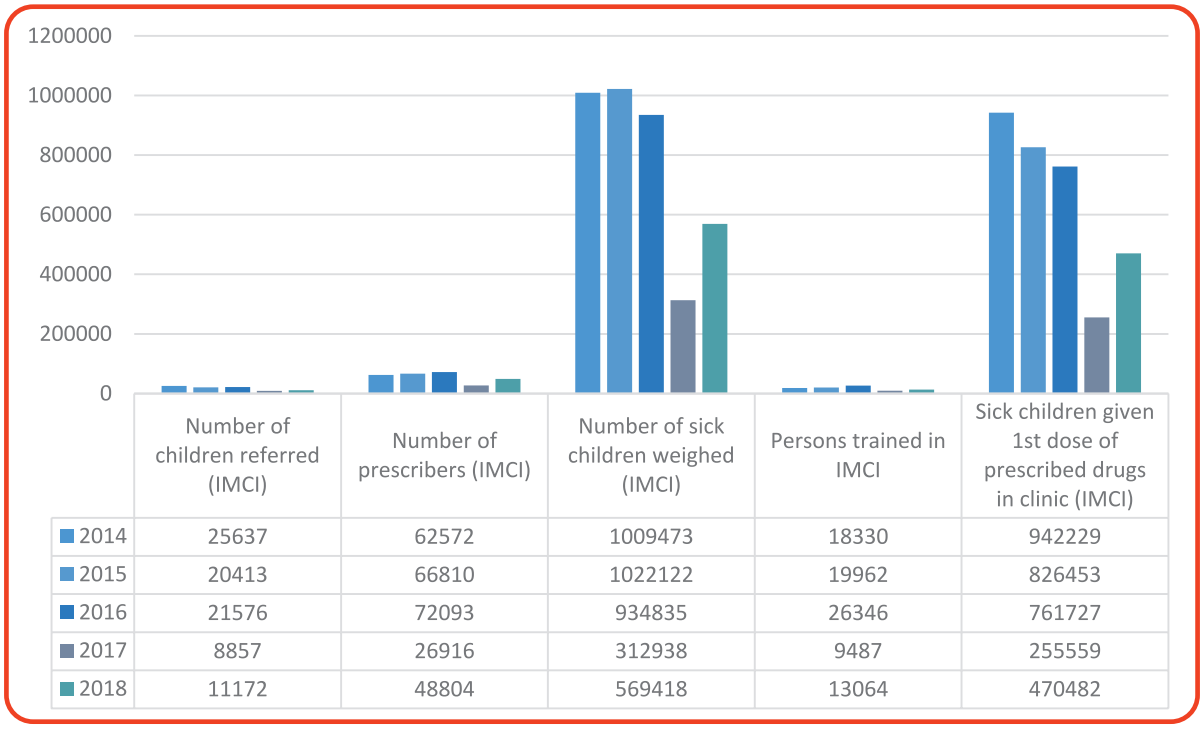
DESCRIPTION	2013	2014	2015	2016	2017	2018
Natural Family Planning	10,821	10,344	15,101	6,756	12,465	11,398
Male Sterilization (Vasectomy) Acceptors	0	4	14	7	31	35
Female Sterilization Acceptors	463	455	807	695	54	0
Condom (Male) Acceptors	52,581	70,715	83,470	67,724	2,721	3,169
Condom (Female) Acceptors	81	162	108	261	48	89
Number of women on Oral Contraceptives	10,542	11,592	10,810	8,326	9,361	9,481
Implant Acceptors	2,956	3,308	4,336	6,478	4,811	5,454
All Other Artificial Methods Acceptors	37,053	33,026	34,280	26,941	4,195	3,629

Figure 12: High Impact Advocacy Training on Family Planning supported by CHAZ, 2018

1.8 Child Health Services

About 11,127 children were seen and referred to the next level of care under integrated management of childhood illness programme. For the health staff to provide quality services aside the provision of equipment/consumables, training is key to enable them be abreast with current treatment regimens and others. However, the number of trained persons in Integrated Management of Childhood Illnesses (IMCI) over the past 5-years (2014 -2018) shows a decreasing pattern. Close to 13,000 personnel from CHAG were trained in IMCI in 2018 compared to 9,487 in 2017. Over a 5-year period, there is a 28.7% decline in the number of staff strained under IMCI. Figure 13 below shows trend of key information on Integrated Management of Childhood Illness.

Figure 13: Integrated Management of Childhood Illnesses (IMCI) 2014 - 2018



	Number of children referred (IMCI)	Number of prescribers (IMCI)	Number of sick children weighed (IMCI)	Persons trained in IMCI	Sick children given 1st dose of prescribed drugs in clinic (IMCI)
2014	25637	62572	1009473	18330	942229
2015	20413	66810	1022122	19962	826453
2016	21576	72093	934835	26346	761727
2017	8857	26916	312938	9487	255559
2018	11172	48804	569418	13064	470482

1.9 HIV/AIDS Services

Some CHAG facilities provide HIV/AIDS services including pre-test and post-test counselling, laboratory testing and home care services to clients. In 2018, a total of 130,417 clients were counselled for HIV, which was 95.6% more than those counselled in 2017 and 159% more than that in 2014. About 98.9% of those counselled were tested out of which 8.4% were positive. This incidence rate represents 3.6 % and 9.6% decline compared to 2017 and 2014 respectively.

For HIV/AIDS Prevention from Mother to Child Transmission (PMTCT), 100,438 pregnant women were counselled for HIV, out of which 98,752 (98.3%) were tested. Of those tested, 1,584 (1.6%) of them were positive. A total of 6,841 new clients were put on ARVs treatment in 2018. This was an improvement of 72.1% compared to the proportion put on treatment in 2017.

Compared to 2017, the testing rate for those counselled improved significantly in 2018. A trend of HIV/AIDS output is shown in table 11 below.

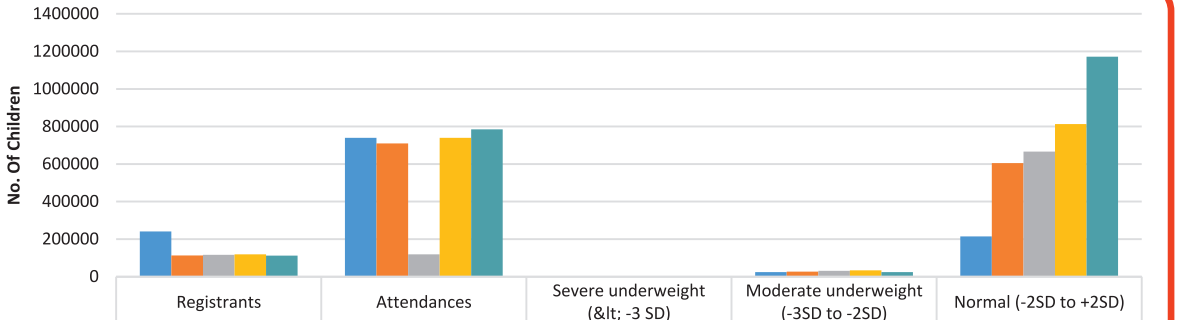
Table 11: HIV/AIDS Service Output 2014 - 2018

Description	2014	2015	2016	2017	2018	% Change 2017-2018	One-year Performance	% Change 2014-2018	5-Year performance
HTC Clients Counseled	50,238	40,161	62,291	66,664	130,417	95.6	Increased	159.6	Significantly increased
HTC Clients Tested	38,593	39,008	58,067	65,721	128,926	96.2	Significantly improved	234.1	Significantly increased
% HTC Tested +VE	18%	17%	15%	12%	8.4%	-3.6	Improved	-9.6	Improved
PMTCT Clients Counseled	110,856	136,836	115,734	118,122	100,438	-15.0	Increased	-9.4	Declined
PMTCT Clients Tested	108,817	93,254	110,655	23,613	98,752	318.2	Significantly increased	-9.2	Declined
% PMTCT +VE	1.50%	2%	2.3%	2.00%	1.6%	-0.4%	Improved	0.1	Increased
All other HIV Tested +VE	5,325	4,072	2,947	8,104	11,016	35.9	Increased	106.9	Increased
No of Clients ARV Treatment	5,325	4,520	3,800	3,974	6,841	72.1	Significantly improved	28.5	Increased

1.10 Child welfare Outreach Health Services

During the year under review, CHAG facilities embarked on outreach services throughout the country. A total number of 785,193 children were reached through outreach programmes. A total of 112,214 children were newly registered. Children with normal weight were 107,405 (-2SD to +2SD) whilst 3,083 were moderately underweight (-3SD to -2SD), and 412 were severely underweight (<-3SD). Figure 14 below shows trend of Child Welfare and Outreach Services from 2014 – 2018.

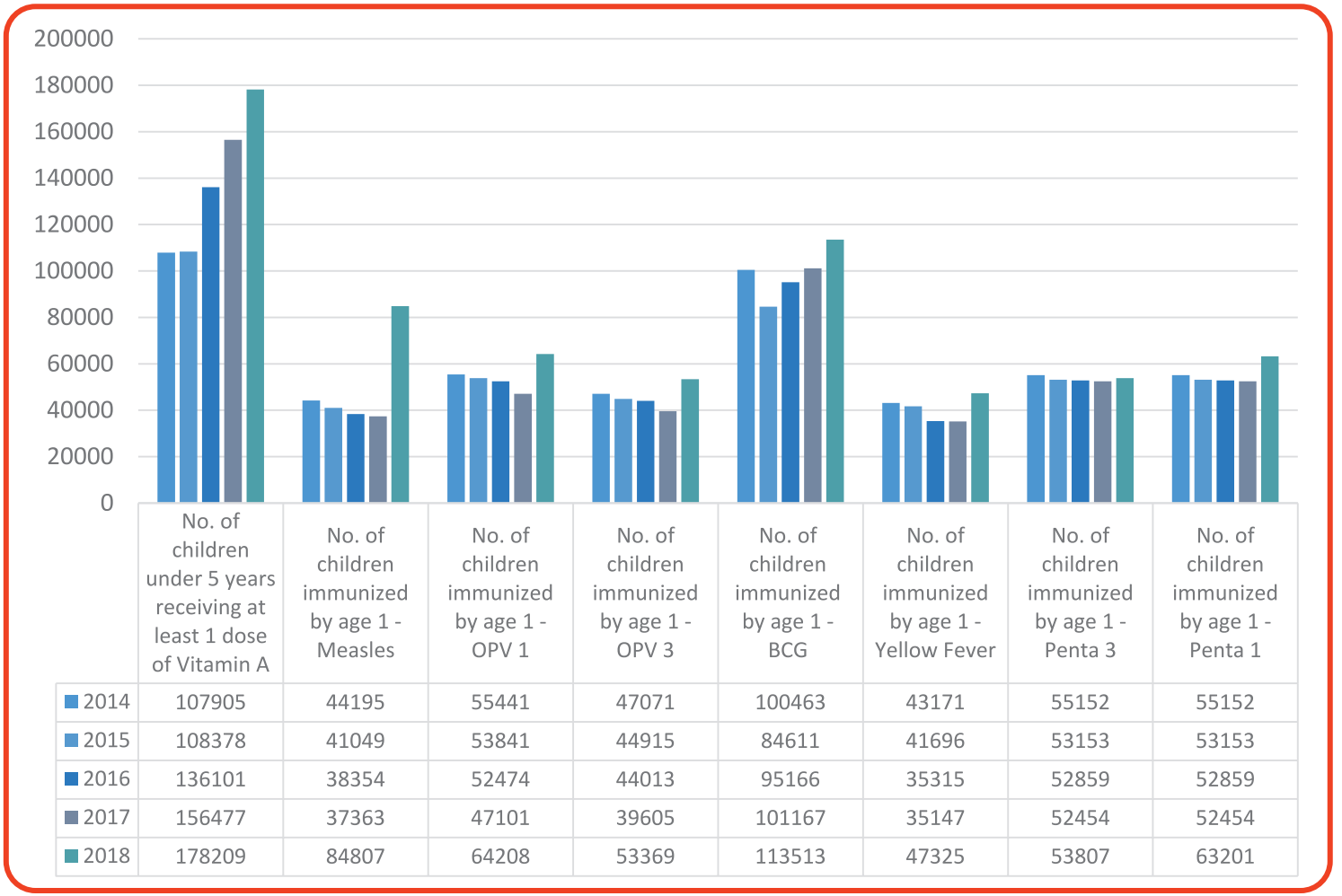
Figure 14: Child Welfare Outreach Services From 2014 – 2018



	Registrants	Attendances	Severe underweight (< -3 SD)	Moderate underweight (-3SD to -2SD)	Normal (-2SD to +2SD)
2014	241231	739705	2245	24405	214581
2015	113241	710056	2420	26592	604990
2016	116656	118672	2633	30916	666263
2017	119212	739408	2603	33416	812754
2018	112214	785193	2760	24089	1172192

During the year under review, 178,209 children under the age of 5 years were given at least one (1) dose of vitamin A whilst 113,513 children under 1 year were immunized against Tuberculosis (given BCG Vaccines). Given that there were over 143,242 deliveries, it presupposes that a significant number of babies did not get the BCG vaccine. This poses danger for TB spread. A total of 84,807 children were vaccinated against Measles while 47,235 doses of Yellow fever were given. The most frequent vaccine given to children during outreaches over the past five years remains Vitamin A whiles the less frequent vaccine given is Yellow fever. Figure 15 below shows the trend of vaccinations within the CHAG network from

Figure 15: Outreach Immunization Coverage and Vitamin- A Supplementation: 2014 – 2018

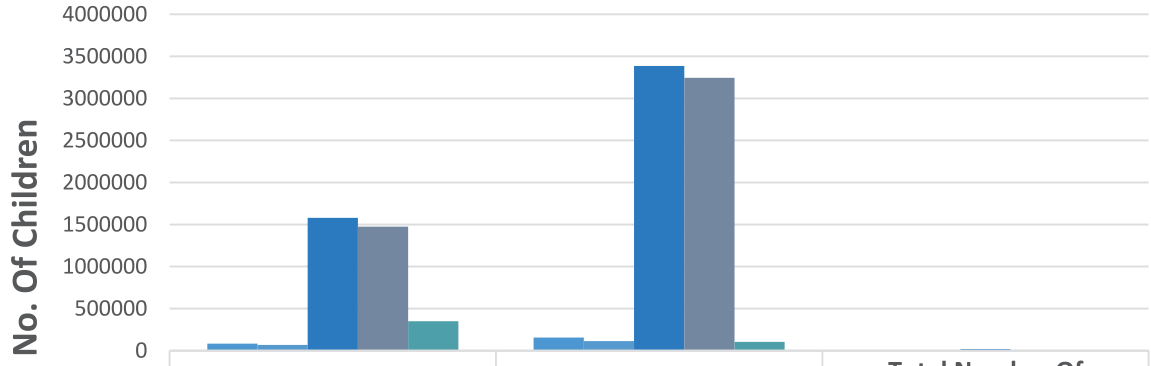


	No. of children under 5 years receiving at least 1 dose of Vitamin A	No. of children immunized by age 1 - Measles	No. of children immunized by age 1 - OPV 1	No. of children immunized by age 1 - OPV 3	No. of children immunized by age 1 - BCG	No. of children immunized by age 1 - Yellow Fever	No. of children immunized by age 1 - Penta 3	No. of children immunized by age 1 - Penta 1
2014	107905	44195	55441	47071	100463	43171	55152	55152
2015	108378	41049	53841	44915	84611	41696	53153	53153
2016	136101	38354	52474	44013	95166	35315	52859	52859
2017	156477	37363	47101	39605	101167	35147	52454	52454
2018	178209	84807	64208	53369	113513	47325	53807	63201

1.11 School Health Programme

A total of 1,559 schools were visited by CHAG health facilities' outreach teams in 2018, which depicts 96.5% drop in the number of school visitations compared to that of 2017. Over 1,700 of the schools visited had more than three (3) health education talks in 2018, which is 20.9% decline compared to that of 2017 and 16% increase over that of 2014. The decline in the number of schools visited could be attributed to the fact that NHIA does not reimburse, and the MOH does not also fund, such outreach services. Given the financial difficulties in the health facilities, outreach services may not have been prioritized, hence the reduced outputs as shown in Figure 16 below.

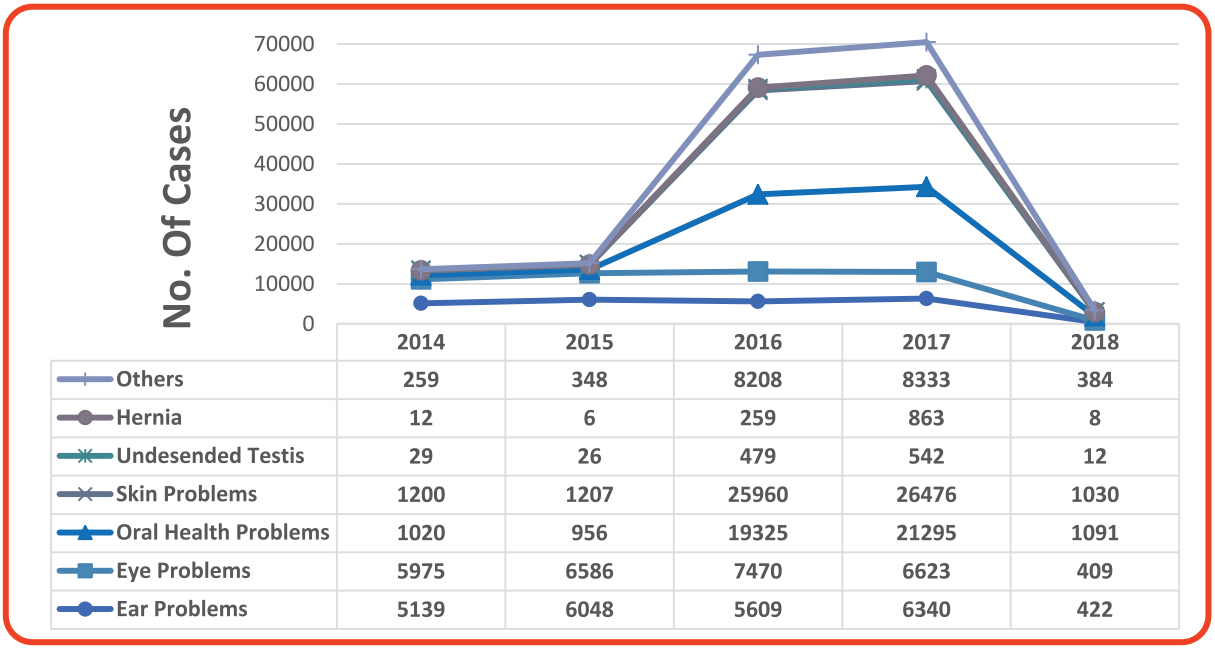
Figure 16: School Health Programme From 2014 – 2018



	Total Number Enrolled	Total Number Examined	Total Number Of Children Referred
2014	82738	155861	3226
2015	68047	114285	2884
2016	1579681	3385285	17523
2017	1474954	3244014	7798
2018	350133	104640	4694

In 2018, CHAG enrolled 350,133 students and pupils under the school health programme. Over 104,640 were examined out of which 7,798 of them were referred as shown in Figure 16 above. The common conditions seen in the school health programs were skin and oral health issues. Eye and ear conditions were less compared to the previous year.

