CHAG

CHRISTIAN HEALTH ASSOCIATION OF GHANA

Health in Body, Mind and Soul

ANNUAL REPORT 2015

Christian Health Association of Ghana (CHAG)

ANNUAL REPORT 2015

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ABBREVIATIONS

ACCM	Annual Conference & Council Meeting
ANC	Ante Natal Care
ARI	Acute Respiratory infections
ARV	Anti-retroviral
BLS	Basic life Support
C4C	Connect for Change
CCG	Christian Council of Ghana
CHAG	Christian Health Association of Ghana
CHC	Church Health Coordinators
CHCU	Church Health Coordination Units
CHPS	Community Health Planning and Services
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CSS	Community System Strengthening
DANIDA	Danish international Development Agency
DPs	Development Partners
DHMIS	District Health Management Information System
EMS	Emergency Medical Services
ENBC	Essential New Born Care
ES	Executive Secretariat
FP	Family Planning
GHS	Ghana Health Service
GOG	Government of Ghana
GPCC	Ghana Pentecostal and Charismatic Council
HEFRA	Health Facilities Regulatory Agency
HR	Human Resources
HSS	Health Systems Strengthening
IGF	Income Generating Funds
IMCI	Integrated Management of Childhood Illness
IPD	In-Patient Department
MAF	MDG Accelerated Framework
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIs	Member Institutions
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSDS	Minimum Service Data Set
NCHS	National Catholic Health Secretariat
NHIA	National Health Insurance Authority
OPD	Out-Patient Department
OPAT	Organizational Performance Assessment Tool
PHC	Primary Health Care
PLHIV	Patients Living with HIV and AIDS
TBA	Traditional Birth Attendant
UTI	Uterine Tract Infection
URTI	Upper Respiratory Tract Infection

Chairman's Letter

Dear Friends,

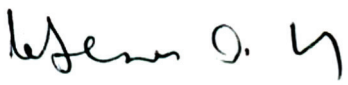
As we reflect on 2015 and all the achievements in improving access to quality healthcare for millions of people as well as training thousands of future health professionals, we are thankful to God for such generous and compassionate community of Christian Health Workers.

Our mandate is to provide healing to all manner of people in fulfillment of the Healing Ministry of our Lord Jesus Christ. In the light of this mandate, we sought to bridge the equity gaps in geographical access to health services by admitting 106 new Church Health Facilities into the CHAG fraternity. Furthermore, our committed professional and other staff in our dedicated Member Institutions upheld our Christian identity and witness even in crisis moments between Organized Labour and Government and for this, we are most grateful.

In spite of the aforementioned achievements, CHAG is still confronted with increasingly dynamic changes and challenges in the health sector. We are experiencing dwindling funding support from our core Development Partners due to new paradigms in their development policies. Ghana, as a Lower Middle Country, is no more attractive to many Development Partners. We are still confronted with an average of 8-month delay in reimbursement of claims from the National Health Insurance Authority. This situation adversely affected our capacity to deliver quality service for needy people in 2015. In many ways, the financial and organizational sustainability of CHAG services remain a major concern. Consequently, the far-reaching transformation process that begun in 2014 is being pursued with several objectives: to strengthen our position as the most reliable partner in the health sector, to drive our ability to innovate and to successfully position CHAG for the long term in the face of emerging challenges. Ultimately, we aim at evolving operational and structural changes that will promote the development and sustainability of Christian health service delivery.

Please, enjoy this 2015 Annual Report, which highlights the impact CHAG has made on the lives of our cherished clients and the Ghanaian public as a whole. Co-operation and Partnership is our cherished core value. We uphold unity in diversity. Together, we are transforming health care and meeting the needs of our clients now and in the future. Your support is highly valued!

With gratitude,



Dr. Kwabena Adu Poku
Board Chairman
Christian Health Association of Ghana (CHAG)

A Note of Gratitude

Dear Colleagues,

In 2015, CHAG once again, proved to be a reliable Partner with significant progress in the health sector. In pursuit of our core value of holistic healthcare, we continued with the provision of curative, preventive, promotive and rehabilitative health services whilst maintaining our commitment to providing quality training of health professionals across our network of 290 Member Institutions.

Together, we handled almost 6,000,000 Outpatient visits, 455,577 admissions, and with 2,491 overall student intake in 14 pre-service CHAG Training Colleges.

We owe these significant contributions to our dedicated Front-Line Staff, Senior Leadership and Board of Trustees for their commitment to the values and ideals of CHAG. As an Organization that believes in and is committed to partnerships, CHAG collaboratively worked with Agencies, Providers, and Organizations to ensure that people have convenient and affordable access to quality health services. In particular, we enjoyed the indispensable support of the Government of Ghana through the Ministry of Health, DANIDA, UKAID/DFID, UNFPA, Catholic Relief Services, and Rockefeller Foundation amongst others.

On behalf of my Management Colleagues, I wish to thank the Board of Trustees for their guidance, direction and support in many ways, and our CHAG Secretariat Staff for their dedicated efforts and for the way they continued to uphold the culture of excellence and creativity. As a Christian Not-For-Profit Organization, our aspiration is to provide extraordinary health services, in all its dimensions, to those we serve. Hence, we would continue to explore innovative interventions and strive to promote health and healing for those who depend on us in the times ahead.

This Annual Performance Report highlights the details of our collective achievements, common challenges and pointers for our future growth prospects as Christian Health Service Providers. The report represents our renewed promise and pledge to promote Jesus Christ's healing ministry everywhere, to everybody, and at all times!

Sincerely,

Peter Kwame Yeboah
Executive Director
Christian Health Association Ghana (CHAG)

Christian Health Association of Ghana (CHAG) in a Nutshell

CHAG is a Network Organisation of 291 Health Facilities and Health Training Institutions owned by 25 different Christian Church Denominations. CHAG provides health care to the most vulnerable, deprived, marginalized and underprivileged population groups in all 10 Regions of Ghana, particularly in the most remote areas.

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

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

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

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

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

Table 1: Core Values of CHAG

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

The overall objective of CHAG is to contribute to national health sector objectives and outcomes. Specific objectives of CHAG relate to representation and partnership development (Table 2):

Table 2: Objectives of CHAG

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

CHAG is governed by a Board of Trustees and directed by a strategic framework outlining medium term aspirations and approaches. [1] At the National level, CHAG operates a Secretariat, which provides stewardship, develops strategic partnerships, builds capacity and articulates the interest of the Association through lobbying, advocacy and policy dialogue. The larger Church denominations operate coordination offices at various levels providing financial, technical, logistical and program support to their respective health facilities. CHAG works closely with the Ministry of Health (MOH) and its Agencies at policy and implementing levels based on performance agreements, mutuality and reciprocity.[2]

1. CHAG Strategic Framework 2014-2016, Unity in Diversity, December 2013.
2. Memorandum of Understanding between MOH and CHAG, 2006. Memorandum of Understanding between GHS and CHAG, December 2013.

Summary Outlook 2015

In fulfillment of its mission, The Christian Health Association of Ghana (CHAG) successfully cared for millions of our fellow citizens in 2015.

Thus, CHAG consolidated its role in the Ghanaian health sector by improving access to quality health services and professional training through its Network of 291 hospitals, Health Centres, Clinics and Training Schools.

On leadership and governance, CHAG sought to strengthen its internal organizations and to foster partnerships with stakeholders in the health sector at the national, regional and district levels. Hence, CHAG adopted a new constitution and charter to regulate the management and administration of the CHAG Network. This further culminated in the maiden Annual General Meeting between the Owners (Church Leaders) and the CHAG Board of Trustees.

Consistent with our pro-poor core values, CHAG sought to extend quality health services to the marginalized, neglected and deprived segments of the society. After a stringent membership audit exercise, CHAG admitted 107 new Health Facilities into the Network that are mostly located in the rural areas of Ghana. This historic admission represents 58% membership growth over time. Consequently, the geographic spread of the Membership now has the potential to increase access to health care for more people in the years ahead.

Finding sustainable funding sources remain CHAG's major concern. We are still inundated with seemingly chronic delay in reimbursement of NHIS-claims. This has resulted in severe financial constraints on our members that is adversely affecting our capacity to fulfil our core mandate of providing sustainable quality health services to our cherished clients. Given that the NHIS has become a vital source of funding recurrent expenditures for MIs, a solution to this perennial crisis must be explored to guarantee the financial and organizational sustainability of CHAG Network. Consequently, we urgently implore the National Health Insurance Authority (NHIA) to ensure prompt reimbursement of validated claims as well as finding a sustainable solution to this acute situation. In the long term, CHAG urges the NHIA to ensure the Sustainability, Efficiency, Equity and Provider/Public satisfaction with the National Health Insurance Scheme.

Nonetheless, CHAG proved to be a reliable partner in the health sector. Overall, CHAG increased its contribution to the national health sector objectives as indicated by a selected number of outcomes, performance and input indicators. In particular, there were improvements in five key health sector outcome indicators from the year 2010 to 2015. These indicators include Under-5, Maternal Mortality, Neonatal Mortality, Still Births and Crude Mortality rates. There was a steep decline in maternal mortality from 167 to 145 deaths per 100,000 live births in the year under review. This represents 13.2% change compared to the previous year. Over a six-year period, there has been 11% reduction in institutional maternal mortality within the CHAG network. This

is attributed to concerted efforts, innovations and active campaigns against avoidable maternal mortality within the CHAG network over the period. Neonatal, infant and under-5 mortality rates reduced by 33.7%, 21.1% and 12.7% respectively, compared to 2014. These are indications of improvement in the quality of health service delivery within the Network. However, Stillbirth Rate stabilized whilst Crude Mortality Rate worsened over the said period. The table on the next page provides detail on the key outcome indicators for CHAG over a six-year period.

Table 3: Health Indicators: 2010 – 2015

Outcome Indicator	Year						% Change 2014 - 2015	One -year Performance	% Change 2010 - 2015	6-Year Performance	National 2015	Developing Countries 2015
	2010	2011	2012	2013	2014	2015						
Maternal Mortality Rate	163	194	158	168	167	145	-13.2%	Improved	-11%	Improved	319[1]	239[3]
Neonatal Mortality Rate	7.2	6.7	5.5	7.1	9.8	6.5	-33.7%	Improved	-8%	Improved	28[1]	52[1]
Infant Mortality Rate	8	7.6	6.6	7.9	10.9	8.6	-21.1%	Improved	+8%	Worsened	43[1]	107[1]
Under 5 Mortality Rate	29.4	21	21.1	19.5	17.3	15.1	-12.7%	Improved	-48.6%	Significantly improved	62[1]	177[1]
Still Births Rate	30	27	26	24	21	21	0.0%	Stable	-30%	Significantly improved	29[2]	18.4[4]
Crude Mortality Rate	25	24	23	23	21	22	4.7%	Worsened	-12%	Improved	9[1]	16[1]

1 The World Bank, Data, 2014, 2015

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

3 World Health Organization: Maternal Mortality Key facts 2015

4 2015 Worldwide estimates: WHO neglected tragedy of stillbirths

Performance Indicators

Furthermore, selected performance indicators showed considerable improvement in 2015 compared to previous years. Total number of outpatient attendance increased by 3.4% for the year under review and 9.8% over a 5-year period (2011-2015). Total hospital admissions increased by 3.7% in the year under review, and 15.5% over a 5-year period.

These two are indications that Clients still prefer CHAG Facilities to others. With the establishment of CHPS compounds in many communities across the country, it was expected that the attendance and admissions would reduce in the year under review; however, the contrary happened, showing Client preference for CHAG Facilities.

Total deliveries however, decreased by 7.5% over the year. Unfortunately, the number of Caesarian Sections (CS) increased by 5.0% over the reporting period resulting in an average CS-ratio of 19.8% in 2015. Used as a proxy indicator for all childhood vaccinations, the number of children vaccinated for BCG decreased by 19.2% over the period.

The average bed-occupancy rate is stabilizing since 2011. Student enrollment with CHAGs Nurses and Midwifery Training Colleges has tripled since 2011. The average student pass rate for final examinations has improved by about 58% since 2011. Table 4 on next page provides detail of the performance indicators.

Table 4: Performance Indicators.

Performance indicator	2011	2012	2013	2014	2015	% Change 2014-2015	One -year Performance	% Change 2011-2015	5-year Performance	National 2015	Sub -Saharan Africa
Total Out -Patients	5,413,475	5,813,740	5,844,783	5,749,927	5,942,777	3.4%	Improved	9.8%	Improved		
Total Admissions	394,442	397,240	428,601	439,186	455,577	3.7%	Improved	15.5%	Improved		
No of Deliveries	101,331	114,205	117,313	119,141	110,228	-7.5%	Decreased	8.8%	Increased		
Total Caesarian Sections	15,959	17,839	19,284	20,779	21,834	5.1%	Increased	36.8%	Significantly increased		
Caesarian Rate	15.70%	15.60%	16.40%	17.40%	19.8%	14.9%	Worsened	26.1%	Worsened	6.46% [1]	2% [1]
Vaccination (BCG)	94,315	109,878	111,371	113,413	91,632	-19.2%	Decreased	-2.8%	Decreased		
HTC? Clients	45,755	31,451	36,946	50,238	40,161	-20.1%	Decreased	-12.2%	Decreased		
Bed Occupancy Rate	69.80%	68.60%	64%	69%							
Student Enrollment	609	726	1,854	2,849	2,491	-12.6%	Decreased	309.0%	Increased		
Student Pass Rate	62.00%	61.00%	65.00%	88.00%	98.00%	11.4%	Improved	58.1%	Improved		

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

Input Indicators

As depicted in Table 5 and Figure 1, selected input indicators showed a considerable improvement in the area of human resources with a noticeable increase of 42% in the total number of CHAG staff enrolled on GOG-payroll since 2011. The average proportion of clinical staff relative to the total staff establishment increased from 48% in 2012 to 53.6% in 2015, although distribution of clinical staff remained uneven.

The average Doctor/OPD-Client and Nurse/OPD-Client ratios also improved compared to 2014, by 5.4% and 0.5% respectively as shown in table 5. The improvement in the Doctor to Client and Nurse to Client ratios was due to these categories of clinical staff accepting posting into CHAG. With the improving trend, it is anticipated that there will be more Doctors in the CHAG network within the next five years with the hope to meeting the World Health Organization (WHO) approved Doctor/patient ratio, which is 1:6000 (WHO 2015).

Consequently, a corresponding improvement in service delivery is anticipated as the ratio for these cadres of staff improves. The nurse/Client ratio at the moment is close to the national average of 1:1080.

Table 5: Input Indicators: 2011 - 2015

Input indicators	2011	2012	2013	2014	2015	% Change 2014-2015	One - year performance	% Change 2011-2015	5-year performance	National (Ghana)	WHO Standard
Total Mechanized Staff	8,861	9,356	11,127	12,328	12,584	2.1%	Increased	42.0%	Increased		-
Clinical/non - clinical staff Ratio		48%	64%	73%	53%	-27.4%	Worsened				-
Doctor/OPD - client Ratio	1:21,357	1:21,645	1:18,845	1:15,987	1:15,122	-5.4%	Improved	-29.2%	Improved	10,417[2]	1:6,000[1]
Nurse/OPD - client Ratio	1:2,200	1:1,666	1:1,556	1:1,411	1:1,404	-0.5%	Improved	-36.2%	Improved	1:1080[2]	

1. WHO 2015
2. WHO 2010: density per 1000, Data by country

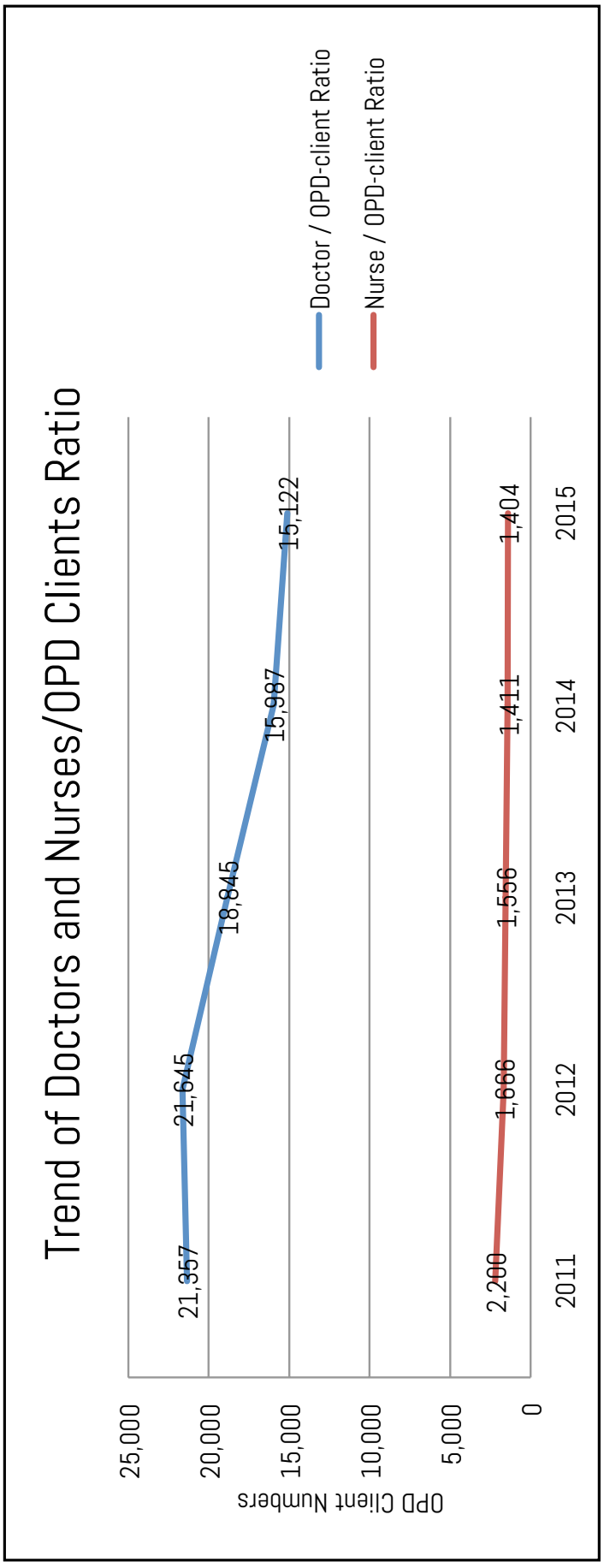


Figure 1: Trend of Doctors and Nurses/OPD Clients Ratio

Performance Outcome and Status for 2015

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

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

This section provides information on the performance, outcome and status of CHAG during 2015. It is structured on the nine (9) health systems building blocks as adopted in 2010 by CHAG as its performance management framework.

1.0 Service Delivery

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

1.1 Out-Patient and In-Patient Services

The total number of outpatients (old and new) seen in CHAG in 2015 was 5,942,777, whereas total number of patients admitted beyond 24 hours was 455,577 (refer to table 6 below). There was an increase of 3.4% in the OPD attendance in 2015 compared to that of 2014 and 9.8% compared to 2011. Out of every 10,000 Out-patients 7,725 Patients were admitted across CHAG Hospitals with 18 beds per 1000 population. In-patient Clients seen in CHAG facilities had a 3.7% growth in tandem with the growth in OPD numbers during the period under review. The overall growth

was 15.5% over the last five years. Eighty-seven percent (87.2%) of the OPD were insured and 85.9% of inpatients were insured, showing 7% growth in insured OPD clients over the past 4 years as indicated in table 6.

The growth in OPD numbers signifies the trust of clients in CHAG Facilities given that many CHPS compounds are being established in many communities, which have the potential of reducing patronage of existing facilities. Again, in the course of the year when Medical Doctors in the country embarked on industrial action to press home their demand for codified conditions of service, CHAG Doctors continued to provide services. This made Facilities see more patients than they would have done if they had joined the strike. In the circumstance, therefore, CHAG's core values were affirmed, and its status as a reliable Partner in the health sector was upheld. This development holds a positive outlook for CHAG Institutions in the impending NHIS capitation scale up, which hinges on Clients' choice of Hospital/Clinic/Health centres as their preferred primary providers.

It is important to note that two Denominational Health Services (Catholic, and Presbyterian Health Services) contributed over 70% of the total OPD figures recorded in 2015 (60.1% and 10.04% respectively). Refer to figure 5.

The Contribution of CHAG to National Out and In-Patient Service

For the year under review, the percentage of CHAG contribution towards national OPD and IPD stood at about 18.2% and 25.6% respectively as shown in figure 2. There has been a downward trend in CHAG's contribution to OPD since 2011. This could be attributed to the proliferation of health facilities, especially CHPS compounds in rural areas where CHAG primarily operates. Contribution to IPD has remained fairly stable over the past 3 years and may be an indication of trust that clients have in CHAG facilities in terms of admission.

