CHRISTIAN HEALTH ASSOCIATION OF GHANA

(CHAG)

2008 Annual Report

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ACRONYMS

ASRH	Adolescent Sexual and Reproductive Health
CCG	Christian Council of Ghana
CHCU	Church Health Coordinating Unit
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
DANIDA	Danish International Development Assistance
DPs	Development partners
ED	Executive Director
GHS	Ghana Health Service
GOG	Government of Ghana
HIRD	High Impact Rapid Delivery
HMIS	Health Management Information System
HR	Human resources
HRD	Human resource development
IGF	Internally generated funds
IMCI	Integrated Management of Childhood Illnesses
MCH	Maternal and Child Health
MI	Member Institution
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NHIS	National Health Insurance Scheme
NHIA	National Health Insurance Authority

NGO	Non-governmental Organisation
OPD	Outpatients Department
PHC	Primary Health Care
POW	Program of Work
PSC	Partnership Steering Committee
RHN	Regenerative Health and Nutrition
TOR	Terms of Reference
UNFPA	United Nations Populations Fund
RHS	Reproductive Health Service

MISSION, VISION AND FUNCTIONS

INTRODUCTION

The Christian Health Association of Ghana (CHAG) was established by the Christian Council of Ghana (CCG) and the Ghana Catholic Bishops Conference (GCBC) in September 1967 and registered as the Church Hospital Association of Ghana on 21 November 1968, under the Trustees (Incorporation) Act of 1962. In 1984, its name was changed to the Christian Health Association of Ghana (CHAG). Membership of the Association is open to any Christian faith-based health institution is recognized by the Ministry of Health (MOH).

a. Vision

"A Healthy Nation, Christ's Healing Ministry Fulfilled"

b. Mission Statement

CHAG is a non-governmental Organization bringing together Churches involved in the provision of Health Services to provide support to members (Church Leaders, Church Health Coordinating Units and Member Institutions). CHAG serves as a link between government and other development partners on the one hand and members on the other through capacity strengthening, coordination of activities, lobbying and advocacy, public relations and translation of government policies; using professionals and well-motivated staff who are honest, accountable, transparent and committed. In all these CHAG respects the diverse nature of members and individual church's philosophy.

c. Values:

The values of CHAG as stated in the revised Constitution are articulated as follows:

a. Christian identity and witness

b. Unity in Diversity

c. Respect for the dignity of the person

d. Holistic health care

e. Creativity and Excellence

f. Accountability and Transparency

g. Co-orporation and partnership

h. Option for the poor and the marginalized

d. Goals

The revised constitution recognises the following as the goals of CHAG:

1. Strengthening the health service delivery capacity of members.
2. Actively promoting and supporting closer partnerships among Church related Health Services, the Government and other Stakeholders
3. Supporting and participating in the development and implementation of national policies affecting health.
4. Ensuring that the health needs of the poor and marginalized are addressed.

CHAG has also been mandated to perform the following core functions:

1. Advocacy
2. Coordination between the Christian Church Supported Health Services and Government
3. Provision of operational support services to Member Health Institutions
4. Translation of Government policies to Churches and their respective Health Institutions
5. Lobbying for resources and partnerships.

KEY DATA ON CHAG (2008)

Total number of denominations	19
Total number of member institutions	168
Total number of hospitals	59
Total number of Health clinics/Health Centre	86
Total number of PHC programmes	13
Total number of Training Institutions	10
% of regions where CHAG is operating	10/10
Number of districts with CHAG facilities	87
Number of CHAG staff on GoG payroll	6852

FOREWORD BY EXECUTIVE DIRECTOR

The Christian Health Association of Ghana (CHAG) hereby presents its annual performance report for 2008.

The report gives an account on the services being provided by the members of the network. It also summarises the main activities carried out during the period and its associated costs, compares progress against operational targets and reflects on the main events that have impacted the work of the Association.

Proper reporting and recording is important to align the work of CHAG with the new framework for development assistance (notably the Paris Declaration) and comply with the administrative requirements of our Memorandum of Understanding (MoU) with the MOH. Due to this, CHAG, since 2008, has started to compile integrated (technical and financial) quarterly progress reports. This practise has proven to be a useful management tool for monitoring and (re) programming purposes. This document should therefore be read in conjunction with these reports, as well as with progress reports prepared by individual Member Institutions.

The year 2008 may be characterised as a 'turning point' in the recent history of CHAG to the extent that increasingly efforts are being made to plan our operations in line with national health policies and strategies. In this regard, good progress is being reported, though there are still multiple challenges remaining to further streamline our interventions with those of other health care providers and development agencies operating at district level. The decision to synchronise our 2009 Annual Work Plan with the Programme of Work (POW) of the health sector can thus be cited as a good example of improved public-private partnership.

The year also marked the beginning of a process aimed at further strengthening the role of the CHAG Secretariat as advocacy, lobbying, coordinating, technical support and training body. With the recent recruitment of the required technical staff, the collection of additional data and an improved functioning of our 'back office', CHAG hopes to be able to play a more (pro) active role in the sector dialogue and - more importantly- advise its members on new strategies and practices pertaining to the sector.

During the period, numerous capacity building initiatives aimed at improving staff performance at service delivery level (Member Institutions and Church Health Coordinating Units) have been undertaken, particularly in the area of contract and claims management, one of the key challenges our institutions are currently facing.

There is increasing recognition within the Association that our interventions should be increasingly geared towards direct service delivery, information, education, communication and outreach. To improve some of the low health outcomes, primary health care initiatives along with (innovative) inter-sectoral activities, therefore need more priority. CHAG is confident it can take up this

challenge considering the expertise in community development and mobilisation it has built up over the years.

In 2008, it also became clear that some important technical and institutional issues urgently need addressing, such as quality of care, drug supply and management, human resource planning and management. Ways and means will have to be identified to address these new challenges within the Association.

Furthermore CHAG will continue to build solid partnerships with the MOH, GHS and other (public and private) stakeholders, in accordance with the principles set out in its Memorandum of Understanding with the MOH. In so doing, improving data collection and management is an important requirement. The HMIS initiative that started in 2008 will therefore be further pursued.

At the same time, increased focus will be given to our interventions in the area of quality improvement, health financing and health insurance, considering that the budget for health is under pressure and facilities will have to comply with new accreditation criteria in order to qualify for a contract with the National Health Insurance scheme.

We hope that this annual report sufficiently illustrates that CHAG as the country's second largest provider organisation is on the right track to play its designated role in the health sector.

Philibert Kankye

Executive Director – CHAG

CHAPTER I

MAJOR CHALLENGES FOR CHAG IN 2008

The work of CHAG in 2008 was affected by 3 major challenges, being:

- A shift in health priorities;
- Increased pressure on the wage bill;
- And changing administrative relationships between purchaser and provider.

Concerned about slow improvements in health outcomes, persistent under-nutrition, persistence of some diseases that can be easily controlled, neglect of other diseases which intensify poverty, growing burden of non-communicable diseases and uneven performance and productivity, the 2007 external health sector review (the recommendations of which were extensively discussed at the Annual Health Summit held in April) called upon all sector stakeholders to revisit future key strategies. Increased inter-sectoral action, more engagement with District Assemblies, integration and linkages of health initiatives to improve MCH (including HIRD, CHPS, RHN and IMCI) were identified as realistic and feasible options to improve sector performance.

Available HR data suggest that the largest proportion of the health budget is currently being spent on wages and salaries, which leaves the budget of many health facilities with little room for direct service delivery. At the ‘Round Table on Human Resource Development’, organised on 11 April 2008, the importance of the issue was only reconfirmed. The meeting concluded that a broad spectrum of measures - ranging from resource-based planning, better defining staffing indicators and cost containment- need to be taken to put this alarming situation to a hold. At the same time, there is a clear sign that the available government budget for personnel emoluments will remain stable or only grow marginally in foreseeable future.

At health facility level there are quite some outstanding operational issues related to the introduction of the national health insurance scheme. Lack of clarity in billing methods, delay in payment and cumbersome administrative procedures were reported as some of the main bottlenecks in the administrative relationships between purchaser and provider. At the same time new accreditation criteria are being defined, all public and private health facilities will have to comply with in the future to qualify for a contract with the national health insurance scheme.

Confronted with changing health priorities, expected (HR) budget constraints and revised funding modalities, health care providers need identifying alternative options for organising service delivery, deployment of staff and financial management.

For CHAG, being the country's second largest provider's network organisation operating in rural and often hard to reach areas this situation may even be more critical as opposed to other health institutions located in urban areas and serving a wealthier segment of the population.

CHAPTER II SERVICES PROVIDED BY THE NETWORK

2.1 Coverage and Number of Facilities

The number of CHAG Member Institutions (MIs) has grown from 25 in 1967 to 168 in 2008. Currently, there are 59 Hospitals (1 polyclinic inclusive), 78 clinics (3 of them being eye specialist clinics), 8 Health Centres (HCs) and 13 Primary Health Care Centres (PHCs). Besides, there are 10 Training Institutions (TI) active within the CHAG organisation that do not provide direct health services but train personnel for the health sector.

The geographical location of CHAG facilities is summarised in the table below:

Table 2.1: Regional distribution of CHAG facilities

Region	Hospital	Clinic	PHC	TI	HC	Polyclinic	Total	%
Ashanti	17	18	1	3			39	23
Brong Ahafo	10	6	2	2	1		21	12.5
Central	4	6					10	6
Eastern	6	11	2	1	1		21	12.5
Greater Accra	2	3			1		6	3
Northern	5	9	2		2		18	11
Upper East	1	8	3	1	3		16	10
Upper West	2	1	1	2			6	3
Volta	7	6	1			1	15	9
Western	4	10	1	1			16	10
Total	58	78	13	10	8	1	168	100

The table above illustrates that the Ashanti region has the highest (23% of all CHAG facilities) number of facilities, followed by the Brong Ahafo and Eastern regions (12.5% each) and the Northern region (11%). The rest ranging between 3 – 10 % are Greater Accra (3%), Upper West (3%), Central (6%), Volta (9%), Upper East (10%) and Western (10%) regions. It can also be

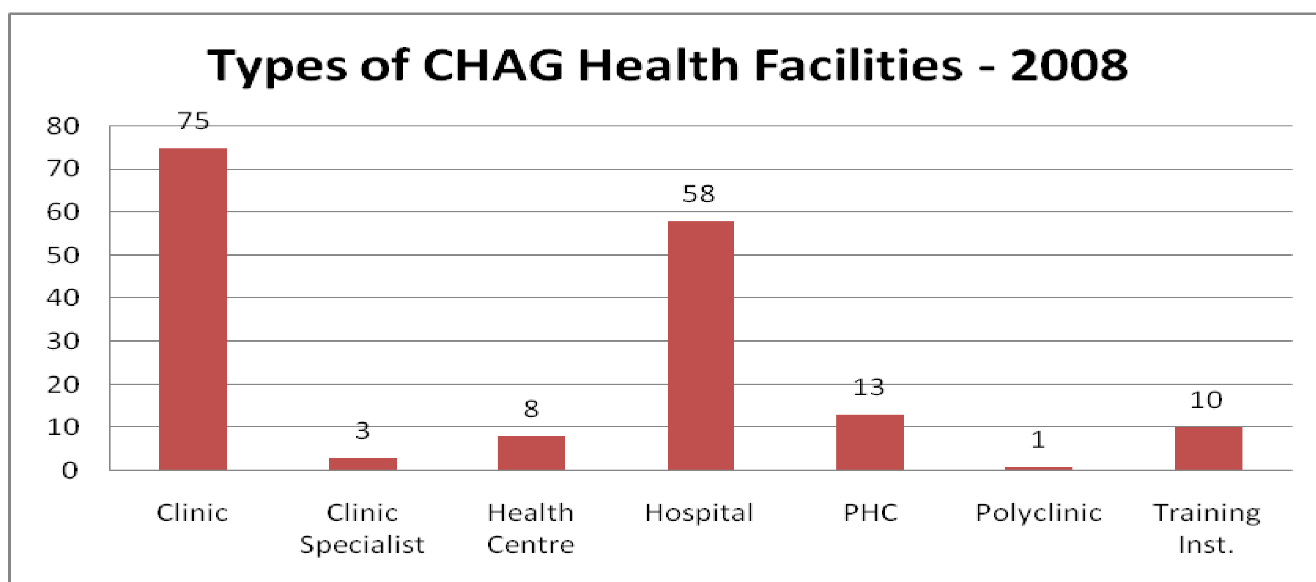
concluded that CHAG facilities mainly operate in rural areas and are aimed at reaching the marginalized and poorest of the poor.

