CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)

Strategic Framework 2014 - 2016

Unity in Diversity

Improving Health Outcomes by Strengthening Health Systems

The Christian Health Association of Ghana

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March 2014

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Abbreviations

ACCM	Annual Council Conference Meeting
CHAG	Christian Health Association Ghana
CHCU	Church Health Coordination Unit
CHPS	Community-based Health Planning and Services
D-by-D	Decentralisation by Devolution
DHMT	District Health Management Team
DHMIS	District Health Management Information System
EPI	Expanded Programme on Immunisation
FP	Family Planning
GHS	Ghana Health Service
GOG	Government of Ghana
GSGDA	Ghana Shared Growth and Development Agenda
HR	Human Resources
HRH	Human Resources for Health
HSS	Health System Strengthening
IPD	In-Patient Department
IGF	Internally Generated Funds
MAF	Millennium Accelerated Framework
MTDP	Mid-Term Development Plan
MDG	Medium Development Goals
MOH	Ministry of Health
MOF	Ministry of Finance
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
O&I	Organisation and Institutional Development
OPD	Out Patient Department
OPAT	Organisational Performance Assessment Tool
PHC	Primary Health Care
PPP	Public Private Partnership
POW	Plan of Works
RHMT	Regional Health Management Team
SDHMT	Sub-District Health Management Team
SOP	Standard Operating Procedure
TWG	Technical Working Group

Foreword and Acknowledgements

This document provides the context that informs the Christian Health Association of Ghana's (CHAG) activities over the next 3 years. It is the first strategic framework for CHAG as a network organisation that presents the collective strategic direction of CHAG member institutions and the network at large. The purpose of this strategic framework is to present the aspiration of CHAG to improve its contribution to the achievement of national health outcomes in partnership with all stakeholders in the health sector.

The Board recognises the proactive and visionary leadership of the CHAG Secretariat and the enthusiasm and commitment of network members to be more efficient and effective in their support to the achievement of national health outcomes.

The Secretariat and members of the network are encouraged to make frequent reference to this document as they develop their own strategic plans and ensure that their plans at all times include interventions that will address the critical issues identified in this framework.

It is our hope that this Strategic Framework will adequately serve the purpose for which it was developed, that is to enable CHAG better support the achievement of national health outcomes

We welcome any support and contribution towards the realisation of the strategic objectives.

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Executive Summary

This document provides a 3-year strategic framework for CHAG for the period 2014-2016. The framework aims to focus CHAG on improving its contribution to the National Health Sector outcomes and CHAGs investments to improve the health sector. In as much as this strategic outlook presents CHAG's collective mission, vision, strategic principles and focus, it also provides a framework to support CHAG member institutions in the formulation of individual strategic plans and annual work plans that reflect member's local contexts, challenges, opportunities and priorities, yet still supporting the overall direction of the network as defined in this Strategic Framework.

After a brief explanation of the main structures of CHAG (chapter 1), the document gives a descriptive analysis of the most important contextual factors that, currently and are likely to, impact on CHAG in the 3-year period under consideration (chapter 2). The chapter elaborates on legal and regulatory issues in the health sector, emerging developments within the MOH, such as the further advancement of the National decentralization policy. The situation analysis provides an outline of the new Medium Term Development Plan (MTDP) of the MOH for the period 2014-2019, providing the national targets and strategies for the Health Sector to which CHAG will align itself. Chapter 2 concludes with a situation analysis of the internal performance of CHAG. It prompts at important areas for consideration and improvements for the period 2014-2016.

Lastly, chapter 3 provides CHAG's strategic framework for the period 2014-2016. Apart from CHAG's vision, mission and core values, the chapter explains CHAG's goal. Furthermore, CHAG's main strategies are elaborated upon. Chapter 3 concludes with a brief explanation of CHAG's network M&E system that will be applied for performance management and to appraise achievements.[1]

[1] Chapter 3 doesn't provide projected short-term and medium-term deliverables for the period 2014-2016 as these will relate to specific plans and budgets of CHAG members, the Church Health Coordinating Units and the secretariat.

1. The Christian Health Association of Ghana

This chapter provides an introduction to CHAG. It briefly describes its main thrust, organisational structures and institutional arrangements. Based on internal appraisals, the chapter summarizes CHAG's role and contribution to the health sector of Ghana.

1.1 Introduction

CHAG is a network of 183 health facilities and health training institutions owned by various Christian Church denominations (Annex 3). Membership is subject to a Christian identity, subscribing to CHAG's constitution and consecutive articles, an annual membership subscription fee and a regular membership audit. Governance is participatory in nature and secured through a full member Council, which meets annually to discuss and approve the strategic direction of the network. A board with nominated representatives of the 3 founding church denominations of CHAG oversees the Secretariat, the apex organisation of the network at the National level, charged with its daily management.[2]

CHAG is a recognised agency of the Ministry of Health and works within the policies, guidelines and strategies of the Ministry of Health (MOH).[3] Nonetheless, CHAG is autonomous and takes an independent position to advocate and promote improvements in the health sector and to advocate the interest of its members. CHAG is directed by Christian values and professional and medical ethics and norms. CHAGs primary beneficiaries are the most vulnerable and underprivileged population groups, particularly those in the rural areas of Ghana.

1.2 Organisation of CHAG

At the national level, CHAG has a Secretariat providing stewardship of the network, developing strategic partnerships in support of capacity development of its members for improved service delivery and articulating the association's position and interest in national policy dialogue and discourse for health sector developments and – improvements. The secretariat is a relatively small organisation with 5 functional units and about 28 full time staff.[4]

The larger Church denominations of CHAG operate health coordinating units at the National level (CHCU). 5 These units operate autonomously but are accountable to their

[2] CHAG is registered as a 'Trustee-ship' and its board comprises representative from the Ghana Catholic Bishops Conference, the Christian Council of Ghana and the Ghana Pentecostal Council, the 'Founding Fathers' of CHAG.

[3] The relationship between CHAG and MOH is guided and agreed upon in a Memorandum of Understanding (2006).

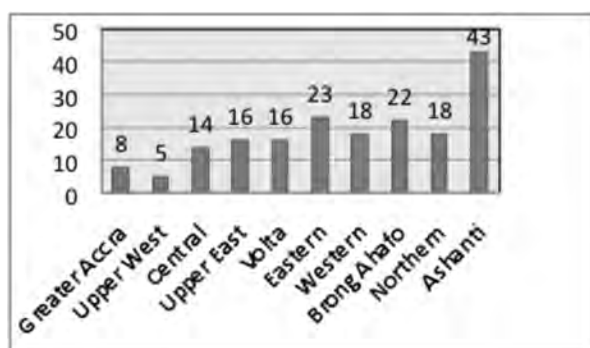
[4] Currently the 5 functional units within the Secretariat are: (1) Operations; (2) Finance; (3) Human Resources; (4) Services; (5) Performance. Next to these functional units the secretariat operates a Directorate and a Compliance and Audit unit.

respective churches. They provide technical, logistical and program support to their corresponding health facilities. To some extent they also mobilise funding for their members. In addition, some Churches operate supplementary and decentralised health coordinating units at the Presbyterian and Diocesan levels.

1.3 CHAG Health Infrastructure

The CHAG network comprises a membership of 173 health facilities and 10 health training institutions owned by 21 different Christian Church denominations (Annex 3). The health facilities are made up of clinics (42%), hospitals (32%), health centres (18%), primary health care (PHC) centres (8%), training schools (5%), specialist clinics (2%) and polyclinics (1%). In all, the network accounts for approximately 5.5% of the total health infrastructure in Ghana.