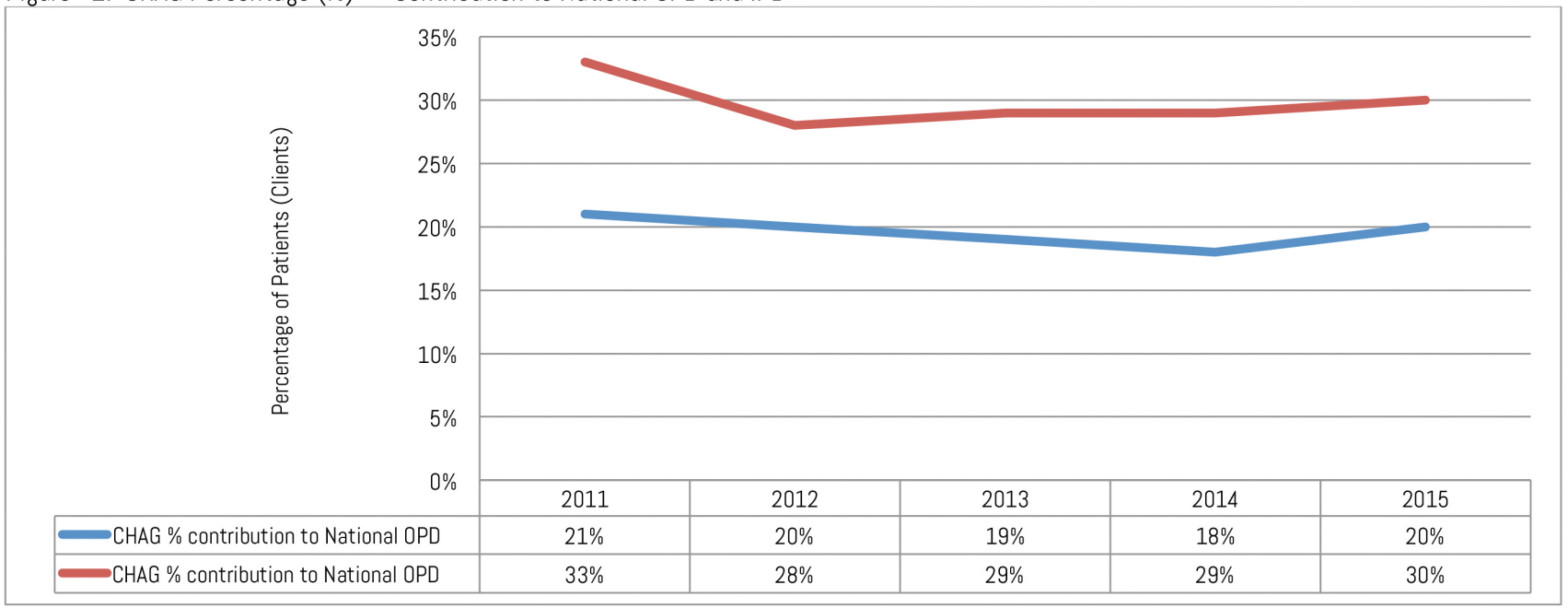
Table 6: CHAG Contribution to National Outpatients, In-patients and NHIS Clients

Output	2011	2012	2013	2014	2015	%Change 2015	1 Year Performance	% Change Performance (2011 - 2015)	5 Year
National OPD Attendance	25,653,672	29,496,283	30,142,274	31,087,824	29,949,173	-4	Decreased	17	Increased
CHAG OPD Attendance	5,413,475	5,813,740	5,749,927	5,749,927	5,942,777	3	Increased	10	Increased
CHAG % Contr. to N ational OPD	21%	20%	19%	18%	20%	11	Increased	(5)	Decreased
National Admissions	1,202,745	1,405,997	1,460,360	1,534,379	1,501,773	-2	Decreased	25	Increased
CHAG Admissions	394,442	397,240	428,601	439,186	455,577	4	Increased	15	Increased
CHAG % Contr. to National . IPD	33%	28%	29%	29%	30%	3	Increased	(9)	Decreased
National OPD Insured	20,517,198	23,625,452	25,033,396	25,827,728	24,715,935	-4	Decreased	20	**Increased**
% National OPD Insured	79.98	80.10	83.05	83.08	82.53	-1	Decreased	3	**Increased**
CHAG OPD Insured	4,384,915	5,116,091	5,404,931	5,117,435	5,170,216	1	Increased	18	**Increased**
% CHAG OPD Insured	81.00	88.00	94.00	89.00	87.00	-2	Decreased	7	Increased

Table 7: OPD and IPD Service Outputs: 2010 - 2015

Performance Indicator	2011	2012	2013	2014	2015	% Change 2014-2015	One -year performance	% Change 2011-2015	5-year performance
OPD	5,413,475	5,813,740	5,749,927	5,749,927	5,942,777	3.4%	Increased	9.8%	Increased
IPD	394,442	397240	428601	439186	455577	3.7%	Increased	15.5%	Increased
OPD Insured	81%	88%	94%	89%	87%	-2.2%	Reduced	7.4%	Improved
IPD Insured	80%	84%	86%	86%	85%	-1.2%	Reduced	6.2%	Improved

Figure 2: CHAG Percentage (%) Contribution to National OPD and IPD



1.2 Contribution to OPD by Region

CHAG has higher number of Member Institutions in the Ashanti Region than any other region in the country. With 39 Hospitals and Clinics the Ashanti Region contributed about 22% of OPD Client attendance in 2015, followed by Brong-Ahafo Region (21%), which has 25 facilities. Upper West and the Greater Accra regions contribute minimally to OPD Clients in CHAG. However, Brong-Ahafo Region contributed a higher proportion of 21% Inpatient admissions. Figures 3&4 highlights regional contribution to OPD and IPD data.

Figure 3: Proportion of 2015 Annual OPD Clients Contributed by Region

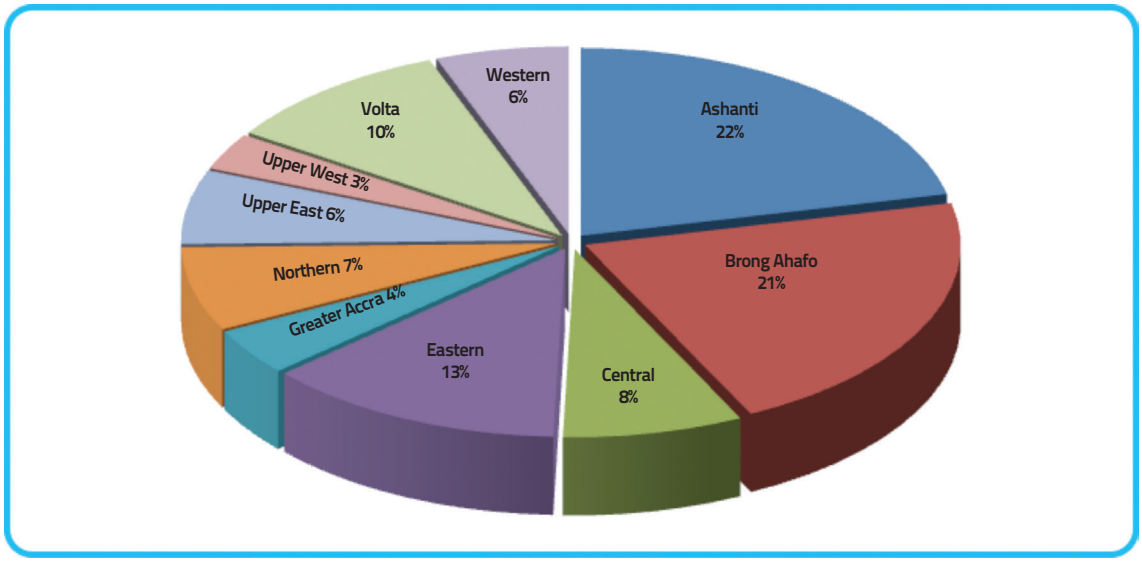


Figure 4: Proportion (%) of 2015 Annual Inpatients by Region

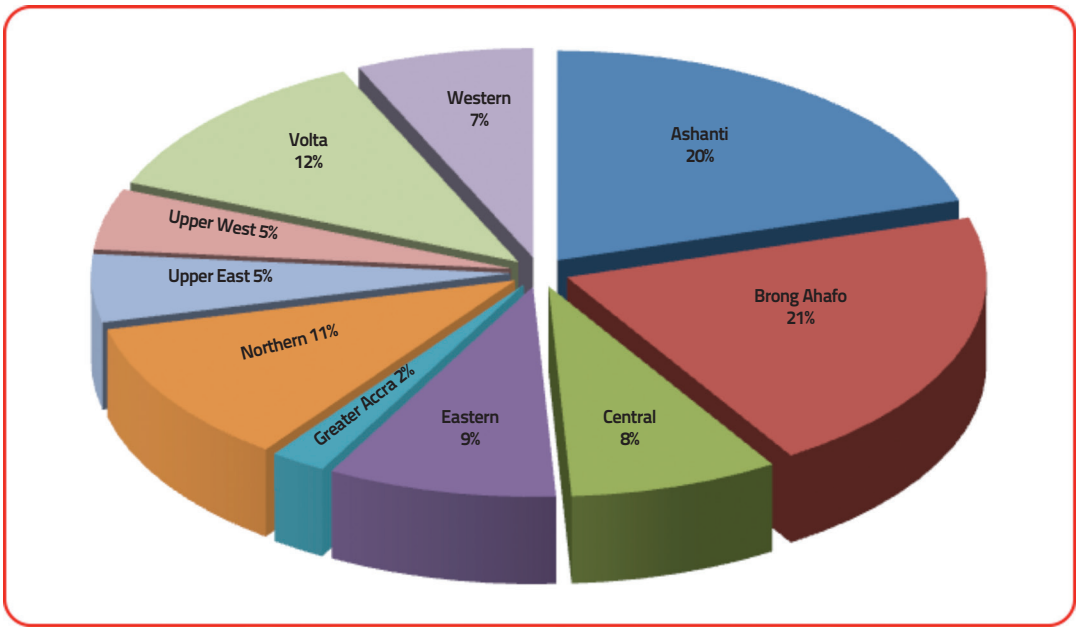
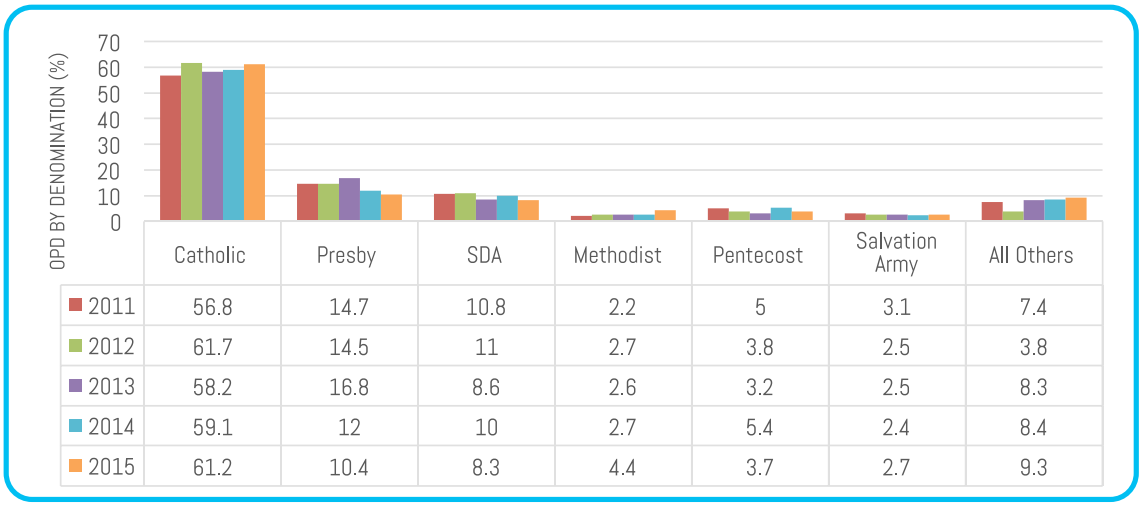


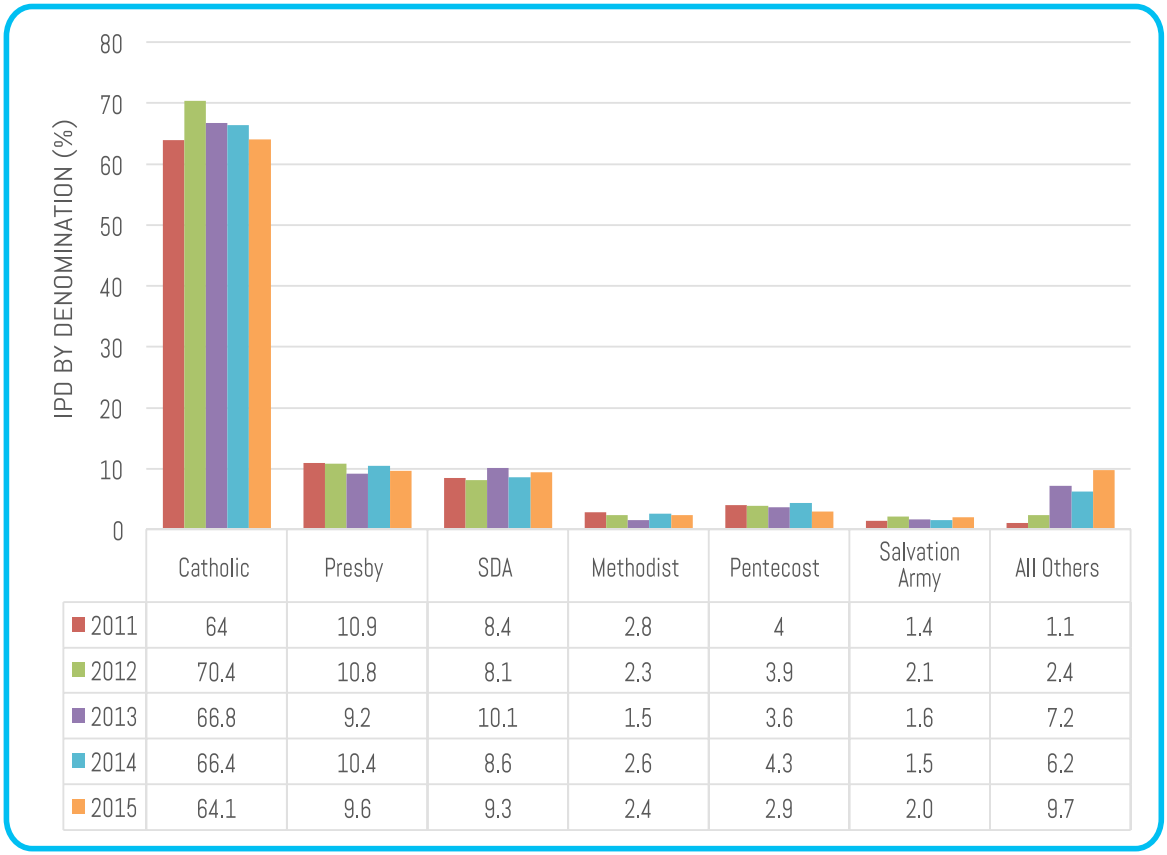
Figure 5: OPD Percentage (%) Trend of CHAG Contribution by Denomination: 2011-2015



	Catholic	Presby	SDA	Methodist	Pentecost	Salvation Army	All Others
2011	56.8	14.7	10.8	2.2	5	3.1	7.4
2012	61.7	14.5	11	2.7	3.8	2.5	3.8
2013	58.2	16.8	8.6	2.6	3.2	2.5	8.3
2014	59.1	12	10	2.7	5.4	2.4	8.4
2015	61.2	10.4	8.3	4.4	3.7	2.7	9.3

From the year 2011 till date, the Catholic Facilities contributed higher proportions of Out- and In-Patient data, followed by Presby. and SDA as shown in figures 6 . For 2015, the NCHS contribute 61.2%, of OPD data, an increment of 2.1% compared to 2014. Notably for Inpatients, the National Catholic Health Service contributed about 64% to the CHAG IPD Client attendance compared to other Denominational Health Services. It was, however, a reduction of its contribution in 2014.

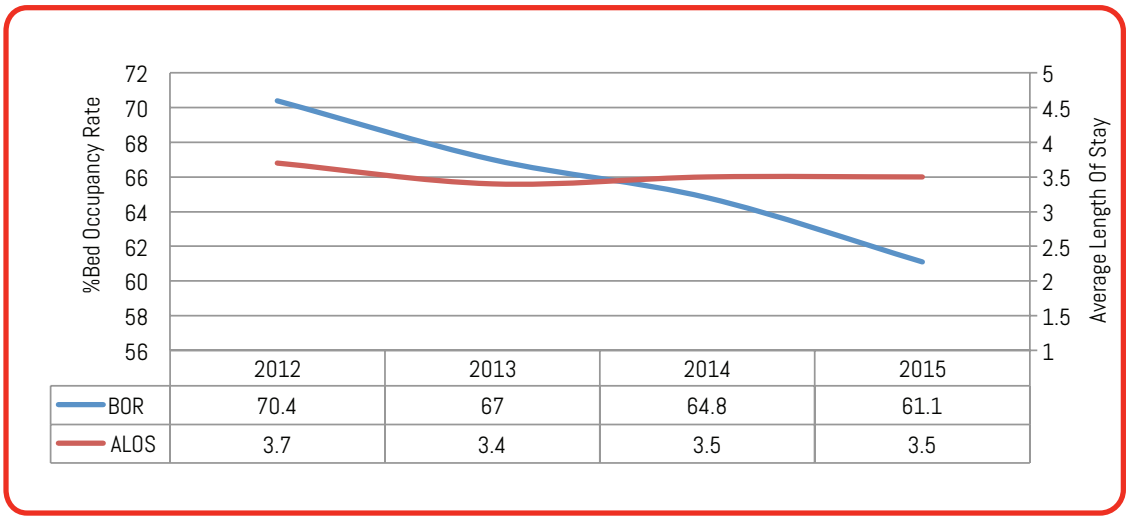
Figure 6: Proportion (%) of Admissions by Denomination 2011 - 2015



	Catholic	Presby	SDA	Methodist	Pentecost	Salvation Army	All Others
2011	64	10.9	8.4	2.8	4	1.4	1.1
2012	70.4	10.8	8.1	2.3	3.9	2.1	2.4
2013	66.8	9.2	10.1	1.5	3.6	1.6	7.2
2014	66.4	10.4	8.6	2.6	4.3	1.5	6.2
2015	64.1	9.6	9.3	2.4	2.9	2.0	9.7

From 2011 to 2015 proportion of beds utilized by inpatients per 100 beds in CHAG decreased from 70 to 61 beds. Average days spent at all wards were 3.5 days. Figure 7 below provides details.

Figure 7: Bed Occupancy Rate (BOR) and Average Length of Stay (ALOS): 2012 to 2015



	2012	2013	2014	2015
BOR	70.4	67	64.8	61.1
ALOS	3.7	3.4	3.5	3.5

1.3 Reproductive and Sexual Health Services

Reproductive and sexual health service provision remains a priority area for CHAG. In 2015 the total number of deliveries was 110,228, which is 7.5% less than that of 2014 and 8.8% increase from 2011. About 20% of all deliveries were performed under caesarian sessions (CS). Caesarian sections conducted (in 2015) increased by 5.2% over that of 2014 and 26.1% over the last 3years. Over the past 3 years (2012 -2015) there has been a progressive increase in C-sections rate beyond the WHO recommendation of 10-15%. It is beyond the national average of 6.46% and that of sub-Saharan Africa of 2%. Although the cause is uncertain in CHAG facilities, in many instances, higher C-sections rates result from having few Midwives and Doctors in Facilities who want to avoid stress of monitoring patients over long time. Hence, they exert pressure on patients to have C-sections. Nevertheless, this unusual rate calls for investigation and for re-cruitment of more Midwives with the skill to monitor patients to reduce the trend of increasing C-sections.

A total of 106,271 pregnant women were registered at CHAG reproductive departments (ANC Units) in 2015. This is 9.4% decline compared to that of 2014 and 5.0% increase over the last 5 years (2011-2015). Approximately 123,000 mothers were registered for Postnatal Care (PNC). All these mothers received antenatal care before delivery. About 92% of the PNC registrants seen at CHAG initiated breast-feeding within 1hour from delivery. Eighty-six percent (86%) of all maternal deaths were audited. (Table 8)

Table 8: Reproductive and Sexual Health service outputs, 2011-2015

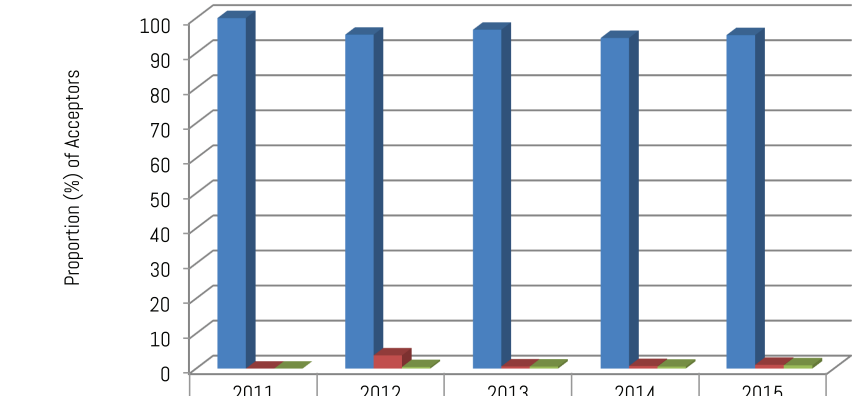
Performance Indicator	2011	2012	2013	2014	2015	% Change 2014-2015	One -year Performance	% Change 2011-2015	5-year performanc e	National 2015	Sub - Saharan Africa
Total Deliveries (Live/Still)	101331	114205	117313	119141	110228	-7.5%	Reduced	8.8%	Increased		
Total C S	15959	17839	19284	20779	21834	5.1%	Worsened	36.8%	Worsened		
CS Rate	15.70 %	15.60 %	16.40 %	17.40 %	19.8%	13.8%	Worsened	26.1%	Worsened	6.46% [1]	2% [1]
Total ANC Registrants	101209	93303	125647	117257	106271	-9.4%	Decline	5.0%	Increase		
Total ANC Attendance	477602	507034	632282	620223	560394	-9.6%	Decline	17.3%	Increased		
ANC 4th Visit Rate	91%	105%	75%	92%	84%	-8.7%	Decline	-7.7%	Worsened		
Total PNC Registrants	70810	81149	87177	91551	122924	34.3%	Improved	73.6%	Increased		
MM Audit Rate	90%	77%	92%	86%	86%	0.0%	Constant	-4.4%	Decline		

During the year under review CHAG provided family planning services to its clients. Greater proportion of family planning clients (95.14%) adopted artificial methods as seen in Figure 8 below. Natural family planning and sterilization have remained less than 1% over the years. In 2015 about 91% of all family acceptors used artificial methods compared to 94.3% in 2014. This is suggestive of the need for counseling sessions for all post-natal women and volunteer sessions for the youth to ensure that acceptor rate does not reduce further in the coming years.

[1] Figure 8: Proportion (%) of Family Planning Method over Total Acceptors by Type: 2011 -2015

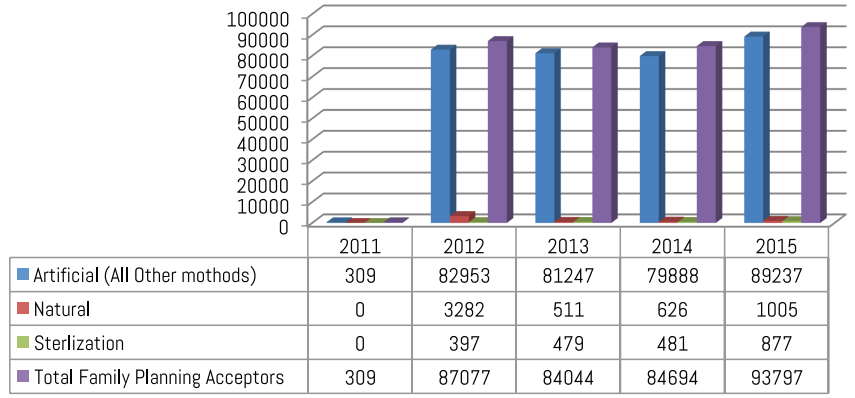
1. World Health Organization - Trends in Caesarean delivery by Country and Wealth quintile: a cross sectional survey in Asia and sub-Saharan Africa

Figure 8: Proportion (%) of Family Planning Method over Total Acceptors by Type: 2011 -2015



	2011	2012	2013	2014	2015
All Other Methods	100	95.26	96.67	94.33	95.14
Natural	0	3.77	0.61	0.74	1.07
Sterlization	0	0.46	0.57	0.57	0.93

Figure 9: Family Planning Acceptors by Method: 2011 -2015



	2011	2012	2013	2014	2015
Artificial (All Other mothods)	309	82953	81247	79888	89237
Natural	0	3282	511	626	1005
Sterlization	0	397	479	481	877
Total Family Planning Acceptors	309	87077	84044	84694	93797

1.4 Child Health Services

The number of trained persons in Integrated Management of Childhood Illness (IMCI) over the past 4 years (2012 -2015) showed a downward trend. One thousand and seventy-five (1,075) personnel from CHAG were trained in IMCI in the year 2015. This is 12% decline compared to that of 2014 and 2 % over that of 2012. Almost 2000 (1974) children were seen and referred to the next level of care through the IMCI. (Figure 10)

Figure 10: Integrated Management of Childhood Illness from 2012 - 2015

	2012	2013	2014	2015
No. of Perscribers	3562	4495	4131	3622
No. Trained In IMCI	3824	3407	1399	1075
No. of Children Referred	2591	2688	2529	1974
No. Given Pre-Referred Treatment	2281	2934	3133	2177
No. of Sick Children Weighed	141054	127603	120701	100485
No. of Sick Children Given First Dose Of Prescribed Drugs in Clinic	117316	107077	101525	87090

1.5 HIV/AIDS Services

CHAG Facilities continued to render HIV /AIDS services in 2015, providing counselling and laboratory testing and home care services to clients. A total of 40,161 clients were counselled for HIV, which was 12.2% more than seen 2011. The proportion of clients tested out of those counselled stood at 97% and 17% of this proportion tested positive. For HIV/AIDS Prevention from Mother to Child Transmission (PMTCT), 136,836 pregnant women were counselled for HIV out of which 93,254 were tested and 2% were positive. The total number of clients who received AVR treatment was 4520.