2.2 Type of CHAG Facilities

As illustrated below, CHAG facilities provide a wide range of services to the population of its respective catchment areas. There are clinics, health centres, hospitals and primary health care (PHC) centres situated in mostly rural and semi-urban areas. The number of facilities within CHAG is made up of 45% of clinics, 35% of hospitals, 8% of PHC and 5% of health centres.

In 2008 the average catchment area population for a Health centre ranged between 7,756 – 31,125, while for a clinic and hospital the catchment population ranged between 1,932 – 37,823 and 9,684 – 466,876 respectively.

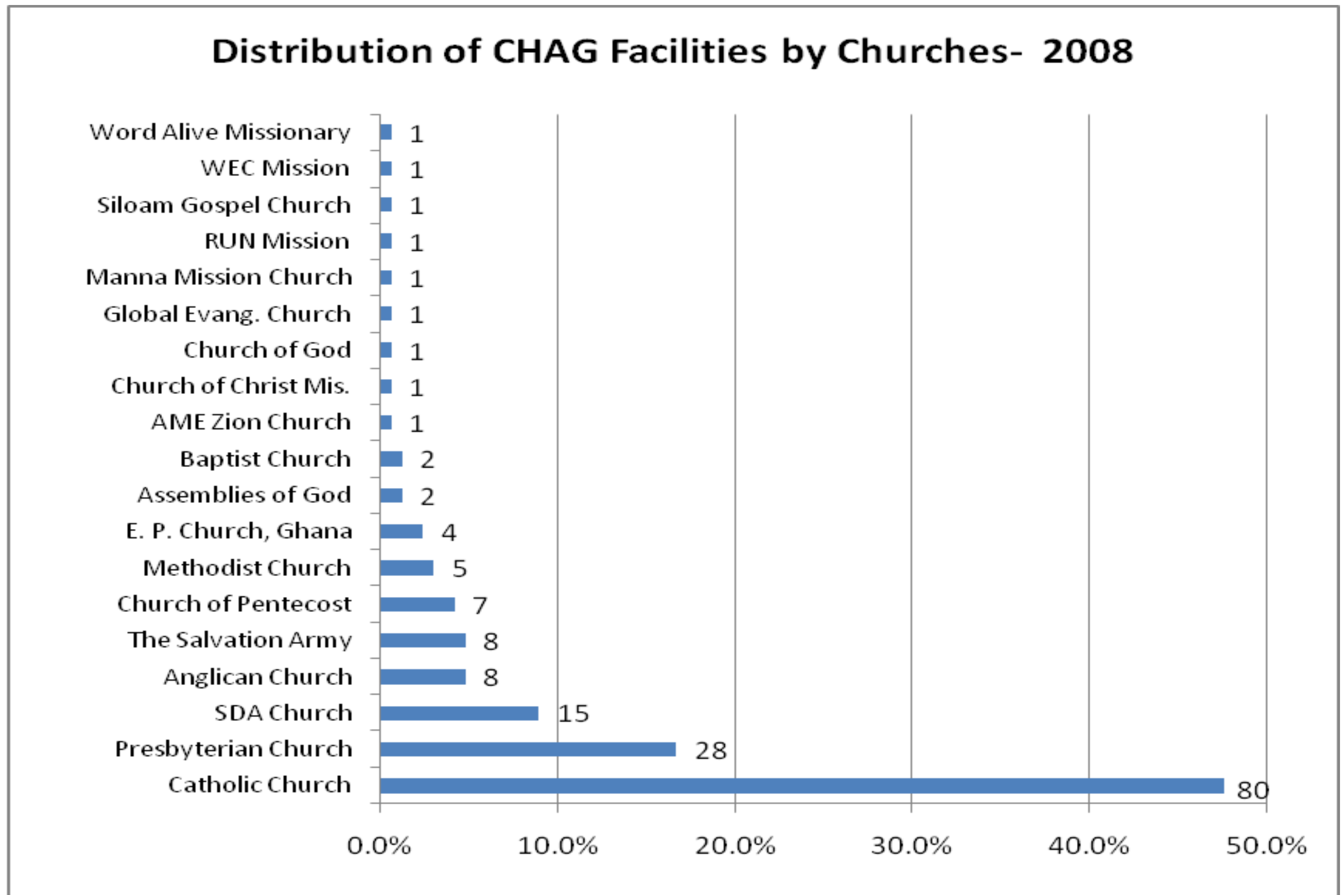
Figure 2.1: Types of Health Facilities



2.3 CHAG facilities by denomination

CHAG is a faith-based network provider network organisation, made up 19 different denominations. In 2008, almost half the health facilities (47.6%) are run by the Catholic Church, followed by the Presbyterian Church with about 17%. Nine church bodies manage but one health facility, as illustrated in more detail in the following table:

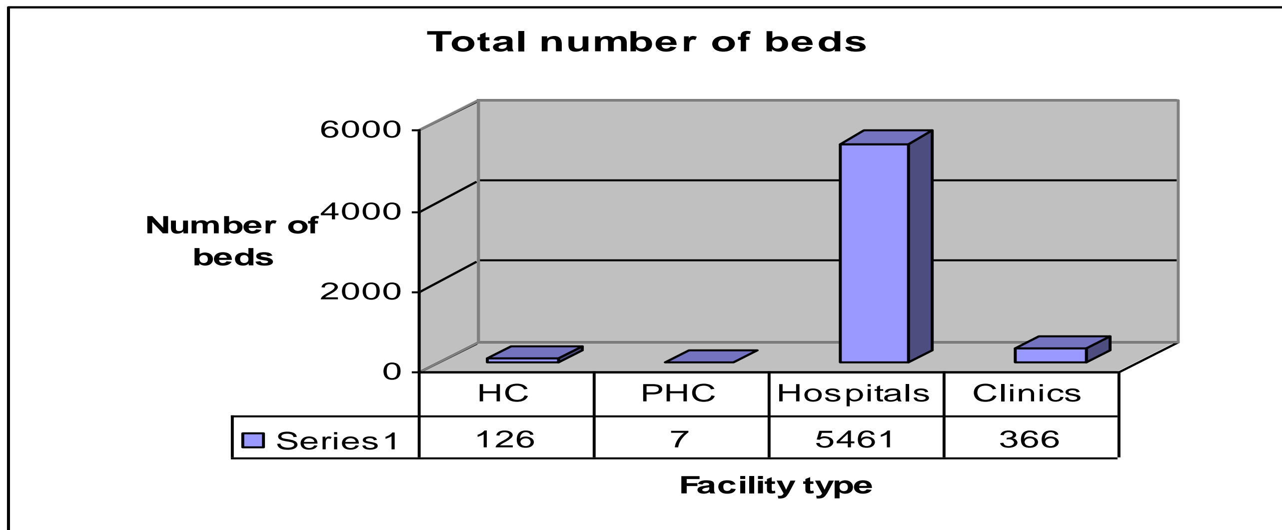
Figure 2.2: CHAG Facilities by Denominations



2.4 Number of Beds

During the year, an inventory was conducted among all CHAG health facilities. Available data from the 134 facilities that responded to the inventory questionnaire show a total of 5,960 numbers of beds, broken down by hospitals, clinics and health centres as follows:

Figure 2.3: Number of Beds



About 90% of the beds are in the hospitals, followed by the clinics and health centres, with the PHC having the least.

2.5 General services offered

CHAG institutions provide a whole range of curative, preventive, promotive and rehabilitative services. Many of the mission hospitals in the rural areas providing primary level curative services also provide one or two specialized services such as eye care or specialist gynaecological surgery for which clients would otherwise have had to travel long distances to bigger centres. Some of these hospitals have been designated centres of good practices by government and are sites for training health professionals.

The following table indicates the various services available in CHAG health institutions. All the institutions that responded to the questionnaire provide OPD (61 clinics, 10 HC, 52 hospitals and 11 PHC) services, where patients who are not severely ill are seen and treated and discharged home the same day.

This is followed by the maternity services which are available in almost all the facilities (120). Ironically, maternity services are not available in 3 CHAG hospitals which are supposed to serve as a referral centres to most of the clinics and health centres in case of any obstetric and gynaecological complications. One health centre and nine clinics do not provide maternity services at the moment.

Table 2.2: General Services offered

Type	No of Beds	SERVICES OFFERED																	
		OPD	Admissions	Maternity	Theatre	Laboratory	X-Ray	Dental	Ophtalmology	Opticals	Prosthetics	Orthopedics	Obst & Gynaec	Paediatrics	Surgery	Medicine	Physiotherapy	Blood Bank	Mortuary	Nutritional Rehabilitation
Clinic	366	61	15	52	5	27	0	1	3	5	1	2	0	2	4	5	0	0	0	5
HC	126	10	5	9	0	7	0	0	3	1	0	0	2	5	1	3	1	0	0	3
Hospital	5461	52	50	49	48	51	37	6	29	12	4	16	45	44	46	47	15	29	23	1
PHC	7	11	0	10	0	4	0	0	1	0	0	0	1	1	0	2	0	0	0	1
Grand Total	**5960**	**134**	**70**	**120**	**53**	**89**	**37**	**7**	**36**	**18**	**5**	**18**	**48**	**52**	**51**	**57**	**16**	**29**	**23**	**10**

Above mentioned table also illustrates that in 2008 half of the CHAG institutions (70) do admissions and 50 out of the 52 hospitals which responded are having inpatient services. Two hospitals are not doing inpatients services even though one of the requirements for a health institution to qualify as a hospital is to offer inpatients services. Fifty percent of the health centres (5) have wards where patients are detained for observation. However, analysis from the data indicates that most of the patients end up spending the night there and even more than a day. Some of the reasons given for this are lack of funds and transport to the referral hospital. Some clinic heads explained that due to their remoteness, when patients are referred getting transport to the hospital is always a problem, especially when it is not a market day. So patients preferred to be treated at the clinics instead of the hospital.