Figure 17: School Health Programme Diagnosed Conditions From 2014 - 2018



	2014	2015	2016	2017	2018
Others	259	348	8208	8333	384
Hernia	12	6	259	863	8
Undesended Testis	29	26	479	542	12
Skin Problems	1200	1207	25960	26476	1030
Oral Health Problems	1020	956	19325	21295	1091
Eye Problems	5975	6586	7470	6623	409
Ear Problems	5139	6048	5609	6340	422

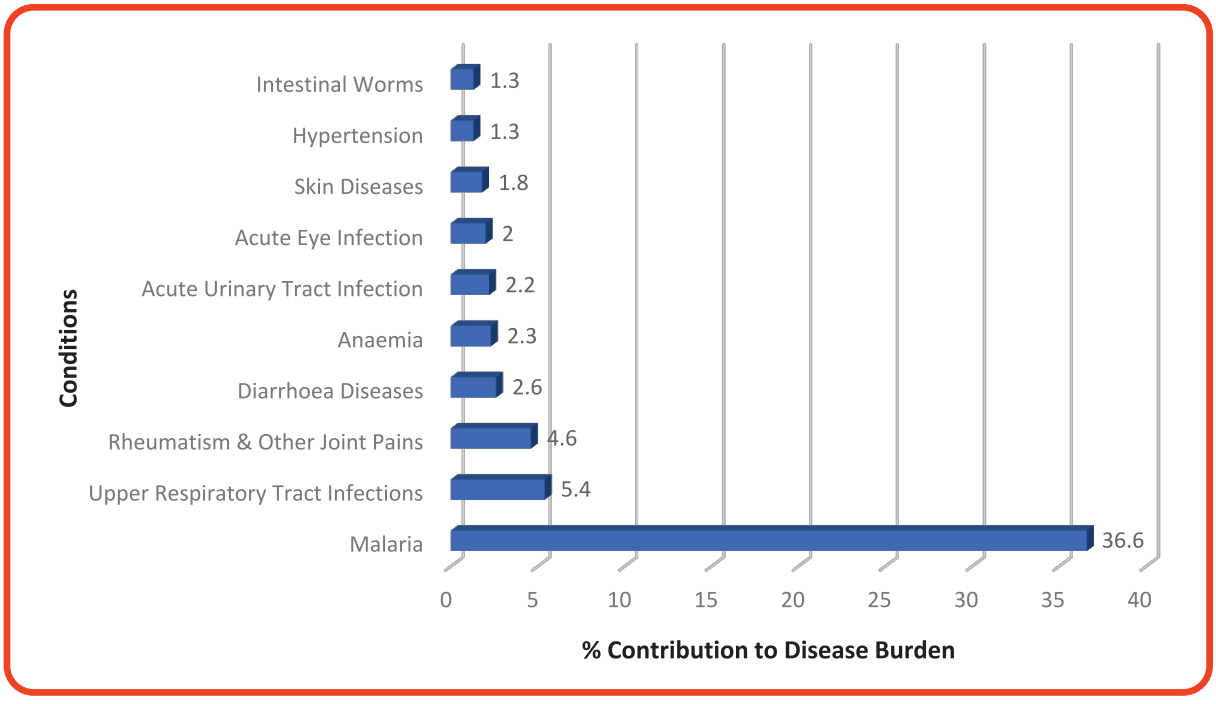
1.12 Summary Burden of Disease (Epidemiology)

There has been very little change in the top 10 common conditions for OPD visits and admission over the past five years (2014-2018).

1.12.1 Morbidity

From 2014 to 2018, the top-10 morbidity statistics remained relatively similar. In 2018, Malaria was the commonest cause of OPD visit accounting for 36.6%, followed by Upper Respiratory Tract infections (5.4%), Rheumatic/joint pains (4.6%), and Diarrhoea (2.6%). The rest were Anaemia (2.3%), Urinary Tract Infection (2.2 %), Eye infection (2.0%), Skin Diseases/Ulcer (1.8%), Hypertension (1.3%), and Intestinal Worm (1.3%). All other diseases contributed (39.8%) as shown in Figure 18 and table 12 below. It is important to note that the contribution of malaria to OPD visits has more than doubled (102%) compared to 2017. In 2019, the test before treatment policy will be assessed if it is still in force.

Figure 18: CHAG Top Ten (10) Causes of Morbidity for the year ending December 31, 2018



The top five causes of OPD attendance nationally in 2018 were malaria, otitis media, upper respiratory tract infections, rheumatic and other joint pains and diarrhea diseases. With the exception of otitis media, the rest of the conditions are same as were seen within the CHAG network.

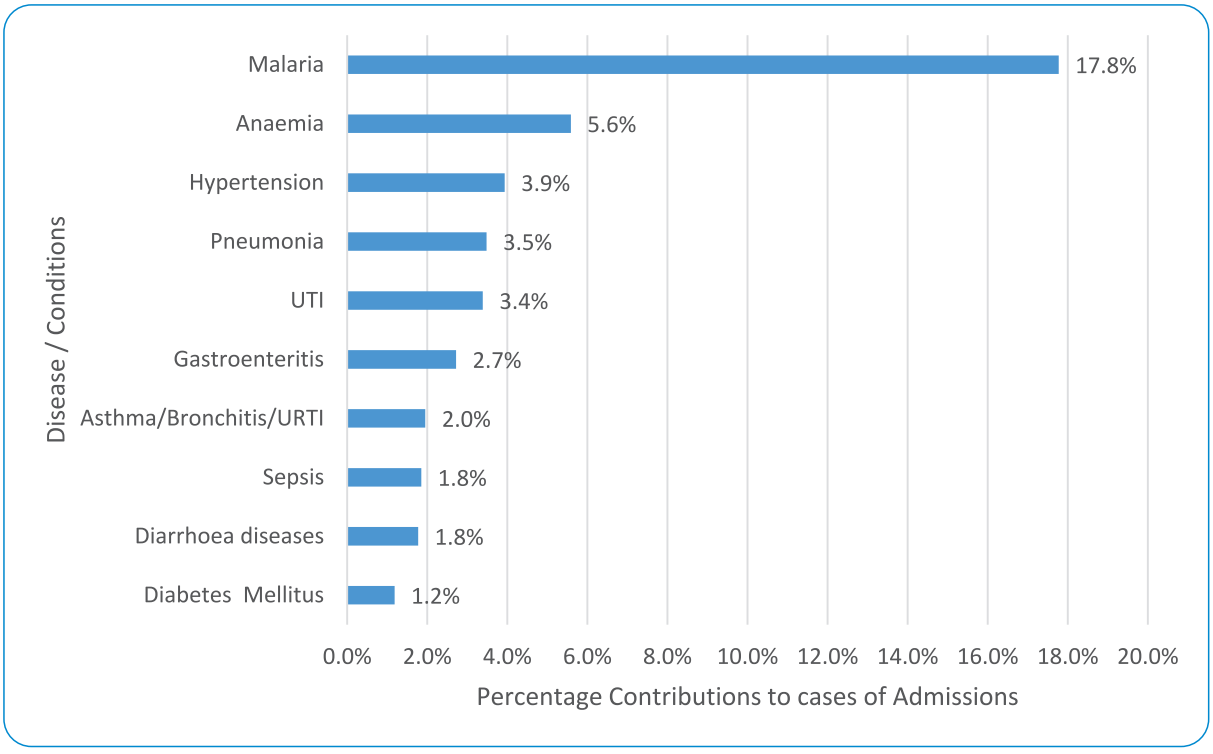
Table 12: Top-10 causes OPD Morbidity: 2014 – 2018

	Percentage (%) Contribution by Condition					% Change	One-year Performance	% Change	5-year Performance
Condition	2014	2015	2016	2017	2018	2017-2018		2014-2018	
Malaria	44.9	22.9	38.8	18.1	36.6	102.2	Worsened	8.3	Improved
URTI	7	8.5	13.8	11.1	5.4	-51.4	Improved	22.9	Improved
Rheumatism / Joint Pains	8.3	5.2	10	7.1	4.6	-35.2	Improved	44.6	Improved
Skin Diseases &Ulcer	7.3	3.5	6.4	4.7	2.6	-31.6	Improved	50.9	Improved
Anaemia	5.3	3.4	6.4	4.1	2.3	-43.9	Improved	56.6	Improved
Diarrhoea Disease	5.3	3	6.7	3.8	2.2	-42.1	Improved	43.6	Improved
Urinary Tract Infection	3.9	2.7	5.1	3.8	2.0	-33.3	Improved	33.3	Improved
Hypertension	4.2	2.2	3.9	2.7	1.8	-61.7	Improved	75.3	Improved
Intestinal Worms	-	1.7	2.8	2.1	1.8	-33.3	improved	57.1	Worsened
Acute eye infections **All Others**	- 41	- 43.7	- 6.1	3.0 39.4	1.3	-38.1		23.5	

1.12.2 Admissions

For the year under review, Malaria accounted for 17.8% of admissions followed by Anaemia (5.6%), Hypertension (3.9%), and Pneumonia (3.5%). Figure 19 shows details of top 10 causes of admission for 2018.

Figure 19: CHAG Top Ten (10) Causes of Admission 2018



Over a 5-year period, the proportions of malaria, gastroenteritis and diarrhoea diseases, which are among the top 5 causes of admissions within CHAG facilities have reduced. Noticeably, the proportion of admissions accounted for by malaria has reduced by 8.2% since 2014 as shown in table 13 below. This is consistent with the downward trend of malaria as seen with the OPD cases. The proportion of Hypertension has increased by about 1%. This is in tandem with the rising non-communicable disease burden globally. Anaemia has remained relatively the same. 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: 2014 – 2018

Condition	% Contribution by Condition					% Change 2017-2018	One-year performance	% Change 2014-2018	5-year Performance
	2014	2015	2016	2017	2018				
Malaria	26	24	21.4	17.7	17.8	0.1	Worsened	-8.2	Significantly Improved
Anaemia	6	3.4	5.3	5.6	5.6	0%	Stabilized	-0.4	Improved
Asthma/Bronchitis/URTI	2	3.1	2.9	2.2	2.0	-0.2%	Improved	0	Stabilized
Hypertension	3	2.2	3.3	3.2	3.9	0.7%	Worsened	0.9	Worsened
Pneumonia	2	2.9	3.2	3.3	3.4	0.1%	Stabilized	1.4	Worsened
Gastroenteritis	3	2.7	3.2	2.7	2.7	0%	Stabilized	-0.3	Improved
Diarrhoea Diseases	2	2.5	2.6	2.4	1.8	-0.6%	Improved	-0.2	Improved
UTI	2	2.5	2.7	3.1	3.4	0.3%	Stabilized	1.4	Worsened
Sepsis	1	1.7	2.2	2.3	1.8	-0.5%	Improved	0.8	Improved
Typhoid/Enteric Fever	1	1.5	1.0	1.0	-	0%	Stabilized		Improved
All Others	52	43.5	52.2	56.5	**57.6**				Worsened

1.2.3 Mortality

A total of 9,497 deaths occurred in 2018 in CHAG facilities. This was 20.7 % increase over that of 2017 (7,872). Bronchopneumonia was the commonest cause of mortality and accounted for 7.3% of all deaths. Cerebro-Vascular Accident (CVA) was the second cause of mortality in CHAG institutions accounting for 5.2% of all adult deaths. With increasing burden of non-communicable diseases, the high proportion of deaths due to CVA is not surprising. It has been reported by WHO and CDC that NCDs account for about 40% of deaths in Ghana. Service delivery should therefore prioritize NCDS to reduce its incidence and hence CVAs. Severe Anaemia and Hypertension and related complications and sepsis were the third, fourth and fifth highest cause of mortality accounting for 5.1%, 4.6% and 4.0% of mortalities respectively. HIV/AIDs, Septicaemia and Malaria accounted for 3.5%, 3.2% and 3.0% of mortalities respectively. The sudden rise in HIV/AIDs related deaths needs a national approach to arrest the situation. Figure 20 and table 14 give details of the mortality for 2018.

Figure 20: CHAG Top Ten (10) Causes of Mortality for 2018

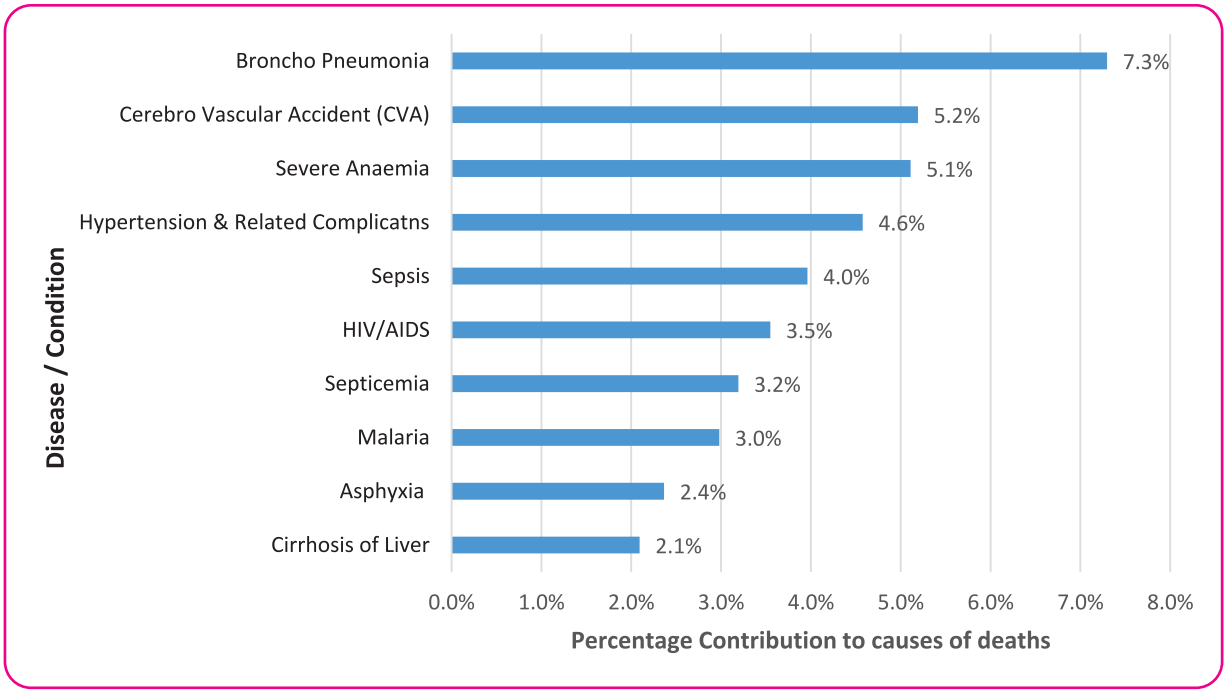


Table 14: Top-10 causes of Mortality: 2010 – 2017

Condition	2014 (% of total deaths)	2015 (% of total deaths)	2016 (% of total deaths)	2017 (% of total deaths)	2018 (% of total deaths)	% Change 2017 - 2018	One-year performance	% Change 2014-2018	5-year performance
Broncho-**Pneumonia**	5.5	5.3	4.1	1.9	7.3	5.4	Worsened	1.8	Significantly improved
Cerebro-Vascular Accident	14.7	5.7	5.6	4.9	5.2	0.3	Marginal increase	-9.5	Significantly improved
Severe Anaemia	15.1	6.7	4.8	5.3	5.1	-0.2	Improved	-10	Significantly improved
Hypertension	6.7	3.1	4.8	2.2	4.6	2.4	Worsened	-2.1	Significantly improved
Sepsis	14.3	4	3.9	6.6	4	-2.6	Significantly improved	-10.3	Significantly improved
HIV/AIDS	13.7	4.3	4.1	2.6	3.5	0.9	Increased	-10.2	Significantly improved
Septicemia	4.9	1.5	3.9	1.9	3.2	1.3	Worsened	-1.7	Significantly improved
Malaria	13	3.3	2.9	2.9	3	0.1	Marginal increase	-10	Significantly improved
Asphyxia	6	3.5	2.8	2.1	2.4	0.3	Worsened	-3.6	Significantly improved
Cirrhosis of Liver	6	2.5	5.6	3.3	2.1	-1.2	Significantly improved	-3.9	Significantly improved
All Others	61	60.1	57.5	66.3	47.2	-19.1	Significantly improved	-13.8	Significantly improved

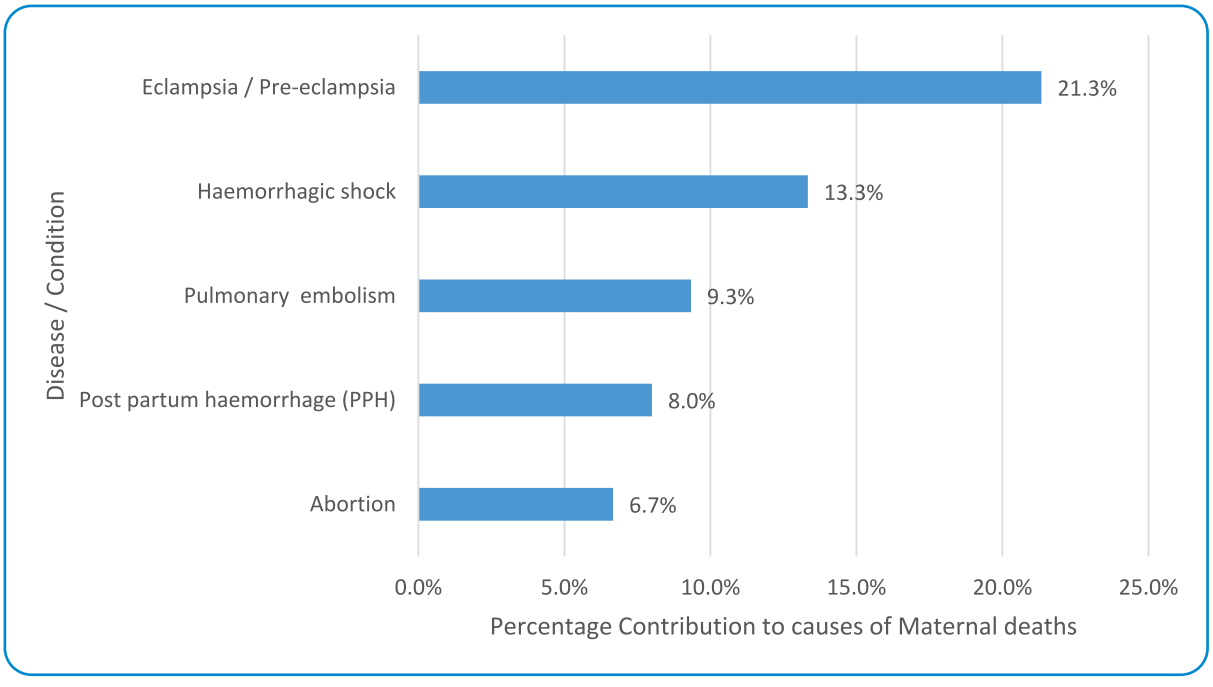
As inferred from table 14 above, the proportion of deaths due to Anaemia was lower compared to 2017 and significantly low compared to 2014. Over a 5-yer period, the proportion of mortality from cerebro-vascular accidents, HIV/AIDs, septicaemia and malaria have significantly reduced as shown in table 14 above. The increased education on NCDs as well as the aggressive treatment of HIV/AIDs conditions seem to be yielding results. Deaths due to asphyxia have significantly improved and may be due to improved response times to complicated deliveries. Again, the number of trained professionals in remote areas is gradually increasing

1.12.4 Maternal Mortality

Maternal and neonatal mortality rates were priorities for the entire network in 2018. Consequently, for the period of reporting, institutional maternal mortality ratio (MMR) reduced from 152/100,000 live births (in 2017) to 124/100,000 live births in 2018 as shown in table 3 above. This represents an 18.4% decline. The institutional maternal mortality is lower than the national MMR of 127.3/100,000 live births in 2018 and 147/100,000 live births in 2017. The decline seen in the CHAG network may in part be attributable to the Safe Delivery App training given to over 100 midwives in Ashanti and Eastern regions. Additionally, a lot of awareness was created within the network on the need to improve key indicators such as MMR.

Eclampsia & Pre-eclampsia, Haemorrhagic shock, Pulmonary embolism, Post-partum haemorrhage and abortions were the common causes of maternal deaths in CHAG Hospitals during 2018 as shown in Figure 21 below.

Figure 21: CHAG Top Five (5) Causes of Maternal Mortality for 2018



Institutional Maternal mortality rate, DHIMS 2, 2018
Facts and Figures, GHS 2018

Nationally, pulmonary embolism is not one of the top five causes of maternal deaths. The situation within the network therefore will be investigated to ascertain why pulmonary embolism has become one of the leading causes of maternal deaths. Given that 99.3% of all maternal deaths were audited in 2018, the findings from these reports will be an important source of verifying the actual reasons for the rising incidence of pulmonary embolism among pregnant women.

1.13 Summary Health Status Indicators

Overall, there were improvements in five key health status indicators over a 5-year period (2014 to 2018). These indicators include maternal mortality, under–5 mortality, stillbirth and crude mortality rates. Specifically, in 2018, institutional maternal mortality reduced by about 18.4%, under-5 mortality by 53.6%, infant mortality by 11.9%, neonatal mortality by 8.9% and crude mortality by about 7.9% as seen in table 15 below. Stillbirth rate remained same as the previous year (19 per 1000 live births).

Over a 5-year period, under 5 mortality has declined by 62.4%, maternal mortality by 25.7% and infant mortality by 18.3%. Not only the above but also, neonatal mortality, stillbirth and crude birth rates have all declined by 16.3%, 9.5% and 16.7% respectively.

