Christian Health Association of Ghana (CHAG)

ANNUAL REPORT

2010

Christian Health Association of Ghana

2010 Annual Report

SEPTEMBER 2011

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List of Abbreviations

ANC	Antenatal Care
ARV	Anti-retro Viral
CCG	The Christian Council of Ghana
CHAG	Christian Health Association of Ghana
CHC	Church Health Coordinators
CHCU	Church Health Coordinating Units
CHIMS	Centre for Health Information Management
CHPS	Community Health Planning and Services
CSO	Civil Society Organisation
CSS	Community Systems Strengthening
DANIDA	Danish International Development Agency
DP	Development Partners
ES	Executive Secretariat (CHAG)
DHC	Diocesan Health Committee
GCBC	The Ghana Catholic Bishops Conference
GHS	Ghana Health Service
GOG	Government of Ghana
HR	Human Resource
HRM	Human Resource Management
HSMTDP	Health Sector Medium Term Development Plan
HSC	Health Service Committee
HSS	Health Systems Strengthening
IGF	Internally Generated Funds
MDG	Millennium Development Goals
MIs	Member Institutions
MMDA	Metropolitan, Municipal and District Assemblies
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCHS	National Catholic Health Service
NHIA	National Health Insurance Authority
PHC	Primary Health Care
PLWHA	Person Living with HIV or AIDS
PNC	Postnatal care
TBA	Traditional Birth Attendant
UNAIDS	United Nations AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Foreword and Acknowledgements

The CHAG 2010 Annual Report reports on what the entire organization of CHAG, collectively has undergone in the year 2010. It gives information on the evolving role the organization plays in the health sector and the situation of the network from a health systems perspective.

The entire membership of CHAG, the Board and the secretariat acknowledge the support received from the Government of Ghana, not only in financial terms but also in terms of the respect and recognition accorded to CHAG in the Ghanaian Health Sector. CHAG wishes to thank all stakeholders in the sector for their supportive collaboration with CHAG.

CHAG and its members are noted for innovations and community and patient-centred initiatives they have carried out over the years, many of which have led to significant changes in the national policy direction as well as the design and delivery of health care services in Ghana. This report identifies a few and describes them in brief.

The activities of CHAG are intended to support the achievement of national health outcomes and as such the report provides information on the inputs, outputs and impact of CHAGs activities during the year under review.

This report is expected to be a reference document for planning and strategy development especially for CHAG members, it is an authentic record of CHAG's performance and contribution to the health sector in Ghana which may be referenced by its members, partners and other stakeholders.

The publication of this report would not be possible without funding support from DANIDA.

Dr. Gilbert Buckle
Executive Director

September, 2011

This report has been compiled and circulated by the secretariat and any comment on it should be sent to the following address

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Message from the Board Chairman

WE WANT TO THANK God for making it possible for us to produce the 2010 annual report. We also want to thank our development partners through whose support we have been able to come this far. We equally thank the member institutions for their collaboration and whatever success CHAG has been able to choke, is due to the collective efforts of all.

This is how far we have come. The annual report has given us a picture of the position of CHAG, our struggles and efforts as far as healthcare delivery in the country is concerned. At the same time, it had brought out clearly our challenges which make people appreciate our environment.
We are grateful to the Government of Ghana through the Ministry of Health for the collaboration and support which we enjoy.

CHAG for all these years has made visible, appreciable and enviable strides in her efforts to promote Christian identity and witness through health. As individual member institutions, we have tried to uphold our core values and showed that we provide healthcare with a difference. Despite the fact that we are inundated with many challenges, we still make efforts to improve and increase access and provide quality healthcare.

The challenges should not break us down but rather spur us on. I pray that you all stand up to these challenges and assure and courageously tell yourselves that "YES WE CAN."

We humbly admit that we have reached the peak but that we a re struggling to attain the ultimate.

I pray that the Good Lord support you in your efforts and together let us strive to make positive impact.

God bless you.

REV. MSGR CLETUS FRANK EGBI
CHAG BOARD CHAIRMAN

Executive Summary

This annual report of the Christian Health Association of Ghana (CHAG) gives account of the role the organization plays in the health sector and outlines its performance in 2010 from the a Health Systems perspective. CHAG has adopted the Ouagadougou Declaration on Health Systems Strengthening as a framework for improving performance and reporting. The model recognises the following system blocks: Leadership and Governance, Health Service Delivery, Human Resource for Health, Health Financing, Health Information, Health Technologies, Community Ownership and Participation, Partnerships for Health Development and Research for Health.

Born as a Voluntary Professional Association in 1967, it became registered in 1968 as a Body-Corporate under the Trustees (Incorporation) Act, 1962 Act 106. CHAG has since grown from two main church denominations of the Catholics and Protestant to include Pentecostals into a faith-based network organisation of 21 Christian church denominations which is involved in health care delivery and the training of health professionals within the context of a Memorandum of Understanding (MoU) with the Ministry of Health.

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

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

As at 2010 the network members had a staff strength of 7,302 and data on staff distribution in CHAG showed that there was inequitable distribution of professional staff among member health services and between CHAG and the public sector. For instance, the doctor patient ratios in CHAG and the national were, 25,367 and 21,988 respectively and the network had a nurse patient ratio was 2,043 as against a national average of 1,161.

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

support accounted for 35% of total inflows in 2010 out of which 99% went into paying salaries and only 1% supported capital investments. IGF generated mainly from NHIA reimbursements which had a 4 to 5 month delay period contributed 60%. Grants, donations, direct funding from development partners and other sources contributed 5%. It is worthy of note that the cost per patient day equivalent for CHAG was GH¢ 32.2 as against GH¢ 28.4 for the public sector in 2010.

The collection, management and use of reliable and timely information for decision making, planning, lobbying and advocacy and performance management purposes has been a challenge for CHAG. The numerous challenges notwithstanding, CHAG was able to collect data from 80% of its members in 2010. CHAG has developed a performance framework with indicators and measures based on the HSS model to support the use of data for decision making at the secretariat and MI levels.

The CHAG network comprised 172 NHIA accredited health care facilities and 10 health training institutions country wide. CHAG facilities make up 5.3% of all health institutions in Ghana and accounted for 19.2 % of outpatient and 37% of inpatient load of Ghana in 2010.

CHAG facilities hardly experienced medicine and non-medicine shortages and were able to meet the needs of its clientele. The cost of medicine was higher in CHAG facilities as against public facilities as a consequence of its pricing mark up on medicines which was designed to support considerable proportion of the facility operational budget.

CHAG's partnership with the MOH is formalized under a Memorandum of Understanding (MoU).

Development Partners (e.g. DANIDA, WHO, UNFPA UNAIDS) continued to work with CHAG through the CHAG Secretariat and some entered into direct contractual project funding arrangements with it in the year under review. CHAG is a member of key national health committees and impacted on the national health development agenda through effective engagement in health sector policy dialogue, where policy and national strategies were discussed and evolved.

Three innovations were implemented based on operational researches conducted. The Fives Alive Project initiated in partnership with Institute for Health Care Improvement a US based organization which was partly aimed at reducing U5 mortality within the National Catholic Health Service, produced positive results. There was an overall U5

mortality reduction of 18%, more than 40% reduction in four hospitals together, and two hospitals individually achieved nearly 60% reduction over the intervention period. Adopting community childbirth practices of allowing a pregnant woman to squat and deliver into a dug hole after a study into the factors responsible for the low supervised delivery coverage in Kings Medical Centre in the Tolon-Kumbungu also led to increased ANC, improved delivery coverage and improved delivery outcomes. Partnership with TBAs to improve maternal and child health in the Goaso Diocesan Health Service also led to an upward trend in supervised deliveries, reduction in still births, and improved PNC attendance, underscoring the fact TBAs have a crucial role to play in maternal and child health at the community level.

A total of 4,134,887 out patients presented themselves for care in 2010. The top ten causes of OPD attendance have remained the same since 2008 and only changed positions on the league table. Malaria accounted for 34% of all OPD cases in 2010 followed by URI, Hypertension, Skin diseases and Ulcers and Rheumatism and joint pains.

Out of 18,463 PLWHA in 2010, only 25% were on ARV treatment. ARV treatment declined from 39% in 2009 to 25% in 2010. The percentage of PLWHA on HBC also dropped from 35% in 2009 to 23% in 2010. HIV/AIDS was the second cause of death in 2010 and it accounted for 14% of all deaths.

A total of 339,242 clients were admitted in 2010 and 8038 of them died yielding an all-cause mortality rate of 237 Deaths/1,000 Admissions. This was lower than national statistic of 397 Deaths/1000 Admissions.

Whereas still birth and Maternal mortality rates were worse than those of the national, infant and under 5 mortality rates were better across the CHAG network. Supervised delivery coverage was also much better in the CHAG network when compared to the national.

Besides providing overwhelming evidence for CHAG relevance in the health sector, the report outlines some emerging issues which would be looked at and addressed to consolidate CHAGs relevance and competitiveness in the health care market environment.

1 The Organization: The Christian Health Association of Ghana

The Christian Health Association of Ghana (CHAG) is a faith-based network organisation of 21 Christian church denominations, involved in the provision of health care and training of health professionals. Established in 1967, the Association currently comprises 58 hospitals, 114 health centres and clinics, and 12 health training institutions, Membership has gone up from 25 in 1967 to 184 in 2010 (an overview of membership by denomination and type of facility can be found in figures 7, 8, 9 and 10). There is potential for further growth, since not all church health facilities have been registered... The network members collectively have a staff strength of approximately 7,300. In 2010 the total number of outpatient contacts exceeded 4,000,000 and inpatients exceeded 300,000 persons.

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

CHAG's governance structure is derived from its constitutions. The governance structure comprises three very distinct layers: i.e. the Council, the Board and Secretariat. The Council meets once a year to discuss issues of concern to members thus setting the direction of the organisation in any given year.

The Board is composed of nominated representatives of the Ghana Catholic Bishops' Conference and the Christian Council of Ghana and the Ghana Pentecostal Council. The Board is tasked to support and monitor the implementation of decisions and programmes by the secretariat that serve the interest of members.

The Secretariat is responsible for managing the network and ensuring that the aims and objectives of the association and the needs of members towards contributing to the achievement of national health outcomes are met. It also plays a role as an interface between the Association and other players in the sector.

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

1.1 The Vision of CHAG is:

"A healthy nation, Christ's Healing Ministry Fulfilled"

1.2 The mission of CHAG is:

To promote the healing ministry of Christ and be a reliable partner in the Health Sector in providing the health needs of the people in Ghana in fulfilment of Christ's mandate to go and heal the sick.

1.3 The core values of CHAG are

- Christian identity and witness
- Unity in Diversity
- Respect for the dignity of the person
- Holistic health care
- Creativity and Excellence
- Accountability and Transparency
- Co-operation and partnership
- Option for the poor and the marginalized

1.4 The objectives of CHAG are:

1. To foster a closer partnership between Church-related health services and the Ministry of Health to promote health care in Ghana.
2. To assist in planning and coordinating the training programmes and other medical work or services of the members of the Association.
3. To assist the members of the Association with respect to the employment of staff, provision of supplies to the hospitals or other medical services maintained or supported or controlled or supervised by any member of the Association.
4. To encourage and assist the members to promote the healing ministry for the benefit and the welfare of the people of Ghana.
5. To implement policies set by the members and do such other things in cooperation with the members of the Association as are conducive to the attainment of the above aims and objectives of the Association or any of them and generally to act for the benefit and welfare of the people living in Ghana.

2. The Role of CHAG in the Health Sector

In recent years, two studies on the role of CHAG within the national health sector were conducted by the World Bank and WHO respectively, both documenting significant contributions of its members to the attainment of national health outcomes at all levels and areas of the health sector. Similar conclusions can be drawn from data collected by the Secretariat itself, and presented in this report.

The member church health services and their respective health institutions have experienced growth and development making them better able to manage their operations. The significant contribution of CHAG member institutions to health service delivery as well as policy development continues to grow and be appreciated by stakeholders in the sector. Government increasingly expects CHAG to continue supporting its efforts in the provision of high quality accessible care to the people of Ghana and especially in rural poor areas.