CHAG facilities are predominantly located in the more isolated districts and localities. They are unevenly distributed over the 10 regions of Ghana with a larger presence in Ashanti (43), Eastern (23) and Brong Ahafo Region (22) and a smaller presence in the remaining Regions of Ghana.



A large majority of CHAG facilities is owned by the Catholic Church (43.5%) followed by the Presbyterian Church (16.5%) and the Seventh Day Adventist Church (9%). The Salvation Army, Anglican Church, the Methodist and the Church of Pentecost each own about 5% of facilities. The remaining 14 Charismatic Churches constitute about 11% of CHAG membership base with each operating just 1 health facility.[6]

[5] Church denomination operating national health coordination units are: the Catholic Church, the Presbyterian Church, the Seventh Day Adventist Church, the Salvation Army, the Anglican Church and the Methodist Church.

[6] All other denominations includes; Word Alive Mission, WEC, Siloam, Run, Church of God, Church of Christ, Saviour, Manna Missions, Lighthouse, Global Evangelical and AME – Zion.

2. Situation Analysis

The following chapter provides a situation analysis of the internal performance as well as the external context of CHAG. The situation analysis provides an overview of critical issues requiring strategic and sustained attention in the coming years to improve organizational performance and outcomes of CHAG members and the network at large.

2.1 Health Sector

Context analysis mainly relate to assessment of the larger health sector, it's systems, institutional, organizational and administrative arrangements and the legal environment posing opportunities, challenges and limitations for CHAG to operate satisfactorily. Being an agency of the MOH, CHAG is an integral part of the Health Sector and will need to appreciate and anticipate changes and developments of the sector as well as the wider legal and political context in Ghana.

2.1.1 The Ministry of Health

The mandate of the MOH is to provide strategic direction, policy development, oversight and coordination, resource mobilization and M&E for the health sector. Notwithstanding progress in recent years, the MOH still performs many functions outside its core mandate. Disproportionally, too much emphasis is with (program) implementation rather than with providing leadership and stewardship resulting underperformance of the health sector.[7] For the MOH to profile itself better in accordance with its core mandate, major organizational and institutional changes are required for which the MOH is currently designing the first initial steps and which may have repercussions in functional relationship with its agencies, including CHAG. A serious concern for the MOH is the substantial increase of the wage bill over the recent years, posing serious challenges for expanding and maintaining current staffing and salary levels.

2.1.2 Legal and Regulatory Framework

The legal and regulatory framework of the health sector is complex. The sector operates under the purview of various Acts such as the Constitution of Ghana, the Public Service Commission Act, the Civil Service Act and Acts establishing the various agencies. Several of the legal frameworks governing the health sector and its agencies are outdated and new bills are proposed and currently under review.[8] However, it is unclear whether these new bills under consideration will contribute to streamlining the sector as they appear to create a multiplicity of new and parallel structures overlapping responsibilities of existing institutions. Moreover, some new bills appear to strengthen centralization of governance functions rather than decentralizing them, in sharp contrast with the overall decentralization policy of the GOG.

[7] Institutional and Organisational Assessment of the MOH and its Agencies, HERA, Ghana, March 2012.

[8] Health Institutions and Facility Bill, mental Health Bill, Medical training and research Bill, health profession Regulatory Bodies Bill, Traditional and Alternative Medicine Bill, Health service Bill, Public Health Bill.

2.1.3 Health Sector Policies and Plans

The health sector is governed by a vast number of policies, guidelines and plans. The sector policy operates under the purview of the National Medium-Term Development Plan (MTDP) and the Ghana Shared Growth and Development Agenda (GSGDA), constituting the overall basis for achieving the Millennium Development Goals (MDGs). Both, the MTDP and the GSGDA are about to be revised and may challenge and influence the strategic direction and priorities of the health sector.

2.1.4 The Health Sector Medium Term Development Plan Framework

The health sector MTDPF 2014-2017 reflects the Government's health development agenda for the medium term. Its main thrust largely follows priority objectives and strategies already mentioned in the previous MTDP (2010-2013) namely:

1. *Bridging the equity gaps in geographical access to health care* through: PHC approach, expansion CHPS, strengthening (sub-)District health systems, capital investments and use of ICT and E-health.
2. *Ensure sustainable financing for health care delivery and financial protection of the poor* through: exploring new financing strategies, increase coverage of the NHIS and strengthening financial management and accountability.
3. *Strengthen efficiency in governance and management of the health system* through; improved stewardship, legislation and regulation, advance decentralization, engage in public-private partnerships, enhance staff development and –management, and advance information management including M&E and research;
4. *Improve quality of health services delivery including mental health services* through; advanced policies and procedures to improve quality and safety, expanded specialist and allied health services, and better commodity management.
5. *Enhance national capacity for the attainment of the health related MDGs and sustain gains* through; scale-up of the Millennium Acceleration Framework (MAF), expand sexual and reproductive health services especially for adolescents, and support specific vertical programs such as childhood and neonatal illnesses, malaria, TB, HIV/AIDS etc.
6. *Intensify prevention and control of communicable and non-communicable diseases* through; enforcement and review of existing policies, strategies and regulations, and strengthen integrated disease surveillance and -response.

2.1.5 Decentralization by Devolution

In the coming years, it is expected that the MOH is forced to adopt its organizational, institutional and financial arrangements in line with the general GOG policy of decentralization-by-devolution (D-by-D). The policy follows the local Government Act (Act 462, 1993), in which the Metropolitan, Municipal and District Assemblies will be the mandated planning authorities responsible for integrated development planning of their respective areas of jurisdiction. With the endorsement and implementation of this policy, the role and functions of each of the players at regional and (sub-) district level are subject to reconsideration and change. Moreover, it is foreseen that Central Government resources the (finances) for funding health development activities shall be increasingly made available through the Local Authorities.

2.1.6 Public Health Financing

With the introduction of the 'Purchaser-Provider' split and the establishment of the National Health Insurance Scheme (NHIS), the sector has created a viable option to improve financial accessibility to basic health care to all residents including marginalized population segments. The NHIS has become the major funding source in the health sector, for service delivery. It receives its capital from the National Health Insurance Fund through the Ministry of Finance (MOF). Each district operates autonomous mutual health schemes, which are integrated into the overall organizational structure of the National Health Insurance Authority (NHIA).

With the introduction of the NHIS, health expenditure has increased dramatically posing serious challenges on the sustainability of the scheme. Alternative payment schemes and modalities are currently being piloted and considered for roll-out ('Capitation'). These may pose challenges on the current level of public health financing and may affect financial liquidity and sustainability of certain category of health facilities.

2.1.7 The Ghana Health Service

Being the largest agency of the MOH mandated to coordinate and oversee major aspects in the health system, the Ghana Health Service (GHS) represents the public health sector with which CHAG and all its members partner, preferably in proper functional relationships. However, on the whole, relationships between CHAG and the GHS could be improved with number and quality of institutional partnerships limited, and many CHAG health facilities operating in relative isolation, rather disconnected from the public health sector. In relation to a better partnership with the GHS and the imminent implementation of D-by-D policy in the health sector a much more prominent role of CHAG in liaising with RHMTs, DHMTs and SDHMTs is important.