Another important service needed to establish the correct diagnosis of patients, laboratory services, is not available in a number of CHAG facilities, with one hospital not having. About half of the clinics (31) do provide this vital service. Equally so is the x-ray service for imagery which is also absent in some CHAG hospitals nationwide, only 37 out of the 52 hospitals have this service.

Theatre services to provide an emergency or elective surgical intervention is however, not available in some of our hospitals (4). This may be due to the lack of the requisite staff or staff mix in some of the CHAG facilities. For instance, a doctor alone cannot perform an operation without the assistance of a general anaesthetist. A few clinics (5), at the referral levels, however have theatre but of course not the type fitted with all the gadgets and equipment to manage all kinds of procedures. This is to enable them handle minor emergency procedures, like suturing lacerations.

There were other lesser known services such as optical and prosthetics being offered in some CHAG facilities. These services cannot be obtained from even government institutions. 18 facilities having optical services provide eye glasses at a much reduced prices to clients. Prosthetics and orthotics is one area CHAG facilities (5) provide assistance to the physically challenged. There is Orthopaedic Training Centre (OTC) in Nsawam where the physically challenged, both young and adult are rehabilitated.

2.6 Health service data

The main focus of CHAG in the year 2008 was the revitalisation and upgrading of the health management information system (H/MIS). Important investments in the process to develop the new H/MIS were made. An H/MIS implementation team was put in place; supported by SNV/ Ghana and HMIS Manager from the NCS. The team was charged to design the data collection format, train MIs on the use of the form and to prepare a statistical report. Important progress was made, and a first 'run-through' was done to test the new system in search of possible improvements.

This however provided an idea of the services provided by the MI. As a sample of 111 out of the 158 (70.3%) facilities: 46 hospitals (representing 29% of all MI hospitals), 54 clinics (representing 34% of all MI clinics), 7 health centres (representing 4.4% of all MI health centres), and 4 PHC centres (representing 2.5% of all MI PHC centres) were studied. These facilities received 1,846,869 OPD patients and 170,767 admissions for hospitalisation – in the table below the figures by age group and by type of facility may be read:

Table 2.3: OPD attendance in CHAG MI

	Facility Age-group	Hospitals	Clinics	PHC/HC	Totals	Proportions
OPD	<1	58,015	19,272	5,135	82,442	4.5%
	1~4	166,110	49,433	18,537	234,080	13.2%
	5~17	230,705	53,139	16,463	300,307	16.3%
	18 - 59	798,456	95,340	33,947	927,743	50.1%
	60 and above	254,052	38,944	9,321	302,327	16.4%
	Total OPD	1,507,338	256,128	83,403	1,846,869	100%
	Proportions	81.6%	13.9%	4.5%		100%
	Total OPD insured	1,162,239	172,952	41,989	1,377,280	74.6%
	Proportion insured	77%	67.5%	50.3%	74.6%	

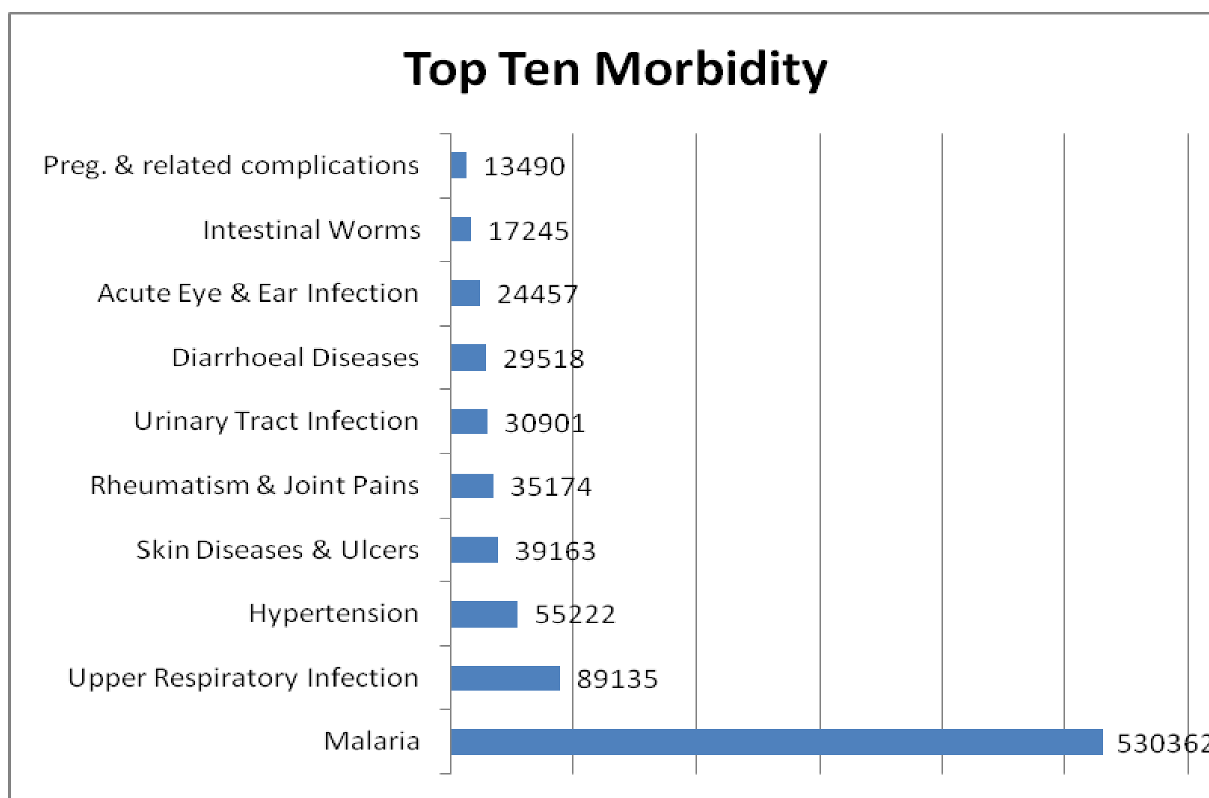
In this sample, of all OPD patients, 81.6% were seen in the hospitals, 13.9% in clinics and 4.5% in PHC/HCs. Of course, the absorption capacity in hospitals is more important, still it may be noted

that the large majority of outpatients is seen at hospital level. Also, 50.1% of the patients come from the economic active population (18-59 years old), while 11.5% are of the under-five population, probably because of the over representation of the hospitals in the sample and in the total MI facilities.

Important to note is that 74.6% of all OPD patients was insured – the NHIS being the most important purchaser of care in the MI.

Analysis was also made of the type of diseases that were diagnosed in the facilities – below the top-10 diseases are visualised in a figure:

Figure 2.4: Top-10 Morbidity of CHAG MIs



In the top-10 diseases seen in the OPD, malaria is by far the most important reason to visit the health facilities. Also important are the upper respiratory infections and rheumatism & joint pains, with malaria the typical communicable diseases in these areas. Hypertension, a non-communicable disease, comes in third place after malaria and URI, meaning that Non Communicable Diseases are becoming more and more important in the typical rural population of CHAG facilities. Diabetes is one of the main causes under 'all others'.

"All other diseases" is a large group of 34 types of morbidity – the demand for OPD services in the CHAG health facilities is highly diversified. Here we find predominantly anaemia, typhoid fever, home/occupational accidents and malaria in pregnancy coming after the top ten.

In the facilities studied, a total of 1,072 tuberculosis patients are under treatment, 653 new cases were found in 2008, while in total 34 patients defaulted from treatment. Of all TB patients, 148 were cured while 37 had a re-infection - 146 of all TB cases were HIV/AIDS related.

In total 17,426 patients received counselling services for HIV/AIDS, of them 16,567 (representing 95%) were tested, and of these 2,733 (17%) tested positive. For PMTCT 39,345 were counselled, while 35,549 (90%) were tested and 1,187 (3%) tested positive. All others who tested HIV positive was 5,404. Still, only a relatively small proportion of them (1665) received ARV treatment or home based care (3,552).

Of all services, those for reproductive health are of utmost importance, as may be learned from the table below:

Table 2.4: Reproductive Health Services

Maternity services	Type of activities	Numbers	proportions
FP - acceptors	Condom - male	1,199	15,2%
	Oral contraceptives	1,228	15,6%
	Injectables	5,354	68,0%
	IUCD	6	0,1%
	Tubal Ligation & Vasectomy	83	1,1%
ANC	ANC Registrants	65,314	
	ANC Attendances	218,230	
TT2	Mothers Immunized	17,454	
MATERNITY	Total delivery	42,008	100%
	Supervised delivery	29,575	70%
	Total CS Delivery	7,154	17%
	SB Macerated	1,120	2.7%

	Sb Fresh	641	1.5%
	Birth Weight <2.5kg	4,688	11.1%
Post-Natal	PNC Registrants	12,483	

In total, 8,069 persons were registered for family planning methods. Supposing those accessed this service all went through ANC, it will mean that only 12.4% of all women who registered for ANC also were registered for FP. By far the most popular FP method is the injectables that are used by 66% of the clients. Condoms and oral contraceptives represent only 15% each. Remarkable is the low utilisation of IUCD and even less important are the surgical interventions for FP.

Antenatal Care was registered for by 65,314 women – making an average visit per client 3.3 times per pregnancy, which means that women accessing CHAG facilities are not making the 4 mandatory visits during pregnancy. The number of mothers who were immunised for tetanus was 17,454.