Table 15: Health Status Indicators: 2012 – 2018

Outcome Indicator	Year							% Change	One-year Performance	% Change	5-Year performance	National	Developing Countries
	2012	2013	2014	2015	2016	2017	2018	2017 - 2018	2017 - 2018	2014 - 2018	2014 - 2018	2018	2016
Maternal Mortality Rate (per 100,000 LB)	158	168	167	145	109	152	124	-18.4	Improved	-25.7	Improved	127.3[1]	239[3]
Neonatal Mortality Rate	5.5	7.1	9.8	6.5	13	9	8.2	-8.9	Improved	-16.3	Improved	7.7[1]	52[3]
Infant Mortality Rate	6.6	7.9	10.9	8.6	12.9	10.1	8.9	-11.9	Improved	-18.3	Improved	8.5[1]	107[3]
Under 5 Mortality Rate	21.1	19.5	17.3	15.1	18.3	14	6.5	-53.6	Improved	-62.4	Improved	4.9[1]	177[4]
Still Births Rate	26	24	21	21	20	19	19	0.0	Stabilized	-9.5	Improved	1.4[2]	18.4[5]
Crude Mortality Rate	23	23	21	22	19	19	17.5	-7.9	Improved	-16.7	Improved	9[2]	16[4]

[1] Institutional Maternal Mortality, DHIMS 2, 2018

[2] Facts and Figures, GHS, 2018

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

[4] World Health Organization: Key facts 2015

[5] 2015 worldwide estimates: WHO neglected tragedy of stillbirths

As indicated earlier, these significant interventions could be attributable to concerted efforts from CHAG Member Institutions to improve these major health outcomes. There were various interventions at the institutional level, including awareness creation during the CHAG Annual Conference, training in IMCI and neonatal resuscitation, some of which were conducted by Systems for Health in selected regions. Again, the increased OPD visits may have contributed to the improvements seen in 2018. The figure 22 below depicts a 5-year trend of maternal mortality rates within the CHAG network.

Figure 22: Trend of Maternal Mortality Ratio: 2014 – 2018

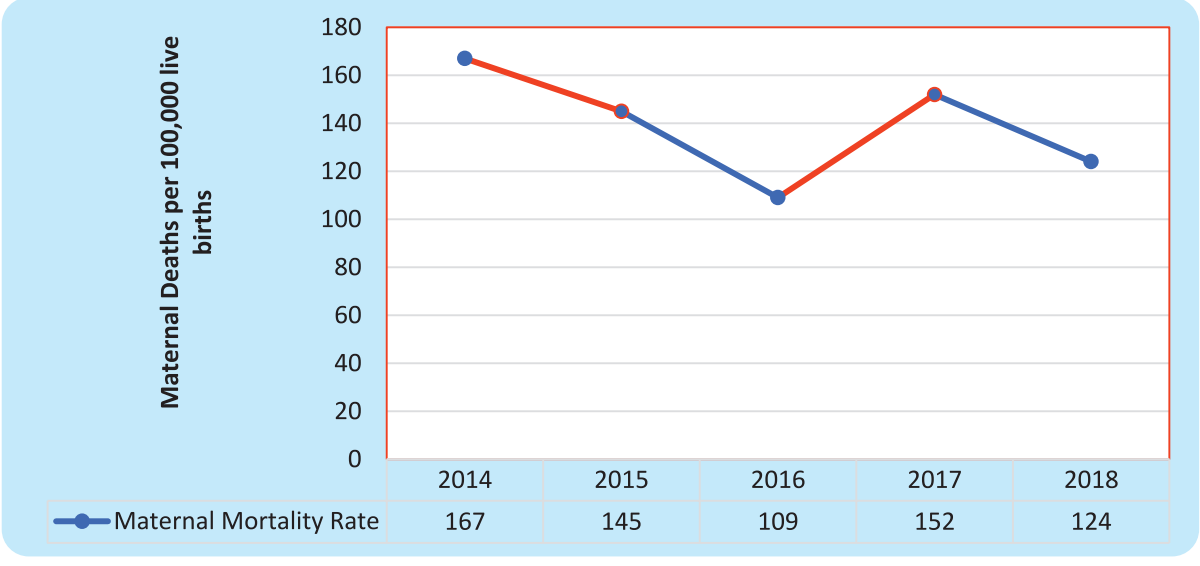
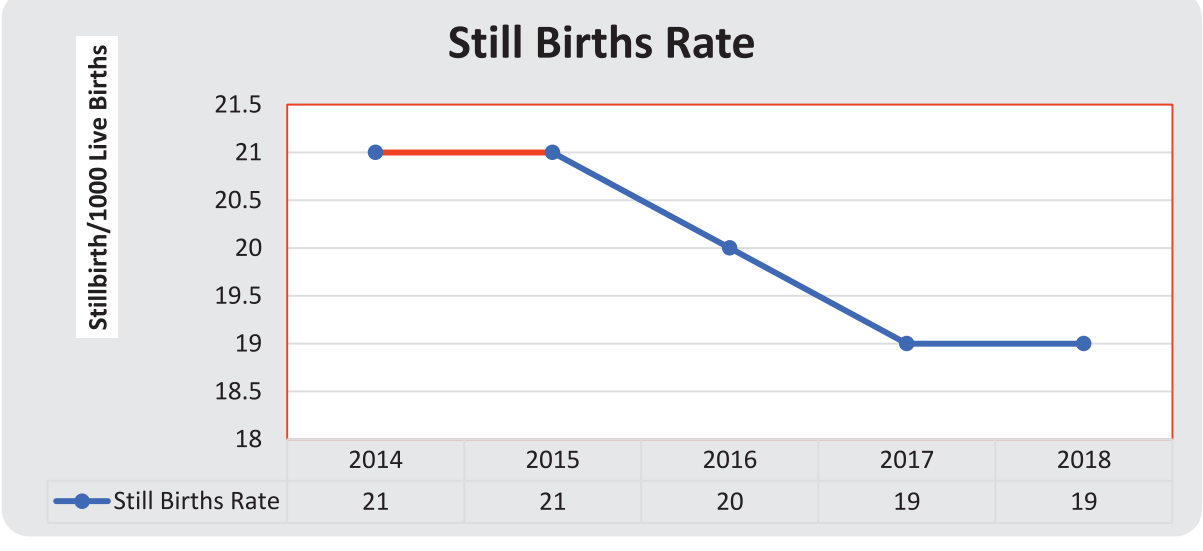
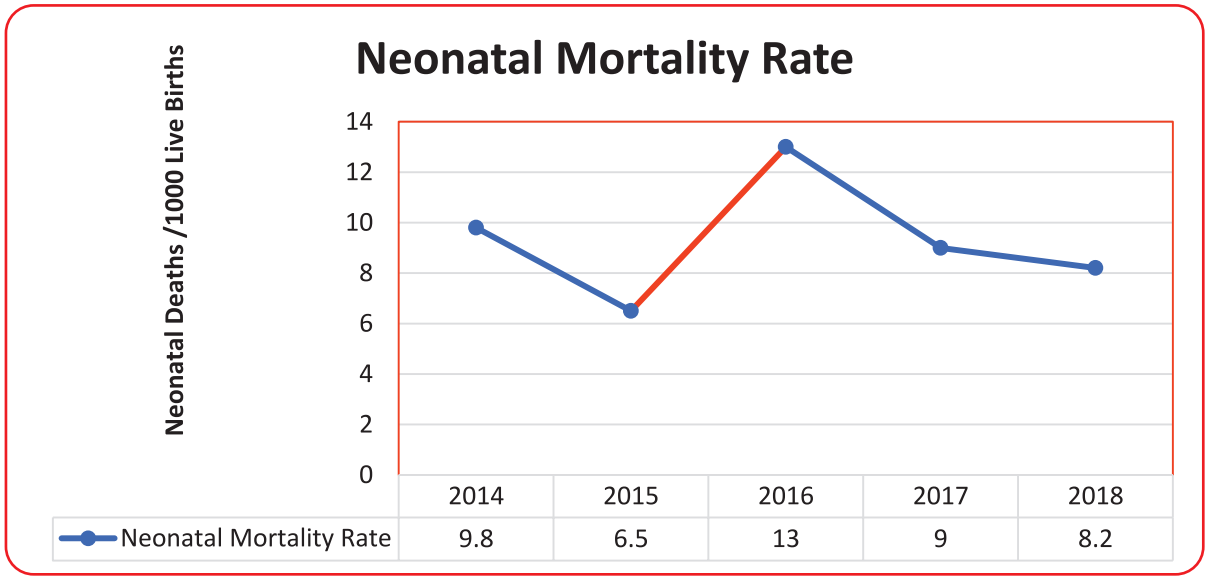


Figure 23: Trend of Still Births Rate: 2014 – 2018



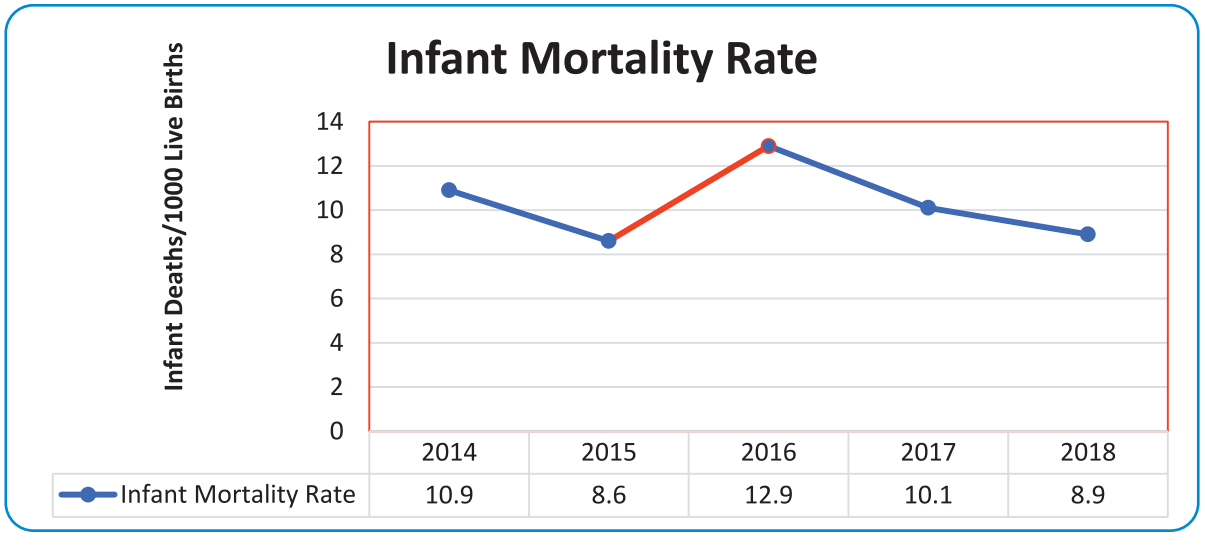
There has been continuous improvement in stillbirth rate since 2014. The highest decline was recorded between 2015 and 2017. Thereafter, the rate has been stable with 19 stillbirths per 1,000 live births. These may be attributed to continuing professional development activities in the various districts particularly the essential new-born care training being carried out nationwide. Again, the training in the use of Safe Delivery App contributed to this reduction.

Figure 24: Trend of Neonatal Mortality Rate: 2014 – 2018



Neonatal mortality has been fluctuating since 2014. There was a sharp decline between 2014 and 2015 and again between 2016 and 2017. There was further decline of 8.9% in 2018 compared to 2017. Figure 24 above shows a trend of neonatal mortality, 2014 – 2018.

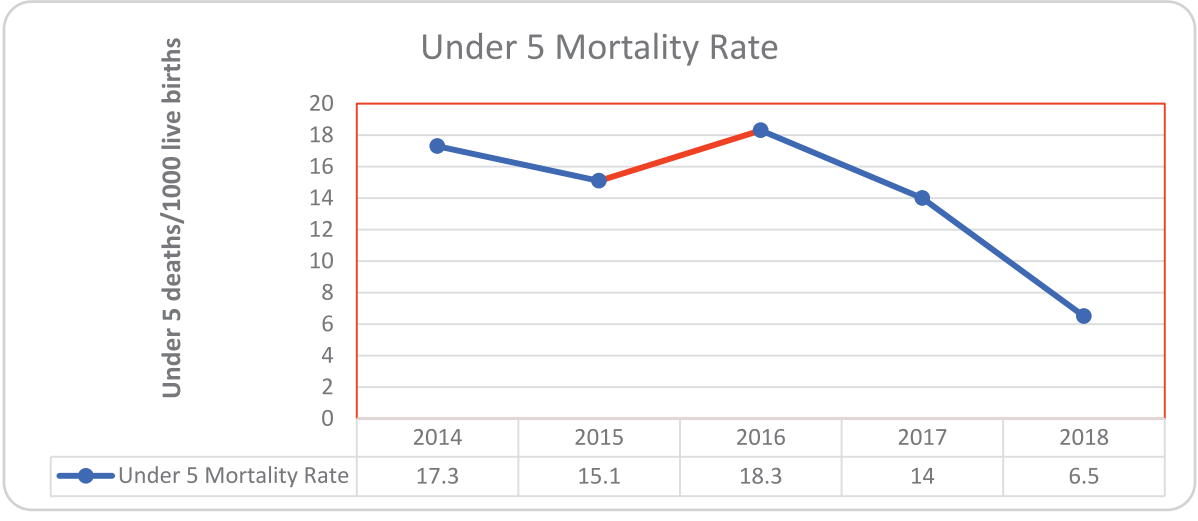
Figure 25: Trend of Infant Mortality Rate: 2014 – 2018



Infant deaths per 1,000 live births declined in 2015 from 11 to 8.6 as shown in figure 25 above. Thereafter, it increased to 12.9. For two years (since 2016), there has been a decline in the number of infant deaths from 12.9 to 10.1 in 2017 to 8.9 in 2018.

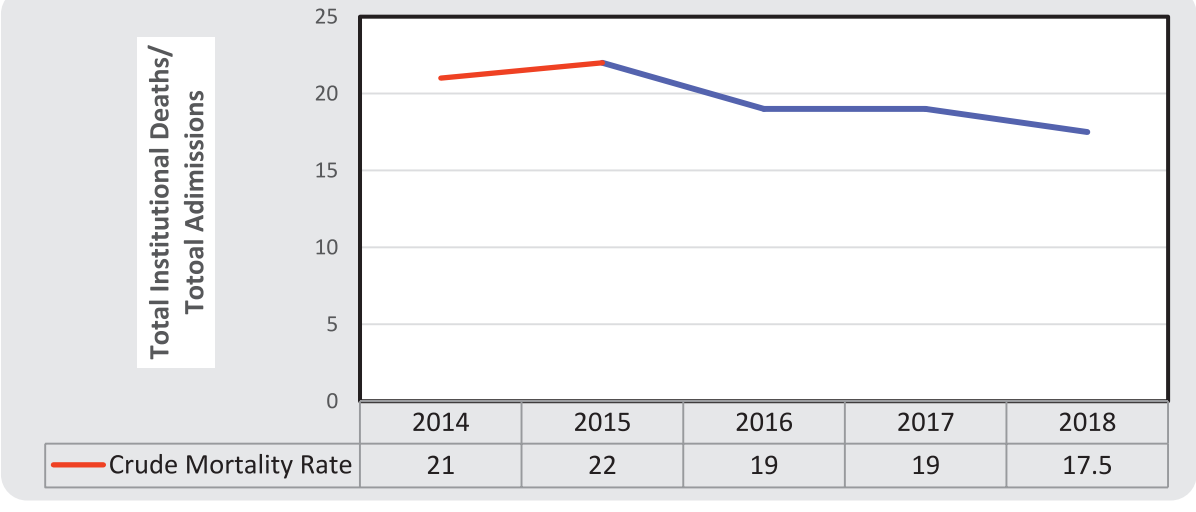
In order to sustain the gains, CHAG would continue to engage healthcare managers in the various institutions to maintain this decreasing trend.

Figure 26: Trend of Under 5 Mortality Rate (U5MR): 2014 – 2018



With the exception of 2016, when there was an increase in under -5 mortality from 15.1 to 18.3 deaths per 1,000 live births, there has been a consistent reduction in Under 5 mortality of 17.3% in 2014 to 6.5 in 2018. Figure 26 above, shows the improvements in reducing the deaths of children under-5 years from 2014 to 2018. The reasons for these improvements are similar to those mentioned for the reduction in infant mortality within the network.

Figure 27: Trend of Crude Mortality Rate: 2014 – 2018



As shown in Figure 27 above, institutional deaths in CHAG have been between 17.5 - 21 per 1,000 patients over the last 5 years with 2015 recording the highest of 22 per 1,000 admissions. The general trend over the past five years is a reduction in the mortalities.

1.14 Mental Health Services

CHAG's 5-year work on Mental Health funded by the Department for International Development (DFID-UK), ended in March 2018. Beginning 2013, CHAG 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 stigma and discrimination towards persons with mental illness; (2) Increase/improve 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 2018, CHAG facilities continued the provision of mental health services to people with mental illness in their communities. The staff collaborated with prayer camps, traditional healers and pastors in providing care for the mentally ill.

In the course of the project, 46 staff who were trained in Clinical Psychiatry at the College of Rural Health and Wellbeing-Kintampo were posted to the various institutions where they are currently working. The 560 community health workers and prescribers who were given refresher trainings in mental health also supported service provision to clients. All facilities that had integrated Mental Health services with OPD services continued providing care.

The main challenge in the course of the year was the shortage of psychotropic medicines. CHAG supplied some facilities with five commonly prescribed psychotropic medicines. These include chlorpromazine, haloperidol, Carbamazepine, Risperidone and amitriptyline. In the next phase of CHAG's mental health project, CHAG is exploring congregational mental health services. These are stable communities that come together every week or in specific days. They include churches, mosques, and traditional healing centres etc. CHAG holds the views that delivering mental health services to these stable groups will be more effective than putting physical health structures or organizing community durbars.

1.14.1 Mentally-Ill Clients seen at OPD and IPD

In 2018, CHAG Mental Health Units conducted 1,332 Mental Health durbars and campaigns across Ghana. The number of new cases seen in 2018 were 10,924. These include those identified through active case search and those seen at the various CHAG facility mental health units. Those seen through active search numbered 1,399. Per data analysis, 54.4% of the clients seen were females as shown in figure 28 below. Total number of clients seen in 2018 was 25,718. These cases came from all over Ghana. Of those mentally ill persons seen, 19,570 (76.1%) of them were on NHIS cover. The proportion of those on NHIS was relatively low compared to the previous year when 94.1% of them were on NHIS. The insurance status of mentally ill persons seen in 2018 is shown figure 31 below.

Suicide cases

There were 18 suicide deaths, 10 males of which were males. The 241 suicide attempts out of which 108 males (44.8%) and 133 females (55.2%).

Deaths

There were 198 deaths (including 18 suicides) of mentally ill persons. Males were 118 whiles 80 were females. Please, refer to figure 29 for details of deaths, admissions and discharges for 2018.
Admissions and Discharges.

A total of 1,419 mentally ill persons were admitted to the various CHAG facilities in 2018. Female clients were 706 (49.8%) whilst 50.2% were males. The total number of those discharged were 1,374 (96.8%) out of which 678 (49.4%) were females. It is important to observe that almost all the clients that were admitted were discharged in the course of the year. However, whilst that is done, care needs to be taken to ensure that those discharged have completely recovered. Epilepsy, depression and generalized anxiety disorders were the commonest causes of admission as shown in figure 30 below.