2.1.8 Sector Development Partners

The sector development partner landscape rapidly changes with reduced funding levels from bi-lateral and multi-lateral donors. This is due to the prolonged worldwide economic crises, a paradigm shift in development aid towards economic collaboration and more support for fragile and underdeveloped countries at the expense of middle-income countries such as Ghana. Although not fully clear yet, it is also expected that with reaching the deadline for achieving the MDGs by 2015, the focus of the international donor support will shift towards a more holistic system approach (HSS) and achieving universal access to health. At the same time it is clear that corporate business and initiatives from private charitable and philanthropic organizations become more prominent in the health sector.

2.2 CHAG

Analysis of the internal situation and performance of the network is based on annual reports of members and the network, scrutiny of relevant documents, operational research and feedback from CHAG members and stakeholders of the health sector. It is structured along the 9 blocks of the Health System Strengthening (HSS) approach. [9]

2.2.1 Leadership and Governance

Leadership and governance relates to providing the direction and the structure which lead and guide the organization to effectively achieve the desired outcomes/impact. It is directed to ensuring proper stewardship, leadership and managing CHAG health facilities and the CHAG network in the most effective way. It involves the competent and transparent use of resources and the management of performance and stakeholders in an accountable, equitable and responsive manner. This involves among others competencies in strategic planning, organizational and institutional development, general - and financial management, monitoring and evaluation, adherence to regulation and inter-sector and network advocacy.

Governance structures and leadership arrangements in CHAG are fashioned on a decentralized model. The focus is on health facility level empowerment to manage service provision autonomously with some degree of technical oversight by respective church owners. Legally, CHAG is registered as a trusteeship and guided by a constitution. Programs and activities are coordinated through the Secretariat, the Church Health Coordinating units or coordinators and senior management Meetings, agreed upon by the general members Council and overseen by a Board. Stewardship of the network is provided by the Secretariat. It develops guidelines and strategic partnerships to support capacity development of the network and its members and to influence health sector developments.

The Secretariat and the majority of the larger member denominations operate under longer-term strategic plans, policies and administrative guidelines. Nonetheless, overall strategic leadership and governance practices of the network and CHAG members could improve. Organizational and institutional (O&I) development of the network and its members at the Region and Districts need more attention in the years to come not only to improve internal performance but also to improve partnerships, collaboration and cooperation with main stakeholders in the health sector at the respective levels.

[9] Since 2010, CHAG applies the Health System Strengthening (HSS) approach to improve organizational performance and outcomes of the individual health facility. Moreover, the model is used to improve the institutional performance of the CHAG network in support of strengthening the Ghana health system. The HSS approach distinguishes 9 HSS blocks: Leadership and Governance, Human Resources, Service Delivery, Finances, Technology, Health Information, Community Participation, partnerships, Research. The blocks are interdependent and mutually contribute to the delivery of quality health services.

[10] The Constitution of CHAG is currently under review.

Being recognized as an agency of the MOH, it is important that the network complies with the many sector policies, procedures, treatment guidelines, staffing norms and reporting requirements. Improving compliance to all these requirements as well as to CHAGs internal guidelines and procedures remains an important focus for the years to come. It will not only strengthen internal performance of the network but also reinforce its position as a trustworthy partner in the health sector.

2.2.2 Human Resources

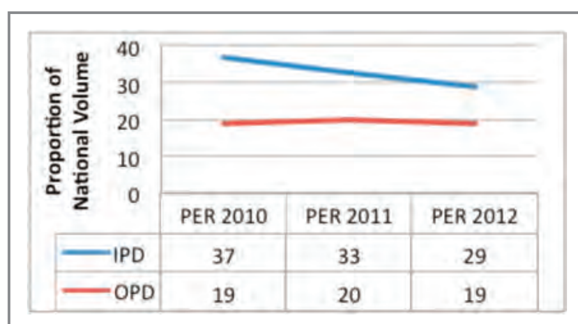
Human Resources relate to all aspects of workforce availability, functionality and performance to attain optimum workforce productivity. The production, distribution, development, retention and utilization of a health workforce of the appropriate quantity, quality and the proper skill mix is essential to secure effective and quality health services. It involves planning, pre-service training continuous professional education/development and managing the performance of both clinical ad support workforce.

The total number of staff employed in CHAG shows a slight increase over the recent years and currently stands at a total of 8,338 (2012). The proportion of medical professional staff is approximately 48% of which the majority is general nurses (15.6%), health assistants (14.9%) and midwives (6.5%). Nonetheless, there is a critical shortage of medical specialists, medical officers and pharmacists, just 1.5% of the total staff strength in CHAG. The precarious shortage of medical staff is most notably felt in remote areas as distribution of professional staff within the network is also un-equal.

Being an agency of the MOH, salaries of the vast majority of CHAG staff (96%) is paid for by the GOG. The Secretariat, on behalf of its members and in consultation with the MOH and the Ministry of Finance (MOF), facilitates all administrative matters related to employment, distribution, promotions and transfer of staff. Across the network, HR planning, management and supervision in compliance with Sector procedures and guidelines need considerable attention and improvement including alignment of internal CHAG HR guidelines. This should also arrest the sizable attrition rate of professional staff. Lastly, overall performance of CHAGs 9 health training institutions need attention with a student pass rate considerably below the National average (61%, 2012).

2.2.3 Service Delivery

CHAG is providing primary, secondary and tertiary health care as well as preventive, pro-motive and rehabilitative services. Nationally and over the recent years, CHAG contributed about 20% of all Out-Patient Department services (OPD) and an average of 33% of all In-Patient Department service (IPD). Health services are provided in line with National priorities and in accordance with Sector treatment protocols.



Despite relevance of health services provided by CHAG, alignment with specific local disease profiles could improve considerably across the network. Alignment could improve based on proper analysis of the local burden of disease also including non-communicable diseases as well as neglected but prevailing health conditions such as common mental disorders, etc. Important dimensions of service delivery such as quality of care, patient safety, protection of patient rights as well as adherence to medical norms and ethics need as well sustained and systematic attention across the network in the coming years.

2.2.4 Health Financing

Health financing is concerned with the mobilization, allocation and management of financial resources for the purpose of financing affordable public health care for the population at large, most notably for the vulnerable and underserved population through pro-poor strategies. This function of the health system involves revenue collection, pooling of resources and the efficient use of these, not only for direct health expenditure but also for financing all in-direct expenses such as salary of staff, capital investments and maintenance of plant and equipment.

The indirect income through payment of staff salaries by GOG aside, the major source for direct revenues for CHAG members are the Internally Generated Funds (IGF) mainly through payment of health insurance claims by the National Health Insurance Authority (NHIA). However, a persistent and average delay of 4-6 months delays in claim reimbursement over the recent years, seriously threatened liquidity status of most CHAG health facilities. Partly this has to do with poor claim management of the members, partly with in-efficiencies of the NHIA. CHAG members will need to improve their internal claim management procedures. This is best done in the context of a more general improvement of financial management including (internal) financial reporting. The Secretariat will need to address this issue more systematically in dialogue with NHIA and other stakeholders concerned. In addition and in relation to this, the low NHIA tariffs for medicines and specialist services need to be resolved as well the current exclusion of family planning (FP) and mental health services from the NHIS.

Overall, external donor support through project grants is gradually diminishing. This poses an additional complication to CHAG members and the Secretariat to engage in needed programs, investments and innovations. Whereas members will need to sustain current donor and project support and live up to the required obligations, the

Secretariat will need to develop strategies for alternative long-term and project financing.