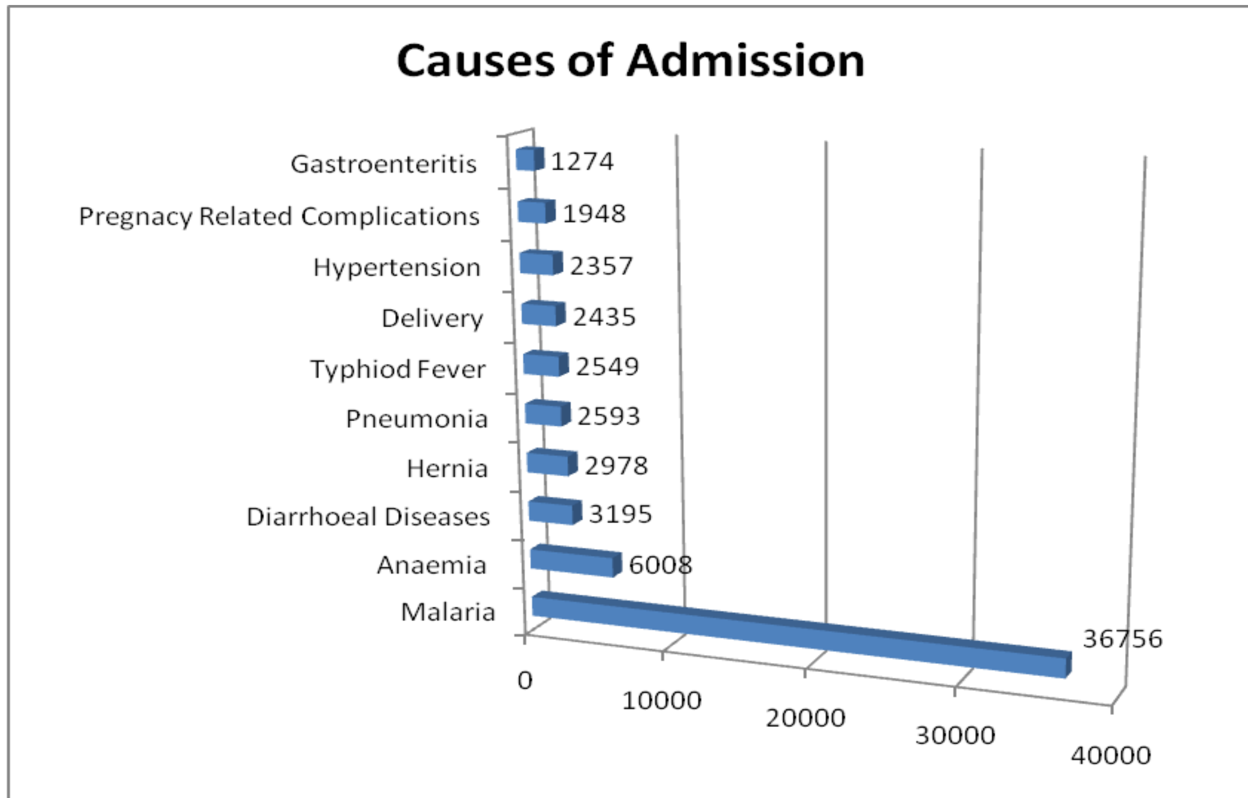
The number of deliveries was high too (42,008) of whom 70 % was supervised by skilled personnel. Still, this high number does not represent more than 64% of all women who were registered for ANC – so, around 36% of all these pregnancies deliver elsewhere – at home or in another type of health facility. Of all deliveries, 17% ended in a caesarean, which is high according to WHO standard. Certainly because it seems that quite a high proportion of the pregnancies in the facilities was at high risk, 11.2 % of the newborns were underweight (<2.5kg), and 4% were stillbirths. Of all women who delivered in a CHAG facility, 30% (12,483) were registered for Post Natal Care, a low proportion.

In total 170,767 patients were hospitalised in the facilities of the sample:

Table 2.5: Admissions by Facility Type

	Facility Age-group	Hospitals	Clinics	PHC/HC	Totals	Proportions
Admissions	‹1	11,041	104	124	11,269	6.6%
	1~4	23,409	462	487	24,358	14.3%
	5~17	20,142	467	366	20,975	12.3%
	18 - 59	96,696	1,219	689	98,604	57.7%
	60 and above	14,792	515	198	15,505	9.1%
	Total Admissions	166,080	2,827	1860	170,767	100%
	Proportion Admissions	97.3%	1.7%	1%		100%
	Total insured inpatients	97,006	1,251	740	98,997	58%
	Proportions insured	56.8%	44.3%	39.8%	58%	
	Total Inpatient Days	727,788	5663	2836	736,287	
	Mean length of stay (days)	4.4	2	1.5	4.3	

Figure 2.5: Top 10 causes of admission in CHAG Facilities



Not surprisingly, most (97.3%) of the hospitalisations took place in the hospitals – less (1.7% in the clinics) and very few (1,860, 1%) in the PHC facilities. This would mean (166,080) admission per hospital and (2827) patients per clinic. The patients stayed at an average of 4.4 days in hospitals – 2 day longer in hospitals than in the clinics, which is understandable as in hospitals patients are hospitalised with more severe or advanced type of morbidity.

Again, more than half of the admissions come from the 18-59 years old group – the under-five and the 60+ age-groups, the most vulnerable population strata, are under-represented.

Of all hospitalised patients, 58% were insured, which again is a high number – but remarkably lower than the 74.6% of all OPD patients. Further analysis is needed to explain this difference – both from the patient's as well as from the provider's perspective.

In the facilities, 50,384 surgical interventions took place, of which less than half (23,765, or 47.1%) were elective minor operations, 15,099 (or 30%) were major elective operations and 22.9% were emergency operations. Of course the majority of the intervention took place in the hospitals (98.2); still 634 interventions were carried out in clinics.

In all 4,876 deaths occurred in the hospitals among the various age groups. 106 maternal deaths occurred with only 17 of them being investigated. The implication of this is that, no intervention

has been put in place to mitigate against certain mistakes which might have contributed to these deaths. Facility heads need to take maternal deaths audits seriously to help remove inefficiency in the system.

CHAPTER III HUMAN RESOURCE SITUATION OF CHAG – 2008

The Human Resource situation of CHAG in 2008 was a serious challenge. Donors are shifting their support to different areas and government is more and more also insisting on health financing through the NHIS. CHAG member institutions together with the Secretariat will need collaborative efforts to deal with the Human Resources challenges that came up and will come up in subsequent years. It is expected that with our present level improved systems in communication receiving and dissemination of critical HR information for decision making will help address some HR challenges experienced by the institutions and the Secretariat

The year 2008 did not record much success in seeking information from member institutions (MIs). Almost all the institutions in 2008 attended workshops and worked hard to compile their budgets for submission to contribute towards the National Health budget. Unfortunately only 52 institutions finally submitted their budgets. Again all member Institutions were asked to submit their Human resources requirement but this was not very successful. If we have to overcome our Human Resources challenges, we need to treat gathering and dissemination of information as critical. It is increasingly clear that the levels of support one can get will very much depend on the quality of information one has. If we don't have the right information the right figures and facts, we cannot argue our case for any support.

As at December 2008, the total workforce within CHAG on government payroll stands at 6,852. The rest of the workforce in the institutions which is also reasonably high are paid from the institutions internally generated funds (IGF) Considering the present health staff salaries levels, paying staff with the IGF especially professionals such as doctors, nurses, pharmacists, etc. puts a lot of stress on management, there by leaving very little for development. With the change in policy direction and donors refocus their resources, it getting extremely difficult to accommodate staff on the health budget. In this direction, the focus for the government is to put what they call "essential staff" on the payroll. For CHAG due to the location of its facilities, what may not be an essential staff for the government is an essential for CHAG. A PHC driver in the Afram plains is certainly an essential staff in the eyes of CHAG. The argument is that NHIS should be able to take care other staff who are not essential in the eyes of the government. The operations of NHIS are clear to all of us.

In 2008, the Ministry released to CHAG a little over 400 nurses/ midwifes for posting. The Secretariat together with the Health Coordinators designed a formula to post them to the various institutions. The results are that many of the nurses did not report to their respective institutions, a number also were referred in their exams and some even left the country. The committee on posting of health staff acknowledged that things did not go well and are working on a better approach to distribute health staff in subsequent batches.

The same was the case in posting of medical officers to CHAG institutions. A lot of challenges came up as a result of the delay from the ministry in posting them. Some of the officers took the

advantage of the delay to find themselves jobs and some Administrators lobbied and engaged a number of them. The effect is that when they were officially posted, most of them refused to report to their respective institutions creating a situation where some institutions are over staffed while others have not. The team is putting in place modalities to address this problem in future.

Recruitment and placement of staff on the government payroll (mechanization) for 2008 did not receive the desired attention. Individual institutions were directly in-charge of applying for financial clearance to the Ministry of Finance through the Minister for health in this regard. The 2007 Annual Council recommended the recruitment of an HR Manager to take this up on behalf of the Member institutions. This is also in line with the Ministry of health directives that recruitment from agencies should be handled by one person. In this regard, the Secretariat will soon engage a full time HR officer to handle all the issues on placement and mechanization of staff. In the meantime the administration has taken up this process collating all the requests from MIs for the 2009 recruitment.

For 2008 a back lock of 685 CHAG staff could not be promoted as a result of the budgetary constraints. It is our hope that the HR situation in our CHAG for 2009 will improve significantly and bring some hope and relief to member institutions.

CHAPTER IV MAIN ACTIVITIES CARRIED OUT IN 2008

4.1 Implementing the 2008-2012 Strategic Plan:

In 2008, CHAG initiated the implementation of its 2008-2012 Strategic Plan, which is aimed at (a) strengthening the capacities of its Executive Secretariat in coordination, lobbying, advocacy and monitoring and evaluation, (b) increasing partnerships with international and local development agencies, (c) strengthening the competencies of its Church Health Coordinating Units (CHCUs) and (d) getting more actively involved in the national debate on health sector development.

The Board of Directors and Partnership Steering Committee approved its first integrated Annual Work Plan in the course of April 2008.

4.2 Overall objective and main focus of 2008 Annual Work Plan:

The overall objective of the 2008 AWP was to "improve the technical and managerial capacities of the various management layers within CHAG (i.e. MIs, CHCUs and Secretariat) to deliver an integrated and affordable package of preventive, curative and rehabilitative services'.

Four specific 'result areas' were defined:

1. Appropriate (technical and financial) planning, management, support and information systems strengthened and functioning at the level of MIs;
2. Strengthened capacity at CHCU level for monitoring, supervision and evaluation of MIs;
3. Strengthened capacity of the Secretariat in health sector planning, health financing, resource mobilisation, coordination and technical support to the CHCUs and MIs ;
4. Strengthened capacity of CHAG for policy development, advocacy and engagement with public and private stakeholders

Improving data collection for planning, decision making, lobbying and advocacy purposes, strengthening CHAG's capacities as regards health financing and insurance and quality assurance were defined as focal areas.

