



CHRISTIAN HEALTH
ASSOCIATION OF GHANA

ANNUAL REPORT 2021

APRIL 2022



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2021
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Abbreviations

AC	Annual Conference
ANC	Ante Natal Care
ARI	Acute Respiratory infections
ARV	Anti-Retroviral Vaccine
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 Coordinating Units
CHPS	Community-Based Health Planning and Services
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CSS	Community System Strengthening
DANIDA	Danish International Development Agency
DFID	Department for International Development
DPs	Development Partners
DHMIS	District Health Management Information System
EMS	Emergency Medical Services
ENBC	Essential New Born Care
ES	Executive Secretariat
FAME	Fellowship and Associates Medical Evangelism
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
MHS	Mental Health Service
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
PMTCT	Prevention of Mother To Child Transmission
TBA	Traditional Birth Attendant
UTI	Urinary Tract Infection
URTI	Upper Respiratory Tract Infection

Chairperson's Letter

Dear Friends,

Over the past year, we have worked with you to facilitate the promotion of Jesus Christ's Healing Ministry in our dear country. With a sense of high privilege and distinct honour, we are pleased to account for our stewardship as a Network for the year 2021 by informing you of our collective achievements, challenges and to present the outlook for the year ahead in this report.

Though we battled with the COVID-19 pandemic, the continuity of essential critical healthcare services delivery remained our priority. Hence, despite the challenges and risks of containing the spread and mitigating the impact of the pandemic, the CHAG Network witnessed a positive surge in key service output indicators.

We recorded 6,402,610 outpatient visits, compared to 5,716,794 in 2020. This represents an increase of 12% on the 2020 figures, and a 5.6% average increase over a 5-year period (2016-2021).

Total Inpatient care/hospital admissions for the period under review also increased by 11.9% from 534,010 (in 2020) to 597,623 (in 2021). This is reinforced by the Bed Occupancy Rate, a measure of the efficient use of hospital beds, which increased from 49.6% (in 2020) to 53.0% in 2021. Over a 5-year period, there has been an average increase of 28.7% in admissions.

The greatest improvements over the five years were seen in percentage declines in infant mortality (12.3% decline), crude mortality (4.4%), and maternal mortality (3.1%).

Clearly, the relatively high performance in 2021 could be attributed to the numerous interventions implemented by CHAG and its Member Institutions. Intervention such as the CRIB project, helped allay the fears, anxiety and panic that prevented majority of our clients from utilizing health care services in the previous year. In addition, the WASH IPC intervention implemented in 25 facilities helped improve the quality of services in the respective facilities. Staff training, the SafeCare quality improvement and presence of skilled personnel at birth were other important contributory factors to the good performance for the year.

Overall, the CHAG Network is encouraged by these achievements, and we are poised to do more in 2022. With your active support as partners, and the trust/confidence reposed in us by Ghanaians, we can, indeed, do more for the health sector in the years ahead. For all the staff who sacrificed in one way or the other and suffered in your line of work, we dove our hats to you. Be encouraged knowing that your labour will not be in vain.

To all Ghanaians who have entrusted the CHAG Network with your health needs, we continue to remain your true and reliable health service providers.

With gratitude,

DR ELIAS K. SORY
BOARD CHAIRMAN



Swearing in of the New Board of Trustees



Group picture of the New Board of Trustees



A Note of Gratitude

Dear Partners and Colleagues,

We come to you once again to offer a brief account of our service to you for the year 2021. Though challenging, the year 2021 presented opportunities to serve Ghanaians in deprived and unreached and underserved parts of Ghana in diverse ways. As a key Implementing Partner to the Ministry of Health, CHAG continued its COVID-19 response actions to complement government's efforts in 40 districts and ensured the availability of basic and essential services at all levels.

OUR ROLE AND CONTRIBUTIONS TO HEALTH SECTOR GOALS/TARGETS

For the year under review– 2021, CHAG's input towards realizing the national health sector objectives was significant with a contribution of 18.7% and 28.4% to National OPD and admissions respectively. Total deliveries in 2021 were 139,531, a slight increase of 2.3% over that of the previous year (2020), and 2.1% over a five year period (2016). With high deliveries notwithstanding, Institutional Maternal Mortality declined by 3.1%; from 123 in 2020 to 117 per 100,000 live births in 2021. Infant mortality and crude death rates also declined by 12.3% and 4.4% respectively. Ultimately, CHAG's role and relevance as a reliable partner in the health sector was affirmed in 2021.

