CHAG NEWS
A Newsletter of the Christian Health Association of Ghana
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Dr. Gilbert Buckle

Message from the Executive Director

I would like to welcome you all and introduce you to the maiden edition of the CHAG Newsletter.

I congratulate us all for standing firm in what we believe in and always performing our duties keeping in mind our mandate.

We may be overwhelmed by the load of work on us, but we have stood the test of time. I believe in you, your ability to be innovative, continuously setting the pace for other health care providers to emulate.

The adoption of the System's thinking has shown to all of us that it is possible to holistically assess our performance and adopt the system's approach to addressing our challenges to achieve desired health out-comes.

CHAG is very much visible now because you have given the Secretariat the mandate and supported it to engage key stakeholders on your behalf and this is yielding results.

I wish to encourage you to continue to look for the best ways of doing things. ■

THE HEALTH SERVICE
Christian Health Association of Ghana

The Christian Health Association of Ghana (CHAG) is a faith-based network organisation of 21 Christian church denominations, involved in the provision of health care and training of health professionals. Established in 1967, the Association currently comprises 58 hospitals, 114 health centres and clinics, and 12 health training institutions, Membership has gone up from 25 in 1967 to 184 in 2010 (refer to 2011 annual report for details on this).

CHAG was initially founded, in 1967, as a Voluntary Professional Association and subsequently registered as a Corporate Body in 1968 under the Trustees (Incorporation) Act, 1962 Act 106, the Ghana Catholic Bishops Conference and the Christian Council of Ghana are the main stakeholders in the Association. The Ghana Pentecostal Council was later admitted into membership as an Associate Member.

CHAG's governance structure is derived from its constitutions. The governance structure comprises three very distinct layers: i.e. the Council, the Board and Secretariat.

The Council meets once a year to discuss issues of concern to members thus setting the direction of the organisation in any given year. The Board is composed of nominated representatives of the Ghana Catholic Bishops' Conference and the Christian Council of Ghana and the Ghana Pentecostal Council. The Board is tasked to support and monitor the implementation of decisions and programmes by the secretariat that serve the interest of members. The Secretariat is responsible for managing the network and ensuring that the aims and objectives of the association and the needs of members towards contributing to the achievement of national health outcomes are met.

The uniqueness of CHAG as an organisation is the independence and autonomy of its members. This is recognised as the strength of the organisation where the diversity of its members is respected and harnessed for human centred, affordable and high quality patient care. ■

EDITORIAL

CHAG is the 2nd largest provider of Health Care Service after Ghana Health Service in Ghana. The catchment area population she serves it mainly rural or peri-urban and strives at all times to be innovative in providing services to its clients guided by her Core Values.

The contribution of CHAG to improve the National Health Outcomes is seen in the limited inputs that are used to deliver high quality services with support of evidence based information to continuously improve performance.

This maiden edition contains valuable information concerning CHAG's performance as a network extracted from your facility data, teams commis-sioned to undertake researches and results of research carried out.

We encourage all with interesting articles on your work to share with us to include in our subsequent editions.

In this Issue

PERFORMANCE OF CHAG

Member Institutions in Tamale to Review Performance and take critical decisions concerning Health Care Provision

In the past few years, CHAG has repositioned itself to become relevant in the health sector. This, it has achieved through negotiations, lobbying and advocacy backed by the use of factual data from the performance of its members institutions.

CHAG Member institutions (MIs) continue to provide services to clients in their hard to reach catchment areas. In 2011, the information from Member Institutions and Church Health Coordinating Units but excluding Training Institutions, on their performance gives account of the role the organization plays in the health sector from a Health Systems perspective. CHAG has adopted the Ouagadougou Declaration Model of Health Systems Strengthening as a framework for improving performance and reporting. The model recognises the following system blocks; Leadership and Governance, Health Service Delivery, Human Resource for Health, Health Financing, Health Information, Health Technologies, Community Ownership and Participation, Partnerships for Health Development and Research for Health.

CHAG provides preventive, promotive, curative and rehabilitative care packages that contribute to the achievement of national health outcomes. Service provision approaches are informed by the emerging disease profile of communicable and non-communicable diseases and the obligations imposed on it towards the achievement of national and international health priorities. Services are provided in line with good practices that meet standard professional norms and procedures.

Outpatient Care

CHAG member institutions contributed 19.2% to the national OPD load in 2010 which increased to 20% in 2011.