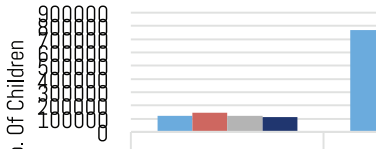
Table 9: HIV/AIDS Service Output 2011-2015

	2011	2012	2013	2014	2015	% Change 2014-2015	One -year Performance	% Change 2011-2015	5-Year performance
HTC Client Counseled	45755	31451	36946	50238	40161	-20.1%	Decline	-12.2%	Decline
HTC Client Tested	43893	29330	32269	38593	39008	1.1%	Marginal increase	-11.1%	Decline
% HTC Tested +VE	16%	24%	21%	18%	17%	-5.6%	Improved	6.3%	Worsened
PMTCT Clients Counseled	93821	73169	111470	110856	136836	23.4%	Increased	45.8%	Increased
PMTCT Clients Tested	87965	66421	92695	108817	93254	-14.3%	Decline	6.0%	Increased
% PMTCT +VE	2.90%	5.20 %	2%	1.50%	2%	33.3%	Increased	-31.0%	Improved
All other HIV Tested +VE	8316	8296	6459	5325	4072	-23.5%	Decline	-51.0%	Improved
No of Clients ARV Treatment	5409	4096	5360	5325	4520	-15.1%	Decline	-16.4%	Decline

1.6 Outreach Health Services

CHAG Facilities embarked on outreach services throughout the year 2015. The number of children reached during outreach programmes was 710,056. Eleven thousand three hundred and forty-one (113,241) children were registered. One thousand (1,000) of the children had normal (-2SD to +2SD) weight whilst 65 of these children were moderately underweight (-3SD to -2SD)). Figure 11 below shows the details.

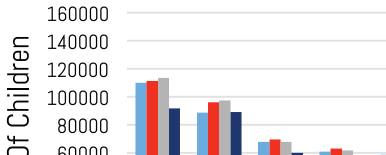
Figure 11: Child Welfare Outreach Services From 2012 - 2015



	Registrants	Attendances	Severe Underweight(<-3 SD)	Moderate Underweight (-3SD to -2SD)	Normal (-2SD tp +2SD)
2012	119195	769253	6791	92791	242795
2013	144192	803005	5691	87554	383840
2014	120947	739705	53	263	1968
2015	113241	710056	0	65	1000

In 2015, Member Institutions immunized 127,904 children during outreach services. The common vaccine (127,904 doses) given to children over the past 4 years (2012-2015) was vitamin A supplement and the vaccine that was less frequently given over the same reporting period was the Measles vaccine with only 49,649 doses. Figure 12 below gives details of vaccination over the period.

Figure 12: Outreach Immunization Coverage and Vitamin- A Supplementation: 2012 – 2015

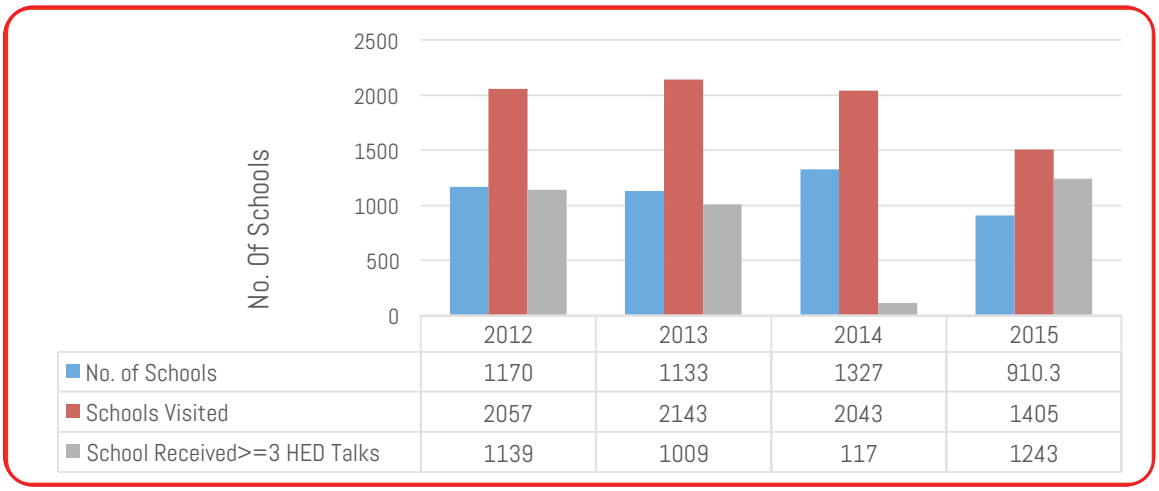


	BCG	Polio 0	Polio 1	Polio 2	Polio 3	Rotavirus 1	Rotavirus 2	Pnta 1	Pnta 2	Pnta 3	PVC 1	PVC 2	PVC 3	Measles	Yellow Fever	Vitamin A Supplement
2012	109878	88898	67845	60827	58699	45017	33335	67692	60607	58656	48833	35075	27150	57258	56209	117782
2013	111371	96136	69557	63166	60618	67972	61295	69206	63095	60633	68105	61303	58716	57663	57538	134730
2014	113413	97563	67625	61529	58686	66779	60554	67164	61272	58773	67020	60923	58385	56528	55346	134794
2015	91652	88929	60144	53248	52002	60402	53460	59330	52468	51341	60447	53487	52153	48649	49575	127904

1.7 School Health Programme

The total number of schools visited by CHAG Health facilities in 2015 was 1,505, which depicts a drop of 26.3% compared to 2014 and 26.8% compared to 2012. With the exception of 2014, there has been a gradual decline in the number of schools visited from 2012 to 2015 as shown in figure 13 below. A little over 1,200 of the Schools visited had at least 3 health education talks in 2015 which is 96.2% or about 11 times that of 2014 and 23.2% increase compared to that given in 2012.

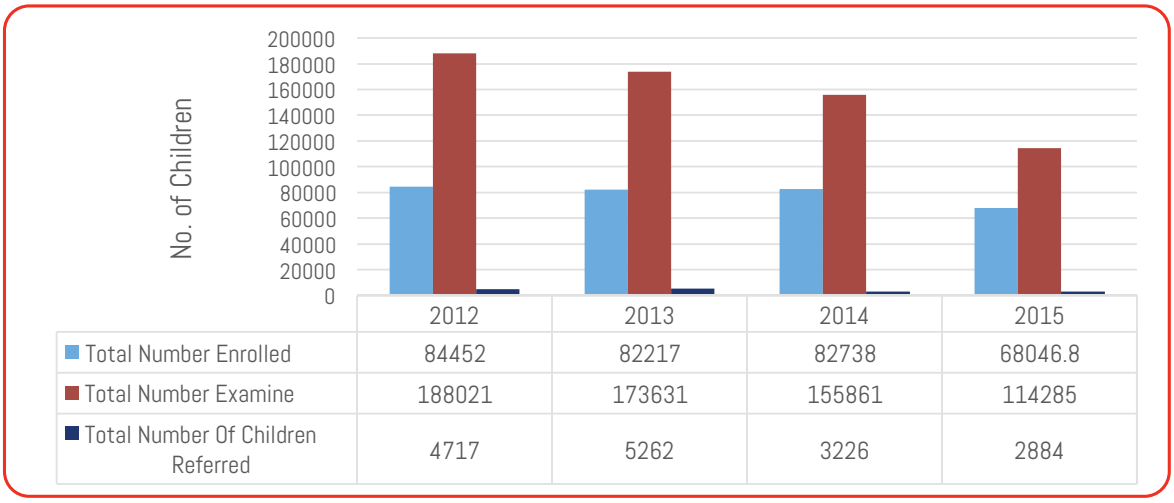
Figure 13: School Health Programme From 2012 - 2015



	2012	2013	2014	2015
No. of Schools	1170	1133	1327	910.3
Schools Visited	2057	2143	2043	1405
School Received>=3 HED Talks	1139	1009	117	1243

Over 68,000 students enrolled for School health programme in 2015. This is 17.8% and 19.4% less than that for 2014 and 2012 respectively. About 114,285 of them were examined whilst 2,884 were referred. Find the detail in figure 14 below.

Figure 14: Student Enrolled In School Health Program from 2012 - 2015

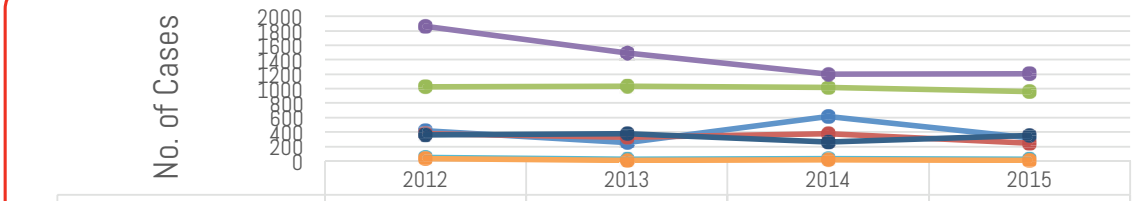


	2012	2013	2014	2015
Total Number Enrolled	84452	82217	82738	68046.8
Total Number Examine	188021	173631	155861	114285
Total Number Of Children Referred	4717	5262	3226	2884

For the year under review a total of 3,107 children were diagnosed with different conditions during the school outreach services. Top five diseases/conditions diagnosed during school health examinations by CHAG facilities were Skin diseases (38.8%), Oral problems (30.8%), Ear problems

(10.3%), Eye problem (7.9%), and Undescended Testis (0.8%). The rest constituted 11% (348 conditions) of all diagnoses, which was 25.6% more compared to 2014 and 3% less compared to 2012. See Figure 15 below for details.

Figure 15: School Health Programme Diagnosed Conditions From 2012 - 2015



	2012	2013	2014	2015
Ear Problems	417	251	617	319
Eye Problems	374	331	377	245
Oral Health Problems	1022	1036	1020	956
Skin Problems	1863	1491	1200	1207
Undesended Testis	45	23	29	26
Hernia	28	9	12	6
Others	359	376	259	348

1.8 Summary Burden of Disease (Epidemiology)

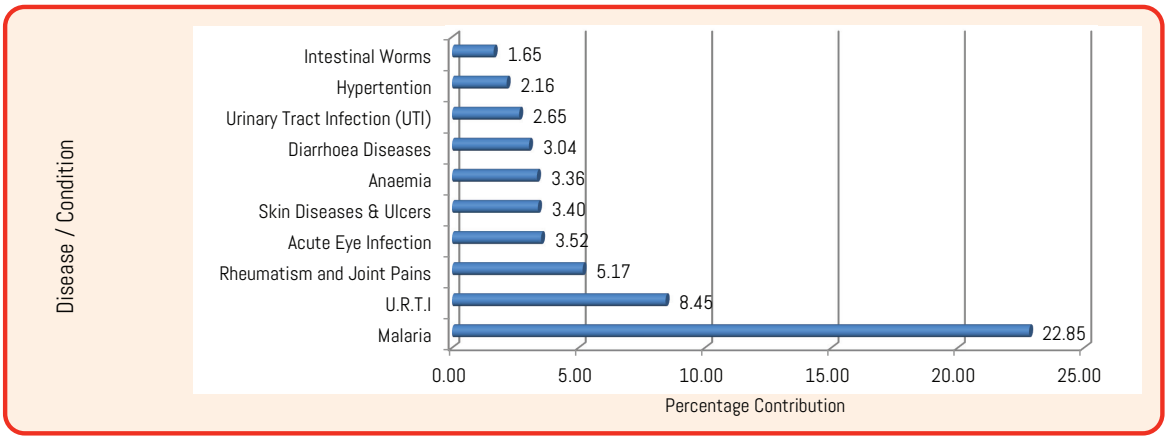
The top 10 common causes of OPD morbidity for the past 4 years (2012 to 2015) have remained the same. Malaria continues to be the commonest cause of OPD morbidity and admissions in CHAG Health facilities since 2012 as shown in Table 10. However, there was a significant drop in the proportion of malaria for 2015. This is a huge success in the fight against malaria and this drop may be attributed to the policy of "no test, no treatment for malaria cases". Over the year, several rapid test kits were distributed to the network to ensure that cases were tested before treatment. Additionally, many prescribers, laboratory personnel and other paramedical staff were taken through malaria case management through various workshops in all the regions. There were also massive campaigns on the use of ITNs especially for pregnant mothers as well as indoor residual spraying against mosquitoes in some regions of Ghana. These activities have made huge impact on malaria. Another plausible explanation may be that prescribers were over diagnosing malaria.

1.8.1 Morbidity

From 2012 to 2015, the top-10 morbidity statistics remained relatively similar. In 2015 Malaria constituted the largest part of diagnosed conditions at OPD with 22.9% followed by Respiratory Tract Infections (8.5%), Rheumatism/Joint pains (5.2%), Acute Eye Infection (3.5%), and Skin Diseases/Ulcer (3.4%) as shown in figure 16. Others were Anaemia (3.7%) and Diarrhoea 3%. All

other diseases contributed 43.7%

Figure 16: CHAG Top Ten (10) Causes of Morbidity for the year 2015



1.8.2 Admission

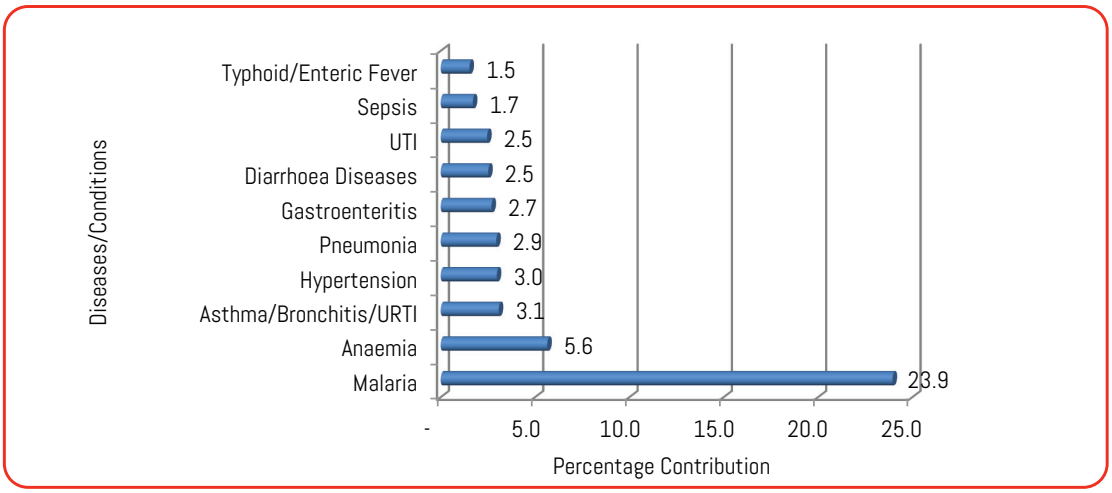
Malaria continues to be the leading cause of admission in CHAG facilities, accounting for 23.9% of OPD morbidity in 2015. Anaemia, respiratory tract infections and hypertension were the 2nd, 3rd and 4th leading causes of admission with 5.6%, 3.1% and 3.0% respectively. Figure17 and Table 11 show the top 10 causes of admissions in CHAG.

Table 10: Top-10 causes OPD Morbidity: 2011 - 2015

Condition	Percentage (%) Contribution by Condition					% Change 2014-2015	One -year performance	% Change 2011-2015	6-year performance
	2011	2012	2013	2014	2015				
Malaria	55.2	50	45.8	44.9	22.9	-49.0%	Improved	-58.5%	Improved
URTI	11	10.2	16.2	7	8.5	21.4%	Decline	-22.7%	Improved
Rheumatism / Joint Pains	5.3	5.8	6.6	8.3	5.2	-37.3%	Improved	-1.9%	Improved
Acute Eye Infection	3.6	4.8	5.7	5.1	3.5	-31.4%	Improved	-2.8%	Improved
Skin Diseases &Ulcer	5.7	5.7	6.2	7.3	3.5	-52.1%	Improved	-38.6%	Improved
Anaemia	2.8	4	3.0	5.3	3.4	-35.8%	Improved	21.4%	Declined
Diarrhoea Disease	4.6	4.5	4.7	5.3	3	-43.4%	Improved	-34.8%	Improved
Urinary Tract Infection	2.5	2.9	3.5	3.9	2.7	-30.8%	Worsen	8.0%	Declined
Hypertension	5.5	6	4.9	4.2	2.2	-47.6%	Improved	-60.0%	Improved
Intestinal Worms				-	1.7	-			
All Others				41	43.7				

Malaria cases dropped by 49% in 2015 compared to 2014 and to 58.5% over the past six years. Current measures regarding malaria case management should continue in order to sustain the gains made in the fight against malaria. It's important to note that with the exception of upper respiratory tract infections, there was a drop in the proportions of the top 10 causes of OPD morbidity especially with skin diseases, hypertension, diarrhea and urinary tract infections.

Figure 17: CHAG Top Ten (10) Causes of Admission (2015 Annual)



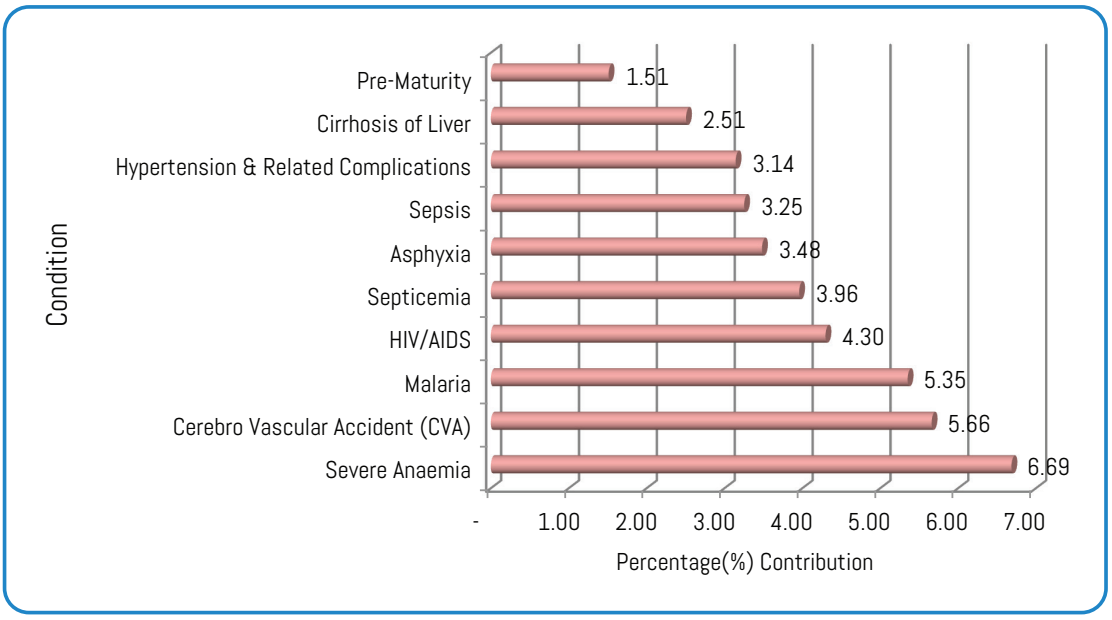
1.8.3 Mortality

Mortalities in 2015, (1482) were similar to that in 2014 (1435)). The vast majority of deaths resulted from Severe Anaemia (6.7%), Cerebro-Vascular Accident (5.7%), Malaria (5.4%), and HIV/AIDS (4.3%). Figure 18 and Table 12 give details of mortalities in CHAG over the reporting period.

Table 11: Top-10 Conditions for Admissions: 2012-2015

Condition	% Contribution by Condition				% Change2014-2015	One -year performance	% Change 2012-2015	4-year Performance
	2012	2013	2014	2015				
Malaria	52.8	50.3	26	24	-7.7%	Improved	-54.5%	Improved
Anaemia	13	11	6	3.4	-43.3%	Improved	-73.8%	Improved
Asthma/Bronchitis/URTI	3.9	3.8	2	3.1	55.0%	Worsened	-20.5%	Improved
Hypertension	5.9	5.9	3	2.2	-26.7%	Improved	-62.7%	Improved
Pneumonia	4.5	4.7	2	2.9	45.0%	Worsened	-35.6%	Improved
Gastroenteritis	3.3	3.9	3	2.7	-10.0%	Improved	-18.2%	Improved
Diarrhoea Diseases	5.7	6.1	2	2.5	25.0%	Worsened	-56.1%	Improved
UTI	-	3.1	2	2.5	25.0%	Worsened		
Sepsis	-	-	1	1.7	70.0%	Worsened		
Typhoid/Enteric Fever	3.5	2.6	1	1.5	50.0%	Worsened	-57.1%	Improved
All Others			51	50.5	-1.0%	Improved		

Figure 18: CHAG Top Ten (10) Causes of Mortality: 2015 Annual



1.8.4 Maternal Mortality

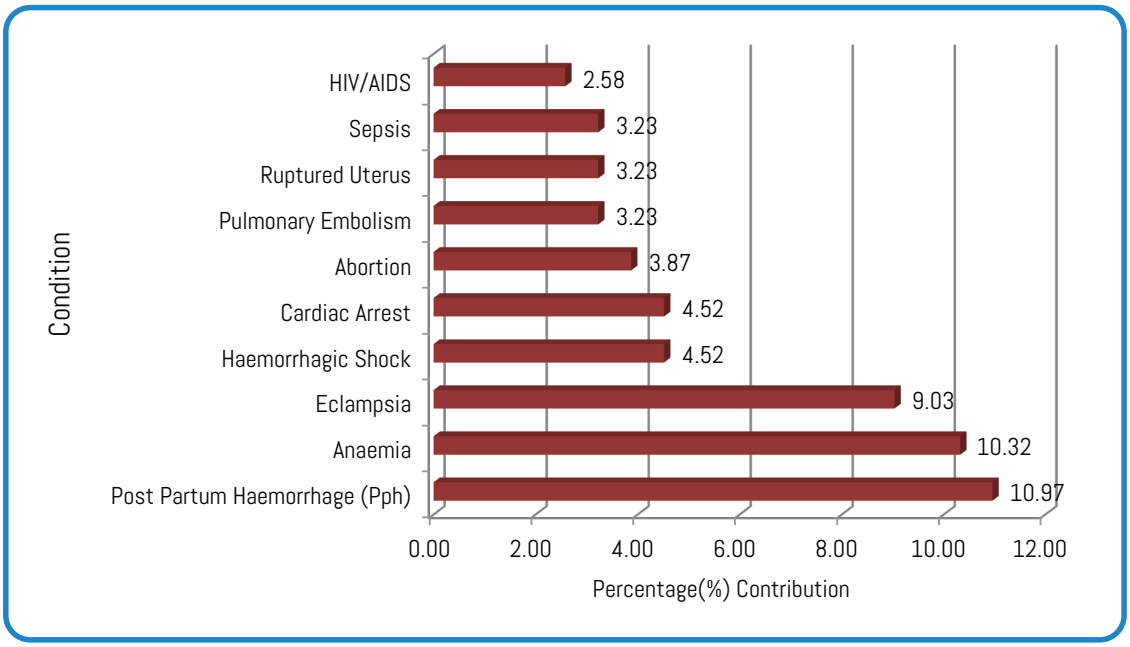
Over the period of 2010 to 2015 there has been progressive reduction in the number of pregnancy related deaths per 100,000 live births within the CHAG network. Post-Partum Haemorrhage, Anaemia, Eclampsia were the common causes of maternal deaths in CHAG Hospitals during 2015 as shown in Figure 19.