One important but largely neglected area where CHAG made contributions in 2021 was in the area of mental health care. Probably exacerbated by the COVID-19 pandemic, a large number of mentally ill persons were attended to in CHAG facilities compared to the previous years. The number of new cases seen in 2021 were 13,044 compared to 8,622 in 2020 representing a percentage increase of 99.9%. Patients that were seen for reviews in 2021 increased from 22,273 in 2020 to 35,123 representing a percentage increase of 57.7%. Sadly, the CHAG Network recorded 27 suicide deaths. Out of the 27 deaths, 13 were females representing 48.1%. This suggests increase in suicidal deaths by 145.5% in 2021 compared to 11 reported in 2020. Total suicide attempts also increased from 237 reported in year 2020 to 293 in 2021 representing a 19.1% rise.

APPRECIATION

Our modest contributions in 2021 resulted from the commitment of our Front-Line Staff, Management Teams and diligent Board of Trustees who consistently ensure that values and ideals of CHAG are upheld. Again, in the spirit of partnerships and co-creation, CHAG collaborated with Agencies, Providers, and Organizations to improve equitable and convenient access to affordable quality health services. In particular, we enjoyed the support of the Government of Ghana (through the Ministry of Health and Finance), UKAID/FCDO, the Global Fund, PharmAccess, Department for Health and Social Care (DHSC - UK) and GIZ. Other partners who supported us in some projects include Difaem, STAR Ghana, Ghana Somubi Dwumadie amongst others.

On behalf of my Management Colleagues, I wish to thank the Board of Trustees for their continuous 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.

OUR STRATEGIC ORIENTATION

Informed by our past, our continued contribution to Ghana's health sector and the changing context, the strategic goal of CHAG in the next five years is to "Build a resilient CHAG Network towards achieving Ghana's Universal Health Coverage (UHC) 2030". Priority attention shall be given to addressing the rising burden of Non-Communicable Diseases, Mental Health, improving the Quality of Care at the all levels through the SafeCare Quality Improvement programme as well as developing the capacity of staff to deliver on their mandate.

Given the gains made in the Digital Supply Chain Platform for medicines, CHAG would expand access to the Platform to more Health Facilities to guarantee institutional access to affordable, safe and quality medicines. The Network would also consolidate its gains in the Community systems Strengthening (CSS) programme and make the detection /diagnoses, treatment and retention in care feasible and meaningful for people living with HIV and TB at the community level

AFFIRMATION AND CONCLUSION

As a Christian Not-For-Profit Organization, our aspiration is to ensure equitable inclusion in society by improving access to quality health services in all its dimensions, to those we serve especially the poor, needy, marginalized and neglected segments of the society. Hence, we would continue to explore innovative interventions and strive to promote holistic health and healing, in all circumstances, for those whose lives and livelihoods depend on us. Indeed, re-igniting Primary Health Care towards attaining Universal Health Coverage shall remain our passion in the years ahead.

Dear Friends, this 2021 annual performance report highlights the details of our collective achievements, common challenges and pointers for our future growth prospects and potentials as Christian Health Service Providers. In many ways, the report represents our renewed promise and pledge to promote Jesus Christ's healing ministry everywhere, to everybody, and at all times!

Sincerely,

Dr. Peter K. Yeboah
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CHAG in a Nutshell

The Christian Health Association of Ghana (CHAG) is a network organization of 349 Health Facilities and Health Training Institutions owned by 35 different Christian Church denominations. It is the second largest provider of health services in Ghana and contributes about 30-40% of national health service provision. Over the past fifty-five (55) years, the contributions of CHAG continue to deepen particularly in remote and urban poor areas. Although CHAG continues to provide health care to the most vulnerable and underprivileged population groups particularly in the most remote areas of Ghana, where the Government of Ghana has no facilities, the network recognizes the need to meet the health needs of the urban poor, where necessary.