2.2.5 Health Technology

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

Maintenance and renovation in buildings remains a concern with limited funds available, restricted support from GOG/MOH and a common lack of maintenance culture. In particular, more attention and support is required to invest in service readiness of medical equipment with important equipment being obsolete or inadequate or simply too expensive to be able to afford. Moreover, Investment in plant and equipment is required as in some locations the existing infrastructure is unable to meet required services or quality demands.

Preventive maintenance schemes as well as pooled procurement arrangements may benefit CHAG and innovative initiatives could be further investigated and extended. Overall, the availability and use of ICT across the network is inadequate and need to improve to meet required efficiency standards.

2.2.6 Health Information

Health information relates to all systems, procedures and staff aimed at the timely collection, analysis and dissemination of information for the purpose of planning, managing, monitoring and evaluating health services. Important aspects of health information are quality, reliability, timeliness and the use of service data. Overall, the analysis of health data and the use of health information by the respective members are still limited and need to improve in the coming years.

Being an agency of the MOH, CHAG members provide routine health-service data into the Health Sector DHMIS-II system. Simultaneously, CHAG members submit facility health information to the Secretariat for aggregate reporting. However, aggregate reporting of health information for the CHAG network is hampered by late, inaccurate and incomplete submission of health data by members. Much has to do with a combination of factors relating to insufficient data management at the facility level, poorly trained staff and limited ICT, including the use of different software among CHAG members. All these contributing factors need improvement in the coming years in order to provide CHAG with a more realistic basis to presents its contribution to the sector and to advocate for improvements and support.

2.2.7 Community Ownership and Participation

Community ownership and participation refers to mechanisms, systems and processes that allow communities to influence policies, planning, operation, use and benefits of health services. It relate to the extent to which health facilities engage with communities in order to make health services more fitting and more relevant for the local context and its specific disease burden. Community participation aims at improving acceptability of health services by the community and strengthening behaviors that promote and preserve health.

Although some CHAG health facilities already engage with communities through formal and informal leadership structures and by partnering with local groups, initiatives and plans, across the network engagement with the communities can improve significantly in the coming years. CHAG will also need to document and disseminate good examples and lessons learnt.

2.2.8 Partnership for Health

The need for partnerships in the health sector is recognized in various health sector policy documents in recent years. Partnerships are generally based on mutual dependency of different partners in achieving a common goal. Each partner is expected to make financial, technical or material contributions in a coordinated manner aimed at strengthening service delivery. Effective partnerships are based on commitment, communication, cooperation and coordination. Important aspects and advantages of partnerships are: (1) improving access to services; (2) access to complementary resources; (3) improved focus and coordination and lastly; (4) improved capacity, innovation and expertise.

Whereas some examples of good partnerships are evident, CHAG health facilities generally operate in relative isolation and overall collaboration and coordination could be much improved at region, district and sub-district levels particularly with Local Authorities and the GHS. To this effect, CHAG has entered into an MOU with the GHS providing a framework for operational collaboration at National, Regional and District levels (December, 2013). Likewise, there is limited cooperation within the CHAG network between members themselves, and much could be shared in the areas of health planning, service delivery, supportive technical supervision and training.

It is imperative that members as well as the network at large need to explore opportunities for new and lasting internal and external partnership. The Secretariat will need to continue to actively engage with many stakeholders in the health sector to explore and develop new strategic partnerships.

2.2.9 Research for Health

Health research relates to the generation and application of information, evidence and knowledge to improve health systems, health management and health service delivery. CHAG is particularly interested in operational research which looks into causes of common or critical problems in the implementation of health services in the health facility. The purpose of operational research is to promote contextual solutions and improve the quality and effectiveness of health services management and care. Operational research can relate to all aspects of managing the health facility as well as to all aspects of managing and implementing health services.

Operational research is just at its infant stages and CHAG will need to develop a systematic research agenda documenting innovative work carried out by members and within the network. Preferably this may be done in collaboration with National and international research institutions. Moreover, research findings will need to be shared among members of the network and strategically applied by CHAG to influence sector policy discourse.

2.3 Critical Challenges

Although there are marked differences in extent and quality of health service provision among members within the CHAG network, all members are primarily pre-occupied with maintaining and improving organizational performance for better-quality health service provision. Critical challenges across the network are summarized in Annex 1. Addressing these challenges will ensure that CHAG is able to achieve the desired outcomes and outputs required in support of contributing to National health outcomes and targets.

3. Strategic Framework: 2014-2016

This chapter describes the strategic framework of CHAG; where CHAG intends to go. It provides the general direction and focus for specific programs and activities of the network at all levels; for the Secretariat, the CHCUs and all individual member institutions.

3.1 Network Vision and Mission

CHAG's over-riding and unique network aspiration and direction for the future ('Vision') is inspired by Christian identity and witness. The Vision of CHAG is:

Health in Body, Mind and Soul, Christ's healing Ministry fulfilled

Guided by its Christian identity and associated core values, the central purpose of CHAG ('Mission') defines the overall objective of the network to which all members describe and which reflects in all the network and individual member plans, actions, strategies and operational decisions. The Mission of CHAG:

Promote the healing Ministry of Christ and be the most reliable partner in the health sector in providing the health needs of the people in Ghana in fulfillment of Christ's mandate to go and heal the sick

3.2 Network Goal and Main Objectives

The goal of CHAG is the long-term overall ambition to which all individual CHAG members and the network at large subscribe. The timeframe for realizing the overall goal is undefined and stretches over many years. The goal informs all medium term objectives and strategies as well as all short-term plans, programs and budgets of members, CHCUs and secretariat:

To support the achievement of National Health Sector outcomes

CHAG is well aware that it can only play a limited part in the achievement of National health outcomes. Nonetheless, CHAG is also conscious that its contribution to provide health services to Ghana's more vulnerable population groups is already significant and can only improve over time. The purpose and main objectives of CHAG are:

1. ***To foster a closer partnership between Church health services and the Ministry of Health to promote health care in Ghana.***
2. ***To assist in planning and coordinating the training programmes and other medical work or services of all its members.***
3. ***To assist all members with respect to the employment of staff, provision of supplies to the hospitals or other medical services maintained or supported or controlled***

or supervised by any member of the Association.

4. ***To encourage and assist the members to promote the healing ministry for the benefit and the welfare of the people of Ghana.***

5. ***To implement policies set by the members and do such other things in cooperation with the members that are conducive to the attainment of the objectives of the Association and generally to act for the benefit and welfare of the people living in Ghana.***

3.3 Network Values

CHAG's Christian identity stands for a core set of principles, values and norms. These provide direction, guidance and the internal driving force and commitment to all its members, resulting in a unique culture of the network, a distinct ethical conduct and professional standards of its members and employees towards CHAG's customers and clients.

Network Values	
Christian identity and values	Health services and patient care is provided in the spirit of love, service, justice, compassion, community, forgiveness and truthfulness.
Unity in Diversity	Each member is autonomous and contributes in a unique way to CHAG's shared vision, mission and objectives.
Respect dignity and gender of the person	Non-discriminatory, appreciating that each person is equally and fairly entitled to life, liberty, security, protection, recognition and equal rights and treatment irrespective of sex, sexual orientation, race, color, religion, political orientation, birth-or societal status.
Holistic Care	Taking all aspects of people's needs into account, including psychological, physical and social while at the same time comprehensively addressing under performance of health service delivery.
Creativity and Excellence	Working towards high quality performance, quality of services and patient care by constantly reflecting on on-going practices and looking for new ideas, approaches, methods and alternatives for improvement.
Accountability and transparency	Taking responsibility for ones actions in an open and honest manner.
Co-operation and partnership	Recognizing the value of others as equal, necessary and complementary to the achievement of CHAG's vision, mission and goals.
Option for the poor and marginalized	Targeting the most vulnerable and less privileged population groups in society.