Component I: Appropriate (technical and financial) planning, management, support and information systems strengthened and functioning at the level of MIs

Key issues:

To enable CHAG facilities to adequately play its role in a decentralised, district health system, the need for establishing the necessary management and support systems has been identified. Accordingly, a series of activities aimed at strengthening the management and provision of health services has been identified. The following table compares overall progress made against targets set for the year:

Main interventions planned	Progress made
Sustainable health financing	• From 19 to 29 March a series of 3 trainings on health financing, contract and claim management and the use of the new tariffs was conducted attended by over 180 medical and administrative staff from across the country; • In the last week of June, a three day working session was organised in Kumasi to assist CHAG member institutions in preparing the 2009 budget. 159 health facilities attended this workshop; • A three day workshop was organized to train member institutions in the DRG and medicines list introduced by the National Health Insurance Authority
Business planning	The development of a medium-term health plan was initiated at the Church of God and Church of Christ clinics
Strengthening the establishment and use of health management information systems	• 90 PC's to be used for data collection were distributed to selected CHCU's and MI's and user training was conducted; • 76 MIs received computer equipment and user training to improve data capturing
Management development	• Under a sub agreement with the National Catholic Secretariat, a management retreat and leadership training was conducted from 8 to 12 and from 15 to 19 September, attended by 93 participants • A capacity building workshop for hospital (30) information Officers was organised at Ho between September 8 and 23, 2008

Performance monitoring	• In June, CHAG and UNFPA have initiated a study aimed at improving emergency obstetric care and Adolescent Reproductive Health (ASRH) services in 10 CHAG facilities in the Volta Region. Publication of the results is being awaited for. • Supervisory and monitoring visits were made to some selected MIs
Human resource development	An overview of CHAG staff on the government payroll was made

Component II: Strengthened capacity at CHCU level for monitoring, supervision and evaluation of MIs

Key issues:

To be able to adequately play their coordinating and supervisory role, CHCUs must be familiar with new concepts on health management & planning, health economics & financing, social insurance and related management aspects. Accordingly, a series of activities has been identified. The following table compares overall progress made against targets set for the year:

Main interventions planned	Progress made
Updating database on CHAG's profile	At year end 80% of the MIs has submitted key information into the data base at the Secretariat
Improving knowledge management and sharing among CHCU's	Eight monthly meetings between the 16 (soon 17) CHCU's and the Secretariat were held to review progress and plan future activities
Capacity development	With a view of identifying future needs for technical support and training a need assessment was carried out among 60% of the CHCU's

Component III: Strengthened capacity of CHAG Secretariat in health sector planning, health financing, resource mobilisation, coordination and technical support to the CHCUs and MIs.

Key issues

For the Secretariat to adequately play its designated role as coordinating /advocacy body, while at the same time offering technical and training support services to its customer groups (i.e. CHCUs and MIs), the need to strengthen the role and functions of the Secretariat was identified. Accordingly, a series of activities has been identified. The following table compares overall progress made against targets set for the year:

Main interventions planned	Progress made
Improving service package to its MIs and CHCUs	A 'service package' defining the products the Secretariat could be delivering to its MIs was developed;
Organisational development	• With the support of a locally recruited facilitator a two day workshop on 'leadership and teambuilding' was conducted for the entire office staff on 5 and 6 June 2008; • A proposal for restructuring the Secretariat was finalised and submitted to the Board for approval • A Management Team (comprising the Executive Director, The Administrative Manager, Projects, Health Financing officer and Management Advisor) was established to improve planning, implementation and monitoring of the AWP; • The Executive Director and management advisor paid a two day courtesy visit to the Christian Health Association in Kenya (CHAK) to familiarise with the experience gained in outsourcing drugs procurement and distribution
Human resource development	An HR study was commissioned, the results are being awaited for
Advocacy and lobbying	• CHAG staff actively participated in the routine meetings of the MOH Budget Committee, the Inter Agency Leadership Committee on Health, and the MDG 5 Committee; • Technical input was provided to Health Partners Business meetings and the Health Summits

Development of health management information systems	By year end 129 facilities had submitted their Inventory forms with 45 submitting for the minimum data set (January – September data; An external consultant from the Royal tropical Institute (KIT) was recruited to assist the HMIS Implementation team with data analysis and report generation of the results of the minimum data set.
Staff development:	• An Interim Manager was appointed to improve the functioning of the Finance Department; • Two new positions were established for a health insurance expert and HMIS officer. • A 'process facilitator' (from SNV) to assist in the implementation of the HMIS-project. • One staff member attended the Flagship course at the World Bank Head Quarters in Washington
System development:	• A computerised accounting system (Tally) became operational • A Finance and Accounting manual was prepared in draft
Public Relations and marketing	An initiative aimed at redeveloping the Website was launched
Capital development	• Two (restricted) tenders were launched in May, one 'works tender' for renovating the office; and one 'supply tender' for the procurement of IT equipment; • Contracts were awarded for an amount of GH¢35.581,15 and GH¢29.113,23 respectively

Component IV: Strengthened capacity of CHAG for policy development, advocacy and engagement with public and private stakeholders

Key issues:

To effectively administer a complex provider network organisation such as CHAG, contribute to the policy dialogue and manage partnership with other stakeholders within the health sector, the

need for strengthening governance has been identified. The following table compares overall progress made against targets set for the year:

Main interventions planned	Progress made
Implementing Board meetings	• The newly appointed Board of Directors approved the 2008 Annual Programme of Work, initiated the negotiation process with the TUC to review the Collective Bargaining Agreement and approved the new Charter; • The Steering, Advocacy and Policy Analysis, Finance and Projects and Programmes Committees were established.
Annual Council	This year's Annual Council meeting coincided with the 40th anniversary
MOH CHAG Partnership Committee	The PSC met 3 times to endorse the 2008 AWP and review progress
Inter-Agency Leadership Committee Meeting (IALC):	CHAG participated in the IALC meeting from 16 - 17 October 2008 to review the consultancy report aimed at fine-tuning legislations in the Health Sector, share experiences on a recent "Team Building" exchange visit and discuss Portfolio management which centred around the prioritisation of health priorities for the 2009 MoH - PoW

CHAPTER V CHAG AND ITS DEVELOPMENT PARTNERS

In 2008 individual member institutions, churches and CHAG Secretariat continued to enjoy financial, logistical and personnel support from a large variety and number of (Ghana, US and Europe) based mother churches, faith-based- funding agencies, bilateral donors and global funding agencies.

A comprehensive overview of the type, nature and magnitude of all external contributions to CHAG does not exist as yet. Available data, however, suggest that 'traditional' funding sources from church and church related development agencies for capital development projects (infrastructure and medical equipment) is decreasing. On the other hand, there seems to be an increasing number of (international and bilateral) DP's committed to enter into a long-term partnership with CHAG (e.g. the World Bank, PEPFAR and the Global Fund). At the same time, there a shift from project towards core funding is being observed. CHAG recognises that these new funding arrangements will have implications for its (financial) management systems and procedures.

CHAG institutions now mainly generate income from the services they provide on behalf of the National Health Insurance, as well as from government contribution to cover salary costs.

DANIDA, UNFPA, SNV, WHO, the CORDAID/ICCO consortium and the NHIA were the most important partners providing support in the implementation of CHAG's 2008 Annual Plan of Work.

5.1 DANIDA

CHAG is benefitting from the DANIDA funded HSPS IV programme. This support is mainly earmarked for improving CHAG's capacity for health policy development, advocacy and engagement with government, (particularly on public health issues and the needs of the poor) supporting the institutional development process of CHAG and strengthening of the management systems and capacity of its Secretariat.

5.2 SNV

In 2008, CHAG entered into a MoU with SNV. Under this partnership agreement consultancy services are being provided to establish and roll out a health information management system across the Association.

5.3 UNFPA

In April 2006 a new partnership was established between CHAG and the United Nations Fund for Population Activities (UNFPA) to promote reproductive Health in Ghana. Under this partnership, CHAG and UNFPA have committed themselves alongside other implementing partners to a project aimed at creating a supportive environment that promotes and ensures Reproductive Health (RH) rights and increased access to and utilization of high-quality Reproductive Health Services (RHS).

In 2008, UNFPA on behalf of CHAG commissioned Management Strategies for Africa (MSA) to undertake an assessment in 10 CHAG facilities in the Volta region, with a focus on Comprehensive Emergency Obstetric Care and the provision of Youth Friendly and Adolescent Reproductive Health Services. This assessment was completed in the 3rd quarter of 2008.

A two-week (2) Life Saving Skills (LSS) was organized in June for 16 midwives drawn from CHAG facilities (those within the UNFPA districts) in the Volta and Northern regions.

5.4 National Health Insurance Authority

Under a World Bank funded Health Insurance Project (HIP), staff of CHAG benefitted from various training programmes. The Secretariat also obtained a vehicle to intensify monitoring and supervision.

5.5 CORDAID/ICCO Consortium

In July 2008 CHAG entered into a renewed partnership with CORDAID and ICCO to strengthen health management information throughout CHAG. Under this arrangement a short-term ' health management information' advisor was recruited to provide expert advice and technical back-up support services to further design the health management information initiative, report generation and data analysis.

5.6 World Health Organization-Health Access Network (WHO-HAN)

CHAG in collaboration with Health Access Network and with support from WHO successfully completed a three (3) module training on drug management and drug and Therapeutic Committees (DTCs) in the hospitals. These training were aimed at improving the skills of prescribers, managers and pharmacists in drug management and therefore to improve efficiency and access to quality drugs and medicines in the CHAG hospitals.

CHAPTER VI MANAGEMENT AND ORGANISATION

6.1 Executive Secretariat:

The governance and structure of CHAG for the year under review remained unchanged i.e. the Council, Board of Directors and the Secretariat. The Council remains the highest governing body and it is made up of representatives of the Member Institutions (MIs) the Board of Directors, Church leader.

The Secretariat is the central point of coordinating all the administrative work for and on behalf of its members. Following the outcome of a restructuring process which was initiated in 2008, a change in the organizational structure of the office is anticipated with the creation of two separate departments: 'Finance & Administration' and 'Technical Support Services'. Additional technical staff will also be deployed. This is based on the recommendation of the 2007 Annual Council meeting to re-organize the Secretariat to meet new challenges in the health sector and demand from our Member Institutions.

In the course of the year, a health insurance officer was appointed to address the difficulties member institutions are facing in handling health insurance claims. The desk officer is also to undertake technical and support visits to member institutions to keep them abreast with the trends and development in health financing.

The Secretariat has also engaged the services of an HMIS officer to strengthen and further develop the HMIS to meet the information needs for decision making. The officer will also give technical support to member institutions to address their needs in HMIS.

Also responding to the needs of the membership, the Secretariat has employed the services of a full time Finance Manager, which has resulted in more activity-based better and timely financial reporting. CHAG will for this year be able to present to its membership all the financial audit reports for the years 2007 and 2008.

For the year under review the Board also approved the creation of two positions to strengthen the Secretariat. They are the positions of a public Health Officer and an HR manager. The creation and the engagement of the HR Manager will be a relief to the institutions as all the issues on mechanization will be handled by the HR desk officer for and on behalf of the institutions. This will also be in compliance with the government directives to have only one person from an agency to handle HR matters in the Ministry.

Efficient communication and exchange of information within the Association continues to be a serious challenge for the Secretariat. Very often information is seriously delayed and there are times some institutions do not even respond to the request. In the year under review all institutions

were asked to submit their budgets to the secretariat to contribute towards the overall National health budget. A little over 70% of the institutions contributed to this exercise while the rest failed.

6.2 Board and Committees

The CHAG Board is the Executive arm of the Council and its main duties are to formulate policies for approval by the Council, approve the annual work plan of the Secretariat, and supervise and monitor its implementation.

In 2008, the Board met three times, 14th March, 23rd April and 19th of September 2008. They had successful meeting in which policy issues and decisions were taken to propel the CHAG into the year 2009.

Under the Board there are five sub-committees functioning, i.e.:

- The Standing Committee
- The Finance Committee
- The Policy and Advocacy committee
- Projects and Programme committee and
- Technical committee.