CHAG is an implementing partner/recognized agency of the Ministry of Health and works within the policies, guidelines and strategies of the Ministry of Health (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 its 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 that outlines the medium-term aspirations and approaches. At the National level, CHAG operates a head office, 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 coordinating offices at various levels providing financial, technical, logistical and programme 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.

¹ CHAG Strategic Framework 2017-2021.

² Memorandum of Understanding between MOH and CHAG, 2006; Memorandum of Understanding between GHS and CHAG, December 2013.

Summary Outlook 2021

In 2021, the CHAG network like many health systems was still dealing with the COVID-19 pandemic which was in its second year of ravaging health systems across the world. Several lessons had been learned in the previous year. Among them was the indispensable need for partnerships. Accordingly, CHAG worked with several partners in continuing interventions that were initiated in the previous year to mitigate the impact of the COVID-19 pandemic on health service delivery and to ensure continuous provision of basic and essential health services.

Consequently, through the support of several partners, CHAG facilities were given considerable support that allowed them to respond to the COVID-19 pandemic in their respective communities. In particular, UKaid through the Foreign Commonwealth and Development Office (FCDO) funded the COVID-19 and Institutional Capacity Building (CRIB) project which started in 2020 in 40 districts where government had no district hospitals. The project successfully complemented the government's response to COVID-19 in those 40 districts.

The Global Fund through its New Funding Model III (NFM3) grant for the Community Systems Strengthening (CSS) for the HIV and TB supported CHAG to work with 99 Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) to improve quality and access to care for persons living with HIV and TB in over 236 districts.

In line with CHAG's core mandate of providing options for the poor and the marginalized, CHAG with funding support from the Department for Health and Social Care (DHSC) provided support to the country's five refugee camps with interventions on COVID-19, capacity development for improved health care and scholarships to qualified refugees and individuals in host refugee communities for nursing, midwifery and other paramedical training programmes.

In 2021 while still dealing with the COVID-19 pandemic, CHAG successfully rolled out the SafeCare Quality Improvement programme. As at the end of December 2021, 264 facilities had been assessed and supported to develop Quality Improvement (QI) plans based on the assessment findings. Key findings were shared with selected church owners to allow them to provide the needed support to their church health facilities. These interventions among others were key in facilitating CHAG to consolidate its role in the Ghanaian health sector by improving access to quality health services and professional training through its Network of 349 Hospitals, Health Centres, Clinics, Primary Health Centres (PHCs) and Health Training Schools.

CHAG strengthened its leadership and partnership structures by leveraging on the support systems that were available through its work with the Ghana Health Service at the national, regional and district levels through the CRIB project and Global Fund CSS grant. The Regional and District Directors of Health Services provided immense support to implementation of the two projects and thereby strengthened their governance. The CHAG-GHS partnership was at all time high during the year 2021.

The support from other partners, local and international, allowed CHAG to provide

comprehensive maternal and child health services, quality improvement, capacity building and psychosocial support to COVID-19 victims and their families. Such helpful partners included STAR Ghana Foundation, DIFAEM, Jhpiego, Ghana Somubi Dwumadie amongst others. CHAG continued to receive substantial amounts of Personal Protective Equipment (PPEs) (about 18-20%) from the Ministry of Health. The Church-State collaboration continued in the year. Consequently, additional support was given by the Ministry of Finance towards addressing COVID-19 vaccine hesitancy and vaccine uptake in selected communities. CHAG also worked closely with the National Health Insurance Authority (NHIA) in settling its indebtedness to CHAG Member Institutions. Overall, the payment of NHIS claims in 2021 saw significant improvement. Nearly every month, some payments were received, and this made it easier to manage health facilities.

The contribution of CHAG to the national health sector objectives was significant as indicated by a selected number of outcomes, performance, and input indicators. Key performance indicators such as maternal, infant, and crude mortality rates declined by 3.1%, 12.3% and 4.4% respectively in 2021 compared with 2020. Antenatal Clinic and Out-Patient (OPD) attendance improved by 7.6% and 12.0% respectively. Other improvements seen in 2021 were deliveries (2.3%), BCG immunization coverage (9.3%), Post Natal care (6.9%) and bed occupancy (6.9%). Neonatal mortality, and Still birth rates remained same as the previous year while Under -5 mortality rate worsened with an increase of 7.3% over the previous year's figure. Table 3 below shows the performance of key indicators for the year under review and a 5-year trend.