CHAG is a network organization of church health service providers. With the introduction and implementation of the Ministry of Health (MOH)/Christian Health Association of Ghana (CHAG) Memorandum of Understanding and Administrative Instructions [October 2006], CHAG has become a formally recognized service agency of the Ministry of Health. This recognition puts additional responsibilities on CHAG to further align its activities and interventions to support national objectives and ensure that services are provided in line with good practices conforming to standard professional norms and procedures. There is also a need now for CHAG to be able to self-monitor the quality of services and the performance of its members.

Government over the past decades has built more health infrastructure to meet its social obligations to the people of Ghana. CHAG recognizes and appreciates this fact. In recognition of this, CHAG by implicit policy, resource limitations and evidence that its current facilities may not be operating optimally, is not growing through putting up of new infrastructure. Growth within CHAG is rather by upgrading existing ones to meet new demands and spreading services where members are already located to newly identified populations of poor, marginalized and disadvantaged people. CHAG continues to develop innovative approaches to serve these groups. The provision of high quality and cost effective care is now the focus of CHAG.

It is important to note that CHAG and government partner in a non-competitive but complementary manner. CHAG provides a credible alternative to public health care service provision where it does not exist. CHAG as well provides a balance in the health

sector by providing important differing perspectives to health development in Ghana. As a network of service providers CHAG recognises that its services contribute to the achievement of national health outcomes. Its activities are therefore designed to clearly focus on impacting national health outcomes.

The recognition of CHAG as a service agency of the Ministry of Health not-withstanding, CHAG remains a private faith based network organization with responsibility to provide health care services in line with Christian teachings and doctrine that support life and the dignity of the human person. CHAG therefore maintains an independent position in health policy dialogues with a focus on supporting policy development that promotes the provision of high quality services in general and particularly equitable access to health care for the poor, marginalized and disadvantaged groups in society.
The Health Sector Medium Term Development Plan (HSMTDP) 2010 – 2013, reflects the government's health development agenda for the medium term. It identifies the key priorities of the sector and provides five objectives for accelerating programmes implementation towards attaining equitable universal coverage. These are:

1. Bridge equity gaps in access to health care and nutrition services and ensure sustainable financing arrangements that protect the poor
2. Strengthen governance and improve the efficiency and effectiveness of the health system
3. Improve access to quality maternal, neonatal, child and adolescent health services
4. Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles
5. Improve institutional care including mental health service delivery to support the improvement of institutional care including mental health service delivery.

CHAG sets out to support the achievement of these national objectives as well as specific health issue in the locality its members find themselves in.

3. CHAG from a Health Systems Perspective

Health System Performance Monitoring Framework

CHAG in 2010 adopted the Health Systems Strengthening model as the performance management framework across the network. This framework is developed upon the model in the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa which recognizes nine building blocks of the health system namely; Leadership and Governance, Health Service Delivery, Human Resource for Health, Health Financing, Health Information, Health Technologies, Community Ownership and Participation, Partnerships for Health Development, Research for Health.

CHAG has developed whole system measures to help provide a balanced set of system-level measures for health care leaders, facility managers and other stakeholders. This will enable the objective evaluation of the overall performance of health institutions on core dimensions of quality and value and also serve as inputs for strategic quality improvement planning.

The state of the network in 2010 has been assessed with the lens of the health systems blocks. From that perspective the current situation in CHAG is as follows:

3.1 Leadership and Governance

Over time, CHAG has evolved from a ´trade unionist´ network, where its preoccupation was predominantly the network institutional members' welfare issues into a ´service delivery´ network where its pre-occupation is the provision of high quality health care services. For the network, made up of 21 different denominations managing over 180 health and training facilities, to set and agree on overall performance targets, develop strategic plans and self-manage its own operations in accordance with national sector and legal regulatory frameworks in a transparent manner in the context of membership autonomy is a challenge requiring efficient and effective governance systems, processes and procedures.

The existing governance structures remain relevant but their composition and functions need reviewing to address the new role and functions required of CHAG by the health sector and necessary for the continued effective engagement and growth of CHAG in the sector. New structures have evolved within the church health systems such as the national health offices and member institutions have grown and become much stronger themselves. These developments require new ways of decision making, coordination and communication amongst network members and between network members and the secretariat.

In 2010 new structures were introduced, such as the ´health coordinators & senior managers' platform to facilitate technical coordination, network decision making and secure member ownership of network activities. This structure and other processes require review as well as further improvement. Efforts are underway to finalize the revision to the constitution, revise the mandate, role and functions of the Board and introduce a formal membership agreement amongst other changes. These are all in support of the trend towards professionalization. These are all in support of the on-going trend towards professionalization. The functions and roles of the secretariat itself are also undergoing review in the light of current developments.

Emerging issues

1. Given the administrative complexity of the network, there is continuous need to explore the most appropriate institutional and management arrangements within the Association.

2. There is the need for increased involvement of facility owners and church leaders in on-going change processes and matters pertaining to the future role of the faith-based sector in national health planning.

3. Horizontal cooperation between network members has not yet been sufficiently explored. Options for intensified technical cooperation and sharing of resources need promoting.

4. CHAG's on-going strategy to strengthen the capacities of management teams towards improved performance continues to be a priority.

5. Need to be constantly reminded of the mission statement and goal of CHAG so that the network maintains its uniqueness and does not deviate as it expands.

6. The secretariat should be strategic in decision-making processes that are in the interest of the larger network and members and not be operational.
7. Decentralize the work of Secretariat via the Church Health Coordinating Units [CHCU] and strengthen the functioning of regional and district structures to engage in dialogue with partners on pertinent issues affecting MIs in their locations.

8. Need to clarify and improve understanding on the new and emerging roles of the secretariat among staff of the ES and the network.

9. The ES needs to develop closer relationships with the Church Health Coordinators [CHC] and also get to know MIs better to elicit more co-operation, local ownership and effective decision making.

10. There is the need to support CHCs to refine their plans in relation to national policy guidelines and objectives and then feed these plans into CHAG's work. Hence, CHAG secretariat's plan should be a coordinated plan to support all CHCU/Church Health Services.

11. There is the need to strengthen advocacy and lobbying skills within the CHAG network.

12. There is the need for timely and effective communication between the secretariat and other levels of CHAG [Board Members, CHC and member institutions].

3.2 Health Service Delivery

CHAG provides services [preventive, promotive, curative and rehabilitative] that contribute to the achievement of national health outcomes in general. With the global and national call towards the achievement of the MDGs, CHAG has prioritised the achievement of the health related MDGs as its service priorities as well. CHAG member institutions as well aligns to other sector priorities and takes into account the burden of disease within the localities in which they are and include these in their service provision priorities. Currently CHAG is documented, in this report, as accounting for 19.2% of all outpatient services and 37% of all inpatient care in Ghana. CHAG facilities operate in the same disease burden environment but achieve better outcomes in general than the public.

CHAG is concerned about the rise in non-communicable diseases and the persistent presence of high levels of communicable diseases that represents the disease burden profile of Ghana. CHAG recognises the role of life style and other determinants of health such as the availability of potable water and improved sanitation to the management and control of these diseases. CHAG therefore is revitalising the application of community health/PHC concept in its service delivery activities.

In carrying out its service delivery activities CHAG institutions ensure that services are provided in line with good practices conforming to standard professional norms and procedures. There is also a need now for CHAG to be able to self-monitor the quality of services and the performance of its members. CHAG continues to develop innovative approaches to serve disadvantaged groups in society and the provision of high quality and cost effective care is now the focus of CHAG.

Emerging issues

1. There is on-going need for improved access to effective and efficient health service delivery community / public health education, strengthening of PHC activities, community participation in care delivery (e.g. CHPS) is required. Continuous improvement in skills and competence of MIs to render quality service in critical technical areas in health care.

2. Need to improve the poor and vulnerable people's access to health care. Hence, MIs operating in inaccessible and poverty stricken areas should be supported.

3. There is a need to review and identify new ways of providing services that will reach a greater number of people not yet reached by the government/public health service.

4. There is the need to improve customer care at the facility level – be of service to people and clients rather than work to rule attitude of staff.

5. Strengthen supervision role to help address quality of care.

6. There is need for support to MIs to enable them focus on health promotion to achieve relevant MDGs.

7. There is need for joint health planning with other service providers at all levels

3.3 Human Resource for Health

The availability of sufficiently qualified and motivated staff at all levels of CHAG continues to be a basic requirement to improve CHAG's contribution towards achieving national health outcomes. Recent HR data on staff distribution in CHAG shows that there is inequitable distribution of professional staff among member health services and between CHAG and the public sector [CHAG has a lower proportion of overall professional staff in comparison with the public sector]. In terms of productivity, the data shows a higher staff productivity in CHAG facilities in comparison with the public sector as evidenced in staff-patient ratios (these can be found in the section of CHAG Inputs). Staff working in CHAG member institutions is highly motivated and committed.

Currently critical information required for HR planning and decision making such as staff attrition rate, age distribution, staff skills mix, standard staff productivity ratios are currently not known and are in the process of being determined.

Emerging Issues

1. Considering on-going developments in the area of HRD, there is need for CHAG to shift its management focus to more strategic issues (e.g. liberalizing labour market, budget constraints, aging workforce, and workload indicators staffing norms) and to develop capacity accordingly.
2. The secretariat also needs to pursue a more active policy support strategy towards the training schools.
3. Strategic alliances with respective professional bodies need strengthening towards improved collaboration

4. The possibility of cost sharing between government and CHAG institutions in respect of labour cost need exploring in a collective effort to improve cost efficiency;
5. Initiatives towards strengthening human resource planning towards improved performance need pursuing as a matter of priority
6. Facility managers seem to be insufficiently aware of new Human Resource Management principles, policies and practices and need to be exposed to modern management and organizational concepts
7. Continuous competence building of staff in functional areas to deliver on their mandates.
8. Mobilize resources to recruit train and retain critical staff within the ES and the entire network.
9. Improve staff capacity to supervise work done at the health facilities to meet standards set and expectations agreed on as partners.
10. Improve quality of care in MIs using a network of retired health professionals of CHAG.

3.4 Health Financing

Members of the network are financed through government contribution, internally generated funds, grants/donations and direct funding support from development partners through projects. 99% of government contribution goes directly to support salary costs and the remaining 1 % supports capital investments. Overall government support accounts for 35% of income of CHAG member institutions (collectively). Internally generated funds are mostly from insurance claims paid by the NHIA, this accounts for an estimated 60 % of income which goes to support service delivery. Grants, donations and direct funding from development partners etc. makes up an estimated 5% of CHAG members' income source which primarily supports capital investment and some amount for service delivery.

The cost per patient day equivalent for CHAG is GHC 32.2 as against GH 28.4 for the public sector. The cost of service delivery is rapidly increasing and NHIA tariff fees do not adequately cover this. In addition there is a 4-5 months delay in re-imbursements from NHIA. This situation creates cash flow challenges resulting in higher input costs, material input shortages, reduced focus on equipment replacement and maintenance as well as the inability to offer and pay competitive remunerations. All these lead to reduced quality and quantity of service provision.

Income from grants and donations from traditional funders continues to dwindle and is no longer considered a significant nor reliable source of funding. However there are new

sources of funding from global initiatives [Global Fund etc.] and private foundations [Bill and Melinda Gates' Foundation etc.] which are available and not being accessed by CHAG. CHAG realizes that 'performance-based' financing concepts, principles and systems will become increasingly important during the years to come and it will have prepared itself for this.