Figure 28: New and Old Cases of Mental Clients seen in CHAG facilities by Sex, 2018

	New cases	Total Clients
Female	5157	13688
Male	4368	12030

Figure 29: Admissions, Deaths, and Discharges of Mentally Ill Clients by Sex, 2018

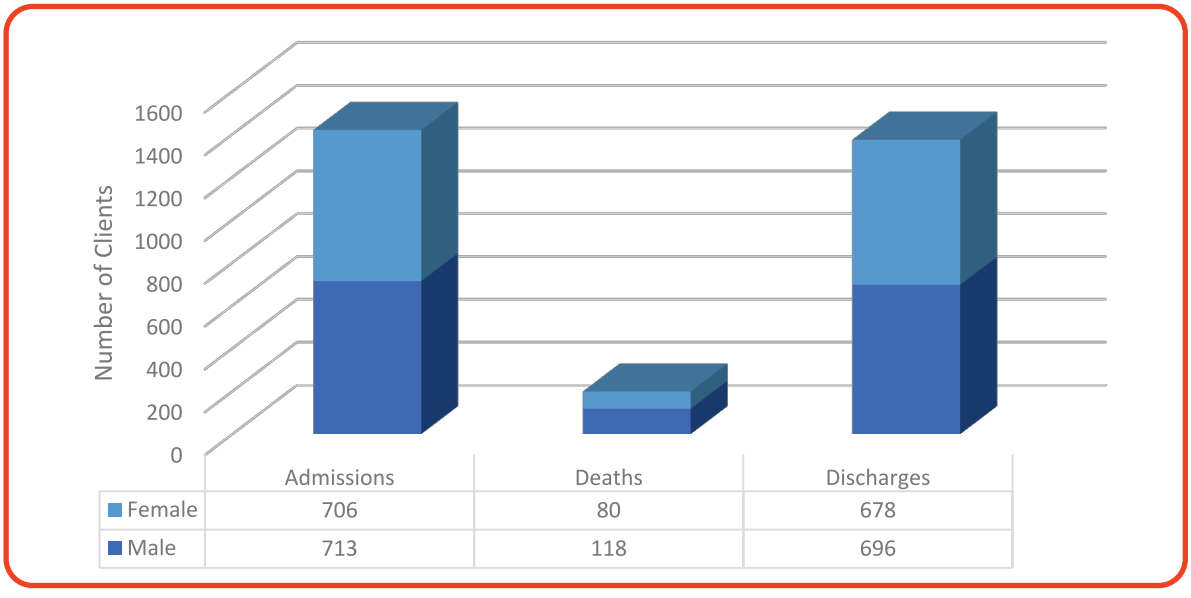


Figure 30: Top 8 Mental Health Conditions seen in OPD 2018

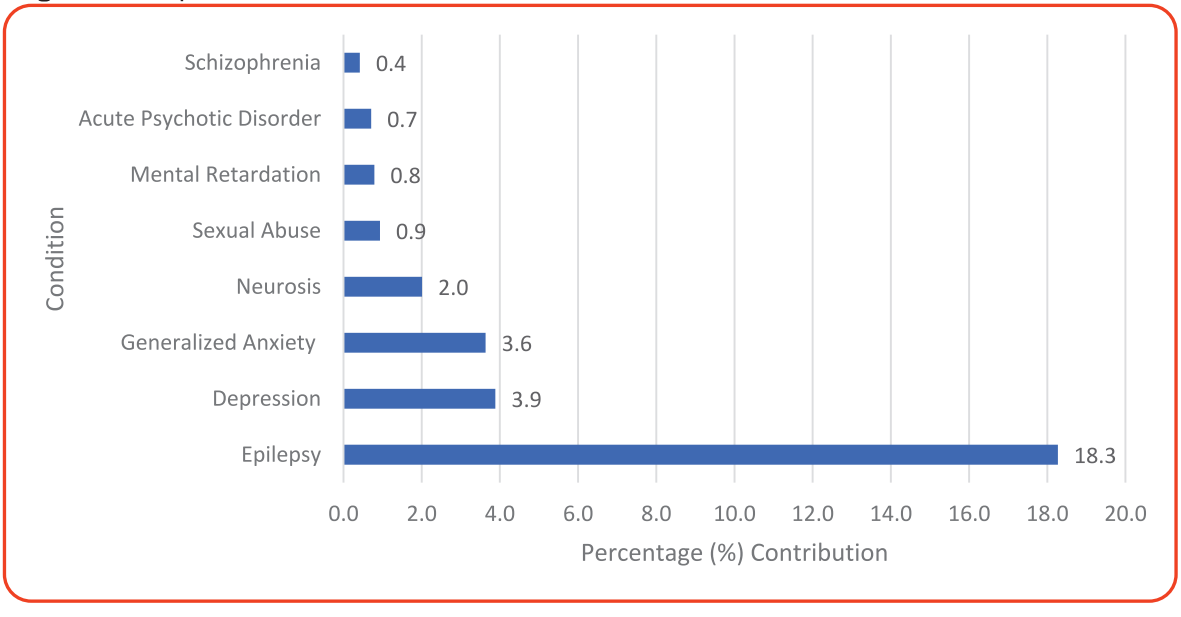
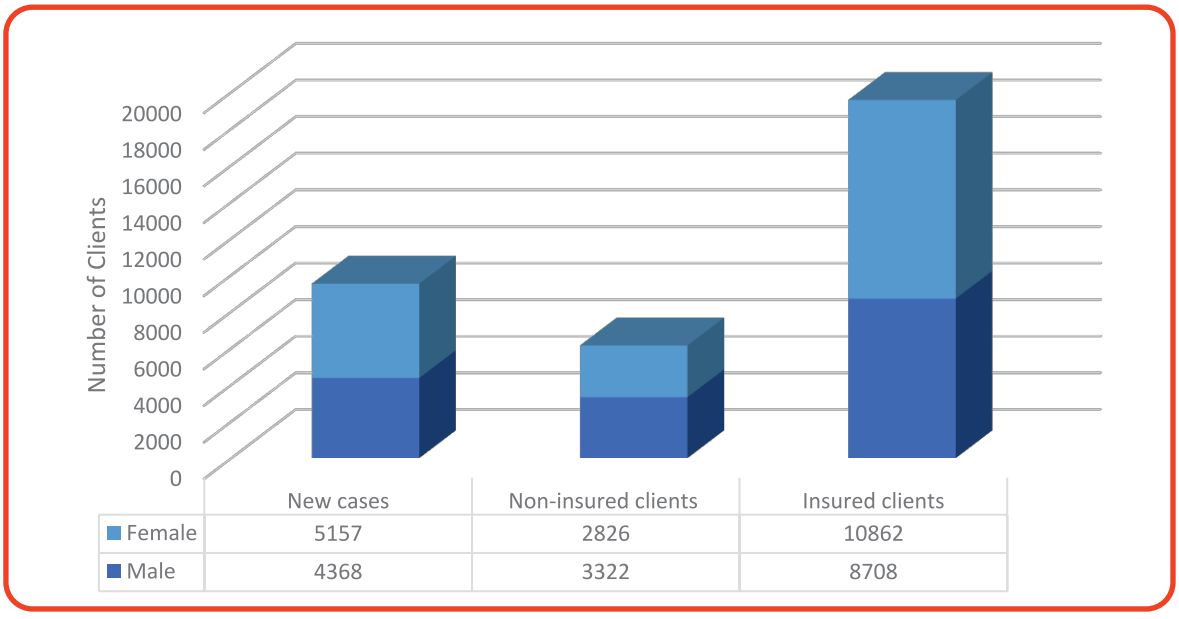


Figure 31: Insurance Status of Mentally Ill Persons seen in CHAG Facilities, 2018



	New cases	Non-insured clients	Insured clients
Female	5157	2826	10862
Male	4368	3322	8708

More clients seen were insured. Over 50% of both existing and new cases were females. Based on analysis of available data, mental health interventions should involve more women, as women tend to be more affected with mental illnesses. And although more women suffer mental illness compared to men, the case fatality rate is higher amongst males; meaning more men with mental illness die compared with females.

2.0 HEALTH 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 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 facilities submit health service data to the government/MOH through DHIMS2. In 2018, 85.7% of CHAG Facilities submitted data to the DHIMS on time. Due to the double work of submitting data to the DHIMS 2 and CHAG, in 2018 manual data submission to CHAG though the minimum data set was not encouraged. Data for decision-making and reporting were taken from the DHIMS 2. Only 261 CHAG health facilities out of the 325, report data into the DHMIS2. Nonetheless, submission rate in 2018 into the DHIMS 2 was 97.3%. In 2019, the Secretariat would ensure that all facilities submit data into the DHIMS2

Table 20: Report Submission Rate by Facilities (2014 - 2018)

Facility	2014	2015	2016	2017	2018
Hospitals	97%	97%	85.3%	95.2%	100%
All Others	89.0%	81%	75.0%	94.5%	94.7%
Overall	93%	86.2%	77.3%	94.8%	97.3%

Obviously, the challenge of not getting all the CHAG Network to submit data into DHIMS 2 is a matter of concern as it affects CHAG's overall health sector attribution/contributions, and regulatory obligations to the MOH and other stakeholders. Hence, in the ensuing years, the CHAG Secretariat would continue to engage CMIs to ensure that all their facilities submit data into the DHIMS 2.

3.0 LEADERSHIP AND GOVERNANCE

Leadership and governance relate 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-sectoral and network advocacy. Critical challenges in leadership and governance that require sustained attention of CHAG are indicated in table 16 below:

Table16: 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

In 2018, CHAG created a common platform for Church Health Coordinating Units (CHCUs) and the Heads of the various Hospitals, Clinics, Health Centres and Health Training Institutions. These platforms were used to disseminate information, share ideas and give feedback on pertinent operational and management issues affecting CMIs the CHAG continued to participate in health sector meetings and technical sessions to promote CMIs 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, Inter-Agency Leadership Committee, 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, HEFRA Advisory Committees, amongst others. Ultimately, CHAG's visibility, role and mandate as a major stakeholder and reliable partner in the health sector was recognized and affirmed in the MOH policy decisions.

The leadership of the Secretariat supported member institutions particularly in the area of capacity building in key service provision areas including Mental Health, registration, accreditation and credentialing of CMIs with Health Facilities Regulatory Authority (HEFRA), National Health Insurance Authority, etc.

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 heath 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 as at the end of December 31st, 2018 stood at twenty-seven thousand, five hundred and eighty-one (27,581) as at December 31, 2018. However, the number of CHAG employees on Government of Ghana payroll stands at twenty thousand, three hundred and forty-four (20,344). Thus, the proportion of staff on GoG payroll as at December 31st, 2018 was 73.7%.

Table 17: Trend of Number of Staff and Corresponding Salaries, 2013 - 2018

Year	2013	2014	2015	2016	2017	2018
Salaries of CHAG staff on GoG payroll in Ghana Cedis	118,084,128	135,812,280	154,883,462	218,886,709	306,668,966	346,034,684.00
% growth	-	15%	14%	41%	40%	12.8%

Analysis of the past five years reveals that the number of CHAG employees on government payroll has been increasing from over 12,328 in 2014 to 20,344 in 2018 as shown in Figure 32 below.

Figure 32: Trend of CHAG Staff on GoG payroll 2009 - 2018

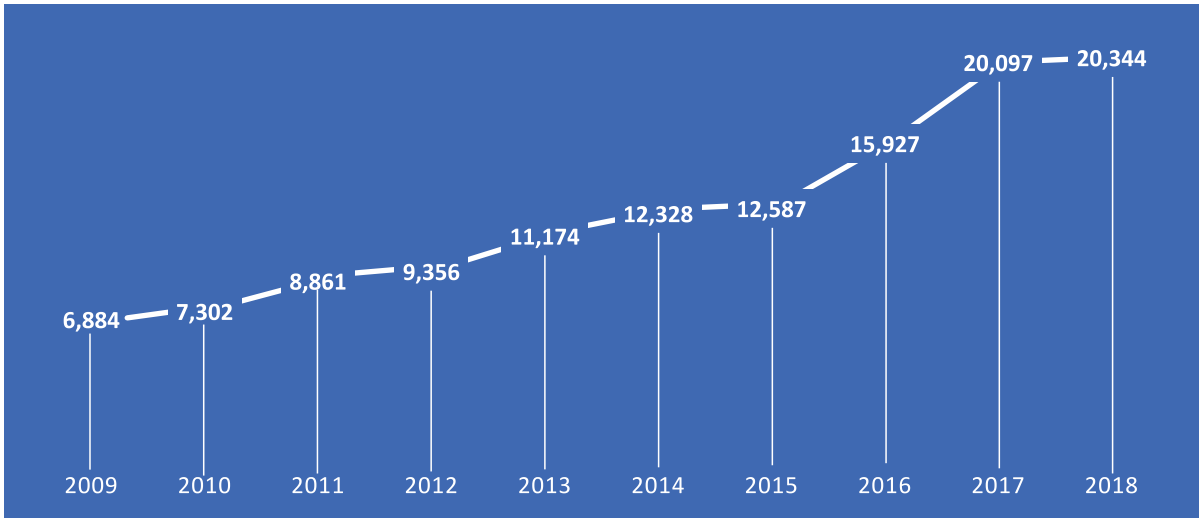
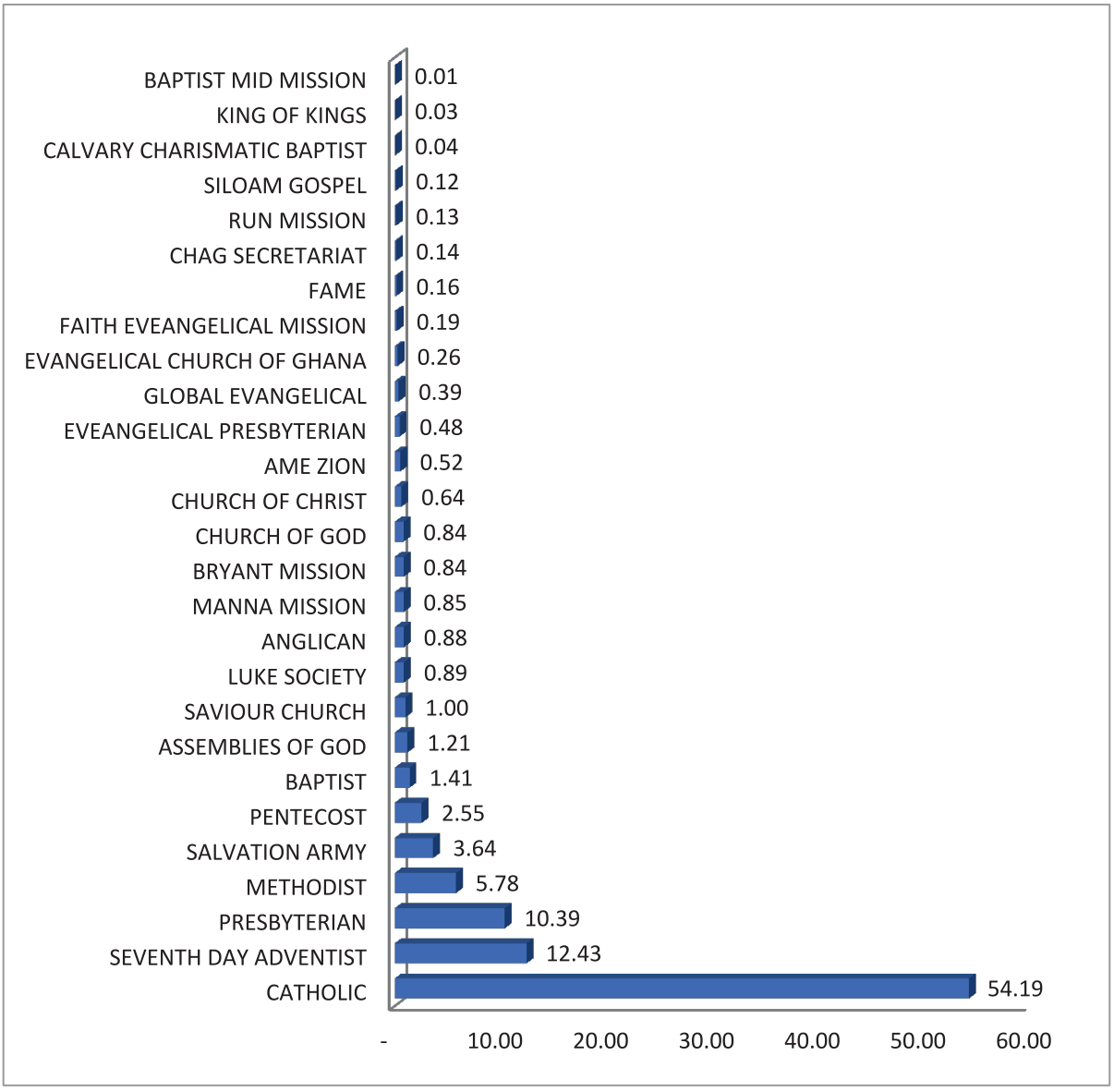


Figure 33: Percentage Distribution of Staff by Church Health Service, 2018



As can be seen in Figure 33 above, the National Catholic Health Service facilities have the highest proportion of CHAG staff with 54.19%. This is consistent with the highest number of facilities as well as the output of the NCHS to the total health services delivery of the CHAG network. In 2018, the HR strength of the NCHS stood at 10,958 employees on government payroll. This represents 54.19%. The Ghana Adventist Health Service (GAHS) and the Presbyterian Health Service follow with 2,513 (12.43%) and 2,101 (10.39 %) in number of employees on GoG payroll, respectively. The proportion of staff in these three Church Health Services constitute 77% of the total CHAG employees on GoG Payroll.

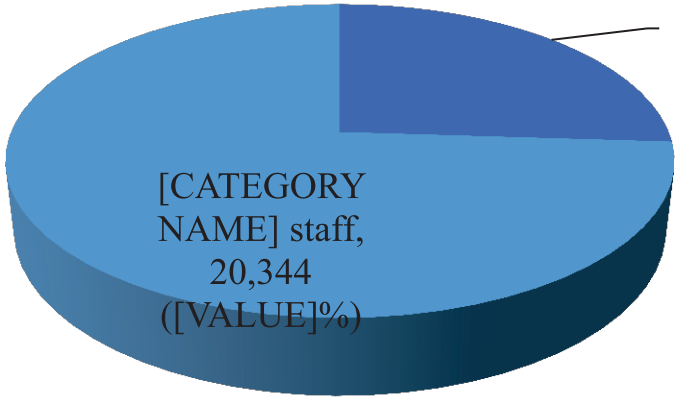
Conversely, the Church Health Services with least number of staff were Faith Evangelical Mission, Baptist Mid Mission, King of King of Kings and Calvary Charismatic Baptist Health Services. The total staff strength of these three Church Health Services comprised 0.08% of the total number of CHAG employees on GoG payroll.

The rapid growth in CHAG staff was anticipated and has been influenced by the fact that Twenty-seven (27) new facilities were admitted into CHAG membership in 2018, and these facilities came on board with staff.

The distribution of employees within the network during the period under reporting was largely influenced by the number of CMIs under each Denominational Church Health service, the need as determined by workload of the CMIs, and the location of the facilities. The staff strength of the Network has consistently seen an upward trend over the recent past years.

As indicated in figure 34 below, seven thousand, two hundred and thirty-seven (7,237) employees, representing 26% of the overall staff strength of CHAG were paid from the Internally Generated Funds (IGF). This phenomenon has aggravated the financial distress of CMIs in the face of delays in NHIS claims reimbursements.

Figure 34: Proportion of GoG & IGF Staff in CHAG, as at December 31, 2018



Source: CHAG 2018 HR Data.

4.1 Ratio of Professional to Auxiliary Nurses

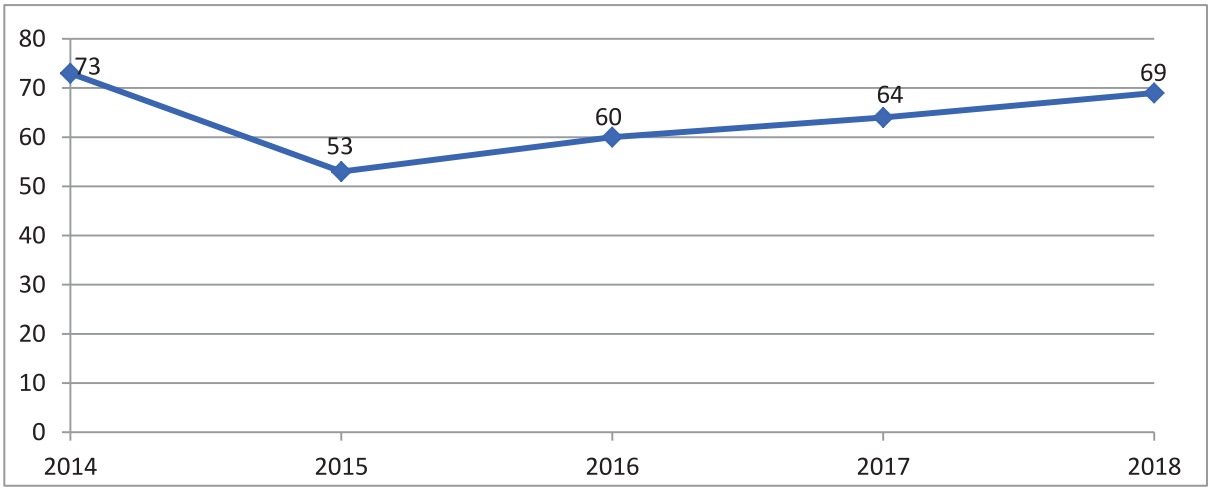
The required proportion of professional and auxiliary nurses is 60% professional and 40% auxiliary. In 2018, the ratio of professional nurses and their auxiliary counterparts was 69% and 31% (figure 35) respectively compared 64% to 36% in 2017. This indicates the CHAG network has the appropriate proportion 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 35: Ratio of Professional to Auxiliary Nurses in CHAG, 2018

Source: CHAG 2018 HR Data.

Figure 35 above shows the ratio of professional to auxiliary nurses.

Figure 36: Trend of clinical to non-clinical staff, 2014 – 2018



From figure 36 above, 2014 was the year that the CHAG network had the highest ratio of clinical to non-clinical staff of 73%. 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. However, from 2016 to 2018 the situation has seen steady improvement with 2018 recording 69%.

4.2 Doctor to population ratio

As at the end of 2018, there were five hundred and seventy-six (576) Medical Doctors including specialists within the CHAG network. Doctor out-patients' ratio recorded in CHAG in 2018 was 1:9,817. Each Medical Doctor saw 9,817 out-patients during 2018 with an average of 27 patients per day in CHAG. This performance is an improvement over the last five years (2014, 1: 15,987) when each doctor saw an average of 44 patients per day. The trend of Doctor to patient ratio is shown in figure 37 below. Nationally, the Doctor to population ratio was 1:7,196 in 2018 with regional variation. The Upper East, Volta, Eastern and Brong Ahafo regions had ratios 1:11,000 or more.