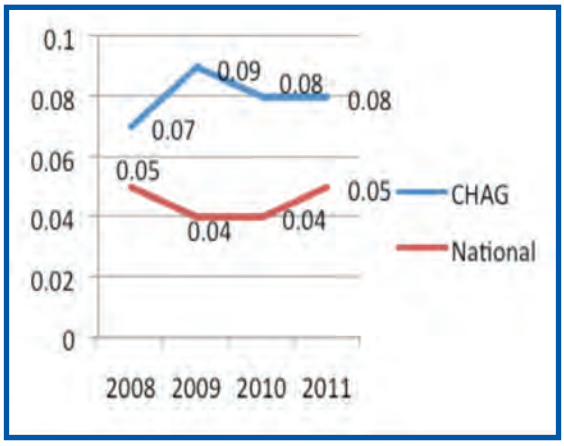
Inpatient Care

CHAG also accounted for 33% and 37% nationally of all inpatient care in 2011 and 2010 respectively. The rate nationally was 25.7 in 2011 and 39.7 deaths/1,000 admissions in 2010. In general CHAG facilities admit proportionately more patients than what pertains nationally. This is depicted by the inpatient outpatient ratio distribution in figure 1 over a 4-year period. However, this has not been investigated to determine the reasons for it. ■

CHAG CALENDAR OF KEY EVENTS

Board Meetings: 28th February, 21st May, 25th July, 21st November
Church Health Coordinators' Meetings: 20th March,19th September
Annual Review Meetings of Church Health Units: As and when
Annual Conference and Council Meeting: 21st May
Christmas Break: 20th December

Figure 1 :
In Patient Out-Patient Load Ratios of CHAG and National, 2008 – 2011



Thus, a total of 394,442 and 339,342 clients were admitted in 2011 and 2010 respectively with 9,161 and 8,038 of them respectively dying. These yielded an all-cause mortality rate of 23.2 in 2011 and 23.7 deaths/1,000 admissions in 2010.

Morbidity

In CHAG facilities, malaria has continued to top the list of conditions that send clients to the OPD, despite the enormous injection of resources to combat it. It was responsible for 35% of all cases that were seen in 2011 as against 34% in 2010. ARI, Hypertension, Skin diseases and Ulcers, Rheumatism and Diarrhoeal diseases, Acute Eye Infections and Anaemia have remained in the top ten diseases since 2008. The top 10 causes of OPD attendance have largely remained the same and have only changed positions year on year.

Mortality

CHAG member institutions recorded 232 institutional maternal deaths in 2011 as against 146 in 2010. These resulted in maternal mortality ratios of 254/100,000 live births in 2011and 181/100,000 live births in 2010. 76.7% and 76% of these deaths were audited in 2011 and 2010 respectively. It is difficult to say that there was an actual increase in the rate because of the higher representativeness and hence reliability of the 2011 data. Maternal mortality ratio nationally was 173 in 2011 as against 163/100,000 live births in 2010.

Whereas still birth rates have been worse than that of the national in the two year period, supervised delivery coverage rates were better across the CHAG network.

HIV and AIDS Care

CHAG member institutions continue to provide services to people living with HIV&AIDS in ARV treatment and Home Based Care (HBC). Out of a total of 18,156 PLHIV in 2011 and 18,463 in 2010, 31% and 25% respectively were on ARV treatment an increase of 19.7%. The percentage of PLHIV on HBC also increased to 35% in 2011 from 23% in 2010, an increase of 46.8%. HIV/AIDS was the second cause of death in 2011 and 2010 and it accounted for 7% and 6.4% respectively of all deaths in the network.

HUMAN RESOURCE FOR HEALTH

The availability of qualified and motivated staff at all levels of CHAG continued to be a basic requirement to improve CHAG's contribution towards achieving national health outcomes.

The network had a staff strength of 8,861in 2011 as against 7,302 in 2010, an increase of 21.4%. This notwithstanding, data on staff distribution in CHAG continued to show that there still existed inequitable distribution of professional staff among CHAG member health services and the public sector. The doctor patient ratio in CHAG in 2011for instance was 21,357 as against 15,896 nationally. The situation in 2010 in CHAG was 25,367 while the national ratio was 21,988. The network recorded a nurse patient ratio of 2,200 while the national had 1,440 in 2011. In 2010 the nurse patient ratio in CHAG was 2,043 as against a national average of 1,304.

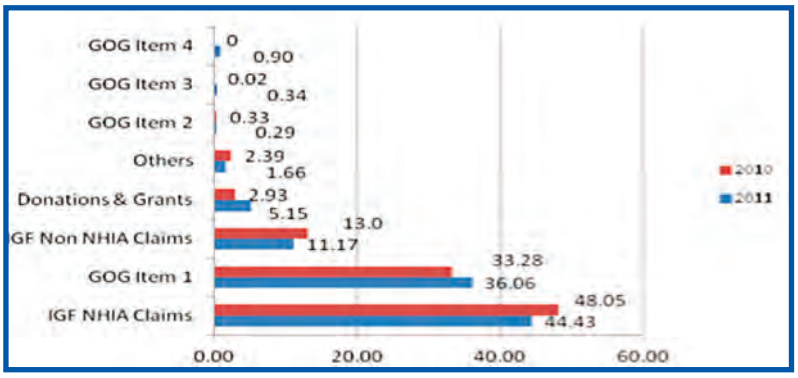
FINANCING CHAG ACTIVITIES

CHAG is financed through government contribution, direct funding support from development partners, internally generated funds and grants/donations.