Table 12: Top-10 causes of Mortality: 2010-2015

Diagnosed Condition	2011	2012	2013	2014	2015	% Change 2014-2015	One -year performance	% Change 2011-2015	5-year performance
Severe Anaemia	4.4	12.8	10.1	15.1	6.7	-55.6%	Improved	52.3%	Worsened
Cerebro Vascular Accident	14	15.8	14.5	14.7	5.7	-61.2%	Improved	-59.3%	Improved
HIV AIDS	16.8	15.9	16.6	13.7	4.3	-68.6%	Improved	-74.4%	Improved
Septicemia	13.3	15.3	14.9	14.3	4	-72.0%	Improved	-69.9%	Improved
Asphyxia	-	-	5.9	6	3.5	-41.7%	Improved		
Malaria	18.7	13.5	12.8	13	3.3	-74.6%	Improved	-82.4%	Improved
Hypertension	7	7.6	7.7	6.7	3.1	-53.7%	Improved	-55.7%	Improved
Cirrhosis of Liver	3.7	4.5	6.7	6	2.5	-58.3%	Improved	-32.4%	Improved
Sepsis	4.9	5.3	5.3	5.5	60.1	992.7%	Worsened	1126.5%	Worsened
Prematurity	-	-	-	4.9	1.5	-69.4%	Improved		
All Others	-	-	-	61	60.1	-1.5%	Improved		

In 2015, the leading cause of death was anaemia followed by CVA and malaria. However, the proportion of deaths due to anaemia was significantly lower compared to 2014 and higher compared to 2011.

Figure 19: CHAG Top Ten (10) Causes of Maternal Mortality: 2015 Annual



1.9 Key Health Indicators

There were improvements in three key health sector outcome indicators from the year 2010 to 2015. These indicators include Under-5, Maternal, and Neonatal Mortality rates. Crude Mortality and Stillbirth rates stabilized whilst Infant Mortality rate worsened over the same period. Specifically, Under-5 Mortality rate reduced by 48.6%, maternal mortality ratio (MMR) reduced by 11% while still Births rate reduced by 30% from 2010 to 2015. On the other hand, infant Mortality increased by 8%. It is worthy to note that maternal deaths had improved over the last 6 years with fluctuation between 2010 and 2013, and a progressive reduction from 2013 to 2015. This is as a result of concerted efforts from Member Institutions to reduce maternal mortality including some innovative approaches and active campaigns.

1.9.1 Contribution of the MDG Accelerated Framework (MAF) towards the Achievement of Key Indicators

For the year under review, a number of activities were undertaken by the CHAG secretariat that sought to improve maternal mortality, neonatal mortality rates, ASRH and FP as part of the MAF programme. These activities directly or indirectly contributed to the gains made in achieving these results. These MAF activities include;

- Training of 20 doctors and midwives in basic resuscitation and Essential Newborn Care

(ENBC)

- Training of a team of 10 from the CHAG network on Maternal health & Death Audits
- 10 community durbars that addressed maternal health issues
- Public lectures in 20 churches that addressed MCH and FP issues
- And supportive supervision visits to 5 facilities in the ASR and UWR on MCH issues.

These activities undoubtedly contributed towards the gains made in maternal mortality and neonatal mortality rates for 2015.

Table 13: Health Indicators: 2010–2015

Outcome Indicator	Y ear						% Change 2014 - 2015	One -year Performance	% Change 2010 - 2015	6-Year Performance	National 2015	Developing Countries 2015
	2010	2011	2012	2013	2014	2015						
Maternal Mortality Rate	163	194	158	168	167	145	-13.2%	Improved	-11%	Improved	319[1]	239[3]
Neonatal Mortality Rate	7.2	6.7	5.5	7.1	9.8	6.5	-33.7%	Improved	-8%	Improved	28[1]	52[1]
Infant Mortality Rate	8	7.6	6.6	7.9	10.9	8.6	-21.1%	Improved	+8%	Worsened	43[1]	107[1]
Under 5 Mortality Rate	29.4	21	21.1	19.5	17.3	15.1	-12.7%	Improved	-48.6%	Significantly improved	62[1]	177[1]
Still Births Rate	30	27	26	24	21	21	0.0%	Stable	-30%	Significantly improved	29[2]	18.4[4]
Crude Mortality Rate	25	24	23	23	21	22	4.7%	Worsened	-12%	Improved	9[1]	16[1]

Maternal deaths have decreased over the last 6 years with fluctuation between 2010 and 2013, and reduction from 2013 to 2015. There was a significant reduction of about 13.2% in maternal mortality for 2015 compared to 2014. This is below both the National average of 319 per 100,000 live births and that for developing countries of 239 per 100,000 live births as seen in table 13 above. Neonatal mortality, Infant mortality and under-5 mortality rates all improved in 2015 compared to 2014. These are all below the national averages. There were various interventions, some of which started a couple of years ago in CHAG institutions such as the Project 5-Alives, QI programs etc. that may have contributed to the improvements seen in 2015. Crude mortality rate was worse while still birth rate remained stable. Table 9 and figure 23 show details of the key health service indicators. Figures 20-22 show the trend of maternal, Still Birth and neonatal mortality rates from 2010 to 2015

Figure 20: Trend of Maternal Mortality Ratio: 2010 - 2015

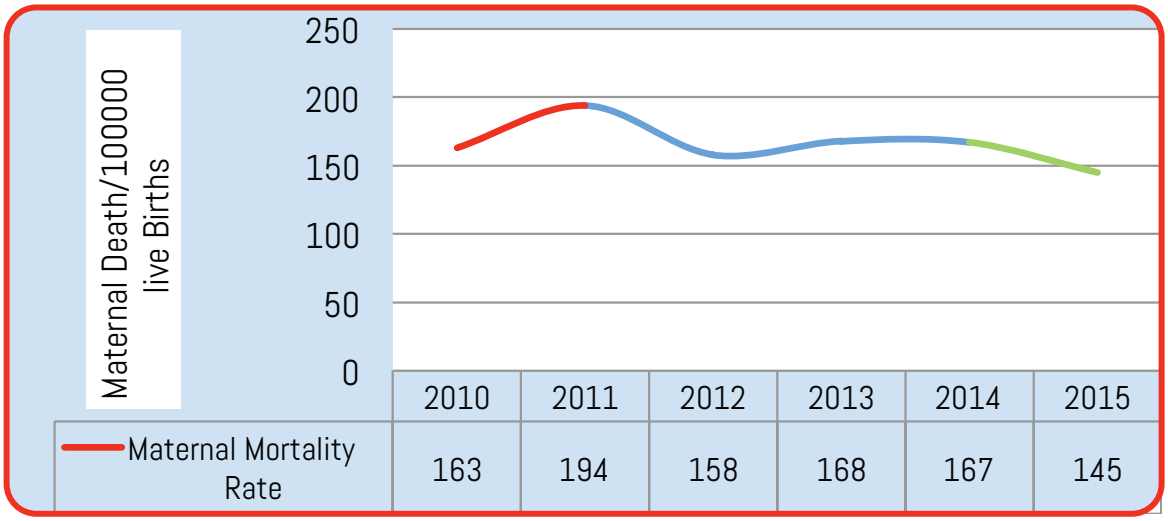


Figure 21: Trend of Still Births Rate: 2010 – 2015

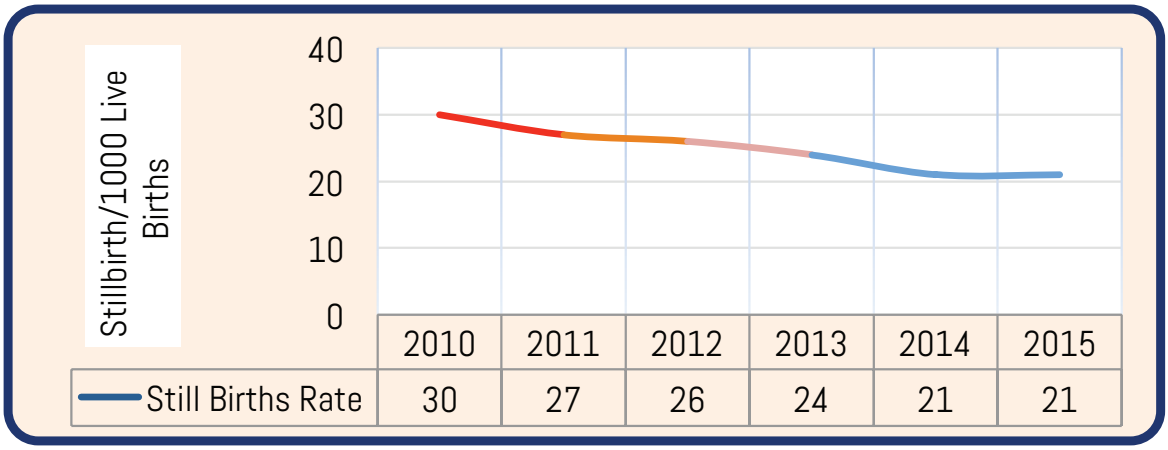
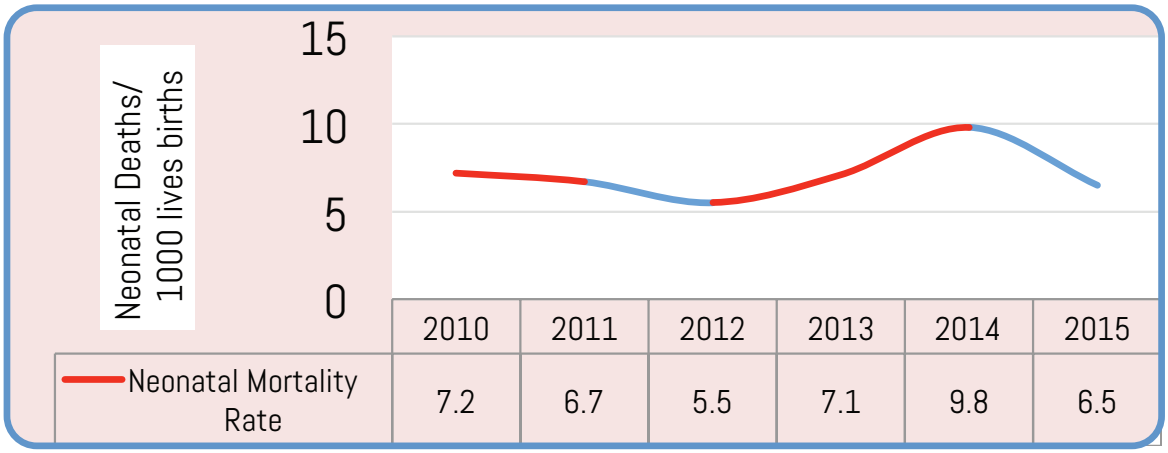
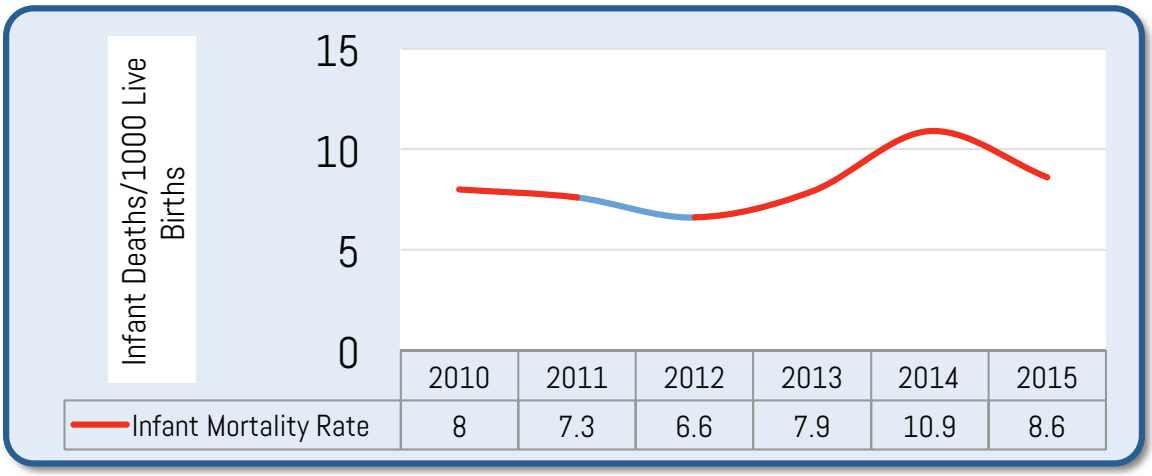


Figure 22: Trend of Neonatal Mortality Rate: 2010 - 2015



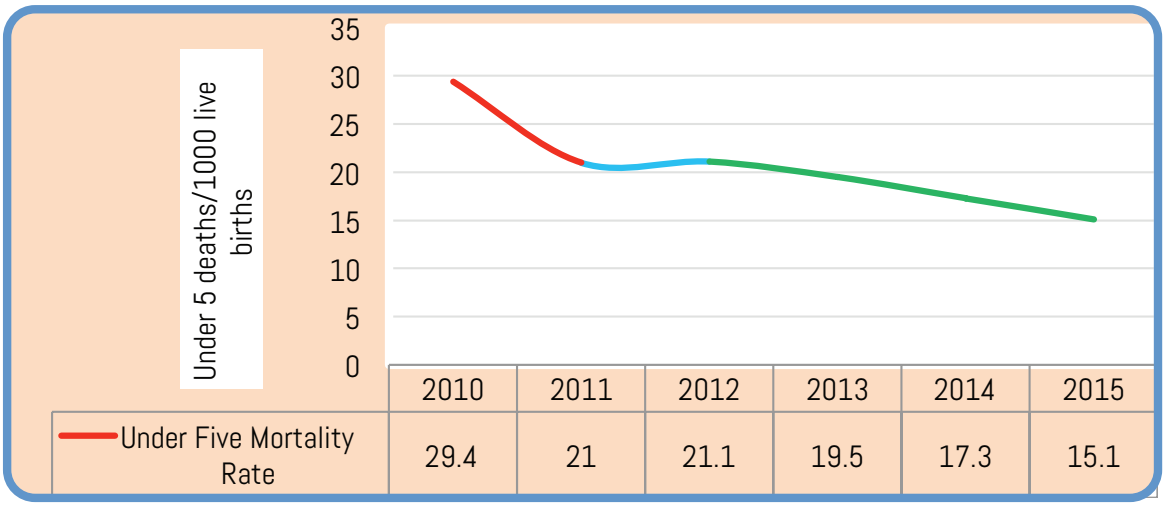
From 2010 to 2015, Infant deaths per 1000 live births had been unstable with an upward movement especially in 2015 as seen in Figure 23.

Figure 23: Trend of Infant Mortality Rate: 2010 - 2015



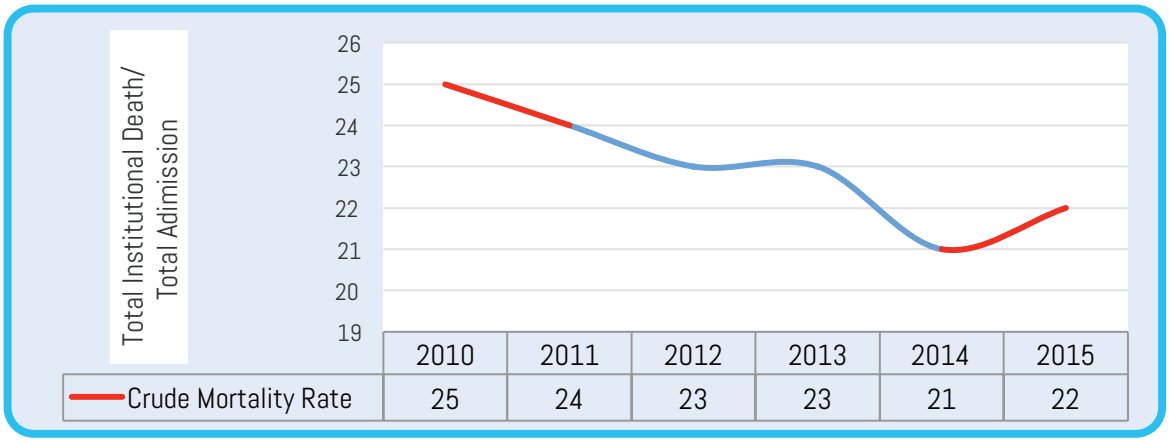
There had been an improvement in the reduction of children under 5 years deaths per 1000 live births over the last 6 years. CHAG has, since 2010, recorded 48.6% reduction in U5MR. This may be partly attributable to the role of "Project Fives Alive" improving Child Health. See Figure 24 for the 5-year trend in U5MR.

Figure 24: Trend of Under 5 Mortality Rate (U5MR): 2010 – 2015



Institutional deaths in CHAG have been between 21-25 per 1000 admissions over the last 6 years with 2010 recording the highest as shown in Figure 25 indicating the lowest rate recorded in. 2014.

Figure 25: Trend of Crude Mortality Rate: 2010 - 2015



1.10 Hospitals' Performance Outcomes

Some selected indicators were used to rank CHAG member institutions as seen below. SDA hospital in Kwadaso, Kumasi recorded the highest CS rate in 2015. This rate is higher than 32% recorded in the US in 2009, an issue that became a concern for Obstetricians in the US. With its closeness to the Komfo Anokye Teaching Hospital, this development ordinarily should not be the case hence further investigation is indicative.

Figure 26: Caesarean Section Delivery Rate: 2015

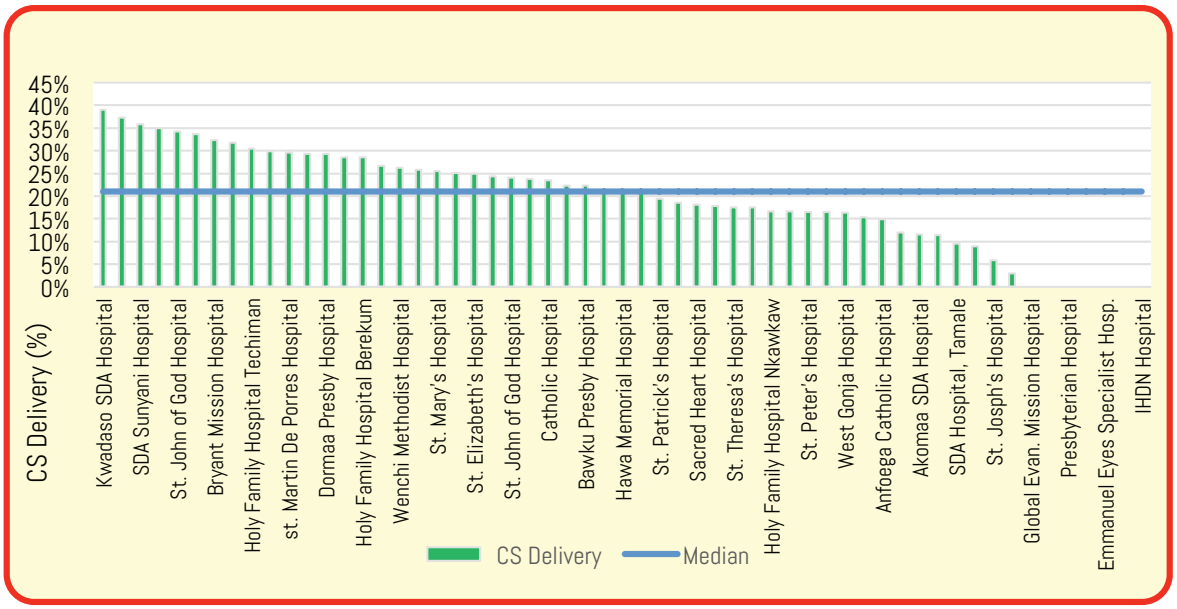
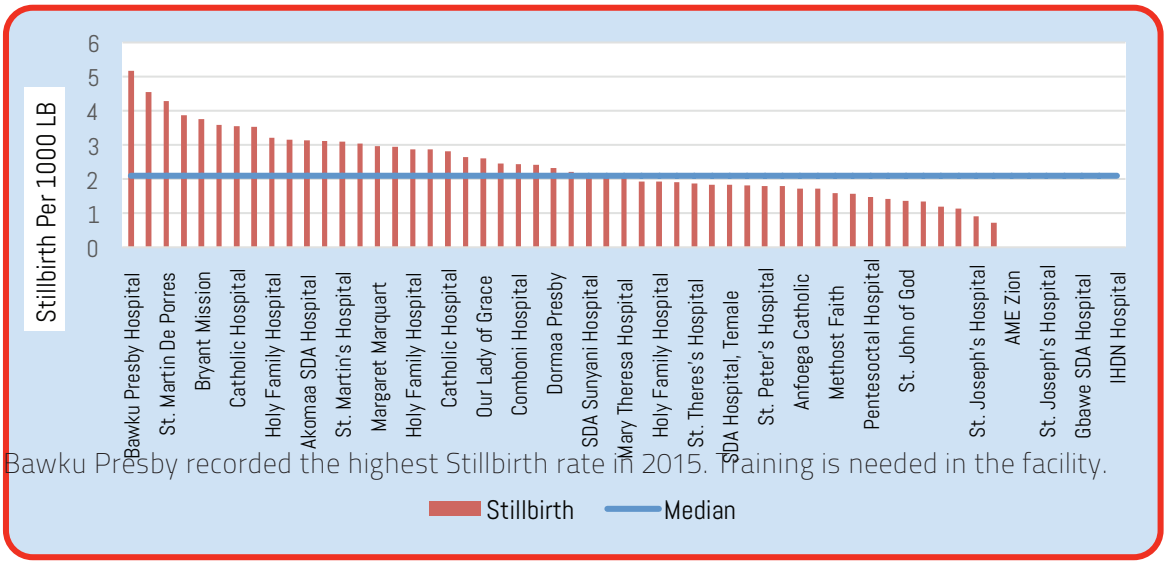


Figure 27: Stillbirth Rate: 2015



Bawku Presby recorded the highest Stillbirth rate in 2015. Training is needed in the facility.