Nurse to population ratio

Nurse out-patient ratio declined from 1:488 in 2017 to 1:618 in 2018. The National Nurse to population ratio for the year under reporting was 1:839[1]. There are, however, regional variations. For every 1:1,015[1] people in the Western region, there is a nurse whereas Upper East region, for every 494 people there is a nurse . The ratio in the CHAG network is thus better than the national average. The decline in the nurse to population ratio contributed to the decline in clinical to non-clinical staff ratio.

Midwife to Patient ratio

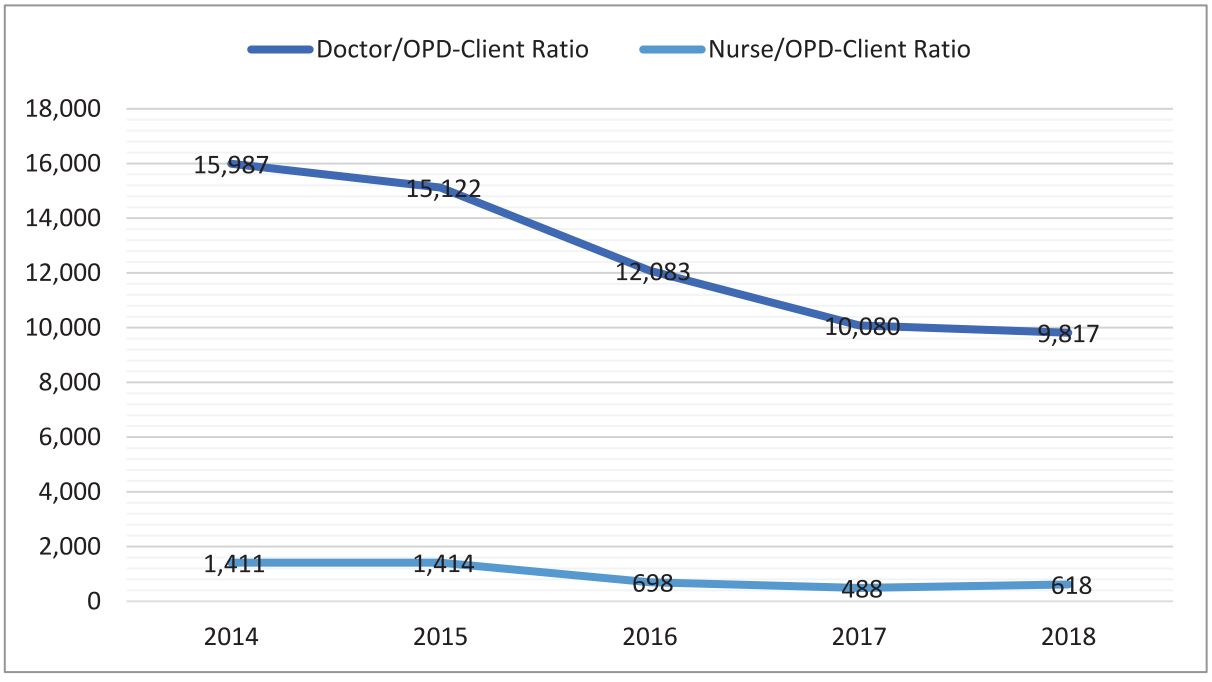
As at December 2018, there were 1,760 midwives working within the CHAG network. This translates into midwife to patient ratio of 1:3,855[1]. Nationally, there was one midwife per 816 women of child bearing age. Central region has the least with 1:816 whilst Upper East is the well-endowed with a ratio of 1:389.

Pharmacist to Patient ratio

More pharmacists are required in the CHAG network. The minimum required for the network is 95 to ensure that at least pharmacy is supervised by a pharmacist. As at December 2018, there were 84 pharmacists. The pharmacist to patient ratio for the period of reporting was 1:80,777. There is an urgent need for more pharmacists to improve pharmaceutical care especially in the wake of rising burden of anti-microbial resistance.

[1] Holistic Assessment Report, MoH 2018

Figure 37: Trend of Doctor and Nurse to patient ratios 2014 – 2018



Nurse to outpatient ratio, just like doctor to outpatient ratio, has been declining steadily since 2015. This is good for Ghana's health system as Nurses could have adequate professional time space to provide quality of care to clients. A trend of Nurse to outpatient ratio is shown figure 37 above.

4.3 Summary of Key HR Performance Indicators 6-Year Trend

Table 5 provides information on some key human resource performance indicators over a five- 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 (2014-2018).

4.4 Promotions And Upgrades

As part of the health sector's efforts at 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 perfomance of their duties. Accordingly, a total of two thousand, six hundred and fifty-seven (2,657) employees of the network were promoted in 2018. This represents a 78.7% increase compared to 2017 when 1,487 were promoted. The increase notwithstanding, the number of employees promoted constitutes 9.6% of the total staff strength of the CHAG Network; an indication that promotion activites have been may have been stalled within the network. Given the importance of promotion in the retention and productivity of qualified staff, a survey will be required to establish the reasons for the low promotion activities.

The Table 18 below provides details of staff promotions in 2018.

The Table 18: Provides details of staff promotions in 2018.

Church Health Service	Number of Staff	% of staff promoted
Assemblies of God	70	2.6
AME Zion	10	0.4
Anglican	10	0.4
Baptist	49	1.8
Bryant Mission	6	0.2
Catholic	1587	59.7
CHAG	3	0.1
Church of Christ	16	0.6
Church of God	24	0.9
E. P. Church	1	0.04
Evangelical Church of Ghana	4	0.2
Evangelical Presbyterian	3	0.1
Faith Evangelical Mission	1	0.04
Global Evangelical	12	0.5
Saviour Church	26	1.0
Luke Mission	33	1.2
Manna Mission	27	1.0
Methodist	94	3.5
Pentecost	66	2.48
Presbyterian	267	10.04
Salvation Army	90	3.38
Seventh Day Adventist	250	9.40
Sight for Africa	10	0.38
Siloam	1	0.04
TOTAL	**2,660**	**100.00**

Inter-Agency Transfers

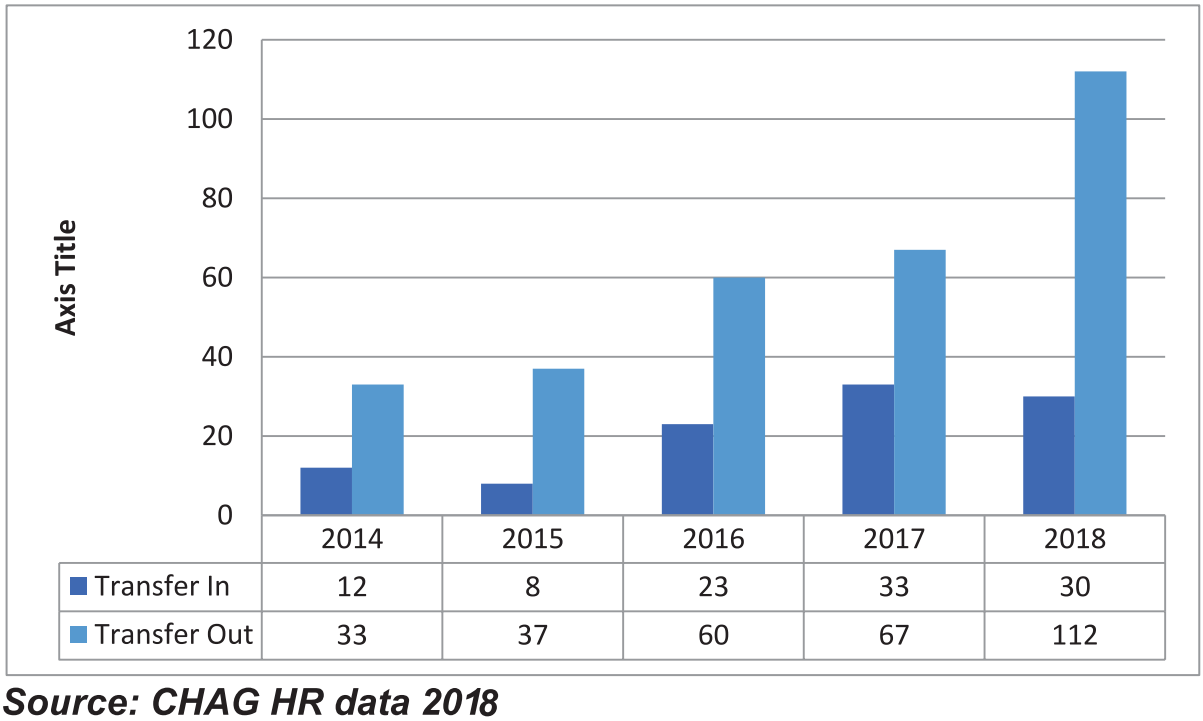
The Ministry of Health policy on transfer allows inter-agency transfer of staff. During the period under review, CHAG recorded three hundred and forty eighty (348) transfers. Of the overall transfer, Two hundred and six(206) were intra CHAG transfers (transfer from one Church Health Service to another); the remaining one hundred and forty-two (142) were transfers to and from other Agencies of the Ministry of Health comprising; thirty (30) from other Agencies to CHAG, and one hundred and twelve (112) from CHAG to other Agencies. Overall, the year 2018 witnessed the highest transfer out of CHAG over the 2014-2018 period. Table 19 below shows details of the inter-Agency transfers:

Table 19: Facilities where CHAG staff were transferred to, 2018

Receiving Agency	Number of Staff
Ahmadiyya Mission Health Service	2
Ghana Health Service	90
Health Training Institutions Secretariat	9
Komfo Anokye Teaching Hospital	3
Korle Bu Teaching Hospital	3
Mental Health Authority	1
MOH Head Quarters	3
Nurses & Midwifery Council	1
TOTAL	**112**

One major receiving agency of transfers from CHAG is the Ghana Health Service. Figure 38 below shows the trend of inter-agency transfers between 2014 and 2018.

Figure 38: Trend of Inter-Agency Transfers 2018 - 2018



Source: CHAG HR data 2018

Figure 39 above shows that over the past five years there has been a significant rise in the transfers out of CHAG relative to transfers-in to CHAG. In 2018, a total of 112 staff left the CHAG network whilst only 30 staff transferred in. Key amongst 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 always been difficult. It is, therefore, imperative to develop strategies that will attract and retain critical health professionals within the network. In 2019, CHAG will conduct retention study and use the findings to develop interventions to mitigate this trend.

KEY HR INTERVENTIONS UNDERTAKEN DURING THE YEAR

Dissemination of Human Resource Policies and Regulatory Documents

During the year under review, CHAG completed and launched Human Resource (HR) policy for the network. Additionally, CHAG disseminated documents aimed at improving the HR management and practice within the network. These include Health Sector Staffing Norm, CHAG HR Policy and Health Sector Conditions of service/Collective agreement. Hospital Administrators and In-Charges as well as Human Resource Managers of all CHAG member institutions participated in this dissemination workshop.

Human Resource Information and Management System

CHAG initiated the operationalization of HR Information and Management System (HRIMS). This intervention aims at providing accurate comprehensive HR data and information for CHAG in particular and the health sector in general.

These interventions undertaken in 2018 have the potential of building capacity of institutional managers for timely and informed decision making, HR investment, effective planning management, as well as HR advocacy. These will further strengthen CHAG HR system and practices for effective and efficient management of human resources for improved performance and productivity

HR Outlook for 2019

The year 2019 appears promising for CHAG. Several HR interventions will be carried out to further improve the HR system and practices for improved performance and productivity to enhance CHAG's contribution toward Ghana's achievement of Universal Health Coverage (UHC). The following are some of the interventions earmarked for 2019:

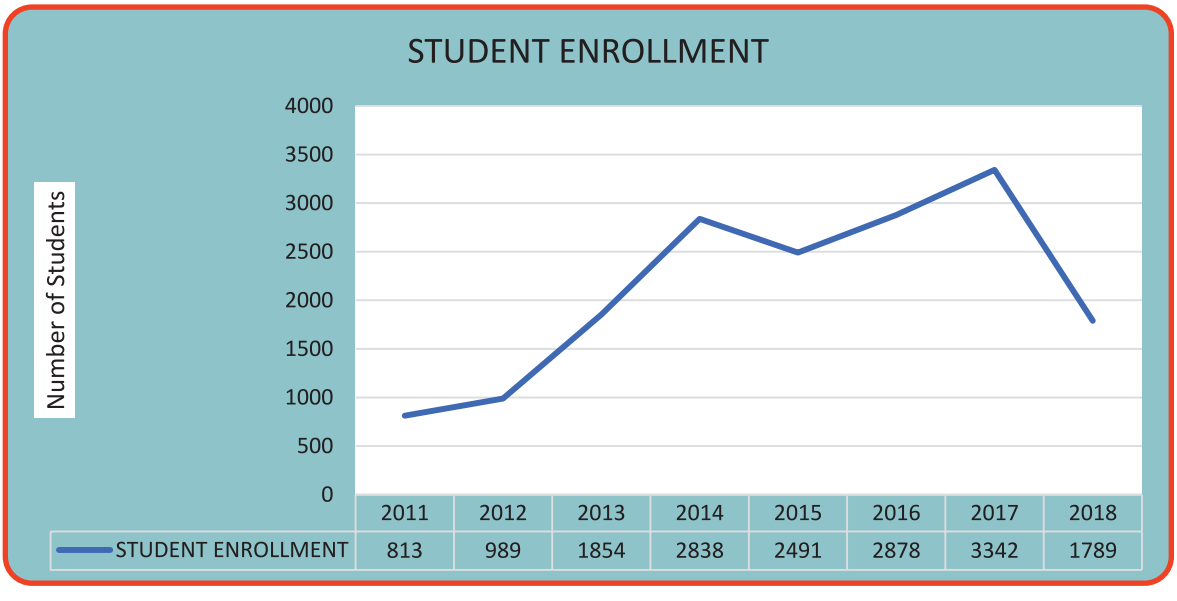
1. Development of Equity index and staff rationalization estimate to facilitate redeployment of staff with the CHAG network.
2. Completion of HRIMS for effective decision making, planning, management, advocacy and investment.
3. Electronic (online) recruitment system for timely and effective recruitment to enhance equitable distribution of health professionals.
4. Retention study to inform strategies to improve retention of health professionals in all CHAG facilities.
5. Harmonized orientation for all new staff to improve staff performance and conduct within the CHAG network.
6. Facilitating the development of strategic plans for all CHAG health training institutions for improved management and performance of the institutions.
7. Resourcing the Training and Development department of the CHAG HR Directorate for improving performance and productivity.

4.9 HEALTH TRAINING INSTITUTIONS

Investment in pre-service training and continuous professional education of staff is a considerable measure for attracting and 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 (CHTI) to nineteen (19). These CHTIs have performed creditably over the years. The graphs in figure 39 & 40 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 2018 was 1,789 compared to 3,342 in 2017. This represents 46.5% decline in students enrolment compared to that of 2017 enrolments as shown in figure 39 below.

Figure 39: Trend of Student Enrolment: 2011-2018



4.9.1 Student Pass rate

The average student pass rate has steadily declined over the past three years; 2015 to 2018. As depicted in figure 40, the student pass rate of CHAG Health Training Institutions is witnessing a declining trend from 98% in 2015 to 95% in 2016, and further to 80% in 2018; recording 18% decline over the three years. This development would need a review as basis for appropriate interventions in order to ensure excellence and professionalism in the recruitment and training of trainees in CHTIs.

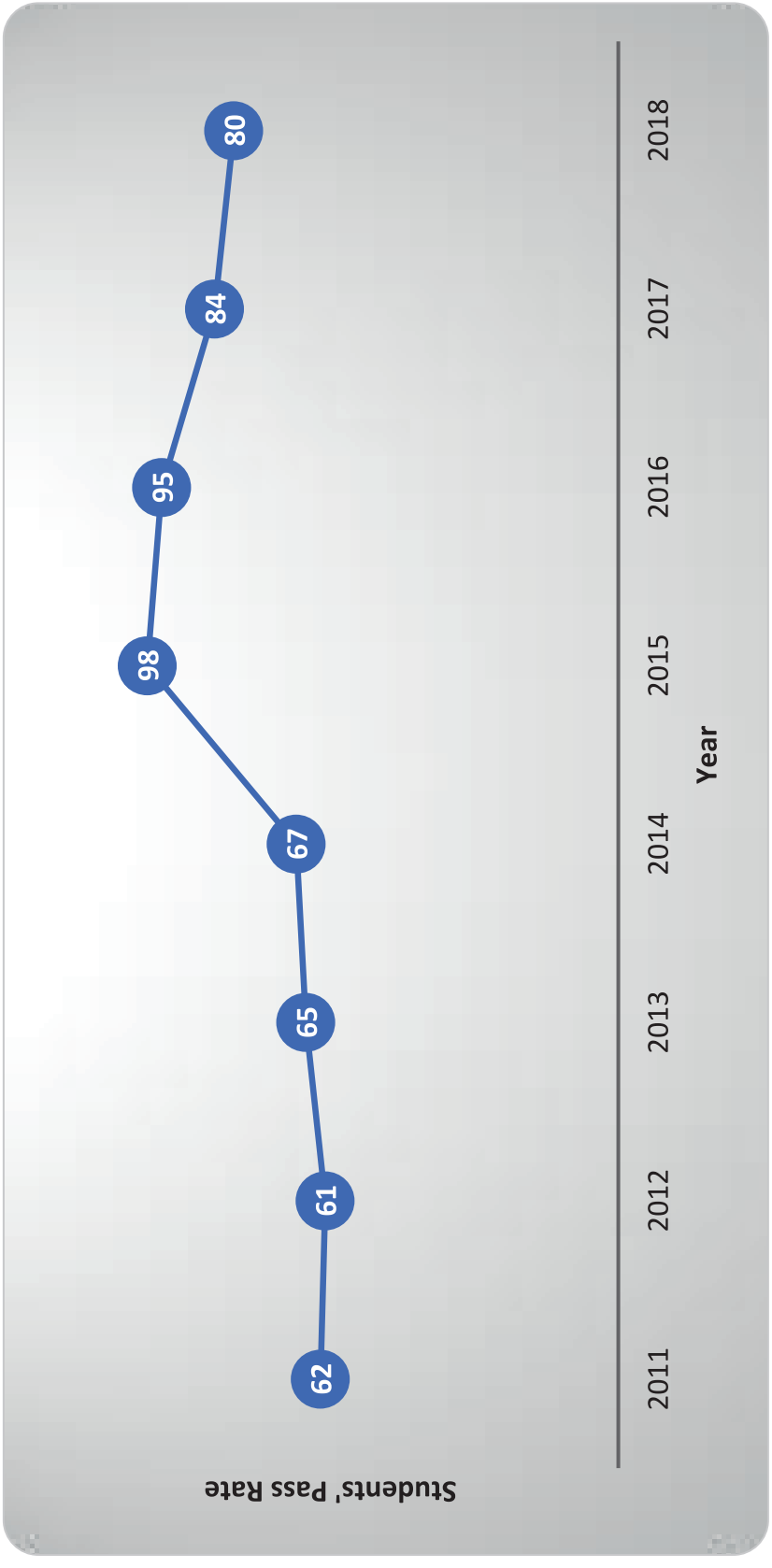


Figure 40: Trend of Student Pass Rate in CHAG Training Institutions, 2011-2018

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 20.

Table 20: 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 budgets and plans.
- Limited availability and inadequate use of ICT infrastructure and tools.

Currently, the CHAG network comprises 345 health facilities and 19 Health-Training institutions. Of the 345 facilities 168 are clinics, 95 are hospitals and 46 Health Centres. In all, the network accounts for 6.0% 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 42).

Although many CHAG facilities have maintained the level and range of services since they were established many years ago, some have also evolved into secondary and specialized units. There is need to upgrade many facilities to respond to the expansion of the catchment communities and the growing medical needs of the clientele. This will help minimize the demands made by Chiefs ,Opinion Leaders and politicians for 'government hospitals' in areas where CHAG facilities already exist.

In 2018, CHAG Network health coordinating units increased to 33 from 26 in 2017. Majority of CHAG facilities is owned by the Catholic Church (38.8%) followed by the Presbyterian Church (15.6%), the Seventh Day Adventist Church (9.3%) and Methodist church (7.2%). The Salvation Army and the Church of Pentecost each own about 4.5% of facilities. The remaining Church denominations each own less than 1% of CHAG facilities.

Thirty (30) per cent reduction in medicines prices

The NHIA reduced prices of medicines by 30% in the course of the year. The intent of reducing prices of medicines following the removal of VAT was to ensure cheaper prices for patients and to reduce cost for the NHIA. However, the unintended consequences of shortage of essential medicines and poor quality of care threaten the sustainability of the NHIS. Facilities suffered huge losses due to non-compliance by medicines suppliers.