Emerging Issues

1. At facility level serious efforts to improve financial planning, accounting and reporting practices must be made in order to comply with administrative procedures laid down in CHAG's MOU with the MOH.
2. Knowledge and awareness of total cost of service delivery needs to be improved throughout the network.
3. Efforts towards cost containment should be intensified
4. The possibilities of rationalising existing NHIA claim management systems and practices need exploring and implementing.
5. High level discussions on the principles and modalities of providing 'output funding' to CHAG must be embarked upon.
6. There is the need to address the question of financial sustainability of the secretariat
7. Provide technical support to address challenges relating to billing system for national health insurance to stop losing cash at the institutional level.
8. Need to enhance openness and transparency in financial transactions at all levels of CHAG.
9. Need to increase the level of public funding to member institutions
10. How can CHAG members benefit from public funding to the MOH from institutions such as World Bank, International Monetary Fund, European Commission, Global Fund etc.?
11. How can CHAG benefit from private funding [commercial and non-commercial]?

3.5 Health Information

The production, analysis, dissemination and use of reliable and timely information for decision making, planning, lobbying and advocacy and performance management purposes has always been a major challenge for CHAG. The need for quality information has become increasingly more important in a situation where resource constraints exist and justification for resources is based on evidence of performance. Currently for 2010 CHAG has been able to gather data from 80% of its members for analysis and decision making. The data collected is received on average 2 months late, is often incomplete yet fairly accurate.

At the membership level data is submitted to the district health directorate for inclusion in the national health data set. The data is not accessible in a disaggregated manner that makes it useful to CHAG. CHAG is still unable to get data from CHIMS/GHS on CHAG data. Member institutions are overburdened with requests from GHS and CHAG and as such leadership commitment to sending data is thus limited. The human resource capacity within CHAG is also limited in this area.

The inability of CHAG to gather and analyse its data not only prevented CHAG as a network from accounting for the resources given to members as required under the MOH/CHAG MOU, but did not allow the Secretariat to take strategic decisions/actions in support of members based on data.

It must however be recognized that the use of data by management at all levels of the CHAG system is still in its infancy. CHAG has developed a performance framework with indicators and measures based on the HSS model that will support the use of data for decision making.

Emerging issues

1. To capitalize on all fragmented initiatives and streamline these
2. CHAG and its MI's should make a collective effort to ensure that multiple and fragmented data collection systems and procedures be further streamlined
3. Skills training at facility level to adequately collect, input and process data is a priority;
4. Further analysis and systematic feedback to MI's on collected data must become a standard practice in the work of the Secretariat
5. With the compilation of evidence based position, policy papers and funding proposals, performance is likely to increase.
6. Develop capacity at the facility level to respond readily to HMIS needs
7. Comprehensive knowledge management practices should be considered and introduced
8. Publicity of CHAG's activities and insights in the mass media, developing a press corps to understand issues on the health sector and the contribution of CHAG in achieving national health outcomes are some interventions to be explored.

3.6 Health Technology

Government over the past decades has built more health infrastructure to meet its social obligations to the people of Ghana. CHAG recognizes and appreciates this fact. In recognition of this, CHAG by implicit policy, resource limitations and evidence that its current facilities may not be operating optimally, is not growing through putting up of new infrastructure. Growth within CHAG is rather by upgrading existing ones to meet new demands and spreading services where members are already located to newly identified populations of poor, marginalized and disadvantaged people.

Current data shows that CHAG owns and manages 5.3% of all health infrastructure in Ghana At the moment there is insufficient information as to whether MI's do have the appropriate infrastructure, medical and ICT equipment and related procedures and inputs in place for service delivery.

CHAG facilities in general do not experience medicine shortages and are able to meet the needs of patients. However, the cost of medicine is higher in CHAG facilities as against public facilities on account of the pricing practice on medicines to support a significant part of the facilities' operational budget.

CHAG is becoming increasingly aware of the need to address its technological requirements in an economically efficient manner by leveraging its collective need to competitive prices and high quality inputs. To date insufficient attention has been given to this component, mainly due to competing and more visibly pressing system priorities such as human as the shortage of human resources for instance.

Improving the level of health technology within CHAG has been and still remains the responsibility of the members themselves. There is virtually no funding support from government in this area. The secretariat is in the process of carrying out a service availability mapping to support efforts to address the health technology gaps identified.

To address the issue of medicines prices a feasibility study looking into the options of pooled procurement was conducted and decision are yet to be made on the findings.

Emerging issues

1. Can CHAG develop a comprehensive capital development plan that covers all its members?
2. There is the need to consider alternative procurement options to reduce the 'medicine bill' and take advantage of CHAG potential economies of scale.
3. Need to develop ways in which MIs could upgrade their infrastructure and equipment to support health service delivery.

3.7 Community Participation and Ownership

The health sector, not only in Ghana, but globally has recognized and is calling for the increased involvement and participation of communities in the provision and delivery of health services. Primary health care concepts and practices are being re-introduced and scaled-up. The community is not a passive recipient of "health" as mostly perceived.

CHAG intends to develop further its skills and competencies in working with communities to improve health outcomes and to continue supporting the national policy direction establishing and managing Community Health and Planning Service [CHPS] zones. The network will search for and improve or develop approaches that will lead to the strengthening of community systems. These approaches will generate positive health seeking behaviours of community members and improve access to health services within the public and private health systems.

Successful innovations and initiatives are being carried out by members, with communities, 3 of which have been identified and reported on in this report.

Emerging issues

1. Knowledge, attitudes and practices about community ownership and participation in health care delivery among health managers should not be overestimated; hence the need for developing practical tools for community diagnosis/assessment.
2. Best practices in working with communities needs to be shared within the network and beyond.
3. Develop joint proposals [internal and external partnerships] to support Primary Health Care (PHC) concept.
4. Membership involvement in CHPS programme needs promoting in close consultation with GHS.
5. Be mindful and operate as a Civil Society Organization (CSO) –being voice of the voiceless.
6. Develop interventions to enable communities where CHAG facilities are to participate in activities and feel a part of the efforts in health service delivery for greater understanding and impact
7. The CHAG secretariat needs to support the creation of a conducive environment and capacity for CHAG members to work effectively and efficiently with communities
8. The member institutions need to improve their engagement and work with the communities they work in
9. All levels of CHAG need to work together towards improving partnership with the local government authorities at respective levels.
10. All levels of CHAG need to work together towards influencing national policies that facilitate and support working with communities.

3.8 Partnership Development

Externally, CHAG's partnership with the MOH is formalized under a Memorandum of Understanding (MOU). The CHAG secretariat is invited to and participates in current regular meetings of the Ministry with its agencies and development partners. This public private partnership arrangement is beneficial for both parties. At regional and district level the relationship between CHAG and GHS remains strained and does not lead to desired complementarity in planning and management of health care delivery. The MOU is not understood nor implemented at this level. Plans are underway to use the MOU as the basis of developing a performance management agreement between CHAG and the MOH.

Development Partners (e.g. DANIDA, WHO, UNFPA UNAIDS) are committed to working with CHAG through the Secretariat and some have entered into direct contractual project funding arrangements with CHAG.

Internal partnership arrangements within the network are considered weak. Network members have not accessed the potential of their parent church's social services to support health actions. There are other civil society organizations working in the health sector which could be strategically partnered with by CHAG in its effort to contribute towards the achievement of national health outcomes.

CHAG recognizes and supports the need for intersectoral collaboration at all levels towards achieving national health outcomes. The development and participation in international partnerships to share experience and learn best practices from similar organizations is considered beneficial to the growth and development of the network.

Emerging issues

1. The level of representation and participation of MI's at regional, district and sub-district levels is low and needs to be improved for MI's to engage with local authorities
2. There is a need to amend the existing MOU between CHAG and the MOH to reflect the maturity of the existing relationship.
3. On-going initiatives to align partnerships with DP's need further strengthening
4. There is heightened awareness about CHAG as a network organization but the function of the network as a network is not strong.
5. ES to update inventory of services being rendered by members and disseminate it.
6. The ES should tap into the strengths and potentials within the network to facilitate work of the entire organization.

7. Continue to build the relationship with the MOH and GHS as beyond the MoU especially at regional and district levels.
8. Improve the implementation of MoU at all levels.
9. There is a need to work towards improving recognition of CHAG's work by GHS and actively participate in health dialogues at district and regional levels.
10. There is a need to address unfair distribution of resources allocated public resources between CHAG and GHS facilities.
11. There is a need to build collaborative relationship with Metropolitan, Municipal and District Assemblies (MMDAs) and MIs through continuous dialogue

3.9 Research for Health

Planning and decision making is often based on anecdotal evidence. Data from existing (health) management information systems is not systematically used. Research is fragmented and the findings of many relevant studies are hardly known, let alone disseminated across the network or sector. The network engages in many innovative interventions that are successful and can be studied for dissemination and spread of the innovation.

CHAG is increasingly recognizing the importance of operational research, particularly at (operational) facility level. The results of four operational research initiatives have meanwhile become available [2 on maternal health, and 2 on child health initiatives]. A research agenda has been drawn up by the CHAG secretariat and disseminated to members.

The network has not made a conscious effort to scale-up research. The capacity for conducting research needs to be further developed.

Emerging issues

1. There is a need to better showcase the work of the Association at all levels,

2. Research capacities and skills and the value of research in improving health outcomes need further promoting;

3. Conduct more evidenced-based research to inform advocacy and lobbying at all levels of the system (district, regional and national levels) as well as to support service delivery towards achieving the national health outcomes.

3.10 Innovations and (Research) Initiatives

During 2010, three innovations / initiatives were identified within the network which have significantly impacted on service delivery and outputs.

3.10.1 Improving Maternal Health Service Utilization in Partnership with Traditional Birth Attendants [1]

The Goaso Diocesan Health Service of the Catholic Church had observed a growing incidence of Maternal Deaths and Still Births. In 2007, there were 145 Still Births, and 11 Maternal Deaths. Subsequent maternal death audits established that delays in seeking healthcare could be a contributory factor in this phenomenon. Despite the relative Availability, Accessibility, and Affordability of Hospital-based Maternal Health Services (ANC, Supervised Delivery, etc.), some pregnant women preferred the services of Traditional Birth Attendants (TBAs).

Consequently, a strategic engagement with Traditional Birth Attendants was considered indispensable, and a cost effective intervention to reduce preventable maternal deaths and still births, and ensure safe delivery was designed.

The intervention comprised of:

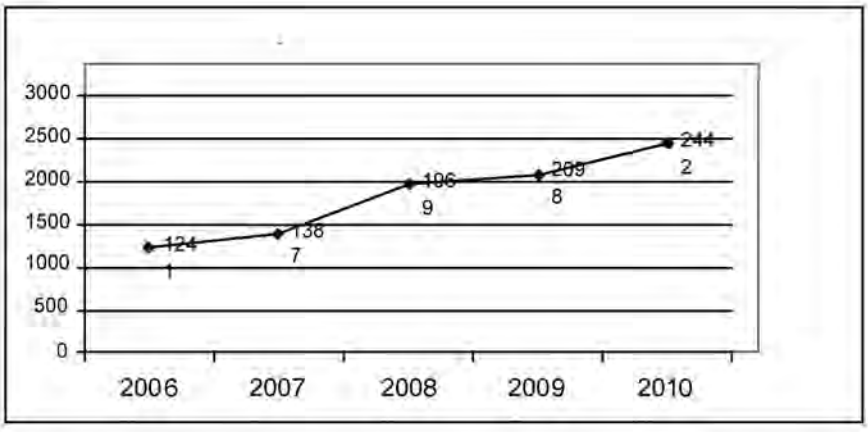
1. **5-day training** in 2008 at the St Elizabeth Hospital –Hwidiem of 37 TBAS selected from 20 communities in the Asutifi District over 5-days. The training covered areas comprising: Antenatal care, Physical assessment, Identification of pregnancy, Risk factors and Danger signs, Signs, Symptoms and Stages of Labour, Delivery training, Infection Prevention techniques and Postnatal care. At the end of the training consensus was reached with the TBA's that their role shall be Conduct only emergency deliveries and prompt referrals of risky/difficult cases, and women with previous primi-gravidas, multi-gravida, previous C/S, mal-presentation, twin pregnancy etc.
2. **Provision of TBA Kits**: After the training, the Graduating TBAs were certificated at a community durbar. The official recognition was intended to befriend the TBAs, enhance their status, accentuate their connection with the hospitals, and ultimately promote TBA referrals to hospitals.
3. **Post training support and supervision:** A monthly monitoring and supervisory visit for TBAs was conducted by a Team comprising Public Health Nurse and a Midwife. Such routine visits ensured periodic replenishment of Delivery Kits, Compilation of Monthly Reports

[1] For more details on this intervention contact **Mr. Peter Yeboah, Director**, Goaso Diocesan Health Service, Tel:+233 244136207 and email is yebpeter@yahoo.com

4. **Referral System:** TBAs were provided with Preferential Identification Tags, T-shirts and Specially Designed Referral Cards to accompany referred cases to hospitals. In some cases, TBAs were invited to observe the conduct of some delivery cases.