Meeting of these committees for the year under review have not been satisfactory. It is hoped that this will improve for the year 2009.

CHAPTER VII FINANCIAL REPORT

7.1 Control Environment

During the year under review, the following developments in the control environment of the Finance Office took place:

7.1.1 Staffing

The Finance Office comprised two staff members at the beginning of the year, i.e. the Principal Accountant and a Senior Accountant. By the end of the year the staff strength had risen to three even though the Senior Accountant had resigned in the course of the year. The new staff members are the Finance Manager, the Principal Accountant and an Accounts officer. Staffing of the office was further given a boost by assigning 2 national service personnel to the office to facilitate the processing of transactions and preparation of timely Finance Report.

7.1.2 Financial Management Manual

A new Finance Manual to guide the operations of the Finance office was developed and approved by the board. Implementation of this started in the later part of the year and will be reviewed at the end of next year.

7.1.3 Accounting System

The accounting system is partially manual and partially electronic. Thus, there were some delays in processing of transactions. Management has approved the proposal of fully computerizing the accounting system in the first quarter of next year. When that is done it is hoped that it would facilitate faster processing of transactions and its consequent financial report.

7.2 Income and expenditure:

In 2008 the Secretariat received a total income of GH¢976,251 and expended a total of GH¢719,160 making a net income over expenditure of GH¢257,091. The detailed income and expenditure of the Secretariat is contained in the table below.

Table 7.1 2008 Quarterly Details of Income and Expenditure

2008 Income and Expenditure										
Particulars	2008 Total		1st Quarter		*2nd Quarter*		3rd Quarter		*4th Quarter*	
Income										
Direct Incomes										
Revenue Grant	850,966		10,018		344,540		12,277		484,131	
Annual Subscription	61,031		46,350		180				14,501	
		911,997		*56,368*		*344,720*		*12,277*		*498,632*
Indirect Incomes										
Other Income		64,254		*3,626*		40,319		*6,207*		14,102
Total Income		**976,251**		**59,994**		**385,039**		**18,484**		**512,734**
Expenses										
Administration	78,196		*13,592*		15,486		*6,398*		42,720	
Personnel Emoluments	189,978		*4,461*		11,603		*6,401*		167,513	
Service Activity	423,004		*81,964*		128,110		*170,412*		42,518	
Travel & Transport	27,982		*1,856*		5,886		*7,982*		12,258	
Total Expenditure		**719,160**		**101,874**		**161,084**		**191,194**		**265,008**
Excess of Income over Expenditure:		**257,091**		**(41,880)**		***223,955***		**(172,710)**		***247,726***

7.2.1 Detailed Income

The details of the income are explained in the following table:

Table 7.2 2008 Annual Incomes

Grant Income		GH¢	
Donor: Danida		610,770	72%
Donor: UNFPA		49,598	6%
GoG - Admin		11,149	1%
GoG Salaries		150,162	18%
GoG Service		27,408	3%
Population Council (Income)		1,878	0%
Sub Total		*850,966*	*87%*
Internally Generated Fund			
Annual Membership Subscription		61,031	49%
Annual Conference Fees		36,407	29%
Proceeds from CHAG Cloth Sales		6,075	5%
Exchange Gain		7,361	6%
Investment Income		6,700	5%
Rent Income		5,212	4%
Sundry Income		2,499	2%
Sub Total		*125,285*	*13%*
Grand Total		**976,251**	

The above table indicates that Grant Income constituted 87% of the total income generated in 2008. Internally Generated Fund (IGF) amounted to only 13% of the annual income. Danida grant constituted the highest source of income to the Secretariat in 2008. It accounted for 72% of the Grant Income of GH¢850,966. The least of the Grant fund was from Population Council.

Annual membership subscription was the highest contributor to IGF having contributed 49% to total IGF.

7.2.2 Detailed Expenditure

The following expenditure was incurred for the year 2008. The highest expenditure was incurred on Service Activity which amounted to more than one – half of the total revenue expenditure.

Table 7.3: Total Expenditure for 2008

Expenditure		
Personnel Emmoluments		189,978
Administration		78,196
Service Activity		423,004
Travel and Transport		27,982
Total Expenditure		**719,160**

7.3 State of Financial Position

By the close of the year the Secretariat, had increased its assets to the tune of GH¢709,370. In course of the year the Secretariat procured 80 pieces of computers costing GH¢85,600. 72 pieces computers were allocated to Member Institutions costing GH¢62,065. These computers were financed by Danida in 2007.

Also in the last quarter of the year, 6 desk top, and 7 lap top computers were procured with the Danida Funds. The office building and compound were renovated at a cost of GH¢45,644.

Find in the table below the Balance Sheet as at December 31, 2008.

Table 7.4: 2008 Balance sheet

Balance Sheet as at Dec. 31, 2008	GH¢	GH¢
Fixed Assets		**143,309**
Bungalow Equip,F&F	*2,275*	
Cold Room Unit	*35*	
Improvement - Office Building	*45,644*	
Land & Building	*9,571*	
Motor Vehicles	*4,571*	
Office Equipment	*73,339*	
Office Funiture & Fittings	*7,874*	
Investments		**8,100**
Long Term Investment	*1,000*	
Short Term Investment	*7,100*	
Current Assets		**557,961**
Deposits (Asset)		
Sundry Debtors	*86,085*	
Cash-in-hand	*7,620*	
Bank Accounts	*464,256*	
Total		**709,370**
Sources of Funds :		
Accumulated Fund		**275,442**
Loans (Liability)		
Current Liabilities		**176,597**
Project Funds	*61,566*	
Trade & Other Payables	*57,831*	
Provisions	*57,200*	
Suspense A/c		
Capital Grants		
Profit & Loss A/c		**257,332**
Opening Balance		
Current Period	*257,332*	
Total		**709,370**
Opening Balance		
Current Period	*308,749*	
Total		**522,131**

7.4 Auditing

In course of the year the 2007 Accounts were audited by Auditors. The 2008 accounts are due to be audited in the first quarter of 2009.

CHAPTER VIII LESSONS LEARNT AND THE WAY FORWARD

8.1 Main challenges in 2008

During implementation of the 2008 AWP some progress in programmatic technical and financial planning and reporting has been made.

CHAG subscribes to national health policies and practices, but the planning and reporting systems of its constituents Member Institutions (MIs) have not yet been fully synchronised and segregated at the district national levels with the health sector Programme of Work (POW).

Due to increased patient attendance as a result of the NHIS, quality of care, contract management and sustainable health financing are becoming increasingly important issues

The diversity of the member churches philosophies and doctrines and policies also present the challenge of alignment and synchronisation of her internal management arrangements that can enable it report in a meaningful manner to the extent of its "widely acknowledged" contribution to the country's health sector.

This may be due to a variety of reasons including:

- Knowledge among CHAG staff on current health sector developments is generally perceived as weak
- The extent to which MIs contribute to the development, implementation and monitoring of district health plans, varies considerably, and this leads to some level of misconnect between MIs, GHS and the MOH
- Related to the latter is the fact that some CHAG facilities are better equipped to define their (future) position in the health sector than others.
- Despite efforts made in the year 2008 to collect essential service data and evidence on future human resource and financial needs there is no comprehensive overview as yet to enhance mobilisation of additional resources

With the establishment of a monthly 'Church Health Coordinators' meetings, coordination between member churches has also improved significantly. Major challenges however remain to further promote the involvement of all MIs in the accounting reporting process of the Association.

8.2 Way forward

To demonstrate CHAG's commitment to synchronising and aligning its MIs interventions with other stakeholders subscribing to the Sector POW the following will be done:

- CHAG's MIs 2009 Annual Programme of Work will be developed using overall planning framework of the health sector so as to make programming, reporting and monitoring easier.
- Improve structured information sharing among Member Institutions (MIs).
- Promote the analytical and health planning skills of MIs.
- Ensure better integration of CHAG facility plans into their respective district plans.
- Strengthen the management and provision of health care at facility level.
- Improve technical cooperation and partnership among Member Institutions (MIs), CHCUs and the Secretariat.
- Frequent interaction with GHS, MOH and other stakeholders.
- Contribute to the policy dialogue, e.g. in the area of health insurance.
- Intensify capacity building, monitoring and evaluation support to the MIs
- Improve Quality Assurance activities to ensure compliance with the accreditation requirements of the NHIA.

8.3 2009 Priority Activities

CHAG will therefore undertake activities under all the four (4) MOH objectives in 2009:

1. Promoting an individual lifestyle and behavioural model for improving health and vitality by addressing risk factors and by strengthening multi-sectoral advocacy and actions
2. Rapid scaling up within the existing capacity, high impact interventions and services targeting the poor, disadvantaged and vulnerable groups
3. Investing in strengthening health system capacity to sustain high coverage and expand access to quality of health services

4. Promoting governance, partnership and sustainable financing

ANNEXES

Annex 1: Composition of CHAG Executive Board

No	Name	Position
1	Rev. Msgr. Frank Cletus Egbi	Board Chairman
2	Dr. (Mrs.) Mamaa Etsua Mensah-	Vice Board Chairman
3	Dr. Gilbert Buckle	Member
4	Mr. Simon Kwaku Amuzu	Member
5	Mr. James Tobiga	Member
6	Rev. Sr. Wilhelmina A Mensah	Member
7	Rev. D A Koranteng	Member
8	Ms. Annie Adeodata Appoh	Member
9	Mr. Sam Sarpong Appiah	Member
10	Ms. Gladys A Odoi	Member
11	Mrs. Isabella Abban	Member
12	Dr. Moses Adibo	Member
13	Cdr (rtd.) Godwin E. Osei	Member
14	Dr. Wilfred Larbi-Addo	Member
15	Mrs. Selina Ardayfio	Member
16	Mr. Kwame Wumbee	Member
17	Mr. Philibert Kankye	Ex- Officio Member

Annex II Composition of Sub-Committees of the Executive Board

Standing Committee

1 .Rev. Msgr. Frank Cletus Egbi	Chair
2. Dr. (Mrs) Mamaa Entsua-Mensah	Member/Alternate Chair
3. Ms Gladys A. Odoi	Member (Finance Committee Chair)
4. Mr. Sam Sarpong Appiah	Member (Proj./Progs. Committee Chair)
5. Dr. Gilbert Buckle	Member (Advocacy & Policy Committee Chair)

Finance Committee

1. Ms Gladys A Odoi	Chair person
2. Mr. John Tietaah	Member
3. Mr George Yeboah	Member
4. Mr Fred Kuchen	Member
5. Rev. D A Koranteng	Member

Projects and programmes Committee

1. Mr. Sam Sarpong-Appiah	Chairman
2. Mr. Bernard Clement Kwesi Botwe	Member
3. Rev. Sr. Wilhelmina Mensah	Member
4. Mr. Willing Vanderpuije	Member
5. Mr. Enoch Osafo	Member

Policy/Advocacy Committee

1. Dr. Gilbert Buckle	Chairperson
2. Mr. Kwame Wumbee	Member
3. Mr. Alex Ofori Mensah	Member
4. Dr. Moses Adibo	Member
5. Ms Annie A. F. Appoh	Member