The greatest improvements over the five years were seen in infant mortality (12.3% decline), followed by crude mortality (4.4%), and maternal mortality (3.1%), as shown in table 3 below.

Capacity building, improvement in access to health services and skilled personnel are some of the contributory factors that accounted for the notable improvements in the key indicators.

Other contributory factors to the improvements seen were the specific projects introduced in recent times including CHAG's institutional capacity building project supported by FCDO, WASH in Health Care Facilities supported by Jhpiego etc.

Table 3 on the next page provides details on the key outcome indicators for CHAG over a five-year period.

Outcome Indicator	Year						% Change	One-year Performance	% Change	6-Year Performance	National	Developing Countries
	2016	2017	2018	2019	2020	2021	2020 - 2021	2020- 2021	2016 - 2021	2016 - 2021	2021	2016
Maternal Mortality Rate (per 100,000 LB)	109	152	124	123	117	113.4	-3.1	Improved	4.0	Worsen	¹³⁸¹	2394
Neonatal Mortality Rate (per 1000 LB)	13	9	8.2	9	9.3	9.3	0.0	Stabilized	-28.5	Improved	^{4.31}	523
Infant Mortality Rate (per 1000 LB)	12.9	10.1	8.9	11.2	3.9	3.5	-12.3	Improved	-72.9	Improved	³⁵¹	1073
Under 5 Mortality Rate (per 1000 LB)	18.3	14	6.5	8.3	15.1	16.2	7.3	Worsen	-11.5	Improved	⁵⁰¹	1773
Still Births Rate (per 1000 LB)	20	19	19	17.9	18.1	18.1	0.0	Stabilized	-9.5	Improved	¹⁴¹	18.45
Crude Mortality Rate (per 1000)	19	19	17.5	14.5	20.3	19.4	-4.4	Improved	2.1	Worsen	^{21.31}	163

TABLE 3**Key Health Indicators: 2016– 2021**¹ MOH POW, 2021² GDHS & MICS, 2019³ GDHS & GMHS, 2017⁴ World Health Organization: Maternal Mortality Key facts 2015⁵ 2015 worldwide estimates: WHO neglected tragedy of stillbirths

HIV/TB Community Systems Strengthening (CSS) Program

Aside the mainstream healthcare delivery services and training of health staff, CHAG undertakes other programs as a Civil Society Organization with the aim of contributing to government's efforts to attain the Universal Health Coverage and Health Security. One of such interventions is the HIV/TB Community Systems Strengthening (CSS) under the New Funding Model 3 (NFM3) of the Global Fund valued at \$ 17.6 million. CHAG was given the responsibility through a competitive bidding process to lead the implementation of the CSS intervention from January 2021 to December 2023. Since January 1, 2021 CHAG has been implementing the program through peer-led HIV community service delivery and community-based organizations led TB case finding in hard-to-reach areas.

The Global Fund in July announced additional funding to mitigate the effects of COVID-19 on HIV/TB services. In this regard, CHAG was awarded additional funds to procure personal protective equipment (PPEs), roll out community interventions on infection prevention and control and to present a plan to mitigate intimate partner violence and gender-based violence (IPV/GBV) due to COVID-19 and HIV/TB in Ghana.

The Global Fund has through the HIV/TB CSS program prioritized interventions that seek to strengthen communities. Communities in this regard refer to people who are connected to each other in varied and distinct ways, such as people who are particularly affected by HIV, TB, and Malaria. The aim is to increase community participation, ownership, and accountability to achieve epidemic control including breaking down barriers to human rights. The HIV/TB CSS broadly supports prevention of mother to child transmission of HIV (PMTCT), psychosocial support for populations living with HIV, TB case finding, reducing human rights related barriers to HIV/TB and community led monitoring, advocacy and feedback.