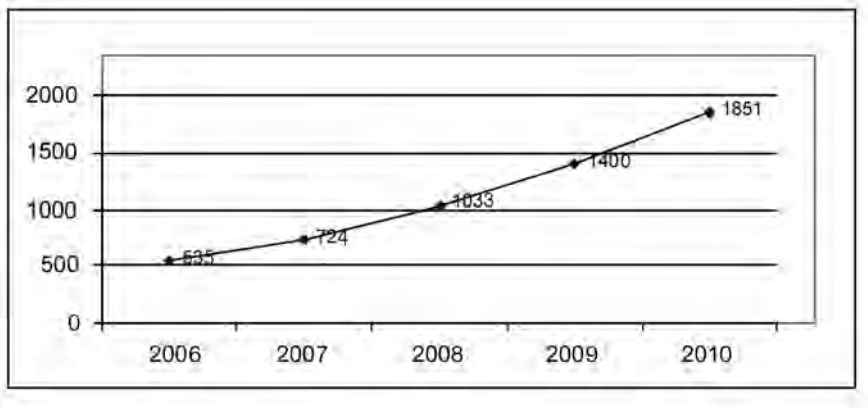
Some of the results of the intervention are as shown in the figures 1, 2 and 3;

Figure 1: Trend of Supervised Deliveries in Goaso Diocesan Health Service, 2006 - 2010



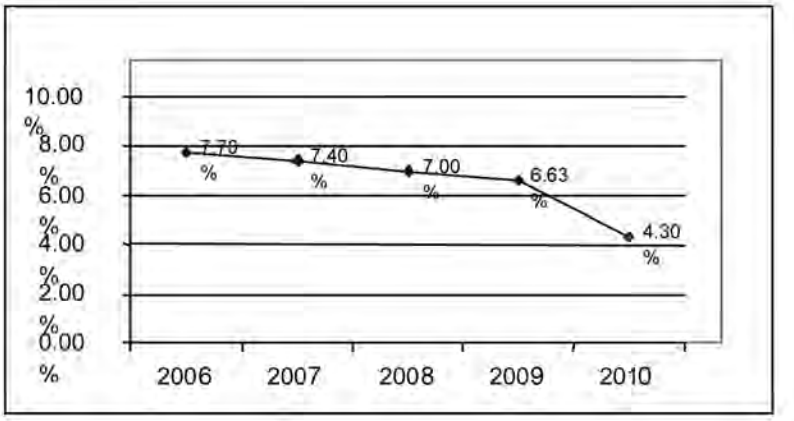
The upward trend in Supervised Deliveries could also be attributed to the increased referred cases by TBAs (i.e. from 326 in 2009 to 535 in 2010). Previously, all these referred complicated labour cases were managed by untrained TBAs.

Figure 2 : Trend of PNC in Goaso Diocesan Health Service, 2006 – 2010



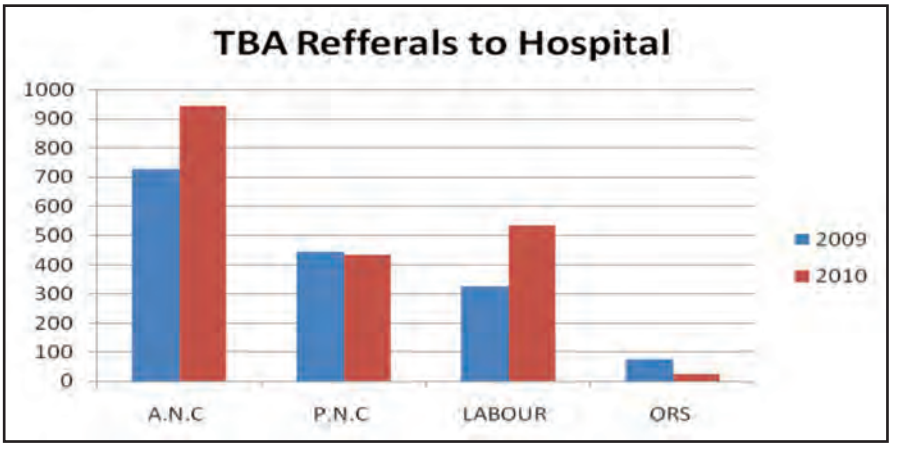
The upward trend of PNC cases can partially be attributed to TBA referrals to Hospital.

Figure 3 : Trend of Still Birth Rate in Goaso Diocesan Health Service, 2006 - 2010



The graph shows a steady reduction in Still Birth Rates subsequent to the TBA engagement.

Figure 4 : TBA Referrals to Goaso Hospital in Goaso Diocesan Health Service, 2009 – 2010



Some of the key lessons learnt out of this intervention were identified as follows:

TBA's have a definite role to play in the provision of maternal health services at the community level

Establishing a collegial relationship with TBA's and providing appropriate frequent supportive supervision improves TBA productivity and performance.

Clearly defining the role of the TBA and supporting them to do so is critical to ensure the safety of the services they provide

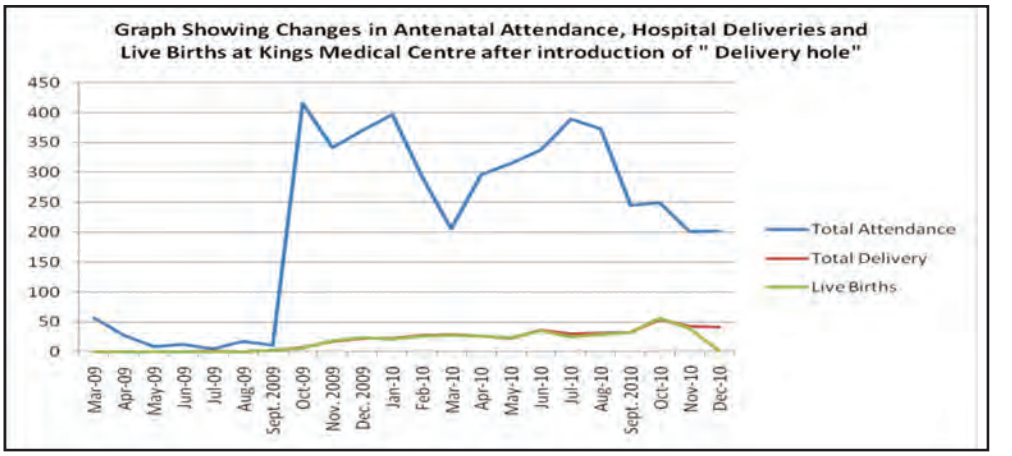
3.10.2 Increasing Supervised Delivery by Adapting Community Practices [2]

At the King's Medical Centre in the Tolon-Kumbungu district, pregnant women refused to deliver at the hospital but rather in their homes through a traditional means known to most women in the district. It is a common traditional practice in the district that women at the point of delivery choose to do so into a small shallow hole dug in the home. The women squat and deliver into the dug hole.

Although the pregnant women patronized the antenatal services at the hospital very well, they refused delivery at the hospital. A survey conducted revealed that women preferred the traditional practice of delivering into the shallow hole dug in their homes. The survey also pointed out that those who want to use the services of the hospital are considered as cowards.

With this in mind the hospital designed an improved version of the traditional system called the "DELIVERY HOLE". This was done alongside the delivery bed at the delivery suit with a carefully designed drainage system (picture shown below). The two systems offered the women choice for mode of delivery. The impact of this intervention is shown in the figure below.

Figure 5 : Post Intervention Changes In ANC, Deliveries and Live Births in Kings Medical Centre, 2009 - 2010



Key lessons from this intervention include:

Identifying and respecting community traditions and practices leads to a higher acceptability of care provided

Community practices can be adapted and used to improve service delivery and access

[2] For more details on this intervention contact **Dr. James Duah (Med. Supt. – King's Medical Centre), Email: jamesduak@yahoo.com Tel: +233 244 771346 or Mr Ben Owusu Sekyere** Director – King's Village, Bontanga, Ghana

3.10.3 Reducing Under 5 Mortality by Applying Continuous Quality Improvement [3]

The focused effort to reduce U5 mortality within the National Catholic Health Service (NCHS) is part a project (Fives Alive Project) initiated in partnership with Institute for Healthcare Improvement (IHI), a US based organization in Cambridge, Massachusetts. The overall aim of the project is to assist and accelerate the achievement of MDG 4 goal in Ghana. The effort in the NCHS hospitals is the third phase of scale-up of the project dubbed Wave 3. The Wave 3 is a spread through the hospitals and clinics of the NCHS. The first part of Wave 3 was to undertake a collaborative network of nine hospitals with worst performing institutional U5 Mortality in the NCHS. The collaborative network was launched in October 2009 with an aim to reduce institutional under-five deaths by 70% from a baseline of 20 deaths/1000 admissions (ward admissions, emergency detentions and live births). One of the goals of this initial network is to generate change packages for reducing U5 deaths within hospital settings for spread to other hospitals and clinics.

The design of the collaborative was based on the theory that the following drivers were causing the under five deaths in the hospital, namely

- Delay in seeking care
- Delay in Responding to care and
- Unreliable use of protocols

Based on the primary drivers, secondary drivers for each primary driver were agreed upon. This was followed by specific change hypothesis that were to be tested in the hospitals using the rapid cycle improvement (Plan-Do-Study-Act) model.
The change hypothesis tested included the following:

- Primary provider engagements on delayed referrals
- Community engagements on delay in seeking care
- Triage
- Fast tracking U5 through the process of care in the hospital
- Ensuring adherence to protocols for malaria with or without anaemia, asphyxia, neonatal sepsis, pneumonia
- Ensuring availability of anti-malarial medicines, oxygen, and blood.

In October 2009, the National Catholic Health Service, working in partnership with the Institute for Healthcare Improvement of Cambridge, USA, initiated a process to address the barriers leading to U5 deaths within the Catholic Health system.

[3] For more details on this intervention contact: The Executive Director, National Catholic Health Services, National Catholic Secretariat, Tel +233302500491-3 and email: admin@nchs.org

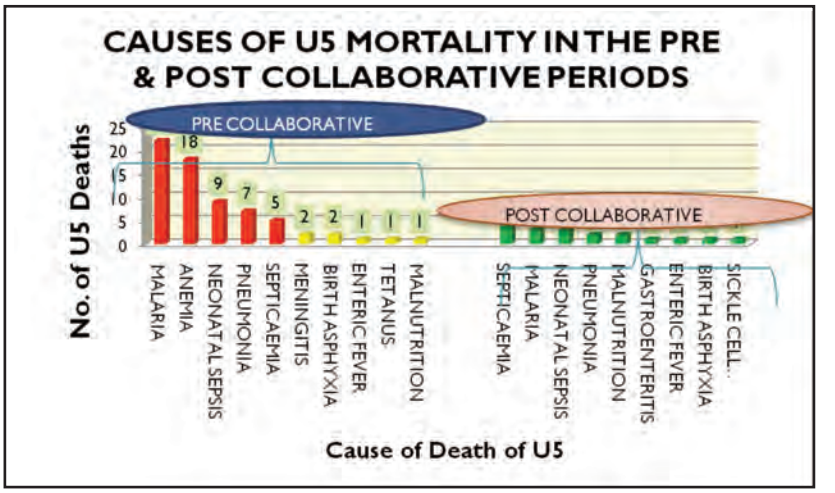
The initiative started with nine hospitals having overall institutional U5 mortality rate of 20.6 deaths per 1000 admissions. Over a period of 14 months (Oct. 2009 – December 2010) the hospitals worked on three barriers leading to U5 deaths: delay in seeking care by mothers, delay in providing care in hospitals, and unreliable use of protocols by health staff, using quality improvement methods.