Annex III: CHAG Secretariat Staff

Functional Units	Functions	Names
Directorate and Policy Administration	Executive Director Management Advisor	Philibert Kankye Charles Gerhardt
Finance/ Administration	Finance Manager Administrative Manager Transport Officer Transport Officer Transport Officer Principal Accountant Junior Account Officer IT officer/ in-charge of Website Administrative Secretary Senior Security Guard Cleaner Emmanuel Sobser	Ronald Acquah Rev. Bro. Henry Surnye Frank Owusu Sekyere Gabriel Turkson Dominic Akowuah Joseph Ofosu Dako Ali Yakubu Victor Akoto Appiah Sarah Bruce-Tagoe Kwarteng Asabre William Agyarko Security officer ED's residence
Technical Support Services	Manager Project & Programmes Principal Health Services Administrator Health Planner	James Yaw Boateng Alex Ofori Mensah Georgina Benyah

Annex IV: Over-view of Church Health Coordinators

No.	Denomination	Health Coordinator	Contact No/s.	E-mail
1	AME Zion	Rev. H. K. Amoah	0244-817465	joeaviscolalas@yahoo.com
2	Anglican	Rev. Dr. E. Bentsi-Enchill	0243-268881	cobina40@yahoo.com
3	Assemblies	Wumbee Joseph	020-7693967	wumbee@agreds.org
4	Baptist	John Azabu	0243-875587	johnzabs@yahoo.com
5	Catholic	Dr Gilbert Buckle	020-8123223	Gilbert@yahoo.com /doh.ncs@ghanacbc.org
6	Church of Christ	Avril Keoughan	0244-2935181	akeoughan@hotmail.com
7	Church of God	Isaac Owusu	0244-638029	cogchurch2009@yahoo.com
8	E.P church	Atiemo Ganyo	020-8177836	epchurch@gh.com
9	Global	Kwasi Adjei	0244-666123	pimagben@yahoo.com
10	Methodist	Lucretia Quist	679223/228160	mcghq@ucomgh.com
11	Pentecost	Dr. Yao Yeboah	0234-581014	yaoyeboah@yahoo.com
12	Presbyterian	Sam Sarpong Appiah	662511/664761	ssappiah@ucomgh.com
13	Salvation	Wendy Leavey	0244-229762	majwendy@hotmail.com
14	SDA	Pastor Annor Boafo	020-8152090	Kwabenaboafo@yahoo.com
15	Siloam	Rev. Egya Blay	020-8718728	egya1938@yahoo.co.uk
16	WEC Mission	Daniel Gbande	0276-614367	N/A
17	Manna Mission	Rev. Mrs. Olivia Dotse	0244 331447	odotse@yahoo.com
18	Word Alive Missions	Rev. Charles Nyane	0244 184133	cnyane@yahoo.com
19	RUN Missions	Mrs. Vivian Akosua	020 8163968	ghartey@yahoo.com

		Ghartey		

Annex V: List of Member Institutions

No	Region	District	Name	Status	Church
*1	Ashanti	Kuntunase	Anglican Eye Clinic, Jachie	Clinic	Anglican Church
*2	Ashanti	Tano	Anglican Health Centre, Tano-Odumase	Clinic	Anglican Church
**3	Ashanti	Adansi-West	Benito Menni Health Centre, Dompoase	Clinic	Catholic Church
**4	Ashanti	Kwabre	Catholic Clinic, Oku Ejura, Ashanti	Clinic	Catholic Church
5	Ashanti	Ejisu Juaben	St. Ann's Maternity Clinic, Donyina	Clinic	Catholic Church
6	Ashanti	Ahafo Ano South	St. Edward's Clinic, Dwinyama	Clinic	Catholic Church
**7	Ashanti	Ahafo Ano South	St. John's Health Centre, Domeabra	Clinic	Catholic Church
8	Ashanti	Kwabre	St. Joseph's Clinic, Abira	Clinic	Catholic Church
**9	Ashanti	Adansi-East	St. Mary's Clinic, Yapesa	Clinic	Catholic Church
**10	Ashanti	Atwima	St. Peter's Clinic/Maternity Home, Ntobroso	Clinic	Catholic Church
**11	Ashanti	Adansi-East	St. Thomas Gen & Maternity Clinic, Hiaa	Clinic	Catholic Church
12	Ashanti	K'si Metro. Assembly	Church of Christ Mission Clinic, Bomso	Clinic	Church of Christ Mis.
13	Ashanti	Ejisu Juaben	Church of God Clinic, Essienimpong	Clinic	Church of God

*14	Ashanti	Atwima	Lake Bosumtwi Clinic, Amakom	Clinic	Methodist Church
*15	Ashanti	Sekyere East	Senchi /Aburaso Clinic	Clinic	Methodist Church
16	Ashanti	Afigya Sekyere	Salvation Army Clinic, Wiamoase	Clinic	Salvation Army
*17	Ashanti	Upper Denkyira	Seventh-Day Adventist Clinic, Dominase	Clinic	SDA Church
**18	Ashanti		Sacred heart Clinic, Bepoase	Clinic	Catholic Church
19	Brong-Ahafo	Dormaa	Presbyterian Clinic , Kwamebikrom	Clinic	PCG
20	Brong-Ahafo	Dormaa	Presbyterian Clinic, Aboabo	Clinic	PCG
21	Brong-Ahafo	Dormaa	Presbyterian Clinic, KojoKumikrom	Clinic	PCG
22	Brong-Ahafo	Dormaa	Presbyterian Clinic, Kwamesua	Clinic	PCG
23	Brong-Ahafo	Dormaa	Presbyterian Clinic, Kyeremasu	Clinic	PCG
24	Central	Upper Denkyira	Pentecost Clinic, Dunkwa-on-Offin	Clinic	Church of Pentecost
25	Central	Assin-Fosu	Presbyterian Church Clinic, Assin-Praso	Clinic	PCG
26	Central	Assin-Fosu	Presbyterian Clinic, Assin Nsuta	Clinic	PCG
27	Central	Agona-Swedru	Salvation Army Clinic, Agona-Duakwa	Clinic	Salvation Army
28	Central	Ajumako Enyan Esiam	Salvation Army Clinic, Ba	Clinic	Salvation Army

29	Eastern	Birim South	Catholic Clinic, Akim-Swedru	Clinic	Catholic Church
30	Eastern	Akwapim South	Notre Dame Clinic, Nsawam	Clinic	Catholic Church
**31	Eastern	Akwapim South	Orthopaedic Training Centre, Nsawam	Clinic	Catholic Church
32	Eastern	Birim South	St. John's Clinic, Akim-Ofoase	Clinic	Catholic Church
33	Eastern	Kwahu South	St. Joseph Clinic & Mat, Kwahu-Tafo	Clinic	Catholic Church
34	Eastern	Kwahu South	St. Michael's Cath. Clinic, Ntronang-Akim	Clinic	Catholic Church
35	Eastern		Kwahu-Praso Presby Clinic, Kwaho-Praso	Clinic	PCG
*36	Eastern	Akwapim South	Kom Clinic, Aburi	Clinic	PCG
37	Eastern	Kwaebibrem	Salvation Army Clinic, Akim-Wenchi	Clinic	Salvation Army
38	Eastern	Asuogyaman	Salvation Army Clinic, Anum	Clinic	Salvation Army
39	Eastern	Fanteakwa	Salvation Army Clinic, Begoro	Clinic	Salvation Army
40	Greater-Accra	AMA	Sight for Africa Eye clinic, Accra	Clinic	RUN Mission
41	Greater-Accra	Dangbe West	St. Andrew's clinic/Mat, Kordieba	Clinic	Catholic Church
*42	Northern	Gushegu Karaga	Ass. of God H'lth Services, Nakpanduri	Clinic	Assemblies of God

43	Northern	Bole	Catholic Clinic, Tuna	Clinic	Catholic Church
44	Northern	West Dagomba	Holy Cross Clinic/maternity, Sambuli Tamale	Clinic	Catholic Church
**45	Northern	Tamale	Holy Cross Mobile Clinic, Tamale	Clinic	Catholic Church
46	Northern	West Mamprusi	Our Lady of Rocio Clinic, Walewale	Clinic	Catholic Church
47	Northern	East Mamprusi	St. Joseph Clinic & Mat Home, Chamba	Clinic	Catholic Church
48	Northern	Bole	St. Joseph's Clinic, Kalba	Clinic	Catholic Church
*49	Northern	Yendi	E. P. Church Clinic, Wapuli	Clinic	E. P. Church, Ghana
*50	Northern	West Mamprusi	Presbyterian Clinic, Langbinsi-Walewale	Clinic	PCG
*51	Upper-East	Bawku West	Anglican Clinic Yelwoko	Clinic	Anglican Church
*52	Upper-East	Bawku West	Anglican Clinic, Widnaba	Clinic	Anglican Church
53	Upper-East	Kassena Nakana	Bui Clinic, Bui	Clinic	Catholic Church
54	Upper-East	Builsa	Catholic Clinic, Wiaga	Clinic	Catholic Church
**55	Upper-East	Talensi-Nabdam	Kongo Clinic, Bolgatanga	Clinic	Catholic Church
**56	Upper-East	Kassena-Nakana	Nakolo Clinic, Bolga	Clinic	Catholic Church
57	Upper-	Kassena	Sirigu Clinic, Bolga	Clinic	Catholic

	East	Nakana			Church
58	Upper-East	Bongo	Zoko Clinic, Bolgatanga	Clinic	Catholic Church
59	Upper-West	Lawra	Methodist Clinic, Lawra	Clinic	Methodist Church
*60	Volta	Ho	Nazareth Healing Comp, Vane Avatime	Clinic	E. P. Church, Ghana
61	Volta	Hohoe	St. George's Clinic, Liati	Clinic	Catholic Church
62	Volta	Krachi	St. Luke's Catholic PHC Clinic, Chinderi	Clinic	Catholic Church
63	Volta	Nkwanta	Pentecost Clinic, Kpasa	Clinic	Church of Pentecost
64	Volta	Krachi	E. P. Church Dan Moser Memo. Clinic, Dambai	Clinic	E. P. Church, Ghana
65	Volta	Ho	Salvation Army Clinic, Adaklu-Sofa	Clinic	Salvation Army
66	Western	Juabeso Bia	Anglican Clinic, Sefwi-Bonzain	Clinic	Anglican Church
67	Western	Sefwi Wiawso	Bishop Anglioby Clinic, Sefwi-Wiawso	Clinic	Anglican Church
68	Western	Wasa West	Pentecost Clinic, Tarkwa	Clinic	Church of Pentecost
69	Western	Aowin Suaman	Presbyterian Clinic, Papueso-Enchi	Clinic	PCG
*70	Western	Sefwi Wiawso	SDA Clinic and Maternity, Sefwi-Asawinso	Clinic	SDA Church
71	Western	Shama Ahanta East	SDA Hospital, Takoradi	Clinic	SDA Church