In 2021, a year after implementation, community cadres – peers living with HIV who support community HIV services – under the classification of Mentor Mothers (MM), Models of Hope (MoH), Community Adolescent Treatment Supporters (CATS) provided peer-to-peer support with the goal of contributing to the UNAIDS 95-95-95 targets for 2030. Also, a specialized group of cadres, Case Managers, who are not necessarily persons living with HIV, provide support to other community cadres to effectively deliver their tasks. Case Managers are mostly trained health service persons who are not under the employment of CHAG or the Ministry of Health and awaiting posting. Similarly, TB Champions (mostly cured TB clients) and TB volunteers have contributed to TB prevention, case finding, linkage to care and cure. Additionally, Community Peer Paralegals (CPP) together with pro bono lawyers and psychosocial counselors supported the reduction of human rights related barriers through legal education and support for community members in seeking redress of human rights violations like stigma and discrimination, IPV/GBV. Table 4 shows the distribution of all community cadres by December 2021.

³ "Civil society" is the term the Global Fund uses to designate all those stakeholders who are neither government bodies nor private sector enterprises – groups such as international and national nongovernmental organizations, advocacy groups, faith-based organizations, networks of people living with the diseases, and so on.

By December 2021, there were 2,122 HIV/TB community cadres in 200 unique districts in 16 regions. These numbers fell short of the anticipated number of 2,211 cadres because

TABLE 4**Distribution of the HIV and TB cadres as at the end of December 2021**

Cadre Type	MM	CATS	CM	MoH	Total HIV Cadres	TB NGOs	TB Champions	Community Peer Paralegals	Total
No. Cadres	245	88	181	420	934	97 (970)	98	120	2,211
No. Facilities	134	48	133	200	238	-	67	136	250
No. Districts	87	42	103	145	159	102	54	93	200
No. Regions	10	11	15	16	16	15	14	13	16

Programmatic Performance - 2021

HIV & Human Rights

In 2021, the HIV/TB program supported 134 facilities with Mentor Mothers which resulted in improved PMTCT programmatic performance. From 1 January 2021 to 30 June 2021, CHAG reported only 419 HIV-exposed infants receiving a viral load test within 2 months of birth, representing 17% coverage. By December 2021, 1,318 of 2,380 of HIV exposed infants received a test representing 55% coverage. While coverage remains low, this is an improvement and an increase to 65% achievement of the target for the semester and 44% achievement of the annualized 2021 target. Machine breakdowns and EID reagent stockouts at the laboratories level remain significant challenges for the program and impact the EID coverage rate. Resolution of lab and supply chain issues over time will allow for improved performance from the expanded Mentor Mother cadres.

There was an improvement in the percentage of HIV-positive women who received ART during pregnancy or labour and delivery (PMTCT-2.1). From 1 January 2021 to 30 June 2021, community cadres contributed in reaching only 691 clients. By December 2021, the number of positive pregnant women accessing treatment increased to 2,303 clients, totalling 2,994 clients receiving ART in 2021. This represents 63% coverage of the estimated 4,760 population and achievement of 76% of the annualized 2021 target. We anticipate that continued strengthening of the community cadres and collaboration with the Ghana Health Service will allow for improved performance in 2022.

Despite improved performance in reaching HIV positive women with ART, there is a challenge with follow up of index clients by community cadres. From 1 January 2021 to 30 June 2021, the facilities with community cadres reached 2,505 listed partners and children of HIV-positive cases, representing 16% coverage of the 15,740-population estimate. By close of December 2021, the results showed an increase to 4,308 clients of the 15,740 population estimate, representing 27% coverage and 43% achievement of the target. This results in

22% coverage of the population for 2021 and achievement of 34% of the annualized target. The program is taking proactive steps with the Ghana Health Service, community members and partners to consider a community- based testing model that will effectively reach index clients, perform tests and link and support positive clients.