The outcome at the end of the period was an overall U5 mortality reduction of 18%. Four hospitals together achieved more than 40% reduction, and two hospitals, individually achieved nearly 60% reduction over the period.

The lessons from the nine hospitals have been scale up to all hospitals within the National Catholic Health Service as at July 31, 2011.

In addition the profile and disease burden of U5MR has changed as shown in the figure below;

Figure 6 : Observed changes in Pre and Post U5 Intervention mortality profile



Documented attributing factors to achievement of these results included;

1. Hospital QI Teams' experience in using QI methods to focus problems using data and making the needed changes to address problems
2. The support provided by the Wave 3 team through regular visits to the hospitals to engage teams and their management
3. The peer learning, sharing and apparent competition among the hospitals through the learning sessions

4 Inputs, Outputs and Impact of CHAG in the Health Sector

This section of the report gives an account of output and impact of CHAG institutions in the health sector for the year 2010.

Analysed data used for the report was submitted by 138 members of the 172 CHAG health care institutions. Forty (47) out of fifty eight (58) hospitals responded yielding a response rate of 81%. Ninety one (91) other facilities reported out of one hundred and fourteen (114) yielding a response rate of 80%. The overall response informing this section is 80% of membership.

The data was verified for inconsistency and is accurate and reliable.

Statistics that are described as national have been calculated from data made available to CHAG by the GHS. The service data captured by the GHS included data from direct services provided by GHS, services provided by CHAG as well as services provided by some other private service providers who submit their data to GHS at the district level. The GHS service data does not include data from the teaching hospitals Korle bu and Komfo Anokye.

The report excludes activities of the ten health training institutions of the network.
It is also hoped that this report will make available relevant data and information to members of the CHAG network and other stakeholders for the purposes of planning and advocacy.

4.1 Inputs

The provision of health services requires adequate resources, health infrastructure, human and financial resources primarily. This section presents the resources CHAG utilized during the year 2010 in providing health services.

4.2 Health infrastructure

The CHAG network comprises 172 health care facilities and 10 health training institutions which are spatially deployed in all the ten (11) regions of the country and belong to 21 church denominations. In all CHAG facilities make up 5.3% of all health infrastructure in Ghana.

Health Facility Distribution

Figure 7 : Percentage Regional Distribution of CHAG Facilities, 2010

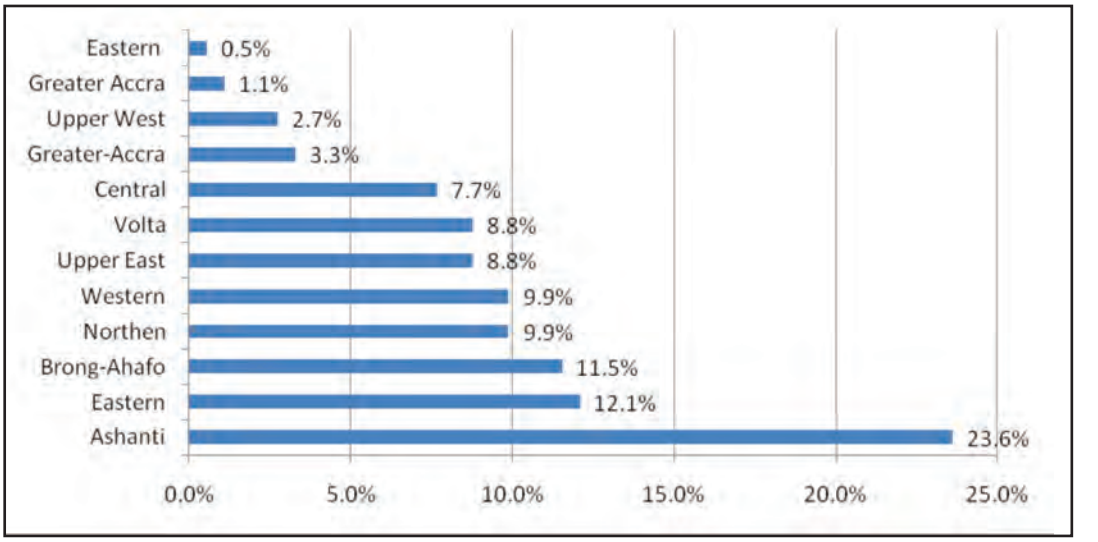


Figure 8 : Number of CHAG Facilities by Facility Type, 2010

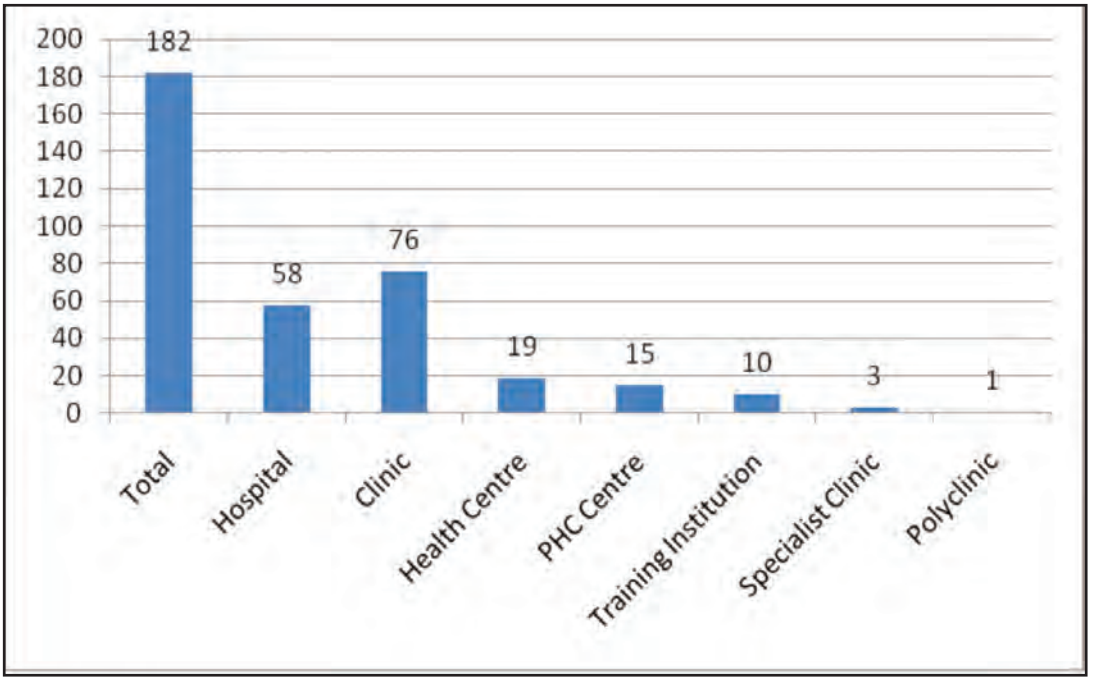


Figure 9 : Percentage Distribution of Facility Type in CHAG Network, 2010

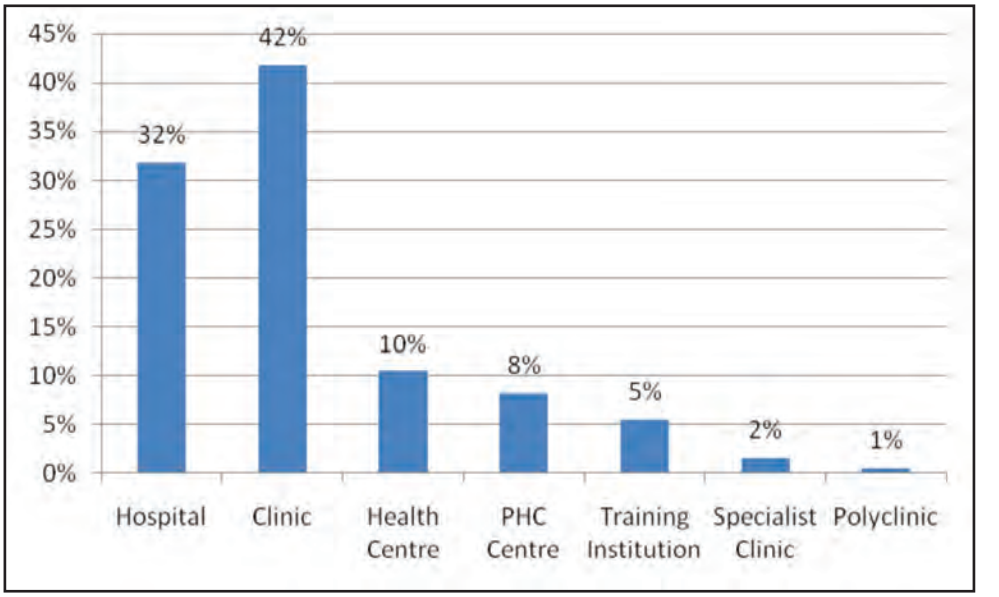
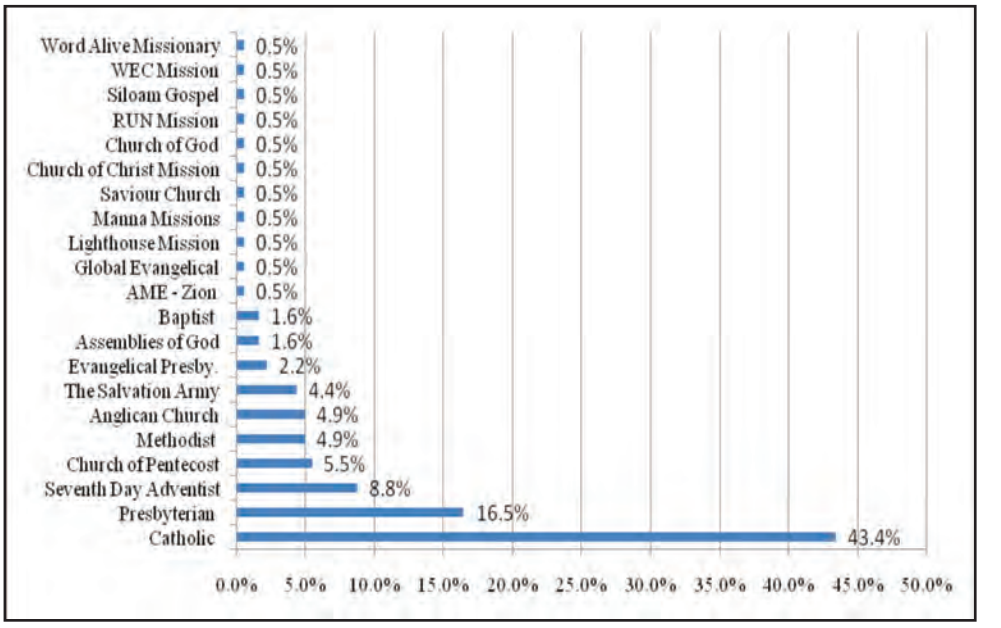


Figure 10 : Percentage CHAG Facility Ownership by Denomination



The Catholics own 43.4% of all the 182 facilities followed by the Presbyterian Church with 16.5% and Seventh Day Adventist Mission 8.8%.

4.3 Human Resources

The total staff strength in 2010 was 7302. General Nurses were in the majority (15.6%), followed by health assistants (14.9%). Pharmacists, Specialists and general practitioners formed only 1% of the staff strength. During the year a total of 799 financial clearances for new staff were secured and 39 doctors posted to CHAG reported.

Staff on Government Payroll versus Staff on IGF

Overall only 4% of staff in CHAG are not on the government payroll [that is not paid by government but by institutions themselves]. The figures below show how this is distributed amongst various staff categories.