Digital Supply Chain System for Medicines

In 2018, CHAG and PharmAccess partnered to address the shortfalls in medicines supply system in Ghana. These include high cost, poor quality and difficult access to medicines. Although the programme had been planned for the year, the 30% reduction in the prices of medicines on the NHIA medicines list supported the need for this digitally supported pooled procurement system.

Following the study that sought to explore the benefits of pooled procurement of medicines that was undertaken in June 2017, a series of engagements were done in 2018. The health coordinators, suppliers and other key stakeholders were engaged and made inputs into the programme. The programme is set to roll out in 2019 and is intended to address quality, access and cost issues associated with the CHAG supply chain system. Importantly, it would also extend credit to health facilities and the suppliers to address the funding gaps and thereby make medicines more affordable and safer.

Secondary Status for CHAG Facilities

CHAG continued to raise concern about the low tariffs paid for specialist services rendered by its 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 has to date refused to compensate CHAG hospitals for providing these services at the convenience of clients. The leadership of CHAG and NHIA have met to discuss a roadmap for resolving this challenge.

6.0 HEALTH FINANCING

Electronic Processing of Claims (Claim-It)

For the year under review, the NHIA sought the support of development partners to introduce electronic systems for the processing of claims at all levels. This is expected to minimize losses due to errors and to fast track vetting and reimbursement of claims. The system was also set to save facilities the cost and time to travel to the claims processing centres (CPCs) to submit claims.

CHAG was the first service provider agency to successfully rollout the Claim-It software that has features to correct claims at the facility level before claims are submitted to the NHIA. With support from PharmAccess International, all CHAG facilities were trained to implement Claim-It, a move that has been lauded by the NHIA. Facilities without computers were provided with laptops on hire purchase basis.

Stale Claims Policy

In 2018, the NHIA introduced a new policy that sought to punish providers that submit claims beyond the 90 days stipulated by the NHIA Act. Some CHAG facilities had their claims rejected whilst others were reduced by 50%. This included delayed submission and expiry of credentialing status of facilities. CHAG member institutions that were affected included Presbyterian Hospitals (Dormaa and Donkokrom), St John of God Hospital (Duayaw Nkwanta), Eikwe, Church of God Hospital, Essienimpong). The Secretariat was able to intervene to get seven of such affected CHAG facilities pardoned and their claims fully paid.

Non-Biometric Registration and Renewal

Insured clients who attend the hospital need to have a valid card to qualify for free care under the national health insurance scheme (NHIS). Such clients are to be validated by providers before service is provided. In 2018, the NHIA developed a simpler system of 5 codes to help validate the membership of clients. This validation can be done using a phone, the computer (off line) or via internet. Providers are required to embrace the system and sensitize their communities to take advantage of the new system to ensure that their cards are always active.

CHALLENGES

Electricity Bills

The cost of utilities (water and electricity) remained a big drain on the meagre resources of members. Some facilities were threatened with disconnection by the Electricity Company of Ghana. CMIs with prepaid meters had no choice but to pay utility bills from their IGF. The Secretariat engaged the Electricity Company of Ghana (ECG) to suspend the threat of disconnection with support from the Ministry of Health until the NHIA includes such charges in the tariffs.

NHIS Claims Reimbursement

CHAG facilities continued to suffer hardships as a result of delayed reimbursement. Only three months of 2018 claims were paid before the year ended. There is the need to find a lasting solution to the perennial delays in the payment of claims as it affects quality of care and reduces the morale of healthcare givers.

NHIS Tariffs

The service tariffs were not reviewed in 2018 and remained same as the previous years. Although the NHIA approved 20% flat upward adjustment across board pending the completion of detailed costing and actuarial studies, implementation was postponed to first quarter 2019.

In spite of the challenges with the NHIS, it remains a key social intervention that has improved access to health care. In Ghana's quest to achieve universal health coverage, the sector cannot do without the NHIS. It is therefore imperative that CHAG supports the sustainability of the NHIS.

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 21).

Table 21: Critical Network Challenges: Partnership for Health

- Weak collaboration with GHS and local authorities at the region, district and sub-district levels.
- The of challenge of balancing the autonomy, diversity and unity of the network.
- 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 2018 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 22).

Table 22: Critical Network Challenges: Health Research

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

Research works

During the year under review, some member institutions embarked on a number of researches. These included clinical control trial study on Mucuna pruriens study and survey on the availability of Parkinson's disease medicines in Ghana.

1) *Long-term Intake of Mucuna pruriens in Parkinson's Disease: A Multi-Centre, Non-Inferiority, Randomized, Controlled Clinical Trial*

Mucuna pruriens, a leguminous plant that grows in most tropical countries, has been noted to contain high concentrations of levodopa. The plant (figure 41) is locally known as "apea" and is found in many communities in Ghana. A research which is part of an international multi-centre randomized control study is being conducted in five countries (Italy, Bolivia, Zambia, Tanzania & Ghana) and aims to demonstrate the non-inferiority of long-term intake of Mucuna powder (in terms of efficacy and safety) compared to standard therapy with Levodopa and Benserazide tablets. In Ghana the study sites are the Richard Norvarti Hospital, Korle-Bu and Komfo Anokye Teaching Hospitals.

Richard Novarti Hospital, a CHAG facility in Sogakope, is the sole producer of Mucuna pruriens powder for all the 3 centers in Ghana. In 2018, a total of 22 patients were recruited into the Mucuna Trial. Richard Novarti has the highest number of patients on the Mucuna Arm of the study in all the 3 centers in Ghana. The recruitment of drug-naïve patients for the trial was made possible by active case finding within surrounding communities by the multi-disciplinary team of doctors, community and mental health nurses of the hospital. In the year under review, CHAG facilitated a meeting of the local Principal Investigator, Dr Momodou Cham and a consultant Neurologist from Korle-Bu Teaching Hospital with the Ghana Association of Parkinson's Disease Patients at Ghana Baptist Convention Centre headquarters in Accra. The Association members received education on their disease and where they could obtain support. Members were also briefed on the clinical trial study on the Mucuna pruriens.

The study is expected to be completed in 2020. It is hoped that the findings will improve the management of Parkinson's disease in Ghana, particularly for clients living in rural areas where CHAG facilities operate.

1) Availability of Parkinson's Disease in Ghana: A National Survey

Another study titled "Availability of Parkinson's disease in Ghana, a National Survey" that sought to determine the affordability, availability, geographic distribution and financing options of Parkinson's disease (PD) medication in Ghana, was conducted in 2018. In the study, a total of 60 public and 61 private pharmacies were sampled. Anticholinergics were the most available drug (41.3%) in both public and private pharmacy outlets, followed by DA-agonists (19.0%, mostly Bromocriptine) and Levodopa (11.0%).

The availability of Levodopa was low nationwide (11%), 3-fold greater in private vs. public pharmacies (14.6% vs. 5.0%, respectively). The Greater Accra (28.6%) and Ashanti (25.0%) regions had the highest Levodopa availability, while it was unavailable in 4 regions. Respondents stated cost of medicines and rareness/low awareness of PD as reasons for the low availability of medicines for PD.

All medications to treat PD were not affordable, with the only exception of anticholinergics. The cost of 100 Tablets of Levodopa/Carbidopa ranged from 35 (100+10mg) to 64 (100+25mg) USD.
There is no public health financing option for PD medications in Ghana, except for anticholinergics.

Despite being considered a cheap medication, the study found that Levodopa was neither widely available nor affordable in Ghana. Alternative low-cost formulations and public financing policies are urgently needed to improve access to PD medications. In this regard, the outcome of the Mucuna study will contribute significantly to Parkinson's disease treatment in Ghana.

Institutional Review Board (IRB)

An IRB that was formed in 2017 was strengthened in 2018. A number of protocols from various researchers across the network were received for ethical review. The committee has scheduled to meet every other month in the coming year to review protocols. It is anticipated that work of the committee will strengthen research in the CHAG network and will contribute to developing evidence-based policies and interventions.

Figure 41: Mucuna pruriens plant for the treatment of Parkinson's Disease

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 23 and 24). 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 23: 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 24: 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

Given the need to consolidate our gains, and address the changes and challenges identified in 2018, the following are pointers shall inform CHAG's strategic direction and operational activities in the ensuing years;

A. Service Delivery

1) The decline in Maternal Mortality is encouraging. 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 Sustainable Development Goals(SDGs)

2) Mental Health: the number of attempted suicides were quite high in 2018. It is important that facilities address the issues of suicides in communities. It may be important to set up counseling units in schools and churches to give platforms to address some of these issues. Equally so, the deaths for mentally ill persons were avoidable if families and communities could get involved.

3) OPD attendance and Bed occupancy rate witnessed appreciable increase, a signal that clients' timeless confidence in CHAG remains stable and encouraging. Some facility managers instituted some impactful interventions that yielded much results in terms of attendance and bed utilization. This included special clients' orientation and responsiveness to patients that helped to address the dwindling OPD attendance. These facilities include St. Dominic Hospital in Akwatia and Hawa Memorial Hospital at Osiem, all in the Eastern Region. The Managers of these facilities would be made to share their experiences with the wider network in due course

4) There is the need for quality and affordable medicines supply to the CHAG network to ensure that clients are getting the right medicines. This would mitigate the unintended effects of the 30% reduction in VAT policy by government, which has resulted in acute shortages of essential medicines in Hospitals, and referral of clients to private pharmacies.

5) Although Caesarean deliveries are still rising, it is associated with decreasing maternal deaths. It was reported in the course of the year (2018) that Caesarean deliveries were becoming epidemic globally. Various reasons have been assigned including health workers' desire to avert law suits that results from stillbirths from vaginal deliveries. Again, it may be an attempt to avoid long periods of monitoring clients who go through labour or the choice of client to avoid going through the labour pains. There are, however, a number of cases that are referred from lower level facilities which get to the CHAG hospitals with complications which warrant CS delivery. Research is needed to establish the real causes of CS deliveries in the network. 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%.ustainable and feasible interventions towards achieving the health-related SDGs.

B. Human Resources

1) There is an urgent need to recruit more pharmacists to boost the numbers within the network. The current eighty-four (84) pharmacists is woefully inadequate for the entire CHAG network. To improve pharmaceutical services to contribute to reducing the burden of AMR, pharmacists are crucial in CHAG institutions

2) High number of transfers from the CHAG network: there was a net transfer out of the CHAG network of 112 staff. The trend shows increasing numbers leaving for GHS and other agencies every year. Real causes of the transfers should be investigated locally by health managers. CHAG would conduct a study into the factors that affect retention of staff within the network. The results of the study would be shared with member Institutions. Again, the findings would help in developing a policy on recruitment of the various categories of staff.

3) A number of conflicts between managers and staff arose in the course of the year over religious and non-compliance with core values. Some Muslim workers in the CHAG network attempted putting Mosques in some hospitals, which generated serious community conflicts. There is the need for orienting all staff who are recruited into the network. Whilst CHAG does not discriminate on ground of religion in recruitment, it does not compromise on enforcing its core values, ethics and morals as well as its Christian denominational identities. That is what sets our institutions apart. Consequently, in 2019, CHAG will conduct regional orientations for all newly recruited staff to avert any potential conflict or misunderstanding of its core values and ethical norms.

4) 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, CHAG shall engage the MOH, Ghana College of Physician and Surgeons and GHS to resolve this issue in order not to deprive the rural areas of specialists.

5) 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 could enhance quality of service within the network.

C. Health Financing

1) Given the NHIA's policy decision not to accept manual submission of claims, All CHAG facilities shall be required to submit their NHIS claims via the claim-it platform. This is to avoid all the delays and avoidable errors with claims submission, that contribute to delays and deductions in validated reimbursable claims.

2) In 2019, NHIS would adjust it charges/tariffs. The adjustments notwithstanding, innovative ways for addressing financial security of CHAG institutions are to be sought. The number of staff whose salaries are paid from IGF should be considered. Salaries to staff on IGF constitute one of the high spending areas and attempts must be made to reduce this phenomenon. The Secretariat will advocate for financial clearance to be given to critical staff on IGF.

3) There is the need explore avenues to address the rising utility bills. With the withdrawal of government subsidies on electricity and water, CMIs are paying high bills of commercial rates, which the NHIS should take into consideration in their tariff structure determination. Whilst CHAG would engage the NHIA and MOH on the matter, an alternative sustainable energy sources including solar power and efficiency measures in the use of utilities shall be explored.

D. Community Ownership and Participation

1) It's clear re-igniting primary health care towards attaining UHC shall require active engagement with the community to promote ownership, participation and sustainability of health programmes. Hence, community engagement shall an important strategic goal in the years ahead.

E. Research

1) The work of CHAG Institutional Review Board (IRB) would be strengthened in 2019 to enhance research into health policy and practice. Training in basic research would be conducted across the CHAG Network to embed research culture and the institutionalization of research into the continuum of work.

F. Partnership

1) Partnership development is indispensable in the growth, development and sustainability of CHAG. Therefore, functional partnerships and networks should be explored to consolidate past gains and embrace the changes and challenges in the health sector with s

ANNEX 1: FACILITIES WITH HIGH OPD AND HOSPITAL ADMISSIONS

Figure 42: Top 10 Facilities with high OPD attendance, 2018

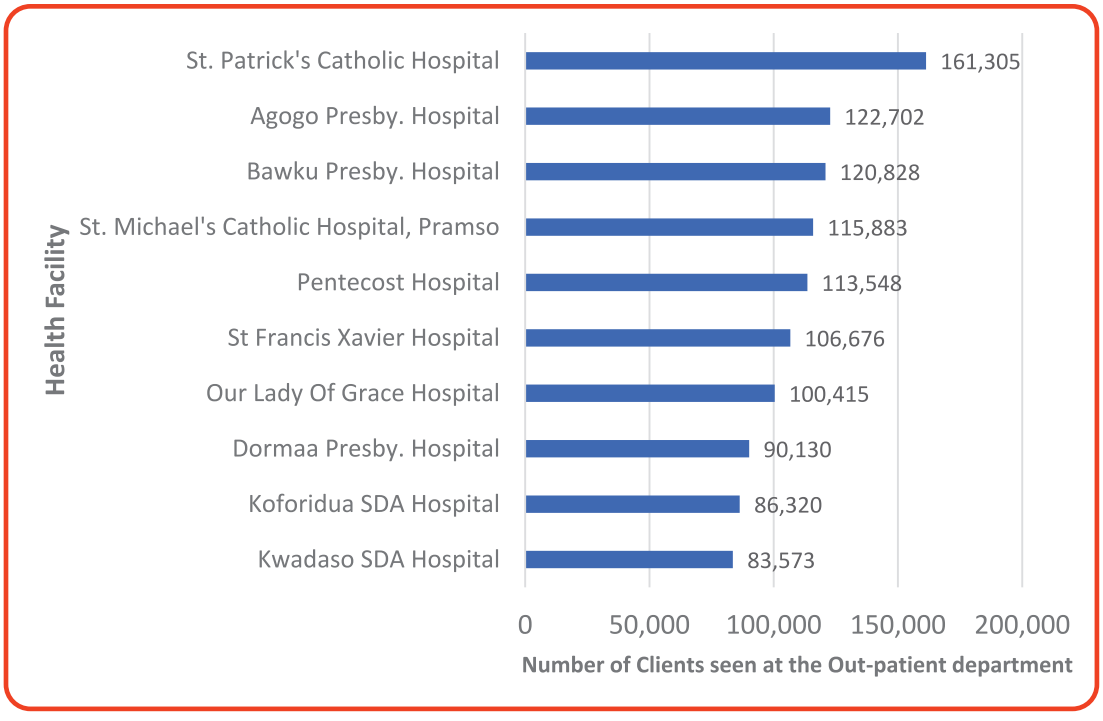
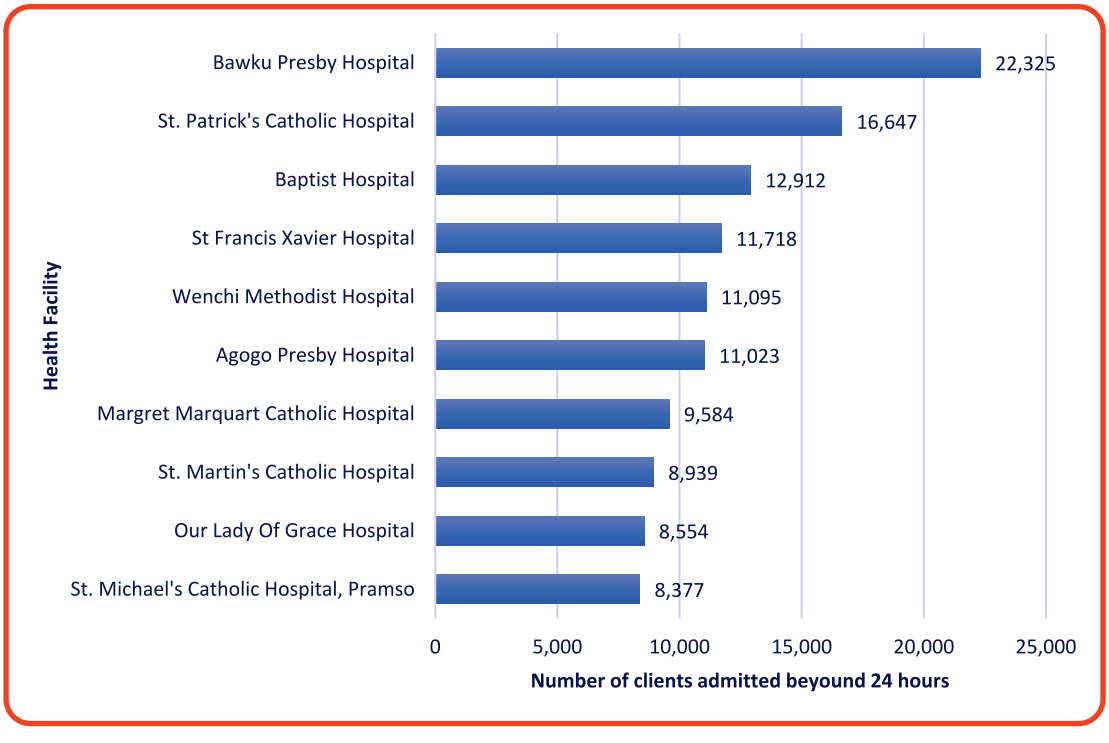


Figure 43: Top 10 Facilities with high hospital admissions, 2018



Annex 1: CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
1	St. Mary Anglican Clinic, Apenkra	Clinic	Ashanti	Anglican	Apenkra	
2	Kumasi Academy Clinic	Clinic	Ashanti	Baptist	Asokore Mampong	Asokore Mampong
3	Mother of God Clinic, Esaase Bontefufuo	Clinic	Ashanti	Catholic	Esaase	Amansie
4	St. Anthony Clinic, Sikaman	Clinic	Ashanti	Catholic	Sikaman	Amansie
5	Church of God Clinic & Maternity Home, Asempanaye	Clinic	Ashanti	Church of God	Asempaneye	Ofinso Norht
6	Abrafi Memorial Clinic, Brahabebome	Clinic	Ashanti	Church of God	Dichemso	
7	Adventist Hospital, Breman	Clinic	Ashanti	Seventh Day Adventist	Breman	Kumasi Metropolitan Assembly
8	True Faith Hospital, Kumawu Bodomase	Clinic	Ashanti	True Faith	Kumawu	
9	Tanoah Memorial Baptist Health Centre, Opuniase	Health Centre	Ashanti	Baptist	Opuniase	Asante Akyim North
10	Janie Speaks A.M.E Zion Hospital, Afrancho	Hospital	Ashanti	AME ZION	Offinso Afrancho	Offinso North
11	Calvery Charismatic Baptist Medical Centre, Atwima Mim	Hospital	Ashanti	Baptist	Atwima Mim	Atwima Nwabiagya
12	Living Spring Baptist Medical Centre	Hospital	Ashanti	Baptist	Atasomanso	Kumasi Metropolitant Assmbly
13	Baptist Medical Centre, Abuakwa	Hospital	Ashanti	Baptist	Abuakwa	Kumasi Metropolitan
14	Todah Hospital, Obuasi	Hospital	Ashanti	Church of God	Obuasi	
15	Dabaa Hope Hospital, Dabaa	Hospital	Ashanti	Harvesters Evangelistic Ministry	Dabaa	Atwima Nwabiagya