Improvements were recorded in the percentage of people newly diagnosed with HIV initiated on ART. From 1 January 2021 to 30 June 2021, the program reported 7,729 clients linked to treatment of 11,569 newly diagnosed PLHIV, representing a 66% linkage to treatment rate. By close of December 2021, 11,567 of 14,275 clients were linked to treatment, representing an 81% linkage rate and 90% achievement of the target. While the linkage rate has improved, there are continued challenges with enforcing the national same-day treatment initiation guidance. The program recognises community cadres’ unique position to provide client support in linkage to treatment process in their facilities and will leverage it to optimise linkage rates.

ART coverage in facilities with community cadres continue to increase. From 1 January 2021 to 30 June 2021, the program reported a 46% treatment coverage rate. By December 2021, 216,327 clients of estimated 330,495 PLHIV nationally were on ART. This represented a 65% treatment coverage rate for 2021 and 113% achievement of the target. Figure 1 below is the annualize performance of the CSS grant in 2021.

Figure 1: Annualized Performance Rating

Active Indicator Name	Country	Target Value	Result Value	Percentage
1 TCP-7c Number of notified TB cases (all forms) contributed by non-national TB program providers – community referrals	Ghana	N: 3,371 D: 22,541 P: 15.0%	N: 3,063 D: 13,214 P: 23.2%	120.0% *
2 TCS-1.1 Percentage of people on ART among all people living with HIV at the end of the reporting period	Ghana	N: 191,763 D: 330,495 P: 58.0%	N: 216,327 D: 330,495 P: 65.5%	113.0%
3 TCP-2 Treatment success rate- all forms: Percentage of TB cases, all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured plus treatment completed) among all TB cases registered for treatment during a specified period, new and relapse cases	Ghana	N: 2,274 D: 2,584 P: 88.0%	N: 988 D: 1,210 P: 81.7%	93.0%
4 TBHIV-6 Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	Ghana	N: 566 D: 708 P: 79.9%	N: 679 D: 711 P: 95.5%	119.0%
5 PMTCT-2.1 Percentage of HIV-positive women who received ART during pregnancy and/or labour and delivery	Ghana	N: 3,927 D: 4,760 P: 82.5%	N: 2,994 D: 4,760 P: 62.9%	78.0%
6 PMTCT-3.1 Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	Ghana	N: 3,927 D: 4,760 P: 82.5%	N: 1,735 D: 4,760 P: 36.4%	44.0% **
7 HTS-3e Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results	Ghana	N: 20,040 D: 31,480 P: 63.7%	N: 6,883 D: 31,480 P: 21.9%	34.0% **
8 HTS-5 Percentage of people newly diagnosed with HIV initiated on ART	Ghana	N: 22,810 D: 25,344 P: 90.0%	N: 19,296 D: 25,844 P: 74.7%	83.0%

*Individual indicators should have a maximum score of 120%, when calculating the mean

**If an Indicator is rated less than 60% then Final Quantitative Rating is downgraded by one rating unless indicator rating is C, D or E

The CSS seeks to support the national efforts in promoting and strengthening an enabling environment to ensure that Ghanaians (community members) have access to HIV/TB prevention, treatment, care and support services. Stigma and discrimination issues still impact access to HIV services and staying on treatment. The program has rolled out stigma and discrimination reduction activities in health facilities and at the community level. To increase awareness of human rights knowledge, access to services and resolution of human rights concerns in the HIV/TB community, Community Peer Paralegals (CPP) were designated to health facilities. By the close of December 2021, 120 CPP were trained and working in 136 facilities in 93 districts. The program aims to reach 160 health facilities with 160 CPPs in 2022.

A baseline assessment was carried out in 20 selected health facilities to determine the level of stigma and discrimination (S&D) in those facilities. The results indicated that though S&D occurs in the facility, much of it occurs in the home/community. Health care workers (HCWs) from the selected facilities were trained in reducing S&D against PLHIV/TB. By the end of the year under review, about 950 HCWs and community members have been trained. Religious leaders were also engaged to support the reduction of S&D against persons living with HIV/TB. A half-day sensitization with them took place in Tamale, Koforidua, Sunyani, Cape Coast and Obuasi.