Figure 11: Proportionate Staff on GOG and IGF Payrolls by Category, 2010

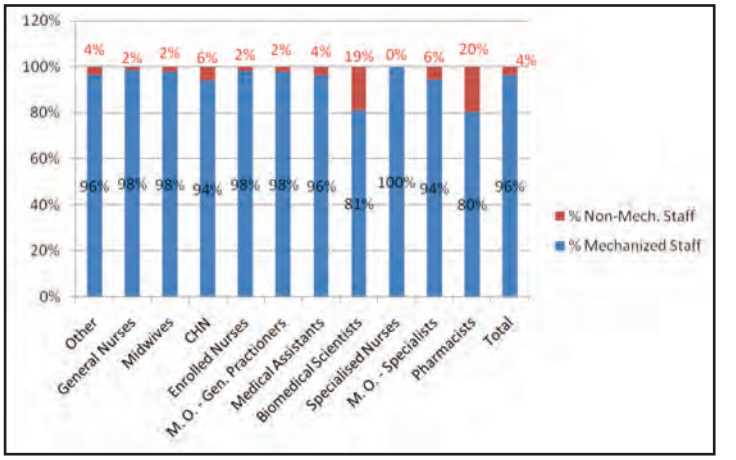
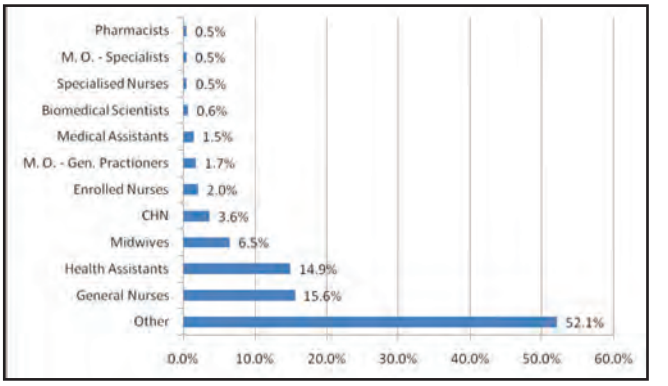


Figure 12 : Percentage Distribution of Staff on Government Payroll by Category, 2010



It is evident that the bulk of staff mechanised are non-professional staff [others].

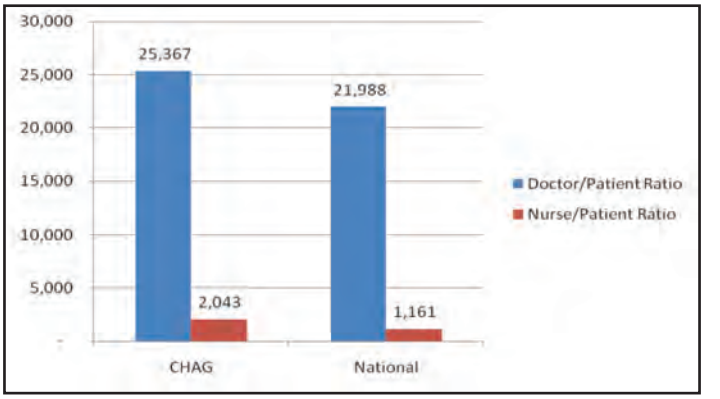
Doctor and Nurse patient ratios

CHAG has 163 and 2,024 doctors and nurses respectively serving an outpatient population of 4,134,887. Data from GHS indicates a total 815 and 16,491 doctors and nurses respectively working in the GHS. The national statistic for total outpatient seen is by proxy that recorded by the GHS, since this includes outpatients served directly by the GHS, those by CHAG and those by some other private service providers whose service output data is collected by the GHS. The total number of outpatients seen by all service providers [less the teaching hospitals Korle bu, Komfo Anokye and some private for profit service providers] is 21,504,656. This information is shown in Table 1 below.

Table 1 Doctors, Nurses and total Outpatients in CHAG and Public Sector

CHAG	Data from GHS	National*	
Doctors	163	815	978
Nurses	2024	16,491	18,515
Outpatient	4,134,887	21,504,656	21,504,656

Figure 13 : Doctor and Nurse Patient Ratios of CHAG and National, 2010

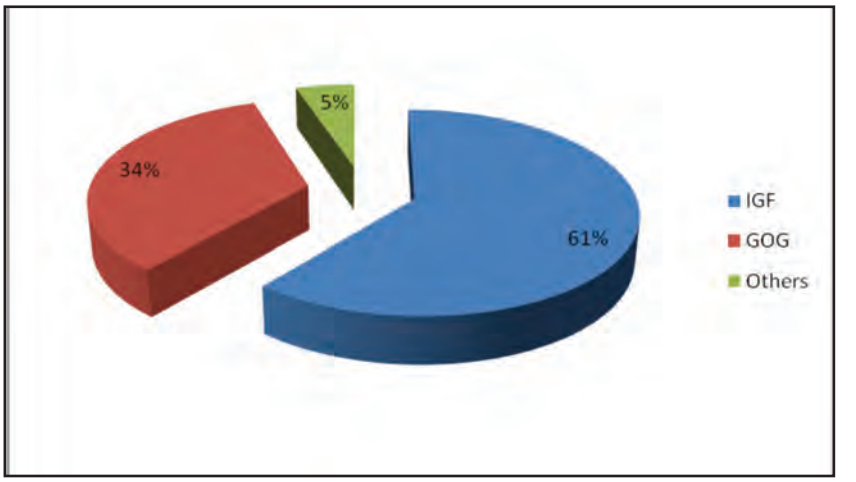


It is clear that the key staff: patient ratios in CHAG are behind the national ratios. The doctor: patient ratio is slightly worse off and the nurse: patient ratio twice as bad. This can be interpreted as doctors in CHAG facilities are on average one point two (1.2) times more productive and nurses two point eight (1.8) times more productive than the average doctor and nurse in Ghana.

4.3 Finances

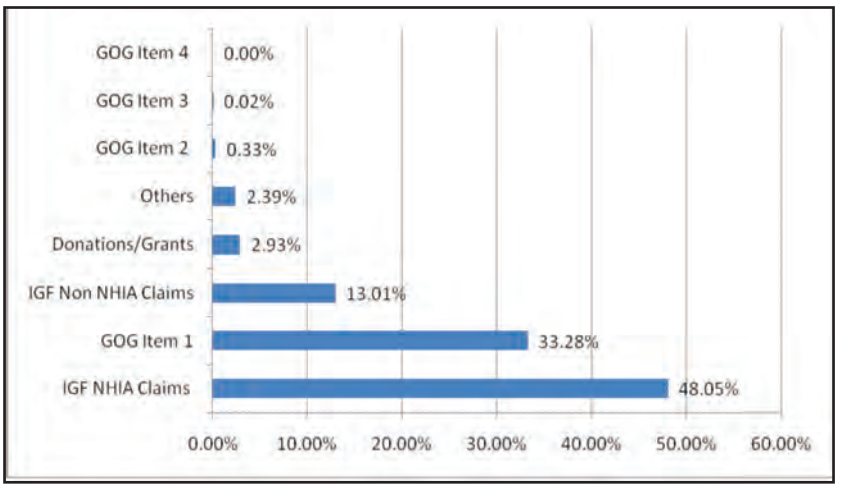
Income Profile

Figure 14 : Percentage Financial Inflows by Source, 2010



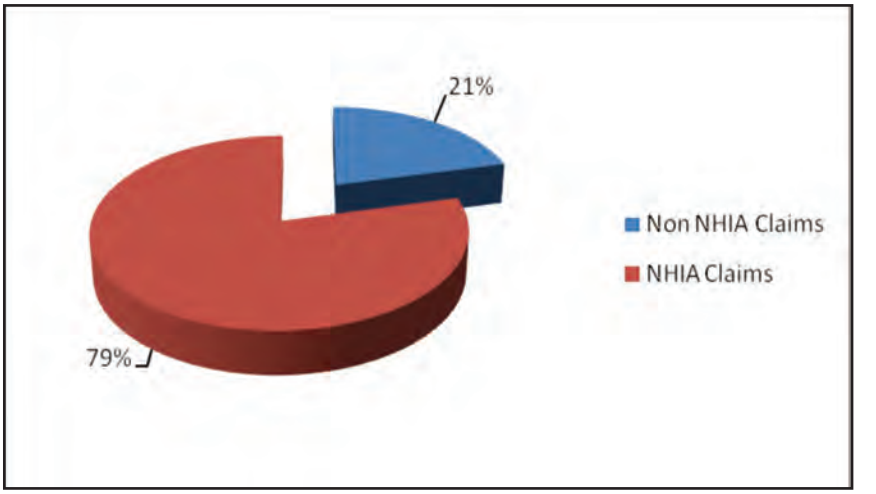
Internally gernerated funds makes up the largest source of income followed by governement funds. Other funds make a relatively insignificant soiurce of income.

Figure 15 : Percentage Income by Item, 2010



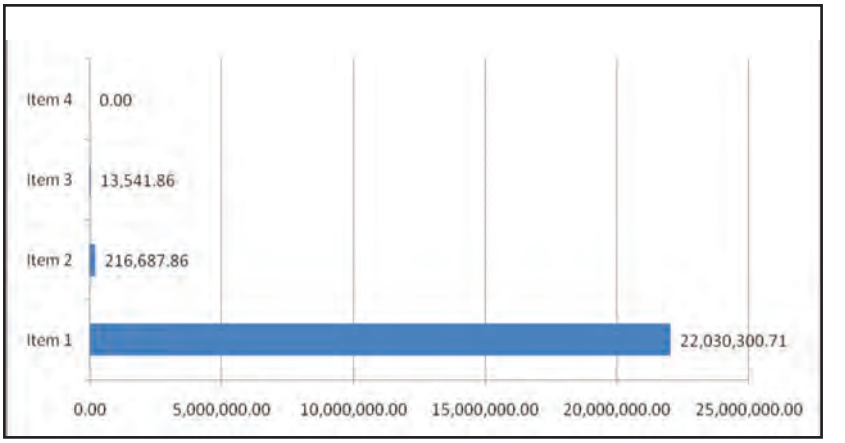
The figure 15 shows the proportion of inflows coming into CHAG from its recognised sources.

Figure 16 : Percentage IGF by Source, 2010



The figure 16 shows that 79% of the IGF of CHAG comes from health insurance re-imbursements and the remaining from non –NHIA claims [direct service fees].

Figure 17 : GOG Inflows (GH¢) By Item, 2010



Of the total income from government 98.7 % goes directly to support staff emoluments [item 1]and just over 1% goes to support services and administrative costs [items 2 and 3]. In 2010 no government funds supported capital investment cost within CHAG. Further analysis of government contribution shows that the staff emolument support accounts for just over 70% of the total emolument budget of CHAG. The remaining 30% is made up by members through IGF. This additional cost covers the non-mechanised staff in CHAG.

Expenditure Profile

The following two figures summarised the expenditure profile of CHAG.