Figure 28: Infants Mortality Rate: 2015

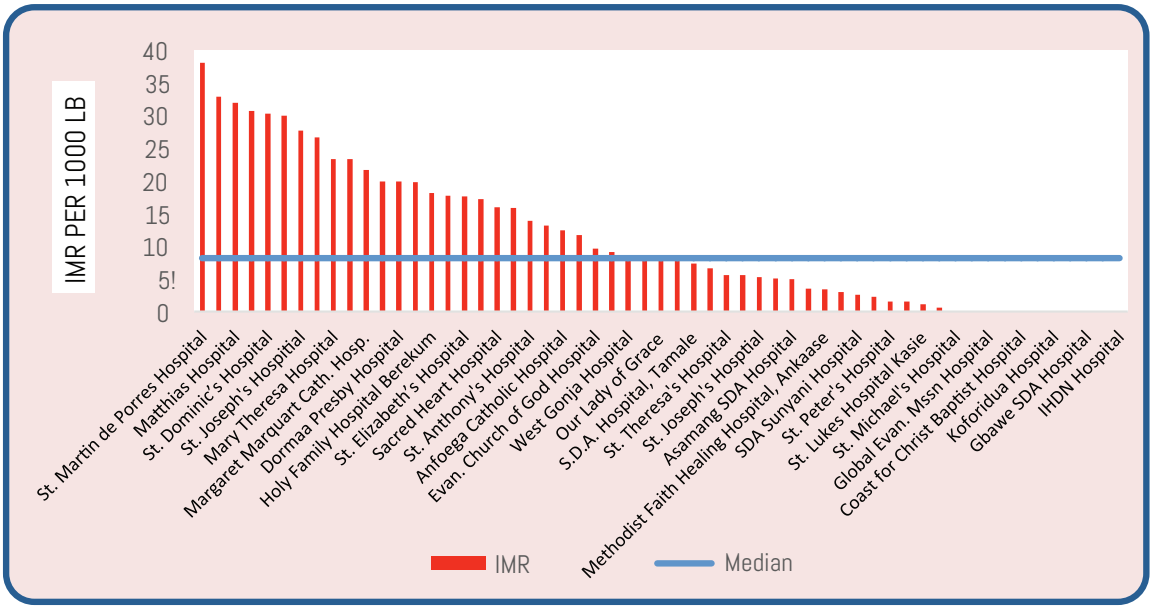
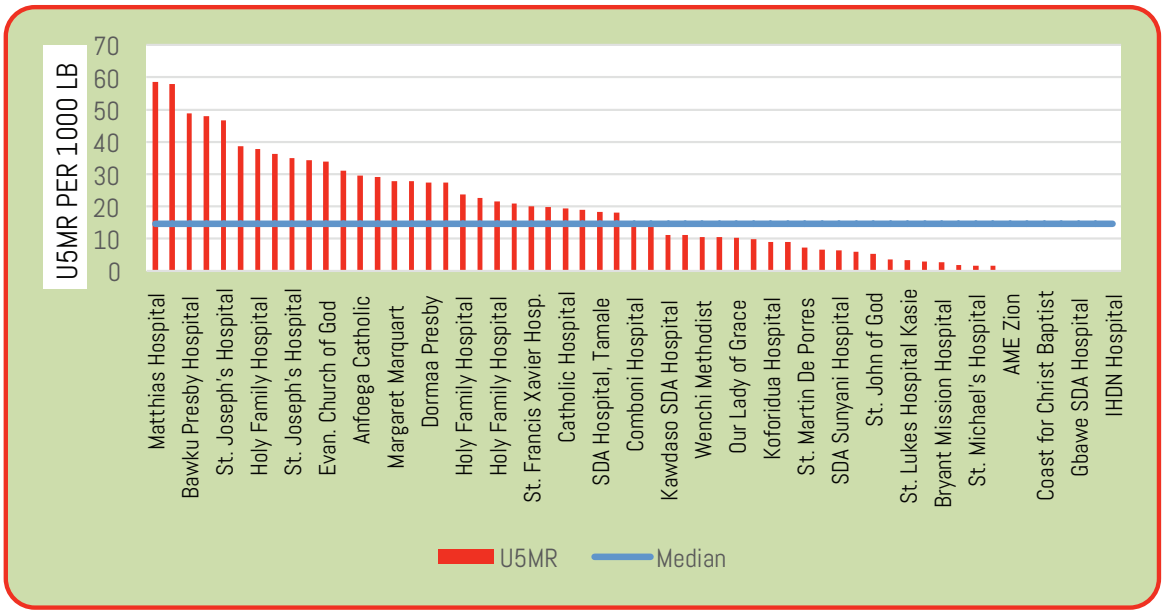
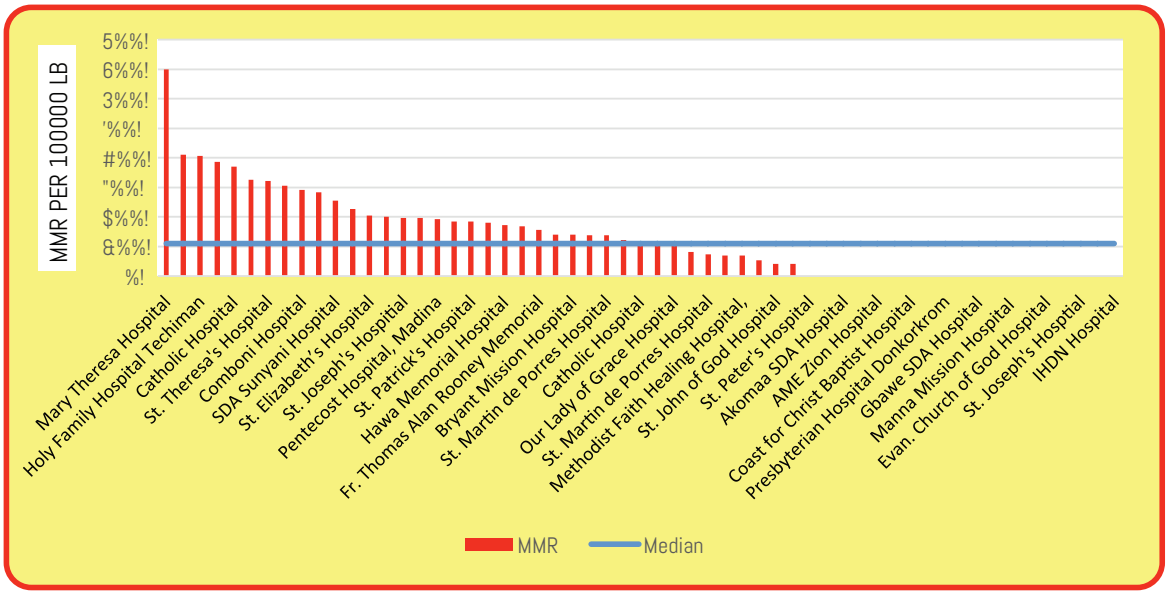


Figure 29: Under 5 Mortality Rate: 2015



St. Martins de Porres Hospital and Mathias Hospital respectively recorded the highest infant and U5MR in 2025. It is unclear why Mathias Hospital is recording the highest in U5MR. Attempts would be made to investigate the matter with respect to the two facilities.
Mary Theresa hospital recorded the highest maternal mortality of about 700 per 100,000 live births. This is way above the Ghana's average figure of 380 as at 2013 (UNFPA 2013).

Figure 30: Maternal Mortality Rate: 2015



1.1 Mental Health Services

Since 2013, CHAG with funding support from the Department for International Development (DFID-UK) has embarked on a number of activities to improve on the quality of life of persons living with mental illness. The objective of CHAG was to reduce the incidence of and stigma towards persons living with mental illness, while increasing access to treatment, care and support for persons suffering from mental illnesses. Furthermore, CHAG sought to re-integrate treated mentally ill persons back into their communities and support them to be economically productive. CHAG adopted the following strategies to achieve the above objectives:

- Support the development of guidelines and protocols on mental health service delivery.
- Support church leaders to increase their advocacy for attention and support for mentally ill persons.
- Improve the capacity of Community Health Workers (CHWs) to manage mentally ill patients at the community.
- Increase the number of qualified mental health staff in CHAG facilities.
- Integrate mental health services into mainline health care services.
- Educate catchment community populations and stakeholders on mental health including stigma.
- Partner with relevant stakeholders in the promotion of effective mental health services.
- Conduct research to improve the delivery of mental health services

Towards achieving the above strategies, 46 students were sponsored for a 2-year mental health at the Kintampo College of Well-Being in Community Mental Health and Community Medicine and Clinical Psychiatry. Furthermore, about 560 community health workers and prescribers were given refresher trainings in mental health to make mental health services accessible to all people in Ghana. To this end, mental health services got integrated with OPD services in about 172 facilities with 92 CHAG institutions having their staff trained in 2015. Ultimately, the year under review saw a total of 3% of all Out Patient Department (OPD) attendances being mentally ill cases totaling 178,284 out of an estimated target of 5,942,777. Compared to 2014, this represents a 3.4% increase over the numbers seen in 2014 (172,498). Over 40% of those seen were females. In the years ahead, CHAG is targeting 10% treatment rate of mental cases annually at the OPD level.

In order to promote population outreach, about 14,113,778 Ghanaians were reached through the use of bulk SMS messages on the availability of treatment for mental illness and other mental health related issues during the year. Also, about 6,350 youth and adults were reached in all the 10 regions through a day's seminar on reducing stigma towards people living with mental illness as well as improving the quality of their lives. In addition, three (3) short documentaries focusing on behaviour change (care and support, stigma reduction and discrimination) towards mentally ill persons were produced and aired. Intending to reach out to the whole

nation with these messages, Ghana Television (GTV) was contracted to air the messages raised by Health Professionals and Religious Leaders.

2.0 Health information

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

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

Table 14: Health Information Challenges

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

CHAG embarks on the provision of health service data to the Ministry of health through DHIMS2 at the facility level. In 2015 completeness and timeliness of submitted data by CHAG Facilities on the DHIMS were 96.8% and 85.7% respectively. Submission rate of CHAG Annual 2015 (January to December) Minimum Service Data (returns) to the CHAG Secretariat were 97% and 81% respectively. The overall reporting rate by facilities to the Secretariat stood at 86.2% (150 out of 174 health facilities).

Table 15: Report Submission Rated by Facilities (2010 - 2015)

Facility	2010	2011	2012	2013	2014	2015
Hospitals	81%	97%	90%	97%	97%	97%
All Others	80%	69%	81%	87%	89.0%	81%
Overall	80%	78%	84%	90%	93%	86.2%

Figure 31: 2015 Minimum Service Data Submission Rate: Facility Type

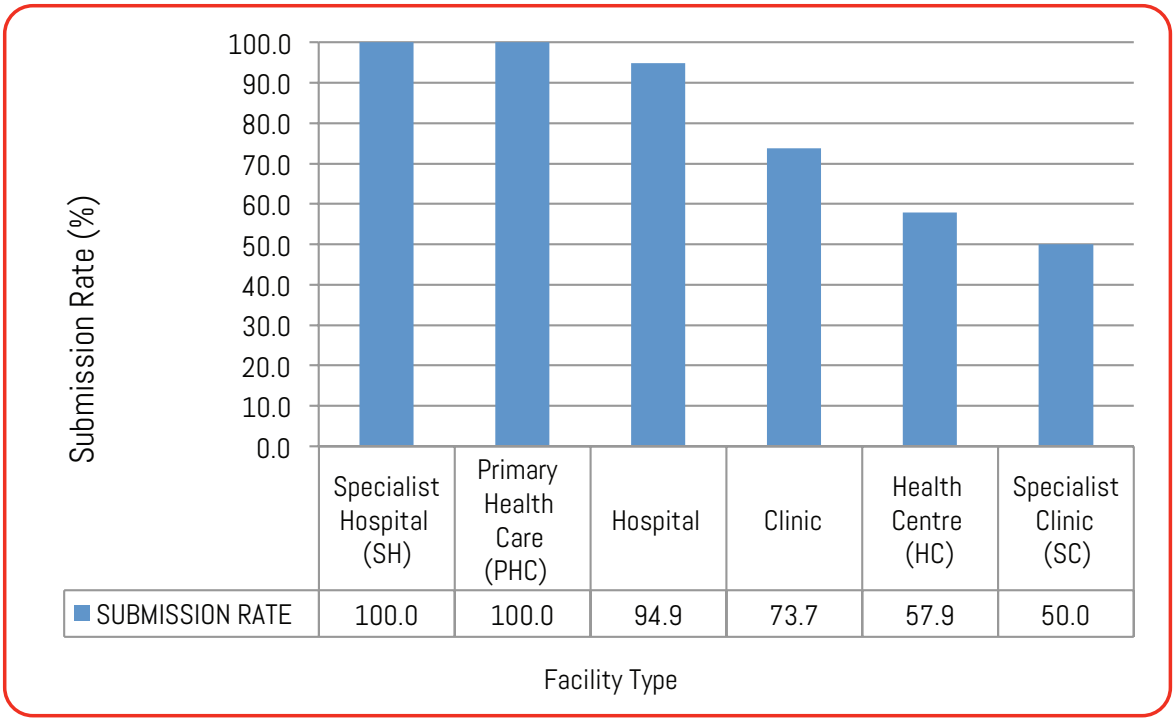
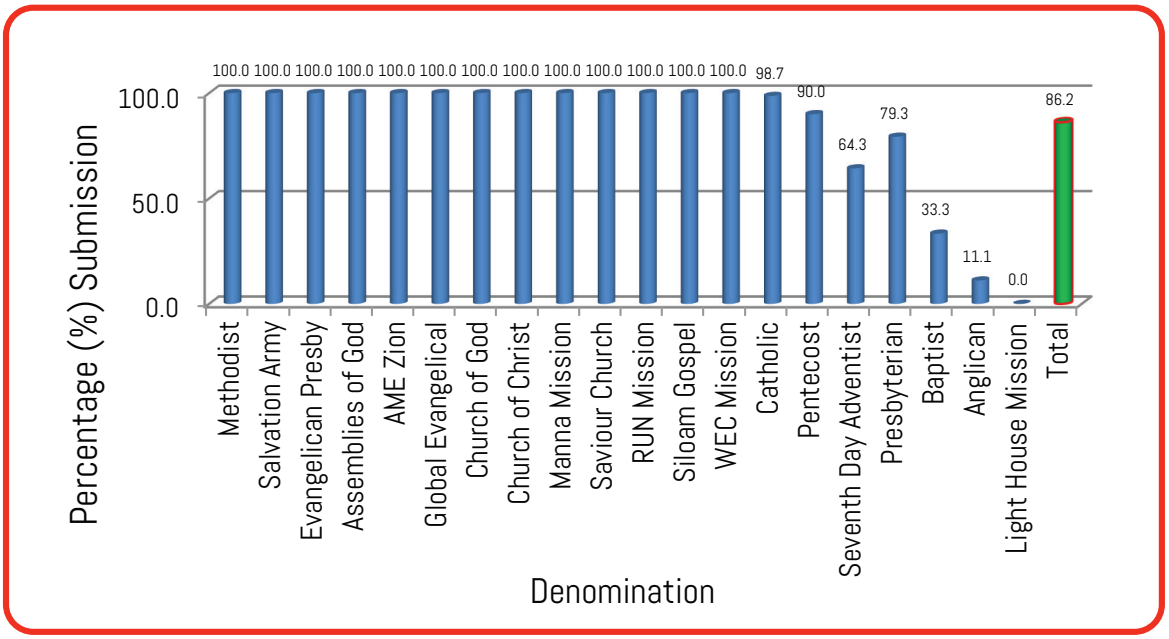


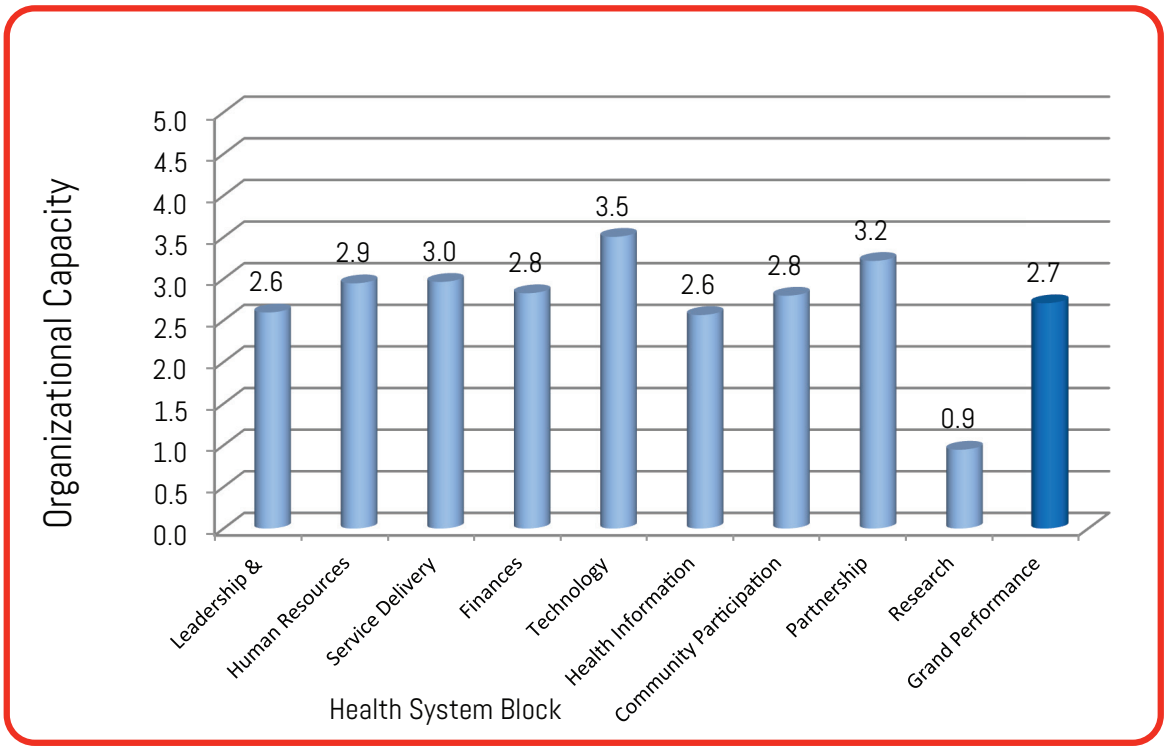
Figure 32: Denominational Minimum Service Data Submission Rates Chart



The Secretariat will continue to invest in systems to improve data management at all levels across its network, including training of health information officers and other frontline staff in data collection and management. Customized Hospital Management and School Administra-

tion software was piloted in 3 health institutions and 1 training College during the year 2015. This software which has the potential of improving data management across the network for health service provision and school administration will be deployed in all member institutions. A new monitoring and evaluation tool for organizational performance assessment called OPAT had been developed and being used by CHAG for continuous capacity improvement. The tool enables Member Facilities and the Secretariat to assess their capacities by the nine health system building blocks adopted by CHAG. By this medium, the overall organizational capacity of CHAG was rated 2.7out of 5, which is a satisfactory performance. Figure 33 below shows details of CHAG's capacity scores for 2015.

Figure 33: CHAG Network Capacity Scores for 2015



3.0 Leadership and Governance

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

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

Table 16: Leadership and Governance: Critical Challenges

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

During the year 2015, the CHAG Board recruited a new Executive Director in the person of Mr Peter Kwame Yeboah to steer the affairs of CHAG Secretariat following the appointment of Dr. Gilbert Buckle in 2014 as the Chief Executive Officer of Korle-Bu Teaching Hospital. The Board also out - doored a new Constitution and adopted a Charter for the Network. This further culminated in the holding of the first Annual General Meeting between the Owners (Church Leaders) and the CHAG Board of Trustees. During the period, a new CHAG membership assessment tool was developed and used to assess new applicants and forty-six (46) existing members. Subsequently, one hundred and seven (107) new members were admitted into the CHAG network. In May, CHAG held its 48th Annual Conference on the theme "Monitoring and Evaluation". [1]

CHAG continued to participate in health sector meetings and technical sessions to promote member's interest, influence health sector policy and advocate for the advancement of the health sector. [2] Regular progress reports were prepared and discussed with health sector stakeholders. The 2014 performance contract with the MOH was evaluated prompting various areas for improvement. [3]

During year under review, Medical Doctors working in the Government health facilities embarked on a strike action to press home their demands for a codified condition of service. However, in line with our principles and ethical considerations as a Christian Health Service, Medical Doctors within the CHAG network remained at post during the period of the strike. This industrial decision quite expectedly, resulted in increases in the number of patients recorded in our member facilities during the period of the strike. The resulting excess workload required logistics and other resources to effectively deal with the situation.
Yet, our member institutions managed to ably contain the situation much to the relief and rescue of the vulnerable segments of the society. In such situations, CHAG evokes such hu-

[1] General Administration and Management Manual, August 2014.
[2] CHAG participated in the national health summit, health sector business meetings, ministerial committee on HRH, NHIA advisory committee and the Parliamentary Select Committee on health. Furthermore, CHAG participated in the following technical working groups: Ebola sub-committee on case management; state of the national health report; health service delivery for the National Population Council; technical committee on capitation; technical committee on national health accounts; working group on health service costing.
[3] Overall score for CHAG on specific outputs and deliverables was 40 out of 100.

mane principles and ethics mainly to lessen the impact of such industrial actions on the rural communities where most of the Association's Member institutions are located and to prevent avoidable loss of lives and suffering. The Network will continue to support Government efforts at making quality health services available and accessible to all Ghanaians at affordable cost.