72	Western	Jomoro	Siloam Gospel Clinic, Bonyere	Clinic	Siloam Gospel Church
*73	Western		SDA Clinic, Kofikrom	Clinic	SDA Church
74	Western	Ahanta-West	Holy Child Clinic, Egyam	Clinic	Catholic Church
**75	Western		Holy Child Clinic, Fijai	Clinic	Catholic Church
*76	Brong-Ahafo	Sunyani	Christian Eye Centre, Abesim-Sunyani	Clinic Specialist	Anglican Church
77	Central	Cape Coast Municipal	Christian Eye Centre, Cape Coast	Clinic Specialist	Anglican Church
78	Greater-Accra	AMA	Emmanuel Eye Centre, East Legon	Clinic Specialist	Church of Pentecost
79	Ashanti	Sekyere East	St. Luke Health Centre, Seniagya	HC	Catholic Church
80	Greater-Accra	AMA	Urban Aid Health Centre, Mamobi	HC	Salvation Army
81	Northern	Zabzugu Tatale	Tatale Health Centre, Tatale	HC	Catholic Church
82	Northern	Nanumba	Kpandai Health Centre, Kpandai	HC	WEC Mission
83	Upper-East	Garu	Garu Health Centre, Garu - Tempane	HC	PCG
84	Upper-East	Widana	Widana Health Centre, Widana	HC	PCG
85	Upper-East	Woriyanga	Woriyanga Presby Health Centre, Garu-Temp.	HC	PCG

86	Eastern	Kwahu North	Ekye Presbyterian Health Centre	HC	PCG
*87	Ashanti	Offinso	Janie Speaks AME. Hospital, Afrancho	Hospital	AME Zion Church
**88	Ashanti	Adansi West	St. Louis Gen. Hospital, Bodwesango	Hospital	Catholic Church
**89	Ashanti	Amansie East	St. Martin's Hospital, Agroyesum	Hospital	Catholic Church
**90	Ashanti	BAK	St. Michael's Hospital, Pramso	Hospital	Catholic Church
91	Ashanti	Offinso	St. Patrick's Hospital, Maase-Ofinso	Hospital	Catholic Church
**92	Ashanti	Amansie East	St. Peter's Hospital, Jacobu	Hospital	Catholic Church
93	Ashanti	Adansi-West	Bryant Hospital, Obuasi-Adansi	Hospital	Church of Pentecost
94	Ashanti	Ejura Sekyeredumase	St. Luke's Hospital, Kasei	Hospital	Church of Pentecost
95	Ashanti	Ejisu Juaben	Global Evang. Church Medical Centre, Apromase	Hospital	Global Evang. Church
*96	Ashanti	Kwabre	Methodist Faith Healing Hospital, Ankaase	Hospital	Methodist Church
97	Ashanti	Ash. Akim North	Presbyterian Hospital, Agogo, Ashanti-Akim	Hospital	PCG
98	Ashanti	Amansie East	Akormaa Memorial SDA Hospital, Kortwia-Abodom	Hospital	SDA Church
*99	Ashanti	Afigya Sekyere	Seventh-Day Adventist Hospital, Asamang	Hospital	SDA Church

100	Ashanti	Amansie East	Seventh-Day Adventist Hospital, Dominase	Hospital	SDA Church
101	Ashanti	K'si Metro. Assembly	Seventh-Day Adventist Hospital, Kwadaso-Kumasi	Hospital	SDA Church
*102	Ashanti	Ejisu Juaben	Seventh-Day Adventist Hospital, Onwe	Hospital	SDA Church
103	Ashanti	Afigya Sekyere	Seventh-Day Adventist Hospital, Wiamoasi-Ashanti	Hospital	SDA Church
104	Brong-Ahafo	Berekum	Holy Family Hospital, Berekum	Hospital	Catholic Church
105	Brong-Ahafo	Techiman	Holy Family Hospital, Techiman	Hospital	Catholic Church
**106	Brong-Ahafo	Atebubu	Mathias Hospital, Yeji	Hospital	Catholic Church
**107	Brong-Ahafo	Asutifi	St. Elizabeth Hospital, Hwidiem	Hospital	Catholic Church
**108	Brong-Ahafo	Tano District	St. John of God Hosp. Duayaw-Nkwanta	Hospital	Catholic Church
**109	Brong-Ahafo	Jaman	St. Mary's Hospital, Drobo	Hospital	Catholic Church
110	Brong-Ahafo	Nkoranza	St. Theresa's Hospital, Nkoranza	Hospital	Catholic Church
111	Brong-Ahafo	Wenchi	Methodist. Hospital, Wenchi	Hospital	Methodist Church
*112	Brong-Ahafo	Dormaa	Presbyterian Hospital, Dormaa - Ahenkro	Hospital	PCG
113	Brong-Ahafo	Sunyani	SDA Hospital, Sunyani	Hospital	SDA Church

**114	Central	Gomoa	Catholic Hospital, Apam	Hospital	Catholic Church
**115	Central	Asikuma	Our Lady of Grace Hospital, Breman-Asikuma	Hospital	Catholic Church
**116	Central	Assin-Fosu	St. Francis Xavier Hospital, Assin-Foso	Hospital	Catholic Church
*117	Central		Coast for Christ Baptist Hospital	Hospital	Baptist Church
**118	Eastern	Kwahu South	Holy Family Hospital, Nkawkaw	Hospital	Catholic Church
**119	Eastern	Kwaebibrem	St. Dominic's Hospital, Akwatia	Hospital	Catholic Church
**120	Eastern	New Juaben	St. Joseph's Hospital, Koforidua	Hospital	Catholic Church
**121	Eastern	Manya Krobo	St. Martin's Hospital, Agomanya	Hospital	Catholic Church
122	Eastern	Kwahu South	Presbyterian Hospital, Donkorkrom	Hospital	PCG
123	Eastern	New Juaben	SDA Hospital, Koforidua	Hospital	SDA Church
124	Greater-Accra	AMA	Manna Mission Hosp, Teshie-Nungua	Hospital	Manna Mission Church
125	Greater-Accra	AMA	Alpha Medical Centre, Madina	Hospital	Church of Pentecost
126	Northern	Saboba Chereponi	Saboba Medical Centre, Saboba	Hospital	Assemblies of God
*127	Northern	East Mamprusi	Baptist Medical Centre, Nalerigu	Hospital	Baptist Church
**128	Northern	West Gonja	West Gonja Hospital,	Hospital	Catholic

			Damango		Church
129	Northern	Tamale	Seventh-Day Adventist Hospital, Tamale	Hospital	SDA Church
*130	Northern		Kings Medical Centre, Bontanga	Hospital	Baptist Church
131	Upper-East	Bawku	Bawku Presbyterian Hospital, Bawku	Hospital	PCG
**132	Upper-West	Lawra	St. Theresa's Hospital, Nandom	Hospital	Catholic Church
**133	Upper-West	Jirapa Lambussie	St. Joseph's Hospital, Jirapa	Hospital	Catholic Church
**134	Volta	Kpando	Anfoega Catholic Hospital, Anfoega	Hospital	Catholic Church
**135	Volta	North Tongu	Catholic Hospital, Battor, Bator	Hospital	Catholic Church
**136	Volta	Kpando	Margaret Marquart Cath. Hosp, Kpando	Hospital	Catholic Church
137	Volta	Kadjebi	Mary Theresa Hospital, Dodi-Papase	Hospital	Catholic Church
**138	Volta	Kete/Anglo	Sacred Heart Hospital, Weme-Abor	Hospital	Catholic Church
139	Volta	Ketu	St. Anthony Hospital, Dzodze	Hospital	Catholic Church
140	Volta	Nkwanta	St. Joseph's Hospital, Nkwanta	Hospital	Catholic Church
**141	Western	Wasa Amenfi	Fr. Thomas Rooney Memo. Hosp., Asankragwa	Hospital	Catholic Church
**142	Western	Sefwi Wiawso	St. John of God Hospital, Sefwi-Asafo	Hospital	Catholic Church

143	Western	Nzema East	St. Martin de Porres Hospital, Eikwe	Hospital	Catholic Church
144	Western	Shama Ahanta East	Nagel Memorial Hospital, Takoradi	Hospital	SDA Church
145	Ashanti	Ashanti Akim North	Presbyterian PHC , Agogo, Ashanti-Akim	PHC	PCG
**146	Brong-Ahafo	Atebubu	Abease PHC. Project, Prang/Abease	PHC	Catholic Church
147	Brong-Ahafo	Dormaa	Dormaa Presby PHC. Project, Dormaa-Ahenkro	PHC	PCG
**148	Eastern	Kwahu South	Kwesi Fantse Clinic PHC Nkawkaw	PHC	Catholic Church
149	Eastern	Kwahu East	Abetifi Presbyterian PHC, Abetifi	PHC	PCG
**150	Northern	Tamale	Catholic Clinic, PHC Unit, Salaga	PHC	Catholic Church
**151	Northern	Bole	Catholic P.H.C. Bole Tamale	PHC	Catholic Church
*152	Upper-East	Bolgatanga	Presbyteriany PHC, Sandema	PHC	PCG
153	Upper-East	Bolgatanga	Presbyterian P.H.C., Bolgatanga	PHC	PCG
154	Upper-East	Bawku-East	Presbyterian PHC, Bawku	PHC	PCG
155	Upper-West	Wa	Wa Diocese P.H.C. Project	PHC	Catholic Church
156	Volta	Ho	E. P. Social Services Centre/Clinics, Ho	PHC	E. P. Church, Ghana
157	Western	Aowin Suaman	Presbyterian PHC, Aowin-Suaman, Enchi	PHC	PCG

**158	Volta	South Tongu	Comboni Polyclinic, Sogakope	Polyclinic	Catholic Church
159	Ashanti	Offinso	St. Patrick's Midwifery School, Maase-Offinso	Training Inst.	Catholic Church
160	Ashanti	Ashanti Akim North	Nurses Training College, Agogo	Training Inst.	PCG
161	Ashanti	Kumasi Metro. Assembly	SDA Nurses Training College, Kwadaso	Training Inst.	SDA Church
162	Brong-Ahafo	Berekum	Holy Family Midwifery School, Berekum	Training Inst.	Catholic Church
163	Brong-Ahafo	Berekum	Holy Family Nurses Training College, Berekum	Training Inst.	Catholic Church
164	Eastern	Kwahu South	Holy Family Nurses Training College ,Nkawkaw	Training Inst.	Catholic Church
165	Upper-East	Bawku East	Presbyterian Nurses Training College, Bawku	Training Inst.	PCG
166	Upper-West	Jirapa Lambussie	St. Joseph's Midwifery School, Jirapa	Training Inst.	Catholic Church
167	Upper-West	Jirapa Lambussie	St. Joseph's Nurses Training College, Jirapa	Training Inst.	Catholic Church
168	Western	Axim	Word Alive School of Nursing, Esiama	Training Inst.	Word Alive Missionary

* Facilities that did not submit their inventory

** Facilities that did not submit information on HR data