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
16	Akoma Memorial SDA Hospital, Kortwia-Abodom	Hospital	Ashanti	Seventh Day Adventist	Kortwia Abodom	Bekwai Municipal
17	Rev. Walker Medical Centre	Hospital	Ashanti	The Apostolic Church	Fumesua - Kokobra	Ejisu Juaben
18	True Faith Hospital, Bethel Juaben	Hospital	Ashanti	True Faith	Bethel	Ejisu Juaben
19	Seventh Day Adventist Midwifery Training School, Asamang	Training Institution	Ashanti	Seventh Day Adventist	Asamang	Sekyere South
20	Anglican Eye Clinic, Jachie	Clinic	Ashanti	Anglican	Jachie Pramso	Bosomtwe
21	Catholic Clinic, Oku Ejura	Clinic	Ashanti	Catholic	Oku via Ejura	Kwabre
22	Madonna Health Centre, Besease	Clinic	Ashanti	Catholic	Besease	Ejisu-Juaben
23	St. Anthony Ann Maternity Clinic, Donyina	Clinic	Ashanti	Catholic	Donyina	Ejisu Juaben
24	St. Anthony's Clinic, Anyinasu	Clinic	Ashanti	Catholic	Anyinasu	
25	St. Joseph's Clinic, Abira	Clinic	Ashanti	Catholic	Abira	Kwabre-East
26	St. Mary's Clinic, Yapesa	Clinic	Ashanti	Catholic	Yapesa	Adansi-East
27	St. Peter's Clinic/Maternity Home, Ntobroso	Clinic	Ashanti	Catholic	Ntobroso - via-Nkawie	Atwima-Mponua
28	St. Theresa's Clinic, Nope, Nope - Obrayentoboase	Clinic	Ashanti	Catholic	Nope - Obrayentoboase	Obuasi Municipal
29	St. Thomas Gen. & Maternity Clinic, Hiaa	Clinic	Ashanti	Catholic	Hiaa	Amansie Central
30	St. Vincent's Clinic, Drobonso	Clinic	Ashanti	Catholic	Drobonso	Drobonso
31	Church of Christ Mission Clinic, Bomso-Kumasi	Clinic	Ashanti	Church of Christ	Kumasi Bomso	Kumasi Metro
32	Church of God Clinic. Apaaso	Clinic	Ashanti	Church of God	Apaaso	Atwiwa Mponua
33	Church of God Hospital, Essienimpong	Clinic	Ashanti	Church of God	Essienimpong	Ejisu Juaben
34	Church of God Clinic, Ahwerewa	Clinic	Ashanti	Church of God	Ahwerewa	

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
35	Methodist Medical Centre, Amakom	Clinic	Ashanti	Methodist	Amakom	Bosomtwe
36	Methodist Medical Centre, Aburaso	Clinic	Ashanti	Methodist	Aburaso	Atwima Kwanwoma
37	Methodist Medical Centre, Apagya	Clinic	Ashanti	Methodist	Apagya	Apagya
38	Methodist Medical Centre, Bebu - Anyiaem	Clinic	Ashanti	Methodist	Bebu-Ahyiaem	Atwima Kwanwoma
39	Methodist Medical Centre, Brodekwano	Clinic	Ashanti	Methodist	Brodekwano	Bosomtwe
40	Methodist Medical Centre, Nyameani	Clinic	Ashanti	Methodist	Nyameani	Bosomtwe
41	Methodist Medical Centre, Senchi	Clinic	Ashanti	Methodist	Senchi	Afigya East
42	Methodist Medical Centre, Tafo	Clinic	Ashanti	Methodist	Tafo	Tafo
43	Methodist Medical Centre, Adum Kumasi	Clinic	Ashanti	Methodist	Kumasi Metro	Adum Kumasi
44	Presbyterian Clinic, Abasua	Clinic	Ashanti	Presbyterian	Abasua	Sekyere East
45	Presbyterian Clinic, Mesewam	Clinic	Ashanti	Presbyterian	Mesewam	Ejisu Juaben
46	Saviour Church Clinic, Bonwire	Clinic	Ashanti	Saviour Church	Bonwire	
47	Saviour Church Clinic, Subriso	Clinic	Ashanti	Saviour Church	Subriso	
48	Seventh Day Adventist Clinic, Anyinasuso	Clinic	Ashanti	Seventh Day Adventist	Anyinasuso	Offinso
49	Seventh Day Adventist Clinic, Apaah	Clinic	Ashanti	Seventh Day Adventist	Apaah	Mampong
50	Seventh Day Adventist Clinic, Konkoma	Clinic	Ashanti	Seventh Day Adventist	Konkoma	Bosumtwi

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
91	St. Anthony's clinic, Badu	Clinic	Brong Ahafo	Catholic	Badu	Wenchi West
92	Our Lady of Fatima Health Centre, Abease	Clinic	Brong Ahafo	Catholic	Prang/Abease	Atebubu
93	Don Bosco Clinic, Tuinso	Clinic	Brong Ahafo	Catholic	Tuinso	Tain
94	St. Dominic Clinic, Cherembo	Clinic	Brong Ahafo	Catholic	Cherembo	
95	Pope Francis Clinic, Komfourkrom	Clinic	Brong Ahafo	Catholic	Komfourkrom	
96	Methodist Medical Centre, Kwakuanya	Clinic	Brong Ahafo	Methodist	Kwakuanya	Dormaa West
97	Methodist Medical Centre, Yawsae	Clinic	Brong Ahafo	Methodist	Yawsae	Sunyani Municipal
98	Methodist Medical Centre, Asuakwaa	Clinic	Brong Ahafo	Methodist	Asuakwaa	Sunyani West
99	Methodist Medical Centre, Dagyamen	Clinic	Brong Ahafo	Methodist	Dagyamen	Tano North
100	Methodist Medical Centre, Kyerekyewere	Clinic	Brong Ahafo	Methodist	Kyekyewere	
101	Presbyterian Clinic, Antwirifo	Clinic	Brong Ahafo	Presbyterian	Antwirifo	Dormaa Central
102	Presbyterian Clinic, Buokrukruwa	Clinic	Brong Ahafo	Presbyterian	Buokrukruwa	Tano North
103	Presbyterian Clinic, Gyankufa	Clinic	Brong Ahafo	Presbyterian	Gyankufa	Dormaa Central
104	Presbyterian Clinic, Tanoboase	Clinic	Brong Ahafo	Presbyterian	Tanoboase	Techiman
105	Presbyterian Clinic, Yaakrom	Clinic	Brong Ahafo	Presbyterian	Yaakrom	Dormaa East

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
71	Presbyterian Hospital, Agogo, Ashanti-Akim	Hospital	Ashanti	Presbyterian	Agogo	Asante Akim North
72	HART Adventist Hospital, Ahinsan	Hospital	Ashanti	Seventh Day Adventist	Ahinsan	Kumasi Metropolitan Assembly
73	Seventh Day Adventist Hospital, Asamang	Hospital	Ashanti	Seventh Day Adventist	Asamang	Sekyere South
74	Seventh Day Adventist Hospital, Dominase	Hospital	Ashanti	Seventh Day Adventist	Dominase	Amansie East
75	Seventh Day Adventist Hospital, Kwadaso-Kumasi	Hospital	Ashanti	Seventh Day Adventist	Kwadaso	Kumasi Metro Ass.
76	Seventh Day Adventist Hospital, Namong	Hospital	Ashanti	Seventh Day Adventist	Namong	Offinso North
77	Seventh Day Adventist Hospital, Obuasi	Hospital	Ashanti	Seventh Day Adventist	Obuasi	Obuasi Municipal
78	Seventh Day Adventist Hospital, Wiamoasi-Ashanti	Hospital	Ashanti	Seventh Day Adventist	Wiamoase	Sekyere South
79	Bryant Mission Hospital, Obuasi-Adansi	Hospital	Ashanti	The Church of Pentecost	Obuasi	Obuasi Municipal
80	Presbyterian PHC , Agogo, Ashanti-Akim	Primary Health Car	Ashanti	Presbyterian	Agogo	Asante Akim North
81	St. Michael's Midwifery Training College, Pramso	Training Institution	Ashanti	Catholic	Pramso	Bosomtwe
82	St. Patrick's Midwifery School, Maase-Offinso	Training Institution	Ashanti	Catholic	Maase-Offinso	Offinso South
83	Nursing & Midwifery Training College, Agogo	Training Institution	Ashanti	Presbyterian	Agogo	Asante Akim North
84	Seventh Day Adventist Nursing and Midwifery Training School, Kwadaso	Training Institution	Ashanti	Seventh Day Adventist	Kwadaso	Kumasi Metro Ass.
85	Holy Spirit Clinic, Dantano	Clinic	Brong Ahafo	Catholic	Tano	Tano
86	St. Joseph's Clinic, Wenchi Koasi	Clinic	Brong Ahafo	Catholic	Wenchi	Wenchi
87	St. Peter's Clinic, Donkorkrom	Clinic	Brong Ahafo	Catholic	Tano	Tano
88	St. Matthews Clinic, Ampenkro	Clinic	Brong Ahafo	Catholic	Wenchi	Wenchi
89	St. Jame's Clinic, Abesim	Clinic	Brong Ahafo	Catholic	Abesim	Sunyani East
90	St. Alban's Clinic(The Refugee Camp Clinic), Fetentaa	Clinic	Brong Ahafo	Catholic	Fetentaa	Berekum West

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
51	Seventh Day Adventist Clinic, Nobewam	Clinic	Ashanti	Seventh Day Adventist	Nobewam	Ejisu-Juaben
52	Salvation Army Clinic, Wiamoase	Clinic	Ashanti	The Salvation Army	Wiamoase	Sekyere South
53	Anglican Health Centre, Tano-Odumase	Health Centre	Ashanti	Anglican	Tano-Odumase	Atwima Mponua
54	Sacred Heart Health Centre, Bepoase	Health Centre	Ashanti	Catholic	Maase-Offinso	Sekyere South
55	St. John's Health Centre, Domeabra	Health Centre	Ashanti	Catholic	Domeabra	Ahafo Ano South
56	St. Louis Health Centre, Bodwesango	Health Centre	Ashanti	Catholic	Bodwesango	Adansi North
57	St. Luke's Health Centre, Seniagya	Health Centre	Ashanti	Catholic	Seniagya	Sekyere East
58	Central Charismatic Baptist Hospital, Gyinase	Hospital	Ashanti	Baptist	Gyinase	Kumasi Metropolitant Assmbly
59	Benito Menni Hospital, Dompoase	Hospital	Ashanti	Catholic	Dompoase	Adansi-West
60	Hopxchange Medical Centre, Santasi	Hospital	Ashanti	Catholic	Santasi	Kumasi Metro
61	Pope John Paul II Medical Centre, Jamasi	Hospital	Ashanti	Catholic	Jamasi	Adwira
62	St. Edward's Hospital, Dwinyama	Hospital	Ashanti	Catholic	Dwinyama	Ahafo Ano South
63	St. Martin's Hospital, Agroyesum	Hospital	Ashanti	Catholic	Agroyesum	Amansie West
64	St. Michael's Hospital, Pramso	Hospital	Ashanti	Catholic	Pramso	Bosomtwe
65	St. Patrick's Hospital, Maase-Offinso	Hospital	Ashanti	Catholic	Maase-Offinso	Offinso South
66	St. Peter's Hospital, Jacobu	Hospital	Ashanti	Catholic	Jacobu	Amansie Central
67	Power House Hospital, Old Tafo	Hospital	Ashanti	Full Gospel	Old Tafo	Kumasi Metropolitant Assmbly
68	Global Evangelical Mission Hospital, Apromase	Hospital	Ashanti	Global Evangelical	Apromase	Ejisu Juaben
69	St. Luke's Hospital, Kasei via Ejura	Hospital	Ashanti	Luke Society Missions	Kasei via Ejura	Ejura Sekyeredumase
70	Methodist Faith Healing Hospital, Ankaase	Hospital	Ashanti	Methodist	Ankaase	Afigya Kwabre

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
106	Pentecost Clinic, Kasapin	Clinic	Brong Ahafo	The Church of Pentecost	Kasapin	Asunafo North
107	St. Joseph's College of Education Health Centre, Bechem	Health Centre	Brong Ahafo	Catholic	Bechem	Bechem
108	Presbyterian Health Centre, Jenjemireja	Health Centre	Brong Ahafo	Presbyterian	Jenjemireja	Jaman South
109	Presbyterian Health Centre, Kyeremasu	Health Centre	Brong Ahafo	Presbyterian	Kyeremasu	Dormaa West Municipal
110	Presbyterian Health Centre, Aboabo	Health Centre	Brong Ahafo	Presbyterian	Aboabo	Dormaa West Municipal
111	Presbyterian Health Centre, KwadwoKumikrom	Health Centre	Brong Ahafo	Presbyterian	KwadwoKumikrom	Dormaa West Municipal
112	Presbyterian Health Centre, Kwamesua	Health Centre	Brong Ahafo	Presbyterian	Kwamesua	Dormaa West Municipal
113	Presbyterian Health Centre, Suma Ahenkro	Health Centre	Brong Ahafo	Presbyterian	Suma Ahenkro	Dormaa West Municipal
114	Holy Family Hospital, Berekum	Hospital	Brong Ahafo	Catholic	Berekum	Berekum
115	Holy Family Hospital, Techiman	Hospital	Brong Ahafo	Catholic	Techiman	Techiman
116	Mathias Hospital, Yeji	Hospital	Brong Ahafo	Catholic	Yeji	Pru
117	St. Elizabeth Hospital, Hwidiem	Hospital	Brong Ahafo	Catholic	Hwidiem	Asutifi-Hwidem
118	St. John of God Hosp., Duayaw-Nkwanta	Hospital	Brong Ahafo	Catholic	Nkwanta Duayaw	Tano North
119	St. Mary's Hospital, Drobo	Hospital	Brong Ahafo	Catholic	Drobo	Jaman South
120	St. Theresa's Hospital, Nkoranza	Hospital	Brong Ahafo	Catholic	Nkoranza	Nkoranza South
121	Methodist Hospital, Wenchi	Hospital	Brong Ahafo	Methodist	Wenchi	Wenchi
122	Presbyterian Hospital, Dormaa-Ahenkro	Hospital	Brong Ahafo	Presbyterian	Dormaa Ahenkro	Jaman South
123	Seventh Day Adventist Hospital, Sunyani	Hospital	Brong Ahafo	Seventh Day Adventist	Sunyani	Sunyani Municipal
124	Valley View University Hospital, Techiman	Hospital	Brong Ahafo	Seventh Day Adventist	Techiman	Techiman
125	Dormaa Presby PHC , Dormaa-Ahenkro	Primary Health Car	Brong Ahafo	Presbyterian	Dormaa Ahenkro	Dormaa West Municipal

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
126	Holy Family Midwifery/Nurses Training College, Berekum	Training Institution	Brong Ahafo	Catholic	Berekum	Berekum
127	Holy Family Nursing Training College, Techiman	Training Institution	Brong Ahafo	Catholic	Techiman	Techiman
128	St. John of God College of Health, Duayaw Nkwanta	Training Institution	Brong Ahafo	Catholic	Duayaw Nkwanta	Tano North
129	Presbyterian Midwifery Training School, Dormaa Ahenkro	Training Institution	Brong Ahafo	Presbyterian	Dormaa Ahenkro	Dormaa Central
130	Presbyterian Midwifery Training School, Duayaw Nkwanta	Training Institution	Brong Ahafo	Presbyterian	Duayaw Nkwanta	Tano
131	Infant Jesus Catholic Clinic, Kasoa	Clinic	Central	Catholic	Kasoa	Awutu Senya East
132	Seventh Day Adventist Clinic, Dominase	Clinic	Central	Seventh Day Adventist	Denkyira Dominase	Upper Denkyira West
133	Pentecost Clinic, Ayanfuri	Clinic	Central	The Church of Pentecost	Ayanfuri	Upper Denkyira East
134	Pentecost Community Clinic, Twifu Agona	Clinic	Central	The Church of Pentecost	Twifu Agona	Twifo Hemang Lower Denkyira
135	Salvation Army Clinic, Agona-Duakwa	Clinic	Central	The Salvation Army	Agona Duakwa	Agona East
136	Bishop Ackon Memorial Christian Eye Centre, Cape Coast	Eye Clinic	Central	Anglican	Cape Coast	Cape Coast
137	Presbyterian Church Health Center, Assin-Praso	Health Centre	Central	Presbyterian	Assin Praso	Assin North
138	Presbyterian Health Centre, Assin Nsuta	Health Centre	Central	Presbyterian	Assin Nsuta	Assin South
139	Salvation Army Health Centre, Ajumako-Ochiso	Health Centre	Central	The Salvation Army	Ajumako Baa	Ajumako Enyan Essiem
140	Mercy Women's Hospital, Mankessim	Hospital	Central	Catholic	Mankessim	Cape Coast

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
141	Our Lady of Grace Hospital, Breman-Asikuma	Hospital	Central	Catholic	Breman Asikuma	Asikuma Odobeng Brakwa Dist Ass.
142	St. Francis Xavier Hospital, Assin-Fosu	Hospital	Central	Catholic	Assin Fosu	Assin North Municipal
143	St. Gregory Catholic Hospital, Gomoa Budumburam	Hospital	Central	Catholic	Budumburam	Gomoa East
144	St. Luke Catholic Hospital, Apam	Hospital	Central	Catholic	Apam	Gomoa West
145	Hope Christian Hospital, Gomoa Feteh	Hospital	Central	Church of Christ	Gomoa	Gomoa
146	Salvation Army Polyclinic, Baa	Polyclinic	Central	The Salvation Army	Baa	Ajumako Enyan Essiem
147	The Salvation Army Rehabilitation Centre, Duakwa	Rehabilitation Cent	Central	The Salvation Army	Duakwa	
148	Catholic Clinic and Maternity, Akim Swedru	Clinic	Eastern	Catholic	Akim Swedru	Birim South
149	Holy Spirit Clinic & Maternity Home, Kwasi Fante	Clinic	Eastern	Catholic	Kwasi Fante	Kwahu North/Afram Plains
150	Notre Dame Clinic, Nsawam	Clinic	Eastern	Catholic	Nsawam	Akwapim South
151	St. John's Clinic/Maternity, Akim Ofoase	Clinic	Eastern	Catholic	Akim Ofoase	Akyemansa
152	St. Joseph Clinic & Maternity Home, Kwahu-Tafo	Clinic	Eastern	Catholic	Kwahu Tafo	Kwahu South
153	St. Michael's Catholic Clinic/Maternity, Ntronang-Akim	Clinic	Eastern	Catholic	Akim Ntronang	Birim North
154	St. Monica's Clinic and Maternity, Akim Sekyere	Clinic	Eastern	Catholic	Akim Sekyere	East Akim Municipal Ass.
155	Orthopaedic Training Centre, Adoagyiri	Clinic	Eastern	Catholic	Adoagyiri	Akwapim South
156	Methodist Medical Centre, Hweehwee	Clinic	Eastern	Methodist	Hweehwee	Kwahu East
157	Methodist Medical Centre, Osuben	Clinic	Eastern	Methodist	Osuben	Kwahu Praso
158	Salvation Army Clinic, Akim-Wenchi	Clinic	Eastern	The Salvation Army	Akim Wenchi	Kwaebibirem
159	Salvation Army Clinic, Anum	Clinic	Eastern	The Salvation Army	Anum	Asuogyaman
160	Salvation Army Clinic, Begoro	Clinic	Eastern	The Salvation Army	Begoro	Fanteakwa

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	LOCATION	DENOMINATION	DISTRICT
162	Holy Rosary Health Centre, Amankwakrom	Health Centre	Eastern	Catholic	Amankwakrom	Kwahu Afram Plains North
163	Presbyterian Health Centre, Abetifi	Health Centre	Eastern	Presbyterian	Abetifi	Kwahu South
164	Presbyterian Health Centre, Ekye	Health Centre	Eastern	Presbyterian	Ekye	Kwahu North
165	Presbyterian Health Centre, Kom- Aburi	Health Centre	Eastern	Presbyterian	Kom - Aburi	Akuapem South
166	Presbyterian Health Centre, Kwahu Praso	Health Centre	Eastern	Presbyterian	Kwahu Praso	Kwahu South
167	Presbyterian Health Centre, Obregyima	Health Centre	Eastern	Presbyterian	Obregyima	Kwahu East
168	Tease Presby Health Centre, Afram Plains	Health Centre	Eastern	Presbyterian	Tease	Kwahu North
169	Holy Family Hospital, Nkawkaw	Hospital	Eastern	Catholic	Nkawkaw	Kwahu South
170	St. Dominic Hospital, Akwatia	Hospital	Eastern	Catholic	Akwatia	Kwaebibirem
171	St. Joseph's Hospital, Koforidua	Hospital	Eastern	Catholic	Koforidua	New Juaben
172	St. Martin's de Porres Hospital, Agomanya	Hospital	Eastern	Catholic	Agomanya	Lower Manya Krobo
173	Presbyterian Hospital, Donkorkrom	Hospital	Eastern	Presbyterian	Donkorkrom	Kwahu North
174	Hawa Mem. Saviour Hospital, Akim-Osiem	Hospital	Eastern	Saviour Church	Akim Osiem	East Akim Municipal Ass.
175	Seventh Day Adventist Hospital, Koforidua	Hospital	Eastern	Seventh Day Adventist	Koforidua	New Juaben
176	Presbyterian Primary Health Centre, Tease	Primary Health Car	Eastern	Presbyterian	Tease	Afram Plains
177	The Salvation Army Rehabilitation Centre, Begoro	Rehabilitation Cent	Eastern	The Salvation Army	Begoro	Fanteakwa
178	Holy Family Nurses Training College, Nkawkaw	Training Institution	Eastern	Catholic	Nkawkaw	Kwahu South
179	Bro. Tarcisius Prosthetics and Orthotics Training College, Nsawam	Training Institution	Eastern	Catholic	Nsawam	Akwapim South
180	Hawa Mem Savour NTC, Osiem	Training Institution	Eastern	Saviour Church	Akim Osiem	East Akim Municipal Ass.