Figure 18 : Percentage Expenditure by Source, 2010

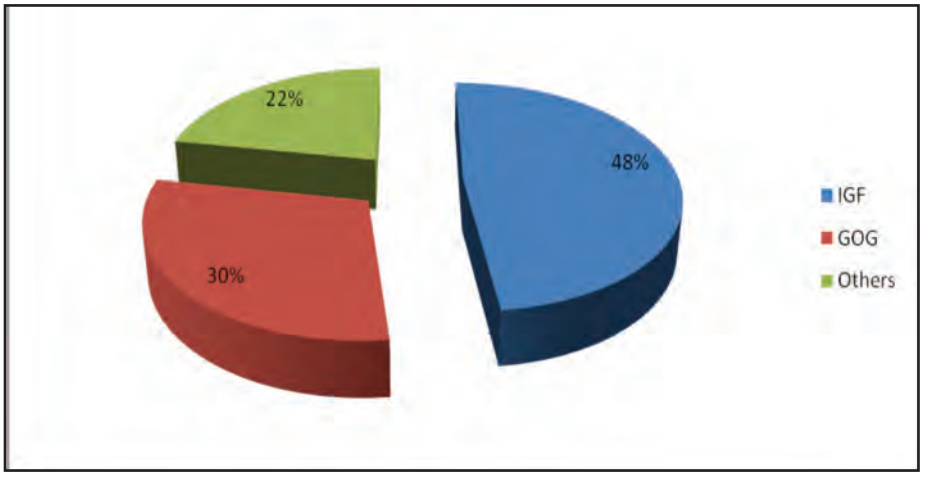
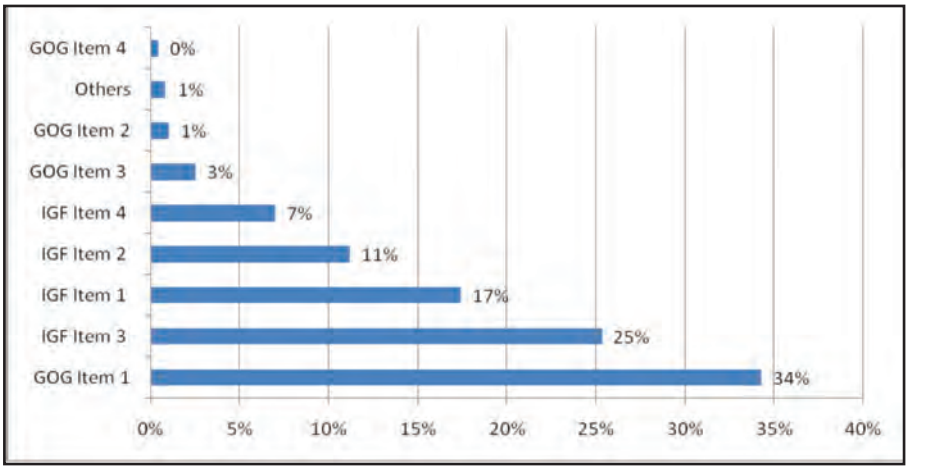


Figure 19 : Percentage Expenditure by Item, 2010



4.4 Outputs

This section documents the key service outputs of CHAG through its member institutions.

4.41 Outpatient Care

4,134,887 out patients sought care in 2010. 60.4% of these clients were seen in Catholic facilities while 18.5% attended Presbyterian facilities. 6.7%, 5.5%, 1.8% and 1.4% of them sought care in the SDA, Pentecost, Salvation Army, Assemblies of God and Methodist facilities respectively. Overall, CHAG accounts for 19.2 % of all outpatient care in Ghana.

Figure 20 : Percentage Contribution of CHAG OPD Load by Denomination, 2010

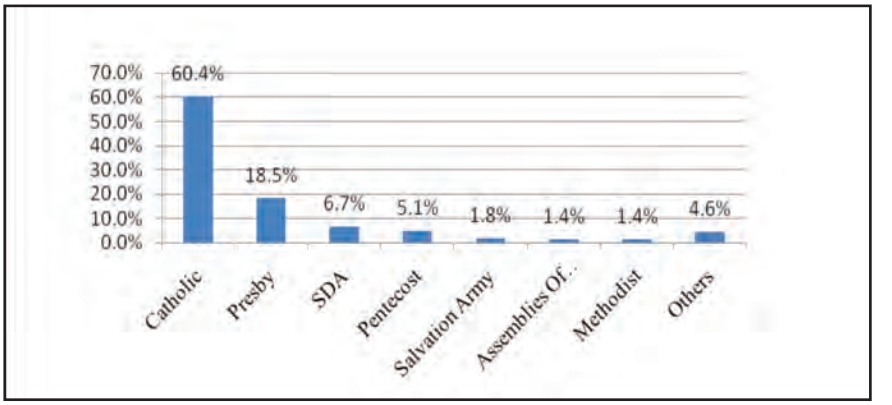
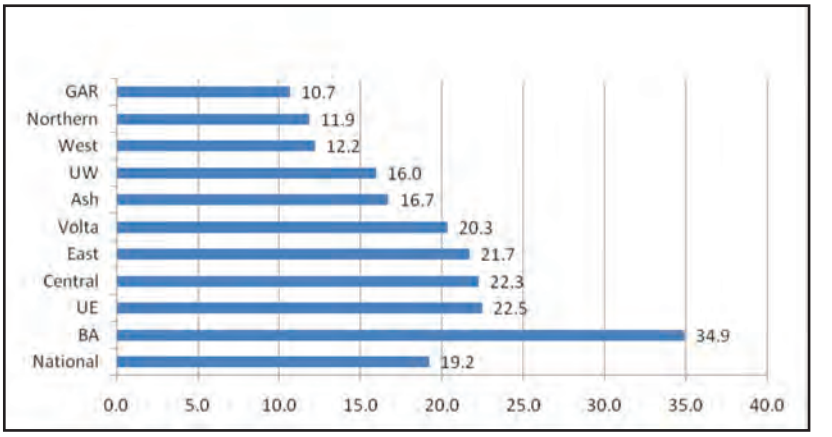


Figure 21 : Percentage Contribution of CHAG to Regional & National OP Load, 2010



As a nework CHAG accounts for 19.2% of all outpatient care. The figure 21 shows CHAG's contribution on a regional basis.

4.4.2 Inpatient Care

A total of 339,242 clients were admitted in 2010. The Catholic Denomination contributed 69.4% of the total load followed by the Presbyterians with a load of 4.2%. CHAG accounted for 37% of all inpatient care in Ghana.

Figure 22 : Percentage Contribution of CHAG to Regional and National IP Load, 2010

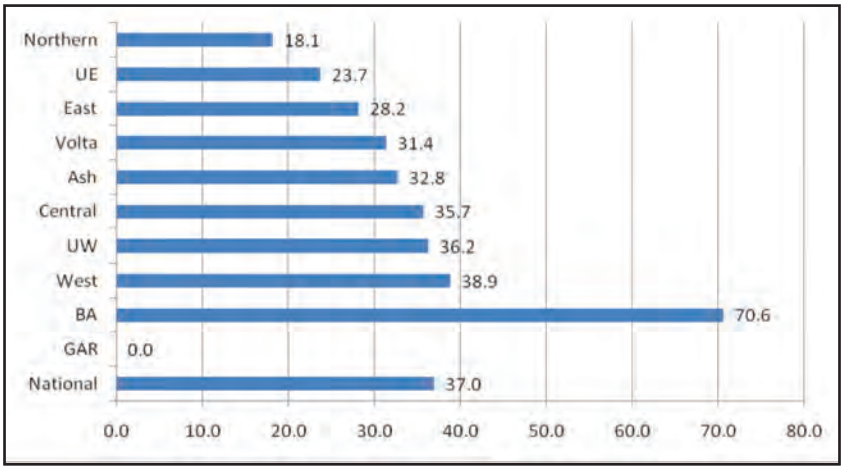
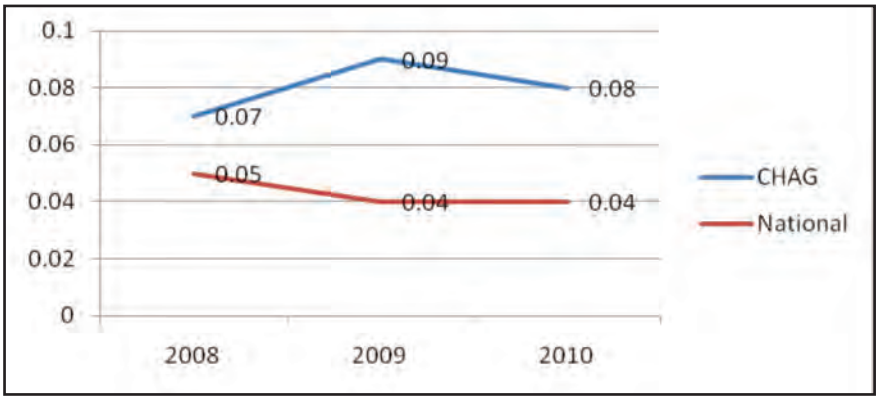
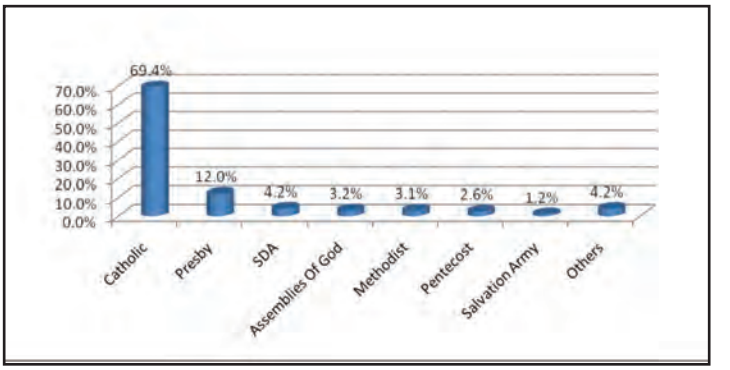


Figure 23 : In-Out Patient Load Ratios of CHAG and National, 2008 – 2010



In general CHAG facilities admit proportionately more patients that what pertains nationally. This has not been investigated to determine why, it may be a phenomenon of rurally situated health facilities where patients seen come from afar or because the disease burden is more of an acute-severe nature on account of delayed access due to poverty?

Figure 24 : Percentage Distribution of Inpatient Load by Denomination, 2010



4.4.3 Top 10 Causes of morbidity in CHAG facilities

Table 1 : Top Ten Causes of OPD Attendance, 2010

Ranking	2010		
	Condition	Total cases	% Of Total
1	Malaria 1	,393,389	33.7
2	Upper Respiratory Infections	258,886	6.3
3	Hypertension	155,237	3.8
4	Skin Diseases & Ulcers	150,577	3.6
5	Rheumatism and Joint Pains	126,954	3.1
6	Diarrhoea Diseases	107,451	2.6
7	Acute Eye Infection	95,342	2.3
8	Anaemia	70,785	1.7
9	Pregnancy & Related Complications	59,233	1.4
10	Intestinal Worms	58,894	1.4
	All Others	1,658,152	40.1
	Total	4,134,900	100

Malaria has continued to top the list of conditions that send clients to the OPD since 2008 despite the huge injection of resources to combat it. It was responsible for 34% of all the cases that were seen in 2010. URI, Hypertension, Skin diseases and Ulcers, Diarrhoeal diseases have also remained in the top five diseases since 2008. The top 10 causes of OPD attendance have virtually remained the same; they only changed their positions on the league table.

4.4.4 HIV and AIDS care

Out of 18,463 PLWHA in 2010, only 25% were on ARV treatment. ARV treatment increased from 17% in 2008 to 39% in 2009 but declined to 25% in 2010. 29 facilities offered home based care in 2010. Percentage of PLWHA on HBC declined from 37% in 2008 to 35% and further to 23% in 2010. HIV/AIDS was the second cause of death in 2010 and it accounted for 14% of all deaths.