4.0 Human Resources

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

The 2015 saw an erratic change in recruitment policy and uncoordinated recruitment processes at the Ministry's level. Consequently, majority of staff Nurses and Midwives allocated to CHAG by the Ministry of Health, and posted to various institutions could not assume duty at the respective CHAG Facilities because they were posted under the previous recruitment policy and have been working with the Ghana Health Service. Nonetheless, significant numbers of Medical Officers, Specialist and other health professionals posted during the period assumed duty in the respective CHAG member institutions. Furthermore, CHAG Secretariat secured financial clearance for its member institutions to recruit health professionals that the institutions require. Critical HR challenges that require sustained attention in the Association are listed in (Table 17):

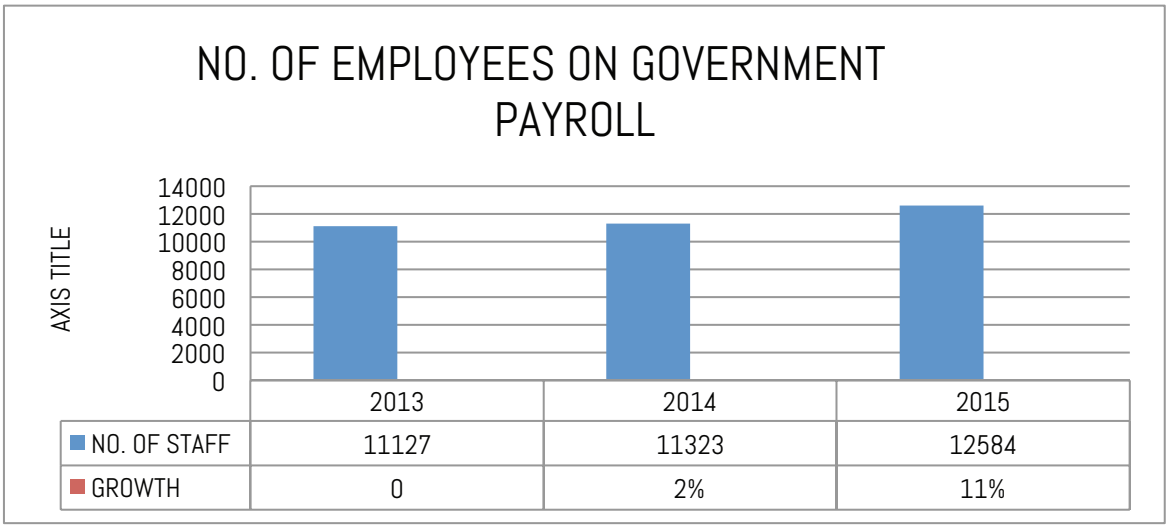
Table 17: Critical and Network Challenges: Human Resources for Health

- Shortage and inequitable distribution of key clinical and professional health personnel.
- Relatively high attrition rate of clinical and professional personnel.
- Inadequate capacity in human resource planning, management and supervision.
- Multiple and conflicting management/administrative guidelines.
- Weak employee performance management.

4.1 Staffing Situation

The staff strength of the Network has consistently seen an upward trend over the year. The CHAG Network has over 15,000 staff of different professional categories. However, the number of CHAG employees on Government of Ghana payroll stands at 12,584, leaving a gap/shortfall of 3500 non-mechanized staff, which represents about 21%. Figure 34 below provides details of the staffing situation of CHAG employees on Government payroll.

Figure 34: Number of Employees on Government Payroll

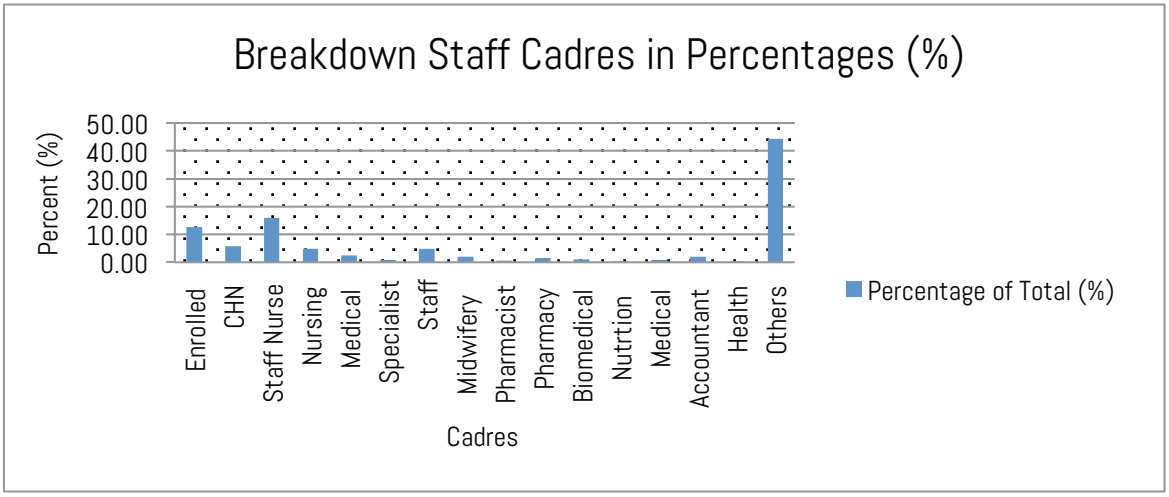


From Figure 34 above, it could be observed that while there was a marginal increase of 2% from 2013 to 2014, an increase of 11% was recorded in 2015. The differences in growth during the period have arisen from the fact that CHAG did not receive Financial Clearance in 2014. Consequently, the Network could not recruit the required staff, apart from those allocated by the Ministry of Health for posting to member institutions.

4.1.1 Staffing Growth In Numbers By Cadres

Professional nurses (Staff Nurse and Nursing Officer) categories recorded the highest growth of 20.85%. This was followed by enrolled nurses, which recorded about 13% growth. The other professional categories did not record any significant change in the year under review. Figure 35 below provides the details.

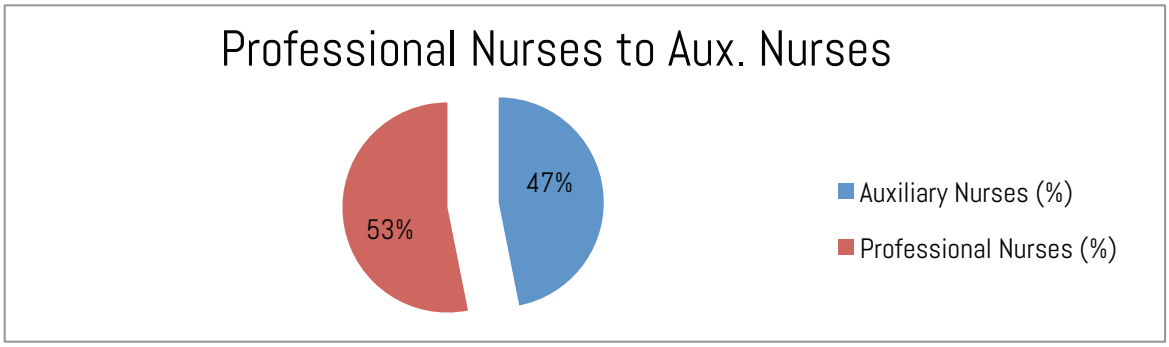
Figure 35: Breakdown of Staff Cadres in Percentages



4.1.2 Ratio Of Professional Nurses To Auxiliary Nurses

An area of interest in healthcare delivery is the ratio of professional to auxiliary staffing. The prescribed standard ratio of professional to auxiliary nurses in Ghana, as indicated by the health sector Staffing Norms and the NHIA accreditation requirements is 60% to 40% respectively. The ratio in the CHAG network stands at 53% to 47%, which is below the benchmark. Conscious efforts have to be made to take advantage of existing opportunities to develop some of these auxiliary nurses into professional nurses to meet this requirement. See figure 36 for details

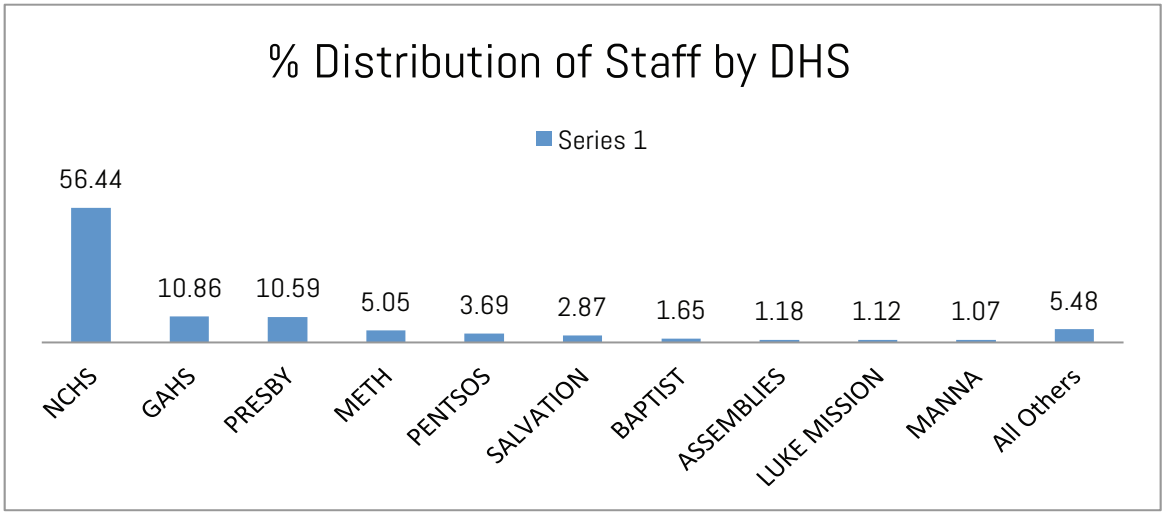
Figure 36: Professional nurses to auxiliary nurses



4.1.3 Classification Of Staff By Denominational Health Services (Dhs)

Out of twenty-five (25) Health Services, the National Catholic Health Service (NCHS), Ghana Adventist Health Services (GAHS), and Presbyterian Health Services contributed about 77.89% of the staff strength in CHAG. The remaining DHS have a collective share of 22.11% as shown in figure 37.

Figure 37: % Distribution of Staff by DENOMINATIONAL HEALTH SERVICES (DHS)



4.1.4 Personnel Emolument

Reward systems are strategically instituted across the CHAG network to motivate staff to deliver optimum healthcare services, attract new employees, and retain competent staff to help achieve the desired health outcomes. Varied packages of incentives such as rural incentive, mission allowance and Diocesan Health Service (DHS) allowances are paid by facilities and health services as salary supplements to employees of CHAG. Data, however, is currently not available to the Secretariat to determine the actual amount involved and report on. These allowances are paid from Internally Generated Funds (IGF) of facilities. The Government of Ghana (GoG) through the Ministry of Health has over the years immensely supported the payment of the salaries of CHAG employees. Table 18 below gives details of GoG (Personnel Emolument) support to CHAG for 2014 and 2015:

Table 18: Total monthly basic salary (GoG)

	GoG BASIC SALARY	
MONTH	2014 (GHc)	2015 (GHc)
JANUARY	9,840,344.03	11,317,690.06
FEBRUARY	10,110,770.38	12,599,169.01
MARCH	10,187,118.68	12,729,205.11
APRIL	10,188,422.78	13,240,183.40
MAY	10,117,701.64	13,080,769.98
JUNE	10,034,422.08	12,889,113.90
JULY	10,476,945.03	12,697,457.81
AUGUST	10,458,401.21	13,036,698.76
SEPTEMBER	10,354,680.72	12,724,758.21
OCTOBER	10,018,400.45	12,777,909.56
NOVEMBER	10,355,414.26	13,079,849.51
DECEMBER	10,907,944.94	14,710,656.97
TOTAL	123,050,566.20	154,883,462.28

The table above shows an increase from about one hundred and twenty-three million in 2014, to about one hundred and fifty-five Ghana Cedis in 2015, representing an increment of 26%.

4.1.5 Financial Clearance

In the year under review, financial clearance was obtained for nine hundred and three (903) staff, out of a total of one thousand, four hundred and thirty-two (1432) applications received from member institutions for financial clearance. The clearance for five hundred and sixty seven (567) persons was meant for recruiting new staff, while three hundred and sixteen was meant for replacement of separated staff. The total annual value of the clearance obtained was nine million, two hundred and seventeen thousand, three hundred and sixty eight Ghana Cedis, fifty pesewas (GHC 9,217,368.50). Most of these personnel are at various stages of the process leading to their mechanization.

4.1.6 Recruitment

Following a directive from the Ministry of Health (MOH) on policy change on recruitment in the year under review, Agencies of the Ministry were required to carry out selection interviews for newly qualified health professionals. Subsequently, they were to submit request for financial to the MOH based on recruitment ceiling given by the Ministry of Health for financial clearance to employ such health professionals. Hence, 2500 potential employees applied to join CHAG. Majority of these applicants trained in institutions other than the Ministry of Health and CHAG Training Colleges. Enrolled nurse cadre constituted the highest number of applicants with majority from private nursing colleges. The breakdown is indicated in Table 19 below.

Table 19: Job applications received in 2015

Job Applications Received in 2015		
Job Applied for	Number of Valid Application Received	%
Enrolled Nurses	870	34.8
Staff Nurse	470	18.8
Staff Midwife	109	4.36
Nursing Officers	301	12.04
Community Health Nurses	61	2.44
Pharmacy Technicians	64	2.56
TO (Laboratory)	74	2.96
Pharmacist	31	1.24
Dieticians	41	1.64
Health Information	81	3.24
Others	398	15.92
TOTAL	**2500**	**100**

This level of applications suggests an impressive acceptance of CHAG by potential employees. In spite of the massive response to our advertisement, we could not keep faith with these potential employees owing to a later directive from the Ministry of Finance (MoF) and MoH to all Agencies to withhold recruitments until Financial Clearance was granted to it before such recruitments. Subsequently, the financial clearance was given for the recruitment of 2,013 diploma graduates and 2,014 certificate graduates from Public and CHAG Health Training Institutions. CHAG could, therefore, not recruit the large number of applicants from private Colleges of Health and the Universities.

Unfortunately, it came to light during the posting of the graduates (diploma) who were granted financial clearance that many of them were posted under the previous recruitment policy by Ghana Health Service before the directive on the policy change was implemented. Many of the health professionals posted to CHAG and the Teaching Hospitals could, therefore, not report for duty.

4.1.7 Separations

4.1.7.1 Inter-agency transfers – three year trend

A critical area of interest is the losing of critical staff to other Agencies in the health sector. Over the years, CHAG has consistently recorded a deficit in the movement of staff within the sector. The breakdown is in Table 20 below.

Table 20: Inter-Agency Transfers

Year	Transfer -Out CHAG to GHS & Other Agencies	Transfer -In GHS & Other Agencies to CHAG	% Deficit /Difference
2013	40	3	92.50
2014	33	10	69.70
2015	37	8	78.38
Total	**110**	**21**	**80.91**

In 2015, a total of 37 employees of CHAG successfully secured transfer to other MOH agencies. In return, CHAG managed to attract only 8, representing 78.38% deficit to CHAG, 8.68% more than 2014. This phenomenon calls for further investigation and intervention.

Table 21: Cadre Breakdown of 2015 inter-agency transfers

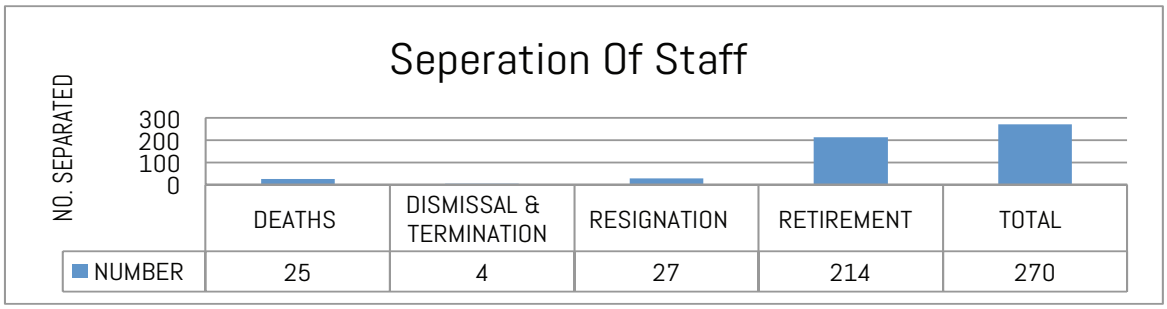
JOB	TRANSFER FROM CHAG TO GHS & OTHER AGENCIES	TRANSFER FROM GHS & OTHER AGENCIES TO CHAG	% DEFICIT/DIFFERNCE
COM. HEALTH NURSE	3	0	100.00
ENROLL NURSE	4	1	75.00
STAFF NURSE	7	2	71.43
STAFF MIDWIFE	2	1	50.00
MEDICAL OFFICER	4	1	75.00
NURSING OFFICERS	3	0	100.00
OTHER CATEGORIES	14	3	78.57
TOTAL	**37**	**8**	**78.38**

From table 21 above, it could be observed that greater numbers of these transfers are clinical and critical staff, professions the Network has serious need for. It has been observed that the practice of CHAG Institutional Managers' refusing to approve transfer requests from employees is a creating unintended intransigent image for the Network. This adversely contributes to newly qualified health professionals' refusal to accept posting to the CHAG Network. Even though the situation is gradually improving, CHAG member institutions need to evolve attractive packages, and improve retention strategies to retain the staff they require.

Other forms of Separations

The network in 2015 registered some deaths, terminations, resignations and retirement totaling Two Hundred and Seventy (270). These separations were fairly distributed across cadres and DHSs.

Figure 38: Other forms of Separations in 2015



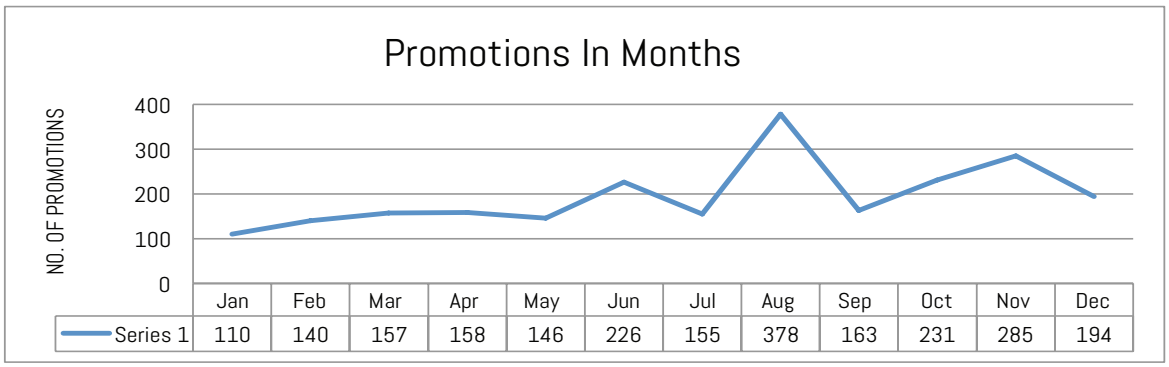
There were also no significant variations from the last three years figures; a sign of relative stability.

Efforts can however be put in place to reduce resignations by improving work climates and relations in the network.

4.1.8 Promotions

In 2015, two thousand, three hundred and forty-three (2,343) employees went through laid down processes and were duly promoted to various levels in their jobs. The line graph below shows the monthly distribution.

Figure 39: Promotions in Months

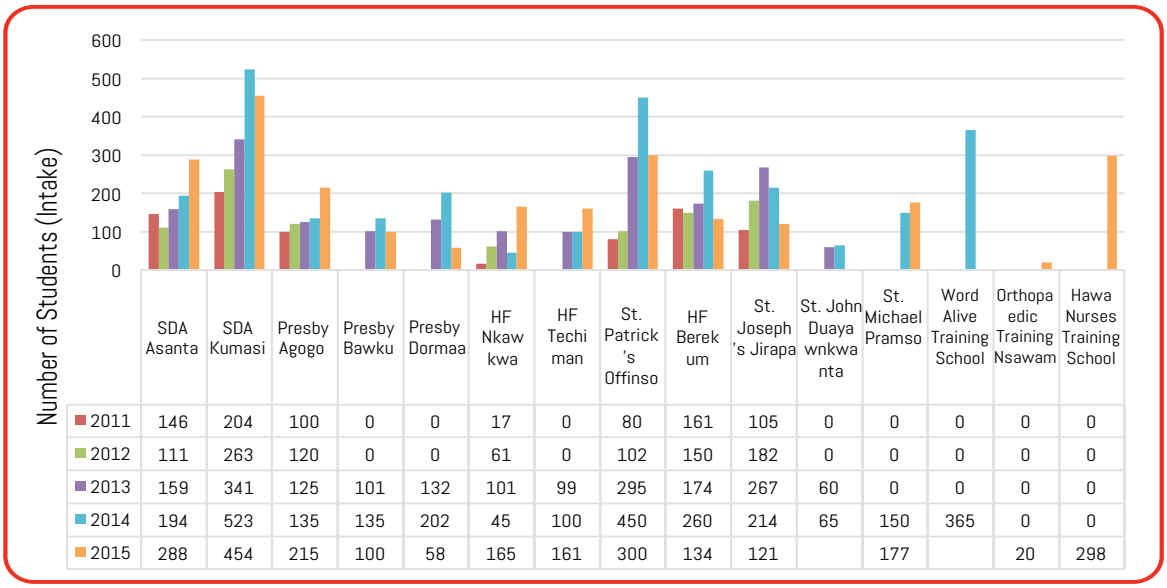


4.2 Health Training Institutions

Investment in pre-service training and continuous professional education of staff is a considerable measure for retaining staff to improve quality of services. CHAG owned and operated 16 Health Training Colleges in the year 2015. The overall student intake at CHAG Training Colleges

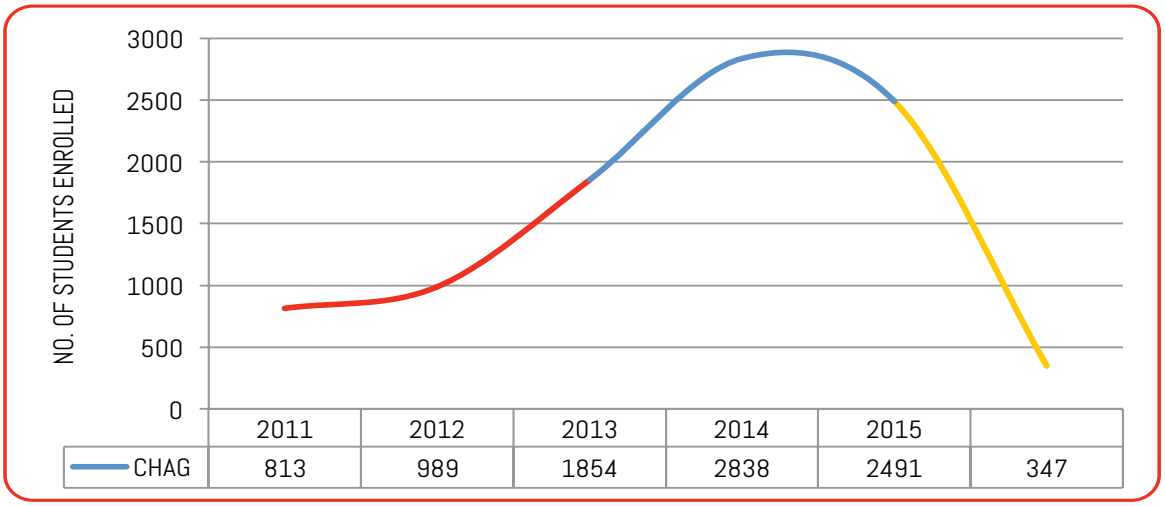
in 2015 was 2,583, which depicts 9.0% decline in students enrolment compared to that of 2014 (2,838) as shown in Figures 40. The decline in enrolment is as a result of the instruction from the Ministry of Health not to admit beyond certain limits. As a result of this restriction, the admission rates for 2014 was low.