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
181	St. John of God Clinic, Amrahia	Clinic	Greater Accra	Catholic	Amrahia	Adentan Municipal
182	Sight for Africa Eye Clinic, Darkuman	Clinic	Greater Accra	Run Mission	Darkuman	Accra Metro. Assembly
183	Holy Bridge Clinic and Maternity Home, New Mmai	Clinic	Greater Accra	The Apostles Continuation	New Nmai, Near Ashaley Bot	La Nkwantanang Madina
184	Tree of Life Medical Centre	Clinic	Greater Accra	Theo Vision	Accra	
185	Emmanuel Eye/ Medical Centre, East Legon	Eye Hospital	Greater Accra	Luke Society Missions	East Legon	Ga East
186	Salvation Army Health Centre, Anidasofie	Health Centre	Greater Accra	The Salvation Army	Mamobi	
187	Urban Aid Health Centre, Mamobi	Health Centre	Greater Accra	The Salvation Army	Mamobi	Accra Metro. Assembly
188	St. Andrew's Catholic Hospital, Kordiabe	Hospital	Greater Accra	Catholic	Kordiabe	Dangme West
189	Faith Evangelical Mission Hospital, Bubuashie	Hospital	Greater Accra	Faith Evangelical Mission	Bubuashie	
190	St. Martin Memorial Hospital, Shukura	Hospital	Greater Accra	King of Kings	Shukura	Sh
191	St. Martin Memorial Hospital, Ashaiman	Hospital	Greater Accra	King of Kings	Ashaiman	
192	St. Martin Memorial Hospital, Dansoman	Hospital	Greater Accra	King of Kings	Dansoman	
193	Lighthouse Mission Hospital, North Kaneshie	Hospital	Greater Accra	Lighthouse Mission	North Kaneshie	Accra Metro. Assembly
194	Manna Mission Hosp, Teshie-Nungua	Hospital	Greater Accra	Manna Mission	Teshie-Nungua	Kpeshie
195	Valley View Adventist Hospital, Oyibi	Hospital	Greater Accra	Seventh Day Adventist	Oyibi	
196	Seventh Day Adventist Hospital, New Gbawe	Hospital	Greater Accra	Seventh Day Adventist	New Gbawe	Ga South
197	Pentecost Hospital, Madina	Hospital	Greater Accra	The Church of Pentecost	Madina	Ga East

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
198	Donald Richard Memorial Health Centre, Nakwabi	Clinic	Northern	Catholic	Sawla – Tuna Kalba	Sawla - Tuna - Kalba
199	Catholic Clinic, Barchabordo	Clinic	Northern	Catholic	Barchabordo	Mion
200	Catholic Clinic/PHC, Salaga	Clinic	Northern	Catholic	Salaga	East Gonja
201	Holy Cross Maternity Home and Clinic, Sambuli	Clinic	Northern	Catholic	Sambuli	Saboba
202	St. Joseph Clinic & Mat Home, Chamba	Clinic	Northern	Catholic	Chamba	Nanumba North
203	Church of Christ Mission Clinic, Yendi	Clinic	Northern	Church of Christ	Yendi	Yendi
204	EP Church Clinic Maternity Home, Blajai	Clinic	Northern	Evangelical Presbyterian	Blajai	Kpandai
205	E. P. Church Clinic, Wapuli	Clinic	Northern	Evangelical Presbyterian	Wapuli	Saboba
206	Fame Clinic, Ekumdi	Clinic	Northern	FAME	Ekumdi	Kpandai
207	Fame Clinic, Loagri	Clinic	Northern	FAME	Loagri	Yagaba-Kubore
208	Fame Clinic, Makango	Clinic	Northern	FAME	Makango	East Gonja
209	Fame Clinic, Tobali/Tatindo	Clinic	Northern	FAME	Tobali/Tatindo	Tatale-Sanguli
210	Fame Clinic, Yezesi	Clinic	Northern	FAME	Yezesi	Mamprugu-Moadugri
211	Methodist Medical Centre, Zanzugu Yipala	Clinic	Northern	Methodist	Zanzugu Yipala	East Gonja
212	Presbyterian Clinic, Fooshegu	Clinic	Northern	Presbyterian	Fooshegu	Tamale Metropolis
213	Assemblies of God Health Centre, Nakpanduri	Health Centre	Northern	Assemblies of God	Nakpanduri	Bunkpurugu Yonyoo
214	Martyrs of Uganda Health Centre, Bole	Health Centre	Northern	Catholic	Bole	Bole
215	Good Shepherd Health Centre, tuna	Health Centre	Northern	Catholic	Tuna	Sawla-Tuna-Kalba
216	Our Lady of Rocio Health Centre, Walewale	Health Centre	Northern	Catholic	Walewale	West Mamprusi
217	St. Joseph's Health Centre, Kalba	Health Centre	Northern	Catholic	Kalba	Sawla-Tuna-Kalba
218	Kuwani Health Centre, Kuwani	Health Centre	Northern	Presbyterian	Kuwani	East Gonja
219	Presbyterian Health Centre, Langbinsi-Gambaga	Health Centre	Northern	Presbyterian	Langbinsi	East Mamprusi
220	Presbyterian Health Centre, Loloto	Health Centre	Northern	Presbyterian	Loloto	

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
221	Assemblies of God Hospital, Saboba	Hospital	Northern	Assemblies of God	Saboba	Saboba
222	The Kings Medical Centre, Bontanga	Hospital	Northern	Assemblies of God	Bontanga	Tolon-Kunbungu
223	Baptist Medical Centre, Nalerigu	Hospital	Northern	Baptist	Nalerigu	East Mamprusi
224	Tatale District Hospital, Tatale	Hospital	Northern	Catholic	Tatale	Zabzugu Tatale
225	West Gonja Hospital, Damango	Hospital	Northern	Catholic	Damango	West Gonja
226	Church of God Hospital, Banda Nkwanta	Hospital	Northern	Church of God	Banda-Nkwanta	Bole
227	Evangelical Church of Ghana Hospital, Kpandai	Hospital	Northern	ECG Mission	Kpandai	Kpandai
228	Seventh Day Adventist Hospital, Tamale	Hospital	Northern	Seventh Day Adventist	Tamale	Tamale Metro
229	St. Lucy Polyclinic, Tamale	Poly Clinic	Northern	Catholic	Tamale	Tamale Metro - West Dagomba
230	Presbyterian PHC, Salaga	Primary Health Car	Northern	Presbyterian	Salaga	
231	Presbyterian CHPS Compound, Tolla	CHPS	Upper East	Presbyterian	Tolla	Talensi
232	Anglican Clinic, Yelwoko	Clinic	Upper East	Anglican	Yelwoko	Bawku West
233	Kayeresi Clinic, Kayeresi	Clinic	Upper East	Catholic	Kayeresi	Talensi
234	St. Martin's PHC/ Maternity Clinic, Biu	Clinic	Upper East	Catholic	Biu	Kassena-Nakana
235	St. Joseph the Worker Clinic, Guabuliga	Clinic	Upper East	Catholic	Guabuliga	East Mamprusi
236	St. Patrick's Clinic, Wulungu	Clinic	Upper East	Catholic	Wulungu	East Mamprusi
237	Villa Regina Maternity Clinic, Gwenia	Clinic	Upper East	Catholic	Gwenia	Kassena-Nankana West
238	Fame Clinic, Benwoko	Clinic	Upper East	FAME	Benwoko	Garu
239	Presbyterian Clinic, Namolgo	Clinic	Upper East	Presbyterian	Namolgo	Talensi
240	Presbyterian Regional Eye Centre, Bolgatanga	Eye Clinic	Upper East	Presbyterian	Bolgatanga	Bolgatanga Municipal
241	Immaculate Conception Health Centre, Kongo	Health Centre	Upper East	Catholic	Kongo	Kaleo-Nadowli
242	Martyrs of Uganda Health Centre, Sirigu	Health Centre	Upper East	Catholic	Sirigu	Kassena-Nakana
243	St. Joseph Health Centre, Nakolo	Health Centre	Upper East	Catholic	Nakolo	Kassena-Nakana
244	St. Theresa Health Centre, Zorko	Health Centre	Upper East	Catholic	Zorko	Bongo
245	Presbyterian Health Centre, Siniensi	Health Centre	Upper East	Presbyterian	Siniensi	Talensi
246	Presbyterian Health Centre, Sumaduri	Health Centre	Upper East	Presbyterian	Sumaduri	Garu Tempane
247	Presbyterian Health Centre, Widana	Health Centre	Upper East	Presbyterian	Widana	Bawku Municipal

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
248	Presbyterian Health Centre, Garu	Health Centre	Upper East	Presbyterian	Garu	Garu -Tempane
249	Atiaba Memorial Baptist Medical Centre	Hospital	Upper East	Baptist	Sandema	Builsa North
250	St. Lucas Hospital, Wiaga	Hospital	Upper East	Catholic	Wiaga	Builsa
251	Presbyterian Hospital, Bawku	Hospital	Upper East	Presbyterian	Bawku	Bawku Municipal
252	Presbyterian Orthopaedic Hospital, Bawku	Hospital	Upper East	Presbyterian	Bawku	Bawku Municipal
253	Presbyterian Health Centre, Woriyanga	Primary Health Car	Upper East	Presbyterian	Woriyanga	Garu -Tempane
254	Presbyterian PHC, Bawku	Primary Health Car	Upper East	Presbyterian	Bawku	Bawku Municipal
255	Presbyterian PHC, Bolgatanga	Primary Health Car	Upper East	Presbyterian	Bolgatanga	Bolgatanga Municipal
256	Presbyterian PHC, Sandema	Primary Health Car	Upper East	Presbyterian	Sandema	Builsa
257	Presbyterian Nurses Training College, Bawku,	Training Institution	Upper East	Presbyterian	Bawku	Bawku Municipal
258	Samuel Seidu Memorial Clinic, Bayiri	Clinic	Upper West	Baptist Mid Mission	Bayiri	
259	All Saints Clinic, Piina	Clinic	Upper West	Catholic	Kane Lanbussie	Karne Lanbussie
260	Immaculate Conception Clinic, Kaleo	Clinic	Upper West	Catholic	Nadoli	
261	Nativity of Our Lady Health Centre, Ko	Clinic	Upper West	Catholic	Ko	Nandom
262	Our Lady of Lourdes Clinic, Yagha	Clinic	Upper West	Catholic	Yagha	Lawra
263	Queen of Peace Clinic, Sabuli	Clinic	Upper West	Catholic	Sabuli	Jirapa
264	St. Christoper Clinic, Dapuori	Clinic	Upper West	Catholic	Dapuori	
265	St. Evarist Clinic, Ullo	Clinic	Upper West	Catholic	Ullo	
266	St. Gregory's Clinic, Nanvilli	Clinic	Upper West	Catholic	Nanvilli	
267	St. Ignatius Clinic, Lasia Tuolu	Clinic	Upper West	Catholic	Tuolu	
268	St. John's Clinic, Funsi	Clinic	Upper West	Catholic	Funsi	
269	St. Martin de Porres Clinic, Eremon	Clinic	Upper West	Catholic	Eremon	Lawra
270	St. Paul's Clinic, Kundungu	Clinic	Upper West	Catholic	Kundungu	
271	St. Stella's Clinic, Karne	Clinic	Upper West	Catholic	Kane Lanbussie	
272	Methodist Medical Centre, Lawra	Clinic	Upper West	Methodist	Lawra	Lawra

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
273	Seventh Day Adventist Clinic, Wa	Clinic	Upper West	Seventh Day Adventist	Wa	Wa
274	St. Catherine of Sienna Health Centre, Jirapa	Health Centre	Upper West	Catholic	Jirapa	Jirapa
275	St. Gerhardt Health Centre, Fielmuo	Health Centre	Upper West	Catholic	Fielmuo	
276	St. Joseph's Hospital, Jirapa	Hospital	Upper West	Catholic	Jirapa	Jirapa
277	St. Theresa's Hospital, Nandom	Hospital	Upper West	Catholic	Nandom	Lawra
278	Wa Diocese PHC Project	Primary Health Car	Upper West	Catholic	Wa	Wa
279	Jirapa Community Health Nursing Training School, Jirapa	Training Institution	Upper West	Catholic	Jirapa	Jirapa
280	St. Joseph's Midwifery Training School, Jirapa	Training Institution	Upper West	Catholic	Jirapa	Jirapa
281	St. Joseph's Nurses' Training College, Jirapa	Training Institution	Upper West	Catholic	Jirapa	Jirapa
282	Fr. Cuniberto's Clinic, Lume	Clinic	Volta	Catholic	Lume	Akatsi South
283	St. Anne's Clinic & Maternity Home, Tagadzi	Clinic	Volta	Catholic	Tagadzi	Tongu Central
284	St. Francis Clinic, Saviefe Agorkpo	Clinic	Volta	Catholic	Saviefe Agorkpo	
285	St. George's Clinic, Liati	Clinic	Volta	Catholic	Liati	Hohoe Municipal
286	St. Luke's Clinic, Chinderi	Clinic	Volta	Catholic	Chinderi	Krachi West
287	Dzodze Ghana Mission Clinic	Clinic	Volta	Church of Christ	Dzodze Ablorme	Ketu North
288	EP Church Clinic, Adaklu Waya	Clinic	Volta	Evangelical Presbyterian	Adaklu Waya	Adaklu
289	E. P. Church Clinic, Dzemeni	Clinic	Volta	Evangelical Presbyterian	Jamani	South Dayi
290	E. P. Church Dan Moser Memo. Clinic, Dambai (Hohoe)	Clinic	Volta	Evangelical Presbyterian	Dambai (Hohoe)	Krachi East
291	E. P. Church Clinic, Hatorgodo	Clinic	Volta	Evangelical Presbyterian	Hatorgodo	Keta Municipal
292	Fame Clinic, Akplale	Clinic	Volta	FAME	Akplale	South Tongu
293	Pentecost Clinic, Kpassa	Clinic	Volta	The Church of Pentecost	Kpassa	Nkwanta South
294	Salvation Army Clinic, Adaklu-Sofa	Clinic	Volta	The Salvation Army	Adaklu Sofa	Adaklu Anyigbe
295	Mater Ecclesiae Hospital, Sokode	Hospital	Volta	Catholic	Sokode	Ho Municipal
296	Anfoega Catholic Hospital, Anfoega	Hospital	Volta	Catholic	Anfoega	Kpando
297	Catholic Hospital, Battor	Hospital	Volta	Catholic	Battor	North Tongu
298	Richard Novarti Memorial Hospital, Sogakope	Hospital	Volta	Catholic	Sogakope	South Tongu

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
299	Margaret Marquart Cath. Hosp, Kpando	Hospital	Volta	Catholic	Kpando	Kpando
300	St. Mary Theresa Hospital, Dodi-Papase	Hospital	Volta	Catholic	Papase	Kadjebi
301	Sacred Heart Hospital, Weme-Abor	Hospital	Volta	Catholic	Abor	Keta Municipal
302	St. Anthony's Hospital, Dzodze	Hospital	Volta	Catholic	Dzodze	Ketu North
303	St. Joseph's Hospital, Nkwanta	Hospital	Volta	Catholic	Nkwanta	Nkwanta South
304	E. P. Church Health Services, Ho	Primary Health Car	Volta	Evangelical Presbyterian	Ho	Ho
305	Presbyterian CHPS Compound, Amonie	CHPS	Western	Presbyterian	Enchi	Aowin Suaman
306	Episcopal Clinic, Nyankamam-Enchi	Clinic	Western	Anglican	Nyankamam Near Enchi	Aowin - Suaman
307	Anglican Clinic, Sefwi-Bonzain	Clinic	Western	Anglican	Bonzain	Juaboso
308	Bishop Anglonby Memorial Clinic, Sefwi-Bodi	Clinic	Western	Anglican	Sefwi Bodi	Juaboso
309	St. Mark's Anglican Clinic, Subiri	Clinic	Western	Anglican	Subiri	Bibiani-Bekwai
310	Angela Memorial Catholic Clinic, Yawmatwa	Clinic	Western	Catholic	Yawmatwa	Bia
311	Holy Child Clinic, Egyam	Clinic	Western	Catholic	Egyam	Ahanta West
312	Holy Child Clinic, Fijai	Clinic	Western	Catholic	Fijai	Sekondi Takoradi Metro Ass.
313	St. John of God Clinic, Oseikojokrom	Clinic	Western	Catholic	Sewfi Asafo	Wiawso
314	Methodist Medical Centre, Takoradi	Clinic	Western	Methodist	Takoradi	Secondi - Takoradi
315	Methodist Medical Centre, Kwawu	Clinic	Western	Methodist	Kwawu	
316	Methodist Medical Centre, Gwira Eshiem	Clinic	Western	Methodist	Gwira Eshiem	
317	Methodist Medical Centre, Nzulezu	Clinic	Western	Methodist	Nzulezu	
318	Methodist Medical Centre, Adjoafua	Clinic	Western	Methodist	Adwuoafua	
319	Presbyterian Clinic, Papueso-Enchi	Clinic	Western	Presbyterian	Papueso-Enchi	Aowin Suaman
320	Presbyterian Clinic, Ohiamatuo	Clinic	Western	Presbyterian	Ohiamatuo	Wasa Amenfi West
321	Mary Ekuba Ewoo Memorial Adventist Clinic, Akwidaa	Clinic	Western	Seventh Day Adventist	Akwidaa	Agona Nkwanta
322	Seventh Day Adventist Clinic and Maternity, Sefwi Punikrom	Clinic	Western	Seventh Day Adventist	Punikrom	Wiawso

CHAG Member Institutions by Type

	FACILITY NAME/LOCATION	TYPE	REGION	DENOMINATION	LOCATION	DISTRICT
323	Seventh Day Adventist Clinic and Maternity, Sefwi-Asawinso	Clinic	Western	Seventh Day Adventist	Sewfi Asawinso	Sefwi Wiawso
324	Seventh Day Adventist Clinic, Dadieso	Clinic	Western	Seventh Day Adventist	Dadieso	Suaman Dadieso
325	Seventh Day Adventist Clinic, Kofikrom	Clinic	Western	Seventh Day Adventist	Kofikrom	Juaboso
326	Seventh Day Adventist Clinic, Sefwi Amoaya	Clinic	Western	Seventh Day Adventist	Sefwi Amoaya	Juaboso
327	Seventh Day Adventist Clinic, Wassa Nkran	Clinic	Western	Seventh Day Adventist	Wassa Nkran	Nsuaem
328	Siloam Gospel Clinic, Bonyere	Clinic	Western	Siloam Gospel	Bonyere	Jomoro
329	Spring of Life Ministry	Clinic	Western	Spring of Life	Anaji, Takoradi	Secondi - Takoradi
330	Pentecost Clinic, Enchi	Clinic	Western	The Church of Pentecost	Enchi	Enchi
331	Pentecost Clinic, Tarkwa	Clinic	Western	The Church of Pentecost	Tarkwa	Wassa West
332	Pentecost Clinic, Yawmatwa	Clinic	Western	The Church of Pentecost	Yawmatwa	Bia
333	Presbyterian Health Centre , Kwamebikrom	Health Centre	Western	Presbyterian	Kwamebikrom	
334	Nzema Baptist Hospital	Hospital	Western	Baptist	Nvellenu-Half Assini	Jomoro
335	Fr. Thomas Alan Rooney Memo. Hosp., Asankragwa	Hospital	Western	Catholic	Asankragwa	Wasa Amenfi West
336	St. John of God Hospital, Sefwi-Asafo	Hospital	Western	Catholic	Sewfi Asafo	Sewfi Asafo
337	St. Martin de Porres Hospital, Eikwe	Hospital	Western	Catholic	Eikwe	Ellembelle
338	Nagel Memorial Adventist Hospital Takoradi	Hospital	Western	Seventh Day Adventist	Takoradi	Shama Ahanta East
339	Presbyterian PHC, Enchi	Primary Health Car	Western	Presbyterian	Enchi	Aowin Suaman
340	Seventh Day Adventist Health Asst. Training School, Asanta	Training Institution	Western	Seventh Day Adventist	Asanta	Ellembelle
341	Word Alive Community Health Nursing Training School, Esiama	Training Institution	Western	Word Alive	Esiama	Nzema East Municipal

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