3.4 Network Outcomes and Outputs

The network outcomes are different for the secretariat, CHCUs and the member Institutions, in line with their respective mandates. Outcomes at these various levels are described in terms of what they are expected to deliver as their contribution to realizing CHAG's overall long-term goal. The Network outcomes are as follows:

1. ***Health Facilities*: Provision of quality health services that meet client expectations;**
2. ***Church Health Coordinating Unit*: Provision of high standard technical, logistical, administrative and program support to health facilities;**
3. ***Secretariat: Provision of leadership and direction of CHAG, represent CHAG in the health sector and provide facilitative and capacity support to members and CHCUs.***

Though the efforts and activities of the secretariat, CHCUs and member institutions are noticeably different, all plans and activities are designed to ensure that CHAG's health facilities perform well and provide quality health services. Work plans and support activities of member institutions, the secretariat and the CHCUs respectively are thus targeted to achieve the following outputs or deliverables at facility level within the period 2014-2016:

Outputs for CHAG Members:	
Leadership & Governance	Regulatory compliance to CHAG guidelines and processes
	Regulatory compliance to MOH and sector guidelines and processes
	Capacity to develop the facility organisation (I&O)
	Development, use and management of long-term strategic plans
	Preparation, implementation and management of annual plans and budgets
Human Resources	Improved number and skill mix of clinical and paramedical staff
	Proper HR planning, management & supervision
	Staff competence and motivation
	Improved pre-service training (training schools)
Service Delivery	Provision of comprehensive basic health services
	Improved advanced health services
	Securing continuation of care (referral practices & procedures)
	Quality of care and patient safety
Health Financing	Sustainable financing through fund mobilisation
	Adequate financial management & administration
	Transparent financial planning & budget management & reporting
Health Technology	Service readiness of basic amenities, plant & administrative tools
	Service readiness of all medical equipment
Health Information	Health information management
	Improved information sharing & usage
Community Partcipation	Community engagement in health service planning
	Adequate community outreach services
Participation	Strong collaboration with GHS at appropriate levels
	Enhanced collaboration with (sub-)District authorities
	Partnership arrangements with NGOs, donors & private sector
Health Research	Implementation of operational research
	Documentation of operational research

3.5 Network Strategies

Based on context, critical issues, challenges, opportunities and an assessment of alternatives, a number of key strategies will be applied by CHAG. Strategies refer to the most viable implementation option referring to criteria such as: cost efficiency, benefits for target group, probability to get results, risks, feasibility and organizational and institutional issues. These strategies are generic in nature and intended to be applied, in context, at all levels of CHAG. Five strategies are recognized; (1) Health systems strengthening; (2) Focused Partnership Development; (3) Use of a common strategic framework; (4) Monitoring and verification for results.

3.5.1 Health System Strengthening

CHAG applies the HSS approach with a view to improve organizational capacity, service delivery and health outcomes in a more systematic and comprehensive manner. In addition the approach lends itself to the systematic analysis of sector issues enabling a more efficient and effective contributions to influence policy discourse and improved public administration and functioning of the health sector. The HSS approach is used to strengthen, monitor and evaluate organizational performance and health service delivery at the individual member health institutions level, across and within member church health services and ultimately aggregated for analysis of the performance of the entire network.

3.5.2 Focused Partnership Development

In line with the National Health Policy, CHAG views partnerships as a core strategy for the effective functioning of the health system and for achieving health sector objectives and outcomes. CHAG appreciates partnership development as involving the encouragement of different institutions and stakeholders both, public and non-public agencies, to work together to achieve the common objective of improving health, based on mutually agreed roles and the principle of sharing resources, risks and results. Partnerships within and across sectors, rather than working alone, offers advantages such as access to complementary resources, improved focus and coordination, the achievement of greater scale and reach and is, in general, an impetus for learning and further development. Partnerships will be pursued by all CHAG agencies at their respective levels of operation. CHAG identifies 5 partnership relations that are necessary and will be pursued as follows:

3.5.2.1 CHAG Internal Partnerships

Being an association of autonomous health facilities with a likeminded Christian identity offers vast opportunities for internal partnerships in support of improving health service delivery. Notwithstanding several partnerships in the area of specific health programs, operational research and sharing of best practices, CHAG is determined to full y explore the potential for internal partnerships in the years to come. Intensified partnerships arrangements are possible between the various autonomous CHCUs as well as between

CHAG members, most notably in the same geographical area of the Region, District and Sub-Districts.

3.5.2.2 CHAG-MOH Partnerships

Driving new partnerships in the health sector and ensuring that they are implemented effectively requires a change of mindset of the main stakeholders in the sector. CHAG is committed to help improve relationships between the public and private sectors in recognition of their complementary development roles. CHAG is committed to advocate for a legal and regulatory framework advancing private sector involvement in the health sector. In this respect CHAG finds it imperative to revitalize, review and drive implementation of the Private Health Sector Policy (2003).

3.5.2.3 CHAG-GHS Partnerships

CHAG will actively engage with the GHS at National, Regional and District level to ensure a proactive and positive approach towards effective partnerships especially in service delivery. To this effect, CHAG has signed an MOU with GHS specifying areas of operational collaboration and modes of engagement (Annex 4). Particularly in the technical areas of health planning, continuous professional education, services delivery, technical support and health information management, there is much room for improvement in working and partnering with the GHS.

3.5.2.4 CHAG-Donor & Private Business Partnerships

With the change in traditional donor support, focus and increased investments from corporate business and private entrepreneurs in the health sector, it is important that CHAG actively assesses new opportunities for partnerships. Based on a thorough appraisal, CHAG will establish strategic partnerships with the international donor community that can contribute to support and develop CHAG at its various levels.

3.5.2.5 CHAG-Research Partnerships

In the context of its advocacy agenda, CHAG will need to position itself more strategically and more profoundly at the center of the National policy debate. In this respect, CHAG recognizes the need to develop a meaningful research agenda covering priority issues in the health sector as well as cross-cutting issues affecting the health sector and wellbeing of the population. Through its technical working groups in operational research (TWGs), CHAG is already engaged in operational and implementation research to investigate and duplicate best practices among its members. However, additional research is required to link micro-level lessons with the macro level policy debate. This will require a more in-depth and longitudinal research approach for which CHAG seeks partnerships with credible national and international research institutions and universities.

3.5.3 Use of a Common Strategic Framework for Annual Planning

Based on this strategic framework document, CHAG health facilities, the CHCUs and the Secretariat will formulate annual Programs of Work (POW) addressing the critical issues identified and other areas of concern described in the context analysis. The POWs will detail specific programs, activities, priorities, implementation modalities and budgets that respective levels will design. The POWs will reflect the specific context and mandates of each of the levels of the CHAG network and will be complementary and coordinated as much as possible where desirable and realistic.