Figure 40: Student Enrolment by Nursing Training Schools: 2010-2015



	SDA Asanta	SDA Kumasi	Presby Agogo	Presby Bawku	Presby Dormaa	HF Nkawkwa	HF Techiman	St. Patrick's Offinso	HF Berekum	St. Joseph's Jirapa	St. John Duayawnkwanta	St. Michael Pramso	Word Alive Training School	Orthopaedic Training Nsawam	Hawa Nurses Training School
2011	146	204	100	0	0	17	0	80	161	105	0	0	0	0	0
2012	111	263	120	0	0	61	0	102	150	182	0	0	0	0	0
2013	159	341	125	101	132	101	99	295	174	267	60	0	0	0	0
2014	194	523	135	135	202	45	100	450	260	214	65	150	365	0	0
2015	288	454	215	100	58	165	161	300	134	121		177		20	298

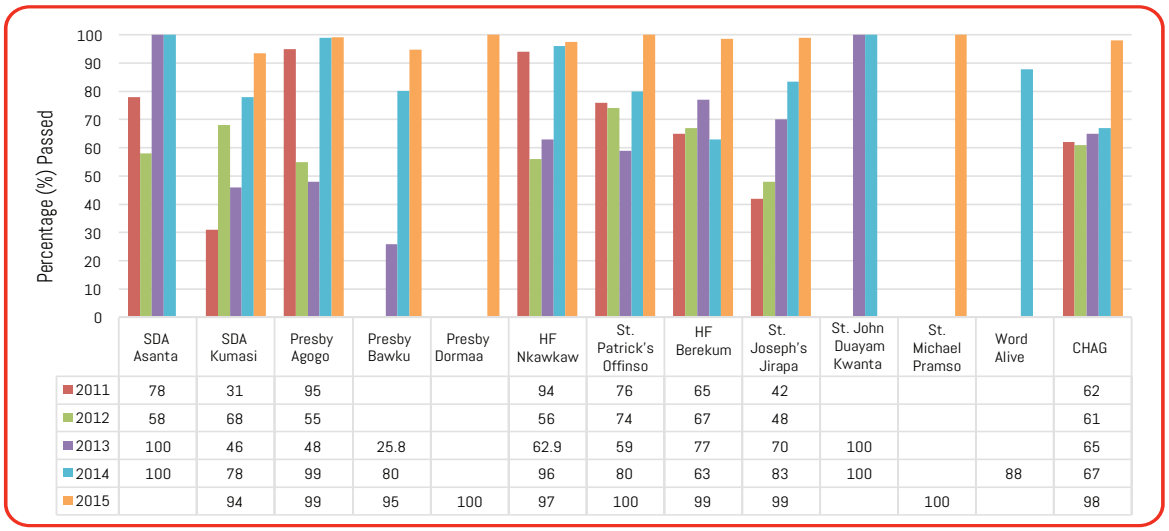
Figure 41: CHAG Student Enrolment Trend: 2010-2015



	2011	2012	2013	2014	2015	
CHAG	813	989	1854	2838	2491	347

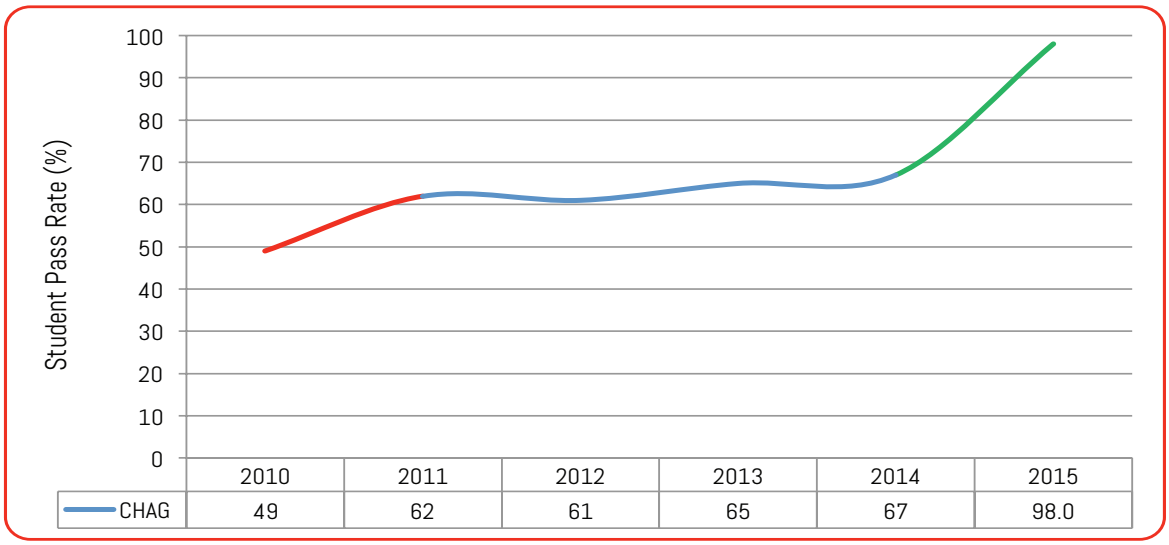
Three CHAG training colleges recorded 100% pass rate. The lowest pass rate recorded in 2015 was 93.5%, giving an average student pass rate of 98% for 2015. All colleges recorded improvement in the number of students who passed their external examination (both diploma, and post diploma. (Figures: 42 and 43).

Figure 42: Student Pass Rate by Training School: 2011-2015



	SDA Asanta	SDA Kumasi	Presby Agogo	Presby Bawku	Presby Dormaa	HF Nkawkaw	St. Patrick's Offinso	HF Berekum	St. Joseph's Jirapa	St. John Duayam Kwanta	St. Michael Pramso	Word Alive	CHAG
2011	78	31	95			94	76	65	42				62
2012	58	68	55			56	74	67	48				61
2013	100	46	48	25.8		62.9	59	77	70	100			65
2014	100	78	99	80		96	80	63	83	100		88	67
2015		94	99	95	100	97	100	99	99		100		98

Figure 43: CHAG Student Pass Rate (%) Trend: 2011 - 2015



	2010	2011	2012	2013	2014	2015
CHAG	49	62	61	65	67	98.0

5.0 Health Technology

Health Technology relates to all aspects of infrastructures, medical equipment, amenities, medicines, vaccines, laboratory equipment and E-health applications. It furthermore relates to all procedures, systems and skills required to manage these items adequately to improve and maintain a high and uninterrupted level of service readiness by the health facility.
Critical network challenges related to health technology that require sustained attention are outlined in table 22.

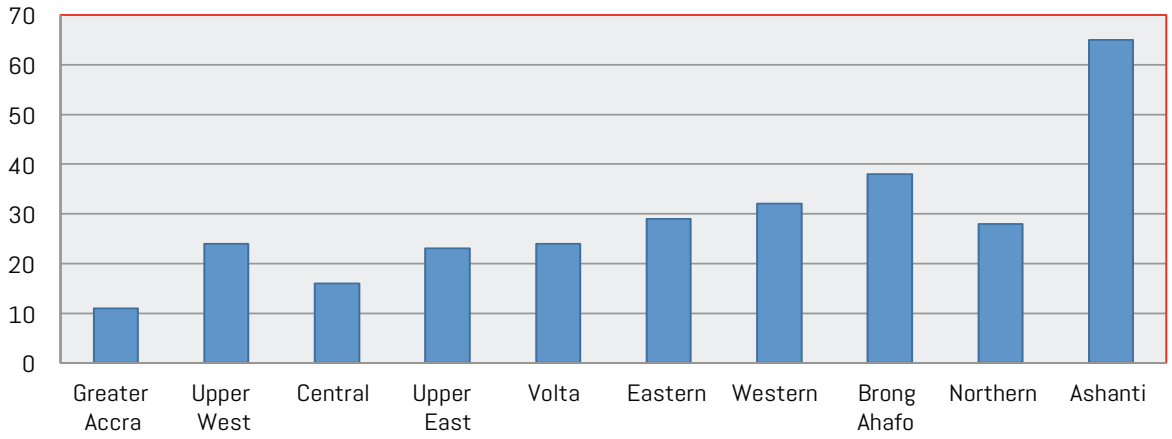
Table 22: Critical Network Challenges: Health Technology

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

Currently, the CHAG network comprises 275 health facilities and 16 Health-Training institutions. In all, the network accounts for 7.4% of the total health infrastructure in the health sector. CHAG Health Facilities are unevenly distributed in all ten regions, particularly in isolated areas and deprived districts (Figure 44).

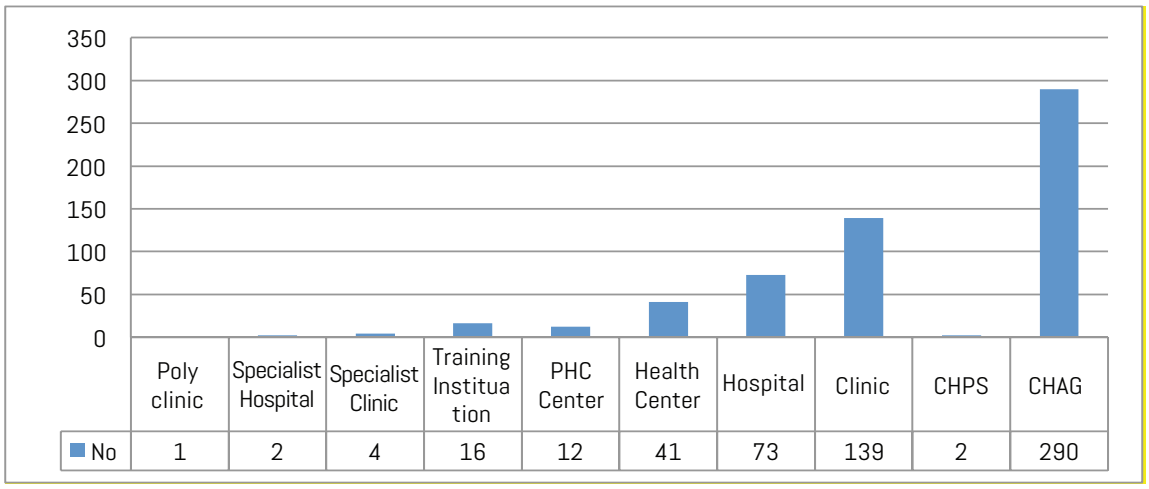
Some CHAG Facilities have maintained the level and range of services since they were established many years ago. There is need to upgrade such facilities to respond to the expansion of the catchment communities and the growing needs of the clientele. This will help minimize the demand by 'Chiefs and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

Figure 44: Distribution of CHAG Facilities by Region (%)



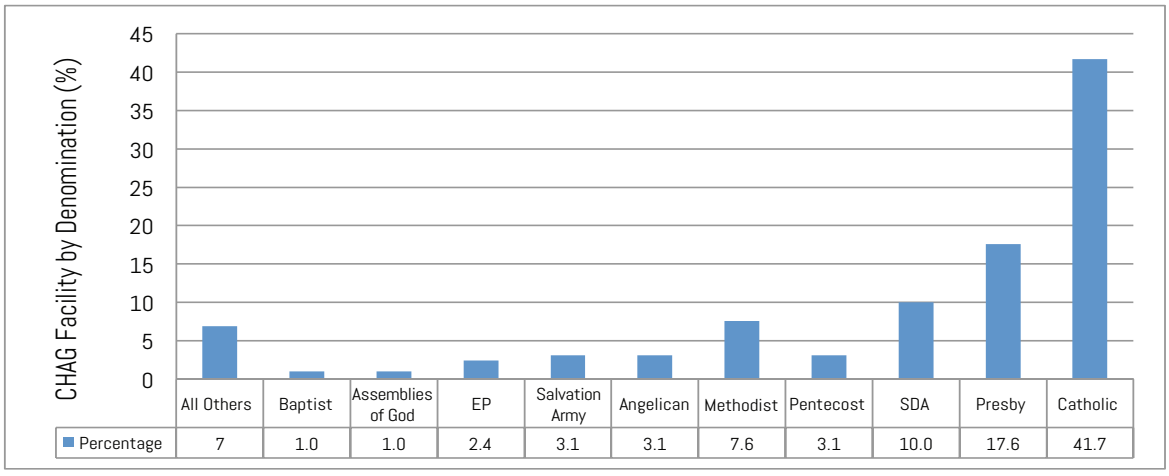
Of the 290 facilities 139 are clinics.

Figure 45: CHAG Facilities by Type



Majority of CHAG facilities are owned by the Catholic Church (42%) followed by the Presbyterian Church (18%), the Seventh Day Adventist Church (10%) and the Methodist Church (8%). The Salvation Army, Anglican Church, and the Church of Pentecost each own about 3% of Facilities while Evangelical Presbyterian Church and FAME Ghana own about 2% each. The remaining 16 other Church denominations own about 1% of CHAG facilities (Figure 46)

Figure 46: Ownership of CHAG Facilities by Denominations



6.0 Health Financing

Health financing is concerned with the mobilization, allocation and management of financial resources for the purpose of providing affordable health care for CHAGs target beneficiaries. This function of the health system involves revenue collection, pooling of resources and the efficient use of these, not only for direct health expenditure but also for financing all in-direct expenses such as staff salaries and capital investments. The major challenge of the network is financial

sustainability. Table 23 highlights the critical factors related to financing sustainability.

Table 23: Critical Network Challenges: Health Financing

- Withdrawal of most health donor partners due to Ghana's lower middle income status
- Withdrawal of government support for capital investment and utilities
- Gap in the NHIS fund
- Persistent delays in NHIS claim reimbursement (fundamental constraints in the sectors health financing architecture);
- Low NHIS tariffs for medicines and specialist services;
- Poor financial management, administration and reporting systems for some facilities

Financing of CHAG was mainly through the Government of Ghana (GoG) funds for salaries, internally generated funds (IGF), and support from development partners. Health insurance continues to be the single largest source of IGF income to health facilities. Over 87% of OPD income and 85.9% of income from inpatient care were financed through the NHIS. Consequently, challenges with the NHIA have direct impact on the finances of the health institutions.

CHAG facilities continued to suffer from up to eight (8) months persistent delays in NHIS claim reimbursement in 2015. These delays affect the supply chain of medical and non-medical consumables and therefore have the tendency of compromising quality service delivered by our member institutions.

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

Besides the effects of the delays in claim payments, the NHIA continued to exert pressure on facilities with respect to registration with the Health Facilities Regulatory Authority (HEFRA) for credentialing. This resulted in the partial suspension of licenses of 29 CHAG facilities by the NHIA for late application or non-compliance in the year under review.

Other cost containment measures by the NHIA such as clinical audit, biometric identification systems, electronic claims processing and centralized claims processing centers continue to expose weak management structures of some CHAG facilities and pose financial liquidity challenge for these health facilities. Whilst CHAG engages with the NHIA to review the modalities for clinical audits, Church Health Coordinating Units are encouraged to improve the claim

processing and reporting systems to meet the NHIA requirements and to minimize losses due to deductions from adverse findings.

6.1 Capitation

CHAG continued to partner with NHIA and other stakeholders on the Capitation project in Ashanti Region, with the aim of seeking innovative ways to provide financial risk protection as well as addressing cost escalation and Client abuse. As the NHIA prepares to extend Capitation to three more regions (bringing total regions covered to seven), it is the expectation of CHAG that the critical problems in the implementation of the pilot project outlined in table 18 below are adequately addressed to avoid shifting cost to providers, instead of cost sharing by all stakeholders.

Table 24: NHIS Capitation Project: Challenges and Recommendations

Challenges:	Recommendations:
• Unrealistically low 'per-capita' rate; • Un -timely payment; • High revenue losses for smaller health facilities (health centres and clinics) which act as gatekeeper for hospitals in same catchment area. • Proposal to reduce benefit package for insured	• Conduct costing of health services to inform realist per capita rate • Differential per -capita rates for clinics, health centres and hospitals; • Improve client -provider education; • Adhere to common management arrangements. • Exempt the poor to keep financial risk cover

Much as capitation has the potential to reduce cost for the NHIA by shifting some risks to providers and users, care must be taken not to over burden insured clients as reduction in the benefit package has the potential of introducing of out of pocket payment for basic services. It could be assumed that every cedi saved by the NHIA is a cost either to the Provider or the Payer.

Table 25: 2015 Budget Executions

	2015 GOG BUDGET EXECUTION ANALYSIS			
ITEM	**APPROVED GOG BUDGET**	**ACTUAL EXPENDITURE**	**VARIANCE**	**% BUDGET EXECUTION**
Compensation	177,832,536.00	154,885,462.27	22,947,073.73	87
Goods and Services	54,000.00	-	-	0
Capital Expenditure	-	-	-	0
Total	**177,886,536.00**	**154,885,462.27**	**22,947,073.73**	**87**

7.0 Partnerships For Health

Effective partnerships are based on commitment, communication, cooperation and coordination. Important aspects and advantages of partnerships are: improving access to services; access to complementary resources; improved focus and coordination; and improved capacity, innovation and expertise. Critical network challenges related to partnerships for health that need sustained attention are (Table 26).

Table 26: Critical Network Challenges: Partnership for Health

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

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

8.0 Research For Health

Critical challenges exist in the implementation of health services in member institution. The purpose of operational research is to promote contextual solutions and improve the quality and effectiveness of health services management and care. Critical network challenges related to health research that need sustained attention are (Table 27).

Table 27: Critical Network Challenges: Health Research

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

During the year under review, CHAG Secretariat sponsored 10 research theses in the area of Mental Health as the network's contribution to public health.

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

The Organizational Performance Assessment Tool (OPAT) is an M&E tool helping the health facilities to periodically assess their organizational capacity and regarding the extent to which they deliver desired health outcomes. The OPAT provides a framework of indicators and measures to assess organizational performance and outcomes of CHAG health facilities in each of the 9 HSS blocks (Tables 28 and 29). CHAG uses the OPAT for consolidated reporting and strategic capacity development of the network and individual members.

Table 28: Health Facility Performance: Organizational Capacity Indicators and Measures

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

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

Annex 1: CHAG Member Institutions by Type

	FACILITY NAME	TYPE	DENOMINATION	REGION
1	Anglican Clinic, Widnaba	Clinic	Anglican	Upper East
2	Anglican Clinic, Yelwoko	Clinic	Anglican	Upper East
3	Anglican Clinic, Sefwi-Bonzain	Clinic	Anglican	Western
4	Bishop Anglonby Memorial Clinic, Sefwi-Bodi	Clinic	Anglican	Western
5	St. Mark's Anglican Clinic, Subiri	Clinic	Anglican	Western
6	Calvary Baptist Micro-Clinic, Cape Coast	Clinic	Baptist	Central
7	Samuel Seidu Memorial Clinic, Bayiri	Clinic	Baptist Mid Mission	Upper West
8	Catholic Clinic, Oku Ejura	Clinic	Catholic	Ashanti
9	Madonna Maternity Clinic, Besease	Clinic	Catholic	Ashanti
10	St. Ann's Maternity Clinic, Donyina	Clinic	Catholic	Ashanti
11	St. Anthony's Clinic, Anyinasu	Clinic	Catholic	Ashanti
12	St. Edward's Clinic, Dwinyama	Clinic	Catholic	Ashanti
13	St. Joseph's Clinic, Abira	Clinic	Catholic	Ashanti
14	St. Mary's Clinic, Yapesa	Clinic	Catholic	Ashanti
15	St. Peter's Clinic/Maternity Home, Ntobroso	Clinic	Catholic	Ashanti
16	St. Theresa's Clinic, Nope, Nope - Obrayentoboase	Clinic	Catholic	Ashanti
17	St. Thomas Gen. & Maternity Clinic, Hiaa	Clinic	Catholic	Ashanti
18	St. Vincent's Clinic, Drobonso	Clinic	Catholic	Ashanti
19	St. Joseph's Clinic, Wenchi Koasi	Clinic	Catholic	Brong Ahafo
20	St. Mattews Clinic, Apenkro	Clinic	Catholic	Brong Ahafo
21	Holy Spirit Clinic, Dantano	Clinic	Catholic	Brong Ahafo
22	St. Peter's Clinic, Donkorkrom	Clinic	Catholic	Brong Ahafo

Annex 1: CHAG Member Institutions by Type

23	Our Lady of Fatima Health Centre, Abease	Clinic	Catholic	Brong Ahafo
24	St. Jame's Clinic, Abesim	Clinic	Catholic	Brong Ahafo
25	St. Alban's Clinic(The Refugee Camp Clinic), Fetentaa	Clinic	Catholic	Brong Ahafo
26	St. Anthony's clinic, Badu	Clinic	Catholic	Brong Ahafo
27	Catholic Clinic and Maternity, Akim Swedru	Clinic	Catholic	Eastern
28	Holy Spirit Health Centre, Kwesi Fante	Clinic	Catholic	Eastern
29	Notre Dame Clinic, Nsawam	Clinic	Catholic	Eastern
30	St. John's Clinic/Maternity, Akim Ofoase	Clinic	Catholic	Eastern
31	St. Joseph Clinic & Maternity Home, Kwahu-Tafo	Clinic	Catholic	Eastern
32	St. Michael's Catholic Clinic/Maternity, Ntronang-Akim	Clinic	Catholic	Eastern
33	St. Monica's Clinic and Maternity, Akim Sekyere	Clinic	Catholic	Eastern
34	St. John of God Clinic, Amrahia	Clinic	Catholic	Greater Accra
35	St. Andrew's Clinic and Maternity, Kordiabe	Clinic	Catholic	Greater Accra
36	Catholic Clinic/PHC, Salaga	Clinic	Catholic	Northern
37	Holy Cross Maternity Home and Clinic, Sambuli	Clinic	Catholic	Northern
38	St. Joseph Clinic & Mat Home, Chamba	Clinic	Catholic	Northern
39	Kayeresi Clinic, Kayeresi	Clinic	Catholic	Upper East
40	St. Martin's PHC/ Maternity Clinic, Biu	Clinic	Catholic	Upper East
41	All Saints Clinic, Piina	Clinic	Catholic	Upper West
42	Immaculate Conception Clinic, Kaleo	Clinic	Catholic	Upper West
43	Nativity of Our Lady Health Centre, Ko	Clinic	Catholic	Upper West
44	Our Lady of Lourdes Clinic, Yagha	Clinic	Catholic	Upper West
45	Queen of Peace Clinic, Sabuli	Clinic	Catholic	Upper West