The CHAG network comprised 172 NHIA accredited health care facilities and 10 health training institutions country wide.

Government support accounted for 38% of total inflows in 2011 as against 34% 2010. In 2011, 96% of government inflows went into personnel emoluments as against 99% in 2010. The remaining 4% was spent on goods and services (2%) and infrastructure (2%) in 2011. In 2010, 99% of government inflows went into paying salaries and only 1% supported capital investments. IGF generated mainly from NHIA reimbursements which had a 4 to 5 month delay period contributed 60%. Grants, donations, direct funding from development partners and other sources contributed 7% in 2011 as against 5% in 2010. Figure 2 shows the proportion of inflows coming into CHAG from its recognised sources.

Figure 2: Percentage Income by Item, 2010 - 2011



RESEARCH FOR HEALTH

Technical Working Groups

CHAG in 2010 adopted the nine (9) Health System Strengthening model as the performance management framework across the network.

In order to document innovations and get evidence on the performance of CHAG member institutions, Technical Working Groups (TWGs) for each of the HSS blocks except "Research for Health" have been inaugurated to undertake researches. Their inauguration took place in October 2012 at Holy Trinity Spa and Health Farm located in Sogakope. The groups are made up of technical Officers from CHAG member institutions and from the health sector.

The TWGs were tasked to undertake research into issues of concern to CHAG facilities. The proposed research topics the TWGs will be working on for 2013 are presented below:

TECHNICAL WORKING GROUPS
SUMMARY OF RESEARCH TOPICS

HSS BLOCK	RESEARCH TOPIC
Leadership & Governance	To what extent does service delivery data interpretation meetings affect management decision making on maternal mortality: Lessons from Duayaw Nkwanta, Hwidiem and Botanga
Health Service Delivery	Improving Skilled Attendance (ANC, Delivery, PNC): Incorporating Clients Preference Into Our Health Care Delivery Process.- The Botanga Experience Increased supervised delivery; what worked? The Botanga case study.
Human Resource for Health Development	Retention of Maternal Health Workforce in rural CHAG institutions: lessons from Battor Catholic Hospital in the North Tongu District in the Volta Region of Ghana Geographical distribution of midwives on maternal health outcomes in CHAG institutions.
Community Ownership and Participation	Improving Skilled Attendance And Birth Outcomes Through Traditional Birth Attendants (TBA) Collaboration. A Case Stud. A Case Study Of Goase Diocese
Partnership Development	Leveraging Partnerships to reduce maternal mortality: The Techiman experience.
Health Technologies	Implementing Performance Improvement Protocols In Selected Essential Medications (Magnesium Sulphate, Oxytocin, And Ergometrine) To Reduce Maternal Mortality. Lessons From Saviour Hospital, Osiem And St. Martins De Porres Hospital, Agomanya
Health Finance	Capitation and selection of preferred primary health provider by pregnant women in Ashanti Region.
Health Information	**The effect of improved health management information system on Antenatal care 4 plus visits. A case-study of Pentecost Hospital, Madina and Ankaase Methodist Hospital.**

HIV&AIDS
Home Based Care (HBC) Research

In May 2012, Christian Health Association of Ghana with support from UNAIDS undertook a study in "How HBC is Addressing HIV-Related Stigma and Discrimination against People Living with HIV and AIDS (PLHIV).

Findings

- Stigmatization and discrimination against PLHIV is perpetuated by the society, the family and the health care staff.
- Most of the PLHIV feel depressed and isolated, have low self-esteem and encounter financial difficulties
- Most of the PLHIV have the tendency to commit suicide or have attempted suicide before
- HBC focuses on providing integrated and appropriate home care services to PLHIV.
- The HBC programme was not specifically tailored to reduce stigma and discrimination, but to enhance the total well-being of the PLHIV.
- Almost all the facilities currently focus on the medical needs of the PLHIV as against financial, nutritional and social needs.
- Apart from CHAG facilities, other Stakeholders are involved in the provision of HBC services.

Conclusion/Recommendation

HBC has had a marginal impact in reducing stigma and discrimination of PLHIV. HBC has the potential to address stigma and discrimination against PLHIV if services and other activities carried out are more specifically designed to achieve this.

TIT BITS

1. **Do you know that?**
   CHAG is a body through which the Christian Church related health facilities/programmes liaise with the Ministry of Health to ensure proper collaboration and complementation of government's efforts to provide for the health needs of Ghanaians?

2. **Do you know that?**
   There no longer exists the practice of secondment of health staff? Staff belong to the Health Service of the facilities with which they are working with.

For more Information, contact:
The Executive Director
Christian Health Association of Ghana
21 Jubilee Wells Street, Labone
P.O. Box AN 7316, Accra-North

Phone: (233)302 777 815 • Fax: (233) 30 2772 2226
Email: chag@chag.org.gh • Web: www.chag.org.gh