3.5.4 Monitoring and Verification for Results

Appraisal of the realization of strategic objectives is done with CHAG's Monitoring and Evaluation (M&E) framework; the Organizational Performance Assessment Tool (OPAT). The OPAT is applied both at the health facility level as well as the aggregate CHCU and network level. OPAT provides the framework for the periodic assessment of organizational capacity and the extent to which health outcomes are achieved in line with National health sector objectives and impacts.

Organizational capacity is measured by assessing key indicators for the quality, ability and functionality of the 9 HSS blocks in line with objectives as outlined in this strategic plan. Appraisal of health outcomes relate to the extent in which the network is able to contribute to: (1) improve key health indices; (2) increase responsiveness to the burden of disease; (3) protect clients from financial risks; (4) increase access and coverage of health services; (5) provide quality and safety of health services and; (6) maintain and improve efficiency in delivery of services. Annex 2 provides an overview of all OPAT indicators. It furthermore provides a baseline of institutional health indices in relation to National baseline (2012).

Annex 1: Critical Challenges across CHAG Network

HSS Block	Critical Network Issues to be addressed during 2014 to 2016
Leadership and governance	Limited awareness and capacity on strategic leadership and governance practices especially in the area of organizational and institutional development across the network;
	Members selectively comply to internal CHAG network processes and guidelines
Human Resource for Health	Shortage and un-equal distribution of key professional health staff across the network
	Significantly high attrition of professional staff: Internal and external migration (e.g. within CHAG and across to GHS)
	Inadequate capacity amongst members in human resource planning, management and supervision across the network;
	Different potentially conflicting guidelines within sector and network
	Declining performance of CHAG health training institutions (pass rate and quality of graduates)
Health Service Delivery	Local disease burden is not adequately addressed by services provided by health facilities
	Member institutions do not sufficiently address some important neglected health conditions and services (mental health, emergency medical services and non-communicable diseases).
	Patient Safety and quality of care is not consistently or systematically addressed.
	Low maternal and child health indicators
Health Financing	Persistent delays in NHIS claims reimbursement
	Inefficient management of NHIS claims by members
	Low NHIS tariffs for medicines and specialist services in particular
	Inability of facilities to comprehensively report on financial data on their operations
	Network members have insufficient funds for capital investment
Health Technology	Dilapidated health facilities infrastructure, plant and equipment;
	High cost of equipment and drugs.
Health Management Information System	Inadequate data management and use at all levels of the network
	Different software which are not interoperable and are unable to provide the required information
Community Participation	Limited engagement of health facilities with communities in planning of health services
Partnerships for Health Development	Need for improved coordination and collaboration of CHAG activities at at all levels but more especially at the regional and district level
	Limited collaboration between CHAG health facilities and GHS at the Region, District and sub-district levels;
	Limited knowledge, understanding and compliance with MOH/CHAG Memorandum of Understanding (MOU) amongst network members
	Members are not aware of or adequately accessing new partnership opportunities available locally and internationally
Research for Health	Limited capacity within the network to do research (design, implement, document and disseminate)
	Good practices within the network and the sector are not sufficiently collated, documented and shared

Annex 2: Performance and Health Outcome Indicators

Annex 2, table 1 provides an overview of indicators and measures to assess organisational capacity and performance of CHAG health facilities. Indicators are proxy to measure progress, quality, ability and functionality in each of the 9 HSS blocks.

Table 1: 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	Mobilizing Funds	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

Annex 2, table 2 provides an overview of indicators assessing the extent to which the network is able to contribute to: (1) improve key health indices; (2) increase responsiveness to the burden of disease; (3) protect clients from financial risks; (4) increase access and coverage of health services; (5) provide quality and safety of health services and; (6) maintain and improve efficiency in delivery of services. New indicators may be added over time, to reflect the local disease burden.

Table 2: Facility Health Outcome Indicators

Indicator	Measure
Health Outcomes	Under Five Mortality
	Neo-Natal Mortality
	Maternal Mortality
	Malaria Mortality
	Malaria Incidence
	HIV Prevalence
Responsiveness	Client Satisfaction
Financial Risk Protection	Health Insurance Coverage
Service Utilization	Out-Patient Ratio
	In-Patient Ratio
	Immunization Ratio
	Ante-Natal Visits per Client
	Referral Ratio
Quality and Safety	Fresh Still Birth
	Compliance with Treatment Protocols
	Post-Surgical Wound Infection
Efficiency	Client-Cost Ratio
	Bed Occupancy Ratio

Annex 3: CHAG Membership

Annex 3 provides a status overview of the membership of CHAG as per December 2013. Health facilities are registered as individual members subject to a defined set of criteria and a periodic membership audit.

Facility		Type	Denomination	Region
1	Church of Christ Mission Clinic, Bomso-Kumasi	Clinic	Church Christ Mis.	Ashanti
2	Bryant Hospital, Obuasi-Adansi	Hospital	Church of Pentecost	Ashanti
3	St. Luke's Hospital, Kasei	Hospital	Church of Pentecost	Ashanti
4	Alpha Medical Centre, Madina	Hospital	Church of Pentecost	Greater-Accra
5	Pentecost Clinic, Kasapin	Clinic	Church of Pentecost	Brong-Ahafo
6	Pentecost Clinic, Kpasa	Clinic	Church of Pentecost	Volta
7	Pentecost Clinic, Yawmatwa	Clinic	Church of Pentecost	Western
8	Pentecost Community Clinic, Twifu Agona	Clinic	Church of Pentecost	Central
9	Pentecost Clinic, Ayanfuri	Clinic	Church of Pentecost	Central
10	Pentecost Clinic, Tarkwa	Clinic	Church of Pentecost	Western
11	Emmanuel Medical Centre, East Legon	Specialist Clinic	Church of Pentecost	Greater-Accra
12	Janie Speaks A.M.E Zion Hospital, Afrancho	Hospital	AME – Zion Church	Ashanti
13	Anglican Health Centre, Tano-Odumase	Health Centre	Anglican Church	Ashanti
14	Anglican Clinic, Sefwi-Bonzain	Clinic	Anglican Church	Western
15	Anglican Eye Clinic, Jachie	Clinic	Anglican Church	Ashanti
16	Bishop Anglioby Memorial Clinic, Sefwi-B	Clinic	Anglican Church	Western
17	St. Mark's Anglican Clinic, Subiri	Clinic	Anglican Church	Western
18	Anglican Clinic, Widnaba	Clinic	Anglican Church	Upper East
19	Christian Eye Centre, Cape Coast	Specialist Clinic	Anglican Church	Central
20	Christian Eye Centre, Abesim	Specialist Clinic	Anglican Church	Brong-Ahafo
21	Anglican Clinic, Yelwoko	Clinic	Anglican Church	Upper East
22	Saboba Medical Centre, Saboba	Hospital	Ass. of God Church	Northern
23	The Kings Medical Centre, Bontanga	Hospital	Ass. of God Church	Northern
24	Ass. of God H'lth Services, Nakpanduri	Clinic	Ass. of God Church	Northern
25	Baptist Medical Centre, Nalerigu	Hospital	Baptist Church	Northern
26	Coast for Christ Baptist Hospital	Hospital	Baptist Church	Central
27	Calvary Baptist Micro-Clinic, Cape Coast	Clinic	Baptist Church	Central
28	God's Glory Baptist Clinic, Kronom – Kum	Clinic	Baptist Church	Ashanti
29	St. Martin's Hospital, Agroyesum	Hospital	Catholic Church	Ashanti
30	St. Peter's Hospital, Jacobu	Hospital	Catholic Church	Ashanti
31	Our Lady Grace Hospital, Breman-Asikuma	Hospital	Catholic Church	Central
32	St. Francis Xavier Hospital, Assin-Fosu	Hospital	Catholic Church	Central
33	St. Elizabeth Hospital, Hwidiem	Hospital	Catholic Church	Brong-Ahafo
34	Mathias Hospital, Yeji	Hospital	Catholic Church	Brong-Ahafo
35	St. Michael's Hospital, Pramso	Hospital	Catholic Church	Ashanti
36	Holy Family Hospital, Berekum	Hospital	Catholic Church	Brong-Ahafo
37	Catholic Hospital, Apam	Hospital	Catholic Church	Central
38	St. Mary's Hospital, Drobo	Hospital	Catholic Church	Brong-Ahafo
39	St. Joseph's Hospital, Jirapa	Hospital	Catholic Church	Upper West
40	Mary Theresa Hospital, Dodi-Papase	Hospital	Catholic Church	Volta
41	Sacred Heart Hospital, Weme-Abor	Hospital	Catholic Church	Volta