Annex 1: CHAG Member Institutions by Type

45	Queen of Peace Clinic, Sabuli	Clinic	Catholic	Upper West
46	St. Christoper Clinic, Dapuori	Clinic	Catholic	Upper West
47	St. Gregory's Clinic, Nanvilli	Clinic	Catholic	Upper West
48	St. Ignatius Clinic, Lasia Tuolu	Clinic	Catholic	Upper West
49	St. John's Clinic, Funsi	Clinic	Catholic	Upper West
50	St. Martin de Porres Clinic, Eremon	Clinic	Catholic	Upper West
51	St. Paul's Clinic, Kundungu	Clinic	Catholic	Upper West
52	St. Stella's Clinic, Karne	Clinic	Catholic	Upper West
53	St. Evarist Clinic, Ullo	Clinic	Catholic	Upper West
54	Mater Ecclesiae Clinic, Sokode	Clinic	Catholic	Volta
55	St. George's Clinic, Liati	Clinic	Catholic	Volta
56	St. Luke's Clinic, Chinderi	Clinic	Catholic	Volta
57	Fr. Cuniberto's Clinic, Lume	Clinic	Catholic	Volta
58	St. Anne's Clinic & Maternity Home, Tagadzi	Clinic	Catholic	Volta
59	St. Francis Clinic, Saviefe Agorkpo	Clinic	Catholic	Volta
60	Angela Memorial Catholic Clinic, Yawmatwa	Clinic	Catholic	Western
61	Holy Child Clinic, Egyam	Clinic	Catholic	Western
62	Holy Child Clinic, Fijai	Clinic	Catholic	Western
63	St. John of God Clinic, Oseikojokrom	Clinic	Catholic	Western
64	Church of Christ Mission Clinic, Bomso-Kumasi	Clinic	Church of Christ	Ashanti
65	Church of Christ Mission Clinic, Yendi	Clinic	Church of Christ	Northern
66	Church of God Clinic Essienimpong	Clinic	Church of God	Ashanti
67	Church of God Clinic, Ahwerewa	Clinic	Church of God	Ashanti

Annex 1: CHAG Member Institutions by Type

67	Church of God Clinic, Ahwerewa	Clinic	Church of God	Ashanti
68	E. P. Church Clinic, Wapuli	Clinic	Evangelical Presbyterian	Northern
69	E. P. Church Dan Moser Memo. Clinic, Dambai (Hohoe)	Clinic	Evangelical Presbyterian	Volta
70	E. P. Clinic, Jamani	Clinic	Evangelical Presbyterian	Volta
71	Nazareth Healing Complex, Vane Avatime	Clinic	Evangelical Presbyterian	Volta
72	E. P. Clinic, Hatorgodo	Clinic	Evangelical Presbyterian	Volta
73	Fame Clinic, Yezesi	Clinic	FAME	Northern
74	Fame Clinic, Ekumdi	Clinic	FAME	Northern
75	Fame Clinic, Loagri	Clinic	FAME	Northern
76	Fame Clinic, Makango	Clinic	FAME	Northern
77	Fame Clinic, Tobali/Tatindo	Clinic	FAME	Northern
78	Fame Clinic, Benwoko	Clinic	FAME	Upper East
79	Fame Clinic, Akplale	Clinic	FAME	Volta
80	Lake Bosumtwi Methodist Clinic, Amakom	Clinic	Methodist	Ashanti
81	Methodist Clinic, Aburaso	Clinic	Methodist	Ashanti
82	Methodist Clinic, Apagya	Clinic	Methodist	Ashanti
83	Methodist Clinic, Bebu - Anyiaem	Clinic	Methodist	Ashanti
84	Methodist Clinic, Brodekwano	Clinic	Methodist	Ashanti
85	Methodist Clinic, Nyameani	Clinic	Methodist	Ashanti
86	Methodist Clinic, Senchi	Clinic	Methodist	Ashanti
87	Methodist Clinic, Tafo	Clinic	Methodist	Ashanti
88	Wesley Cathedral Clinic, Adum	Clinic	Methodist	Ashanti
89	Methodist Clinic, Kwakuanya	Clinic	Methodist	Brong Ahafo

Annex 1: CHAG Member Institutions by Type

90	Methodist Clinic, Yawsae	Clinic	Methodist	Brong Ahafo
91	Methodist Clinic, Hweehwee	Clinic	Methodist	Eastern
92	Methodist Clinic, Mpraeso	Clinic	Methodist	Eastern
93	Methodist Clinic, Osuben	Clinic	Methodist	Eastern
94	Methodist Clinic, Zanzugu Yipala	Clinic	Methodist	Northern
95	Methodist Clinic, Lawra	Clinic	Methodist	Upper West
96	Bethel Meth. Clinic Kwawu	Clinic	Methodist	Western
97	Methodist Clinic, Gwira Eshiem	Clinic	Methodist	Western
98	Methodist Clinic, Nzulezu	Clinic	Methodist	Western
99	St Luke Methodist Clinic, Adwuofua	Clinic	Methodist	Western
100	Presbyterian Clinic, Abasua	Clinic	Presbyterian	Ashanti
101	Presbyterian Clinic, Mesewam	Clinic	Presbyterian	Ashanti
102	Presbyterian Clinic, Buokrukruwa	Clinic	Presbyterian	Brong Ahafo
103	Presbyterian Clinic, Gyankufa	Clinic	Presbyterian	Brong Ahafo
104	Presbyterian Clinic, Antwirifo	Clinic	Presbyterian	Brong Ahafo
105	Presbyterian Clinic, Tanoboase	Clinic	Presbyterian	Brong Ahafo
106	Presbyterian Clinic, Yaakrom	Clinic	Presbyterian	Brong Ahafo
107	Presbyterian Clinic, Fooshegu	Clinic	Presbyterian	Northern
108	Presbyterian Clinic, Namolgo	Clinic	Presbyterian	Upper East
109	Presbyterian Clinic, Papueso-Enchi	Clinic	Presbyterian	Western
110	Presbyterian Clinic, Ohiamatuo	Clinic	Presbyterian	Western
111	Saviour Church Clinic, Bonwire	Clinic	Saviour Church	Ashanti
112	Saviour Church Clinic, Subriso	Clinic	Saviour Church	Ashanti

Annex 1: CHAG Member Institutions by Type

113	SDA Clinic, Anyinasuso	Clinic	Seventh Day Adventist	Ashanti
114	Seventh Day Adventist Clinic, Apaah	Clinic	Seventh Day Adventist	Ashanti
115	Seventh Day Adventist Clinic, Konkoma	Clinic	Seventh Day Adventist	Ashanti
116	Seventh Day Adventist Clinic, Nobewam	Clinic	Seventh Day Adventist	Ashanti
117	Seventh Day Adventist Clinic, Dominase	Clinic	Seventh Day Adventist	Central
118	Seventh Day Adventist Clinic, Wa	Clinic	Seventh Day Adventist	Upper West
119	Seventh Day Adventist Clinic and Maternity, Sefwi Punikrom	Clinic	Seventh Day Adventist	Western
120	Seventh Day Adventist Clinic and Maternity, Sefwi-Asawinso	Clinic	Seventh Day Adventist	Western
121	Mary Ekuba Ewoo Memorial Adventist Clinic, Akwidaa	Clinic	Seventh Day Adventist	Western
122	Seventh Day Adventist Clinic, Dadieso	Clinic	Seventh Day Adventist	Western
123	Seventh Day Adventist Clinic, Kofikrom	Clinic	Seventh Day Adventist	Western
124	Seventh Day Adventist Clinic, Sefwi Amoaya	Clinic	Seventh Day Adventist	Western
125	Seventh Day Adventist Clinic, Wassa Nkran	Clinic	Seventh Day Adventist	Western
126	Siloam Gospel Clinic, Bonyere	Clinic	Siloam Gospel	Western
127	Pentecost Clinic, Kasapin	Clinic	The Church of Pentecost	Brong Ahafo
128	Pentecost Clinic, Ayanfuri	Clinic	The Church of Pentecost	Central
129	Pentecost Community Clinic, Twifu Agona	Clinic	The Church of Pentecost	Central
130	Pentecost Clinic, Kpassa	Clinic	The Church of Pentecost	Volta
131	Pentecost Clinic, Enchi	Clinic	The Church of Pentecost	Western
132	Pentecost Clinic, Tarkwa	Clinic	The Church of Pentecost	Western
133	Pentecost Clinic, Yawmatwa	Clinic	The Church of Pentecost	Western
134	The Salvation Army Clinic, Wiamoase	Clinic	The Salvation Army	Ashanti
135	The Salvation Army Clinic, Agona-Duakwa	Clinic	The Salvation Army	Central

Annex 1: CHAG Member Institutions by Type

136	The Salvation Army Clinic, Baa	Clinic	The Salvation Army	Central
137	The Salvation Army Clinic, Akim-Wenchi	Clinic	The Salvation Army	Eastern
138	The Salvation Army Clinic, Anum	Clinic	The Salvation Army	Eastern
139	The Salvation Army Clinic, Begoro	Clinic	The Salvation Army	Eastern
140	The Salvation Army Clinic, Adaklu-Sofa	Clinic	The Salvation Army	Volta
141	Presbyterian CHPS Centre, Tolla	CHPS	Presbyterian	Upper East
142	Salvation Army CHPS Centre, Anidasofie	CHPS	The Salvation Army	Ashanti
143	Janie Speaks A.M.E Zion Hospital, Afrancho	Hospital	AME ZION	Ashanti
144	Saboba Medical Centre, Saboba	Hospital	Assemblies of God	Northern
145	The Kings Medical Centre, Bontanga	Hospital	Assemblies of God	Northern
146	Coast for Christ Baptist Hospital, Winneba	Hospital	Baptist	Central
147	Baptist Medical Centre, Nalerigu	Hospital	Baptist	Northern
148	HopXchange Medical Centre, Christian Village - Kumasi	Hospital	Catholic	Ashanti
149	Pope John Paul II Medical Centre, Jamasi	Hospital	Catholic	Ashanti
150	St. Martin's Hospital, Agroyesum	Hospital	Catholic	Ashanti
151	St. Michael's Hospital, Pramso	Hospital	Catholic	Ashanti
152	St. Patrick's Hospital, Maase-Offinso	Hospital	Catholic	Ashanti
153	St. Peter's Hospital, Jacobu	Hospital	Catholic	Ashanti
154	Holy Family Hospital, Berekum	Hospital	Catholic	Brong Ahafo
155	Holy Family Hospital, Techiman	Hospital	Catholic	Brong Ahafo
156	Mathias Hospital, Yeji	Hospital	Catholic	Brong Ahafo
157	St. Elizabeth Hospital, Hwidiem	Hospital	Catholic	Brong Ahafo
158	St. John of God Hosp., Duayaw-Nkwanta	Hospital	Catholic	Brong Ahafo

Annex 1: CHAG Member Institutions by Type

158	St. John of God Hosp., Duayaw-Nkwanta	Hospital	Catholic	Brong Ahafo
159	St. Mary's Hospital, Drobo	Hospital	Catholic	Brong Ahafo
160	St. Theresa's Hospital, Nkoranza	Hospital	Catholic	Brong Ahafo
161	Mercy Women's Centre, Mankessim	Hospital	Catholic	Central
162	Our Lady of Grace Hospital, Breman-Asikuma	Hospital	Catholic	Central
163	St. Francis Xavier Hospital, Assin-Fosu	Hospital	Catholic	Central
164	St. Gregory Catholic Hospital, Gomoa Budumburam	Hospital	Catholic	Central
165	St. Luke Catholic Hospital, Apam	Hospital	Catholic	Central
166	Holy Family Hospital, Nkawkaw	Hospital	Catholic	Eastern
167	St. Dominic Hospital, Akwatia	Hospital	Catholic	Eastern
168	St. Joseph's Hospital, Koforidua	Hospital	Catholic	Eastern
169	St. Martin's de Porres Hospital, Agomanya	Hospital	Catholic	Eastern
170	Tatale District Hospital, Tatale	Hospital	Catholic	Northern
171	West Gonja Hospital, Damango	Hospital	Catholic	Northern
172	St. Joseph's Hospital, Jirapa	Hospital	Catholic	Upper West
173	St. Theresa's Hospital, Nandom	Hospital	Catholic	Upper West
174	Anfoega Catholic Hospital, Anfoega	Hospital	Catholic	Volta
175	Catholic Hospital, Battor	Hospital	Catholic	Volta
176	Comboni Hospital, Sogakope	Hospital	Catholic	Volta
177	Margaret Marquart Cath. Hosp, Kpando	Hospital	Catholic	Volta
178	Mary Theresa Hospital, Dodi-Papase	Hospital	Catholic	Volta
179	Sacred Heart Hospital, Weme-Abor	Hospital	Catholic	Volta
180	St. Anthony's Hospital, Dzodze	Hospital	Catholic	Volta

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181	St. Joseph's Hospital, Nkwanta	Hospital	Catholic	Volta
182	Fr. Thomas Alan Rooney Memo. Hosp., Asankragwa	Hospital	Catholic	Western
183	St. John of God Hospital, Sefwi-Asafo	Hospital	Catholic	Western
184	St. Martin de Porres Hospital, Eikwe	Hospital	Catholic	Western
185	Hope Christian Hospital, Gomoa Feteh	Hospital	Church of Christ	Central
186	International Health Development Network Mission Hospital, Wheta Hospital		Evangelical Presbyterian	Volta
187	Faith Evangelical Mission Hospital, Bubuashie	Hospital	Faith Evangelical Mission	Greater Accra
188	Global Evangelical Mission Hospital, Apromase	Hospital	Global Evangelical	Ashanti
189	Lighthouse Mission Hospital, North Kaneshie	Hospital	Lighthouse Mission	Greater Accra
190	St. Luke's Hospital, Kasei va Ejura	Hospital	Luke Society Missions	Asanti
191	Manna Mission Hosp, Teshie-Nungua	Hospital	Manna Mission	Greater Accra
192	Methodist Faith Healing Hospital, Ankaase	Hospital	Methodist	Ashanti
193	Methodist Hospital, Wenchi	Hospital	Methodist	Brong Ahafo
194	Presbyterian Hospital, Agogo, Ashanti-Akim	Hospital	Presbyterian	Ashanti
195	Presbyterian Hospital, Dormaa-Ahenkro	Hospital	Presbyterian	Brong Ahafo
196	Presbyterian Hospital, Donkorkrom	Hospital	Presbyterian	Eastern
197	Presbyterian Hospital, Bawku	Hospital	Presbyterian	Upper East
198	Hawa Mem. Saviour Hospital, Akim-Osiem	Hospital	Saviour Church	Eastern
199	Akoma Memorial SDA Hospital, Kortwia-Abodom	Hospital	Seventh Day Adventist	Ashanti
200	Seventh Day Adventist Hospital, Asamang	Hospital	Seventh Day Adventist	Ashanti
201	Seventh Day Adventist Hospital, Dominase	Hospital	Seventh Day Adventist	Ashanti
202	Seventh Day Adventist Hospital, Kwadaso-Kumasi	Hospital	Seventh Day Adventist	Ashanti
203	Seventh Day Adventist Hospital, Namong	Hospital	Seventh Day Adventist	Ashanti

Annex 1: CHAG Member Institutions by Type

204	Seventh Day Adventist Hospital, Obuasi	Hospital	Seventh Day Adventist	Ashanti
205	Seventh Day Adventist Hospital, Wiamoasi-Ashanti	Hospital	Seventh Day Adventist	Ashanti
206	HART Adventist Hospital, Ahinsan	Hospital	Seventh Day Adventist	Ashanti
207	Adventist Hospital, Breman	Hospital	Seventh Day Adventist	Ashanti
208	Seventh Day Adventist Hospital, Sunyani	Hospital	Seventh Day Adventist	Brong Ahafo
209	Seventh Day Adventist Hospital, Koforidua	Hospital	Seventh Day Adventist	Eastern
210	Seventh Day Adventist Hospital, New Gbawe	Hospital	Seventh Day Adventist	Greater Accra
211	Seventh Day Adventist Hospital, Tamale	Hospital	Seventh Day Adventist	Northern
212	Nagel Memorial Hospital Takoradi	Hospital	Seventh Day Adventist	Western
213	Bryant Mission Hospital, Obuasi-Adansi	Hospital	The Church of Pentecost	Ashanti
214	Pentecost Hospital, Madina	Hospital	The Church of Pentecost	Greater Accra
215	Evangelical Church of Ghana Hospital, Kpandai	Hospital	Wec Mission	Northern
216	Anglican Health Centre, Tano-Odumase	Health Centre	Anglican	Ashanti
217	Nakpanduri Health Centre	Health Centre	Assemblies of God	Northern
218	Benito Menni Health Centre, Dompoase	Health Centre	Catholic	Ashanti
219	Sacred Heart Health Centre, Bepoase	Health Centre	Catholic	Ashanti
220	St. John's Health Centre, Domeabra	Health Centre	Catholic	Ashanti
221	St. Louis Health Centre, Bodwesango	Health Centre	Catholic	Ashanti
222	St. Luke's Health Centre, Seniagya	Health Centre	Catholic	Ashanti
223	Martyrs of Uganda Health Centre, Bole	Health Centre	Catholic	Northern
224	Tuna Health Centre	Health Centre	Catholic	Northern
225	Immaculate Conception Health Centre, Kongo	Health Centre	Catholic	Upper East
226	Martyrs of Uganda Health Centre, Sirigu	Health Centre	Catholic	Upper East

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227	St. Joseph Health Centre, Nakolo	Health Centre	Catholic	Upper East
228	St. Lucas Health Centre, Wiaga	Health Centre	Catholic	Upper East
229	St. Theresa Health Centre, Zorko	Health Centre	Catholic	Upper East
230	St. Catherine of Sienna Health Centre, Jirapa	Health Centre	Catholic	Upper West
231	St. Gerhardt Health Centre, Fielmuo	Health Centre	Catholic	Upper West
232	Presbyterian Health Centre, Jenjemireja	Health Centre	Presbyterian	Brong Ahafo
233	Presbyterian Health Centre, Kyeremasu	Health Centre	Presbyterian	Brong Ahafo
234	Presbyterian Health Centre, Aboabo	Health Centre	Presbyterian	Brong Ahafo
235	Presbyterian Health Centre, KwadwoKumikrom	Health Centre	Presbyterian	Brong Ahafo
236	Presbyterian Health Centre, Kwamesua	Health Centre	Presbyterian	Brong Ahafo
237	Presbyterian Health Centre, Suma Ahenkro	Health Centre	Presbyterian	Brong Ahafo
238	Presbyterian Church Health Center, Assin-Praso	Health Centre	Presbyterian	Central
239	Presbyterian Health Centre, Assin Nsuta	Health Centre	Presbyterian	Central
240	Presbyterian Health Centre, Abetifi	Health Centre	Presbyterian	Eastern
241	Presbyterian Health Centre, Ekye	Health Centre	Presbyterian	Eastern
242	Presbyterian Health Centre, Kom- Aburi	Health Centre	Presbyterian	Eastern
243	Presbyterian Health Centre, Kwahu Praso	Health Centre	Presbyterian	Eastern
244	Presbyterian Health Centre, Obregyima	Health Centre	Presbyterian	Eastern
245	Tease Presby Health Centre, Afram Plains	Health Centre	Presbyterian	Eastern
246	Presbyterian Health Centre, Langbinsi-Gambaga	Health Centre	Presbyterian	Northern
247	Presbyterian Health Centre, Loloto	Health Centre	Presbyterian	Northern
248	Kuwani Health Centre, Kuwani	Health Centre	Presbyterian	Northern
249	Presbyterian Health Centre, Widana	Health Centre	Presbyterian	Upper East

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249	Presbyterian Health Centre, Widana	Health Centre	Presbyterian	Upper East
250	Presbyterian Health Centre, Garu	Health Centre	Presbyterian	Upper East
251	Presbyterian Health Centre, Siniensi	Health Centre	Presbyterian	Upper East
252	Presbyterian Health Centre, Sumaduri	Health Centre	Presbyterian	Upper East
253	Presbyterian Health Centre , Kwamebikrom	Health Centre	Presbyterian	Western
254	Presbyterian CHPS Compound, Amonie	Health Centre	Presbyterian	Western
255	Urban Aid Health Centre, Mamobi	Health Centre	The Salvation Army	Greater Accra
256	Koni Health Centre, Kpassa	Health Centre	WEC Mission	Volta
257	St. Lucy Polyclinic, Tamale	Polyclinic	Catholic	Northern
258	Our Lady of Rocio PHC, Walewale	Primary Health Care	Catholic	Northern
259	St. Joseph's PHC, Kalba	Primary Health Care	Catholic	Northern
260	Wa Diocese PHC Project	Primary Health Care	Catholic	Upper West
261	E. P. Church Health Services, Ho	Primary Health Care	Evangelical Presbyterian	Volta
262	Presbyterian PHC , Agogo, Ashanti-Akim	Primary Health Care	Presbyterian	Ashanti
263	Dormaa Presby PHC Project, Dormaa-Ahenkro	Primary Health Care	Presbyterian	Brong Ahafo
264	Presbyterian Primary Health Centre, Tease	Primary Health Care	Presbyterian	Eastern
265	Presbyterian Health Centre, Woriyanga	Primary Health Care	Presbyterian	Upper East
266	Presbyterian PHC, Bawku	Primary Health Care	Presbyterian	Upper East
267	Presbyterian PHC, Bolgatanga	Primary Health Care	Presbyterian	Upper East
268	Presbyterian PHC, Sandema	Primary Health Care	Presbyterian	Upper East
269	Presbyterian PHC, Enchi	Primary Health Care	Presbyterian	Western
270	Anglican Eye Clinic, Jachie	Specialist Clinic	Anglican	Ashanti
271	Bishop Ackon Memorial Christian Eye Centre, Cape Coast	Specialist Clinic	Anglican	Central

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271	Bishop Ackon Memorial Christian Eye Centre, Cape Coast	Specialist Clinic	Anglican	Central
272	Sight for Africa Eye Clinic, Darkuman	Specialist Clinic	Run Mission	Greater Accra
273	Emmanuel Eye/ Medical Centre, East Legon	Specialist Hospital	Luke Society Missions	Greater Accra
274	Presbyterian Regional Eye Centre, Bolgatanga	Specialist Hospital	Presbyterian	Upper East
275	St. Michael's Midwifery Training College, Pramso	Training Institution	Catholic	Ashanti
276	St. Patrick's Midwifery School, Maase-Offinso	Training Institution	Catholic	Ashanti
277	Holy Family Nursing Training College, Techiman	Training Institution	Catholic	Brong Ahafo
278	Holy Family Midwifery/Nurses Training College,	Berekum Training Institution	Catholic	Brong Ahafo
279	Physiotherapy & Orthotic Training School, Duayaw	Nkwanta Training Institution	Catholic	Brong Ahafo
280	Holy Family Nurses Training College,	Nkawkaw Training Institution	Catholic	Eastern
281	Orthotics & Prosthesis Training School,	Nsawam Training Institution	Catholic	Eastern
282	Jirapa Community Health Nursing Training School,	Jirapa Training Institution	Catholic	Upper West
283	St. Joseph's Midwifery Training School,	Jirapa Training Institution	Catholic	Upper West
284	St. Joseph's Nurses' Training College,	Jirapa Training Institution	Catholic	Upper West
285	Nursing & Midwifery Training College, Agogo	Training Institution	Presbyterian	Ashanti
286	Presbyterian Midwifery Training School, Dormaa Ahenkro	Training Institution	Presbyterian	Brong Ahafo
287	Presbyterian Nurses Training College, Bawku,	Training Institution	Presbyterian	Upper East
288	Seventh Day Adventist Nurses Training College, Kwadaso	Training Institution	Seventh Day Adventist	Ashanti
289	Seventh Day Adventist Health Asst. Training School, Asanta	Training Institution	Seventh Day Adventist	Western
290	Word Alive Community Health Nursing Training School, Esiama	Training Institution	Word Alive	Western

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