HIV/AIDS Interventions

Table 2 : HIV Activity Outputs, 2008 - 2010

ACTIVITIES	2008		2009		2010	
	No.	**%**	**No.**	**%**	**No.**	**%**
CT No. Counselled	27,401		36,352		43,238	
CT No. Tested	24,306	**89**	34,999	**96**	42,395	**98**
CT NO. Tested Positive	4,426	**18**	4,851	**14**	6,783	**16**
PMTCT No. Counselled	57,140		62,995		84,421	
PMTCT No. Tested	50,288	**88**	56,683	**90**	81,215	**96**
PMTCT No. Tested Positive	1,714	**3**	1,805	**3**	3,764	**5**
All other HIV Tested Positive	6,492		5,712		7,916	
No. on ARV Treatment	2,088	**17**	4,789	**39**	4,661	**25**
No. on Home Base Care	4,641	**37**	4,353	**35**	4,306	**23**
All HIV Positive	**12,632**		**12,368**		**18,463**	

Figure 25: HIV/AIDS Counselling and Testing Outcomes, 2008 - 2010

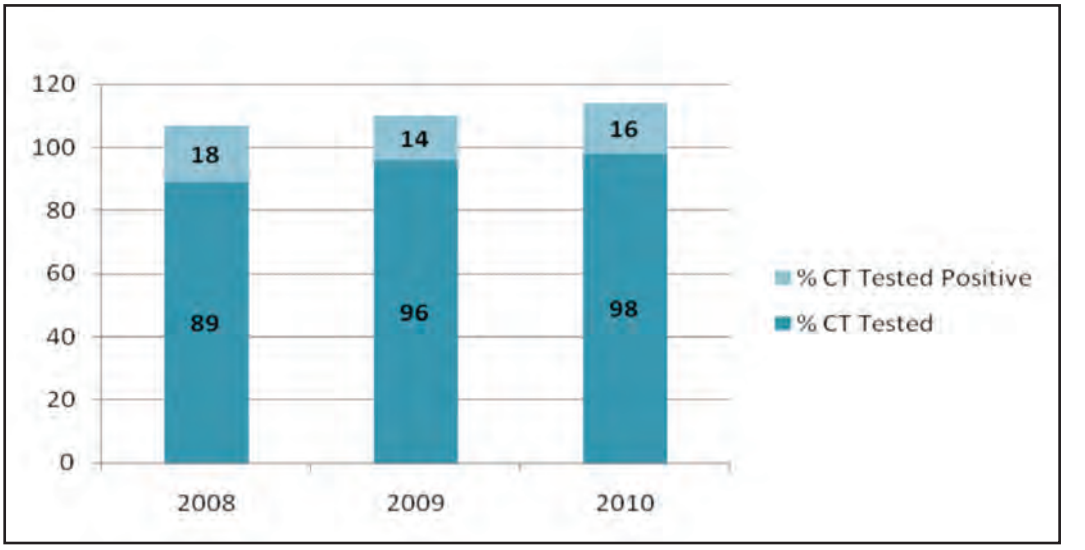
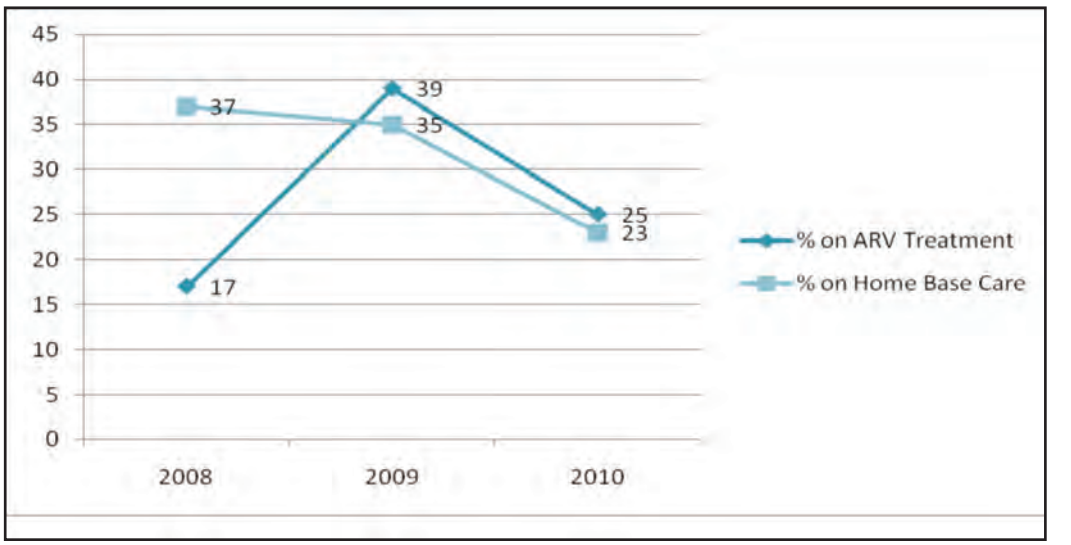


Figure 26: Percentage PLWHA on ARV Treatment and Home Based Care, 2008 - 2010



2.14.5 Summary of CHAG Service Outputs

Table 3 : CHAG Service Outputs, 2010

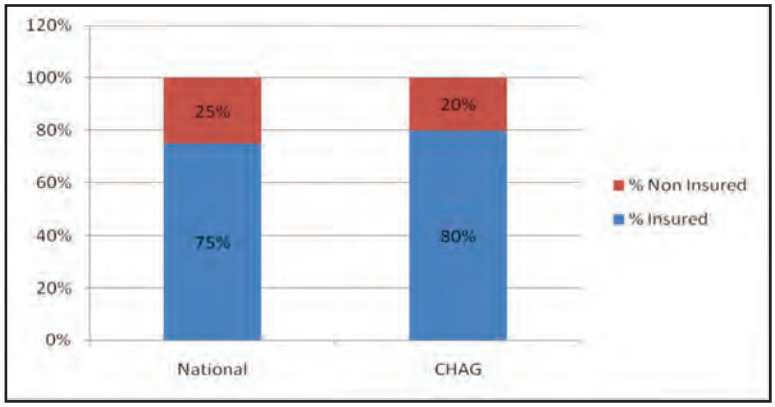
Service		Total
OPD	Total OPD	4,134,887
	OPD Insured	3,264,821
IPD	Total Admissions	338,998
	Total IP Insured	256,820
Maternity	Total delivery	83,769
	CS delivery	14,044
	Supervised delivery	64,844
	Non-Supervised delivery	8,105
	Maternal Death Audit	111
ANC	Registrants	105,135
	Attendants	441,530
	TT2	78,749
PNC	Registrants	59,687
HIV/AIDS Activities	VCT # counsel	43,238
	VCT # Tested	42,395
	PMTCT # counsel	84,421
	PMTCT # Tested	81,215
	ARV	4,661
	HBC	4,306

4.5 Impact

The activities of CHAG are intended to impact on the health outcomes and the development of national health policy. The direct provision of health services contributes to achieving national health outcomes by directly reducing morbidity and mortality in the population. Advocacy and partnership engagements of CHAG with sector stakeholders and its participation in health policy dialogue fora contributes to the development of national health policy.

4.5.1 Financial Accessibility

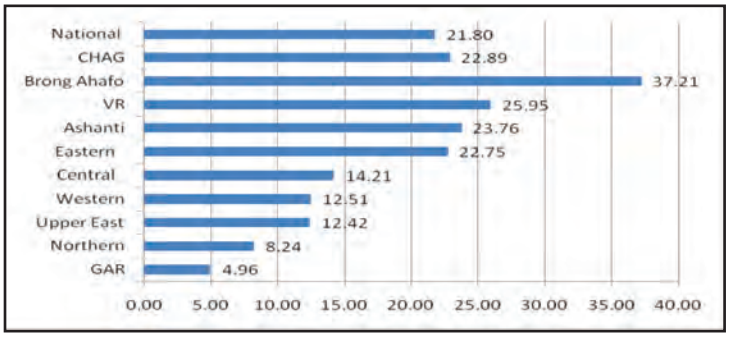
Figure 27: Percentage OPD Insured in CHAG & National, 2010



CHAG facilities are accredited by the National Health Insurance Authority. As shown in figure 27, 80% of outpatients are insured, this increases the accessibility of the population served to CHAG facilities.

4.5.2 Average cost of services in CHAG facilities by region.

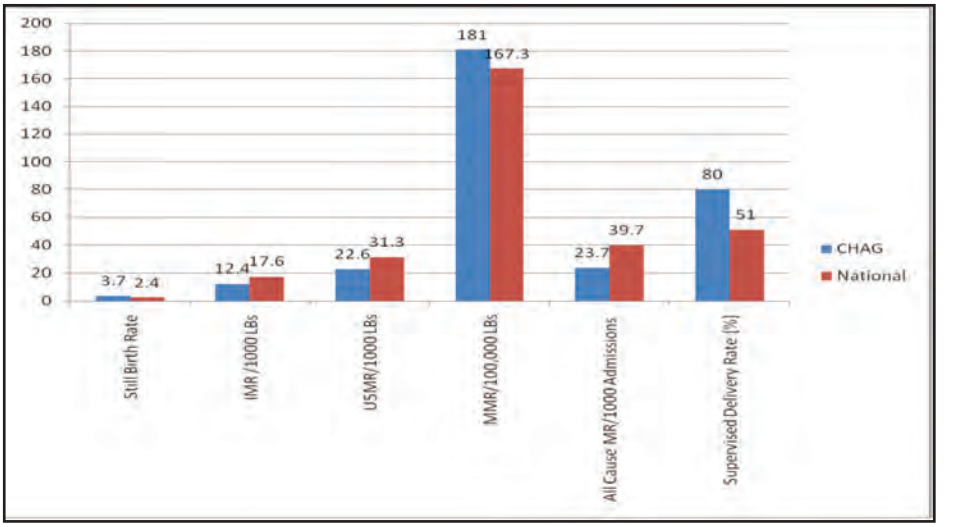
Figure 28 : Regional Average Service Cost in CHAG Facilities, 2010



The average cost per patient day equivalent in CHAG facilities is marginally higher than the national average. The average cost per region is shown in the figure above.

4.5.3 Impact on National Health Outcomes

Figure 29 : Mortality Rates & Supervised Delivery Coverage of CHAG and National, 2010

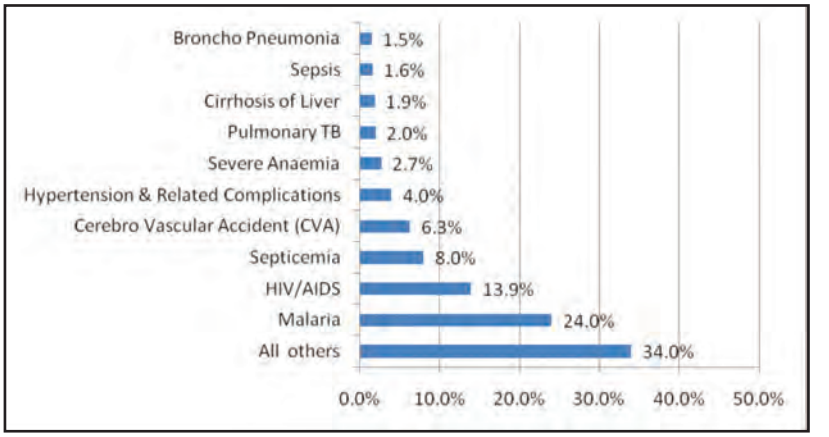


Overall all-cause mortality rates across CHAG is significantly lower than the national figure. CHAG facilities have a significantly higher maternal mortality rate and a marginally higher still birth rate across the network. Infant and under five mortality rates are significantly lower.

CHAG recorded a significantly higher supervised delivery coverage.

4.5.4 Top 10 Causes of Mortality, 2010

Figure 30 : Top 10 Causes of Death, 2010



4.5.5 Health Policy Development

CHAG impacts the national health development agenda through effective engagement in the health sector policy dialogue. Most of its participation is carried out at the national level, with inputs from members. CHAG is a member of key or strategic national committees where policy and national strategy is discussed and evolved.

These include;

1. Interagency Leadership Committee
2. Monthly Partners Meeting
3. National Emergency Medicine Committee
4. Health Insurance World Bank Project Inter-agency Steering Committee
5. National Health Insurance Capitation Technical Steering Committee
6. Ministerial Human Resource Committee [MOH]
7. GHS /CHAG Human Resource Allocation Committee
8. National Health Summit Planning Committee
9. National Health Accounts Committee
10. Ghana AIDS Commission
11. Ministry of Health Budget Committee
12. Cuban Health Brigade Committee
13. Country Coordinating Mechanism of the Global Fund
14. MOH/CHAG MOU Partnership Steering Committee
15. Public Private Partnership Steering Committee [WHO]

In all these fora CHAG contributes to the discussions which has shaped a number of key policies and bills. CHAG was involved in the design of the 2010 Health Summits, the finalisation of the Common Management Arrangements III, the review of the new health sector bills, and the development of the 2011-2013 Health Sector Medium Term Development Plan amongst others.

3. Conclusions

CHAG as an organisation continues to support the achievement of national health outcomes. Its contribution remains proportionately as well as in absolutely terms, significant. CHAG still finds its services relevant and needed in general by the nation and in particular to those who directly benefit from services it provides in the rural areas where its members are situated.

There are emerging issues noted by the organisation which must be studied and addressed for CHAG to remain relevant and sustainable in the changing environment of the Ghana's health sector.