42	St. Anthony's Hospital, Dzodze	Hospital	Catholic Church	Volta
43	Anfoega Catholic Hospital, Anfoega	Hospital	Catholic Church	Volta
44	Margaret Marquart Cath. Hosp, Kpando	Hospital	Catholic Church	Volta
45	St. Dominic's Hospital, Akwatia	Hospital	Catholic Church	Eastern
46	Holy FamilyHospital, Nkawkaw	Hospital	Catholic Church	Eastern
47	St. Theresa's Hospital, Nandom	Hospital	Catholic Church	Upper West
48	St. Martin's Hospital, Agomanya	Hospital	Catholic Church	Eastern
49	St. Joseph's Hospital, Koforidua	Hospital	Catholic Church	Eastern
50	St. Theresa's Hospital, Nkoranza	Hospital	Catholic Church	Brong-Ahafo
51	St. Joseph's Hospital, Nkwanta	Hospital	Catholic Church	Volta
52	Catholic Hospital, Battor	Hospital	Catholic Church	Volta
53	St. Martin de Porres Hospital, Eikwe	Hospital	Catholic Church	Western
54	St. Patrick's Hospital, Maase-Offinso	Hospital	Catholic Church	Ashanti
55	St. John of God Hospital, Sefwi-Asafo	Hospital	Catholic Church	Western
56	Comboni Hospital, Sogakope	Hospital	Catholic Church	Volta
57	St. John of God Hosp., Duayaw-Nkwanta	Hospital	Catholic Church	Brong-Ahafo
58	Holy Family Hospital, Techiman	Hospital	Catholic Church	Brong-Ahafo
59	Fr. Thomas A. R.Memo. Hosp, Asankragwa	Hospital	Catholic Church	Western
60	West Gonja Hospital, Damango	Hospital	Catholic Church	Northern
61	Merci Women's Hospital, Mankessim	Hospital	Catholic Church	Central
62	St. Louis Health Centre, Bodwesango	Health Centre	Catholic Church	Ashanti
63	Benito Menni Health Centre, Dompoase	Health Centre	Catholic Church	Ashanti
64	Sacred Heart Health Centre, Bepoase	Health Centre	Catholic Church	Ashanti
65	St. John's Health Centre, Domeabra	Health Centre	Catholic Church	Ashanti
66	St. Theresa Health Centre, Zorko	Health Centre	Catholic Church	Upper East
67	St. Lucas Health Centre, Wiaga	Health Centre	Catholic Church	Upper East
68	Martyrs of Uganda Health Centre, Sirigu	Health Centre	Catholic Church	Upper East
69	St. Joseph Health Centre, Nakolo	Health Centre	Catholic Church	Upper East
70	Holy Spirit HC, Kwesi Fante, Afram Plains	Health Centre	Catholic Church	Eastern
71	Tuna Health Centre	Health Centre	Catholic Church	Northern
72	St. Luke's Health Centre, Seniagya	Health Centre	Catholic Church	Ashanti
73	Imma. Concept. of Mary H. Centre, Kongo	Health Centre	Catholic Church	Upper East
74	Tatale Health Centre, Tatale	Health Centre	Catholic Church	Northern
75	St. Mary's Clinic, Yapesa	Clinic	Catholic Church	Ashanti
76	St. Thomas Gen. & Maternity, Hiaa	Clinic	Catholic Church	Ashanti
77	St. Edward's Clinic, Dwinyama	Clinic	Catholic Church	Ashanti
78	Holy Child Clinic, Fijai	Clinic	Catholic Church	Western
79	Notre Dame Clinic, Nsawam	Clinic	Catholic Church	Eastern
80	St. Peter's Clinic/Maternity Home, Ntobroso	Clinic	Catholic Church	Ashanti
81	Catholic Clinic, Akim-Swedru	Clinic	Catholic Church	Eastern
82	St. John's Clinic, Akim-Ofoase	Clinic	Catholic Church	Eastern
83	St. Andrew's Clinic and Maternity, Kordieba	Clinic	Catholic Church	Greater-Accra
84	St. Joseph Clinic & Mat Home, Chamba	Clinic	Catholic Church	Northern
85	St. Ann's Maternity Clinic, Donyina	Clinic	Catholic Church	Ashanti
86	St. Gregory Catholic Clinic, Gomoa Budum	Clinic	Catholic Church	Central
87	Mater Ecclesiae Clinic, Sokode	Clinic	Catholic Church	Volta
88	St. George's Clinic, Liati	Clinic	Catholic Church	Volta
89	St. Martin's PHC/ Maternity Clinic, Bui	Clinic	Catholic Church	Upper East

90	St. Luke's Catholic PHC Clinic, Chinderi	Clinic	Catholic Church	Volta
91	Catholic Clinic, Oku Ejura	Clinic	Catholic Church	Ashanti
92	St. Joseph's Clinic, Abira	Clinic	Catholic Church	Ashanti
93	St. Joseph Clinic & Mat, Kwahu-Tafo	Clinic	Catholic Church	Eastern
94	St. Michael's Catholic Clinic, Ntronang-Akim	Clinic	Catholic Church	Eastern
95	St. Joseph's HC, Kalba	Clinic	Catholic Church	Northern
96	Holy Child Clinic, Egyam	Clinic	Catholic Church	Western
97	Catholic Clinic/PHC Unit, Salaga	Clinic	Catholic Church	Northern
98	St. Lucy's Polyclinic, Tamale	Clinic	Catholic Church	Northern
99	Holy Cross Clinic/maternity, Sambuli	Clinic	Catholic Church	Northern
100	Abease PHC Project, Prang/Abease	PHC	Catholic Church	Brong-Ahafo
101	Catholic PHC, Bole	PHC	Catholic Church	Northern
102	Wa Diocese PHC Project	PHC	Catholic Church	Upper West
103	Our Lady of Rocio PHC, Walewale	PHC	Catholic Church	Northern
104	Orthopaedic Training Centre, Nsawam	Training Inst.	Catholic Church	Eastern
105	Holy Family Midwifery College, Berekum	Training Inst.	Catholic Church	Brong-Ahafo
106	St. Joseph's Midwifery College, Jirapa	Training Inst.	Catholic Church	Upper West
107	Holy Family Nurses Train.College, Nkawkaw	Training Inst.	Catholic Church	Eastern
108	St. Patrick's Midwif. School, Maase-Offinso	Training Inst.	Catholic Church	Ashanti
109	Church of God Clinic, Essienimpong	Clinic	Church of God	Ashanti
110	EP Nazareth Healing Complex, Vane Avatime	Clinic	Evangelical Presby.	Volta
111	EP Dan Moser Memo. Clinic, Dambai	Clinic	Evangelical Presby.	Volta
112	EP Clinic, Wapuli	Clinic	Evangelical Presby.	Northern
113	EP Church Health Services, Ho	PHC	Evangelical Presby.	Volta
114	Global Evangelical Mission Hospital, Apromase	Hospital	Global Evan. Church	Ashanti
115	Lighthouse Mission Hospital, North Kaneshie	Hospital	Lighthouse Mission	Greater-Accra
116	Manna Mission Hosp, Teshie-Nungua	Hospital	Manna Mission	Greater-Accra
117	Methodist Faith Healing Hospital, Ankaase	Hospital	Methodist Church	Ashanti
118	Methodist Hospital, Wenchi	Hospital	Methodist Church	Brong-Ahafo
119	Methodist Clinic, SenchiClinic		Methodist Church	Ashanti
120	Lake Bosumtwi Methodist Clinic, Amakom	Clinic	Methodist Church	Ashanti
121	Methodist Clinic, Bebu – Anyiaem	Clinic	Methodist Church	Ashanti
122	Methodist Clinic, Nyameani	Clinic	Methodist Church	Ashanti
123	Methodist Clinic, Brodekwano	Clinic	Methodist Church	Ashanti
124	Methodist Clinic, Lawra	Clinic	Methodist Church	Upper West
125	Methodist Clinic, Aburaso	Clinic	Methodist Church	Ashanti
126	Presbyterian Hospital, Agogo,	Hospital	Presby. Church	Brong-Ahafo
127	Presbyterian Hospital, Bawku	Hospital	Presby. Church	Upper East
128	Presbyterian Hospital, Dormaa-Ahenkro	Hospital	Presby. Church	Brong-Ahafo
129	Presbyterian Hospital, Donkorkrom	Hospital	Presby. Church	Eastern
130	Garu Health Centre, Garu	Health Centre	Presby. Church	Upper East
131	Tease Presby Health Centre, Afram Plains	Health Centre	Presby. Church	Eastern
132	Widana Health Centre, Widana	Health Centre	Presby. Church	Upper East
133	Kom Clinic, Aburi	Clinic	Presby. Church	Eastern
134	Presbyterian Clinic, Papueso-Enchi	Clinic	Presby. Church	Western
135	Presbyterian Clinic, Assin-Praso	Clinic	Presby. Church	Central
136	Presbyterian Clinic, Assin Nsuta	Clinic	Presby. Church	Central

137	Presbyterian Clinic , Kwamebikrom	Clinic	Presby. Church	Brong-Ahafo
138	Presbyterian Clinic, Aboabo	Clinic	Presby. Church	Brong-Ahafo
139	Presbyterian Clinic, KojoKumikrom	Clinic	Presby. Church	Brong-Ahafo
140	Presbyterian Clinic, Kwamesua	Clinic	Presby. Church	Brong-Ahafo
141	Presbyterian Clinic, Kyeremasu	Clinic	Presby. Church	Brong-Ahafo
142	Jenjemireja Clinic, Drobo	Clinic	Presby. Church	Brong-Ahafo
143	Presbyterian Clinic, Langbinsi-Gambaga	Clinic	Presby. Church	Northern
144	Presbyterian PHC, Enchi	PHC	Presby. Church	Western
145	Presbyterian PHC , Agogo	PHC	Presby. Church	Ashanti
146	Presbyterian PHC, Bawku	PHC	Presby. Church	Upper East
147	Presbyterian PHC, Sandema	PHC	Presby. Church	Upper East
148	Presbyterian PHC, Bolgatanga	PHC	Presby. Church	Upper East
149	Presby PHC Project, Dormaa-Ahenkro	PHC	Presby. Church	Brong-Ahafo
150	Woriyanga Presby. Health Centre, Bawku	PHC	Presby. Church	Upper East
151	Ekye Presbyterian Health Centre, Ekye	PHC	Presby. Church	Eastern
152	Kwahu-Praso Presby Clinic, Kwahu-Praso	PHC	Presby. Church	Eastern
153	Abetifi Presbyterian PHC, Abetifi	PHC	Presby. Church	Eastern
154	Nurses Training College, Agogo	Training Inst.	Presby. Church	Ashanti
155	Presby. Nurses Training College, Bawku,	Training Inst.	Presby. Church	Upper East
156	Sight for Africa Eye clinic, Accra	Clinic	RUN Mission	Greater-Accra
157	Hawa Mem. Saviour Hospital, Akim-Osiem	Hospital	Saviour Church	Eastern
158	Seventh-Day Adventist Hospital, Asamang	Hospital	Seventh Day Advent	Ashanti
159	Seventh-Day Adventist Hospital, Wiamoasi-Ashanti	Hospital	Seventh Day Advent	Ashanti
160	Akoma Mem. SDA Hosp. Kortwia-Abodom	Hospital	Seventh Day Advent	Ashanti
161	Seventh-Day Adv. Hosp., Dominase	Hospital	Seventh Day Advent	Ashanti
162	Seventh-Day Adv. Hosp., Kwadaso-Kumasi	Hospital	Seventh Day Advent	Ashanti
163	SDA Hospital, Koforidua	Hospital	Seventh Day Advent	Eastern
164	SDA Hospital, Sunyani	Hospital	Seventh Day Advent	Brong-Ahafo
165	Seventh-Day Adventist Hospital, Tamale	Hospital	Seventh Day Advent	Northern
166	SDA Clinic, New Gbawe	Clinic	Seventh Day Advent	Greater-Accra
167	SDA Clinic and Maternity, Sefwi-Asawinso	Clinic	Seventh Day Advent	Western
168	SDA Clinic, Kofikrom	Clinic	Seventh Day Advent	Western
169	Nagel Memorial Clinic, Takoradi	Clinic	Seventh Day Advent	Western
170	SDA Clinic, Konkoma	Clinic	Seventh Day Advent	Ashanti
171	SDA Health Asst. Training School, Asanta	Training Inst.	Seventh Day Advent	Western
172	SDA Nurses Training College, Kwadaso	Training Inst.	Seventh Day Advent	Ashanti
173	Siloam Gospel Clinic, Bonyere	Clinic	Siloam Gospel	Western
174	Urban Aid Health Centre, Mamobi	Health Centre	The Salvation Army	Greater-Accra
175	Salvation Army Clinic, Wiamoase	Clinic	The Salvation Army	Ashanti
176	Salvation Army Clinic, Agona-Duakwa	Clinic	The Salvation Army	Central
177	Salvation Army Clinic, Baa	Clinic	The Salvation Army	Central
178	Salvation Army Clinic, Anum	Clinic	The Salvation Army	Eastern
179	Salvation Army Clinic, Begoro	Clinic	The Salvation Army	Eastern
180	Salvation Army Clinic, Adaklu-Sofa	Clinic	The Salvation Army	Volta
181	Salvation Army Clinic, Akim-Wenchi	Clinic	The Salvation Army	Eastern
182	Kpandai Health Centre, Kpandai	Health Centre	WEC Mission	Northern
183	Word Alive School of Nursing, Esiama	Training Inst.	Word Alive Mission	Western