Community-Led Monitoring

An important goal of the HIV/TB CSS program is to ensure accountability and responsiveness of HIV/TB Services. A significant intervention to realize this goal is the Community Led Monitoring (CLM) initiative. This initiative seeks to ensure the accountability of the delivery of quality health care services to the PLHIV/TB community. It is a mechanism that allows for the collection of data on healthcare service delivery, the data is analyzed to identify gaps and best practice and resolving the potential issues that may arise at various levels (from the facility/district, regional or national levels). Unlike most health service accountability mechanisms, persons living with and affected by HIV and TB are the lead of this initiative with CHAG providing technical guidance and oversight. Currently, the CLM initiative is being implemented in 30 districts in 12 regions. In 2022, the program will fully roll out district, regional and national level CLM activities.

TB

The HIV/TB CSS program aims to contribute to the national target of TB case finding. Despite the COVID-19 pandemic, community TB case finding was optimal. In 2021, 3,063 TB cases were notified through community interventions by TB Champion and TB Volunteers. 82% of positive TB cases notified through TB community cadres and supported for treatment adherence were successfully treated. By end of December 2021, the TB program performed at 90%. From July to December, 1,250 TB cases were notified as compared to 1,758 TB cases which were expected to be notified during the period. The Program aims to continue working with partners to strengthen program quality through an in-depth programmatic analysis of challenges impacting implementation with a specific focus on regions showing low performance. Other innovative approaches to TB case finding are considered for 2022. For example, the program will implement an intervention with Over-the Counter Medicine Sellers (OTCMS) and Chemical shops to scale up TB case finding. Figure 2 is the cascade analysis of TB cases in the 2021.

Figure 2: TB Case Find Cascade

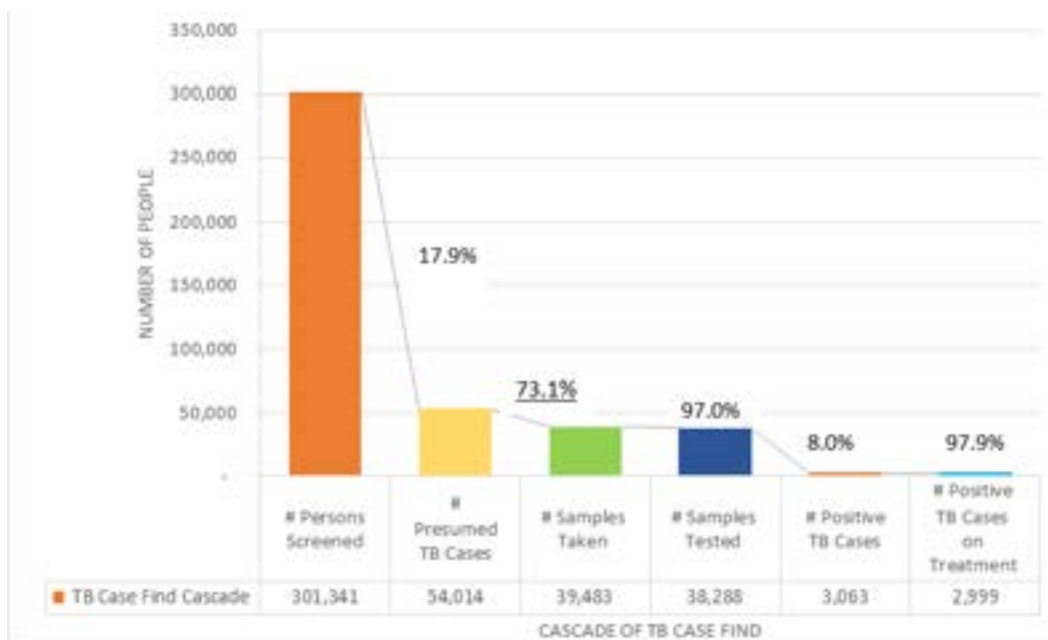


Figure 2 shows that 301,341 people were screened by the TB Champions and NGOs with 17.9% being presumed as TB cases. Of the presumed TB cases 39,483 samples were taken and 38,288 (97.0%) were tested for TB. There was a positivity rate of 8.0% (3,063) TB cases with (97.9%) 2,999 on treatment.

Program Rating

The Global Fund assesses grant performance based on indicator results to confirm the programmatic rating and budget utilization and in-country absorption to confirm the financial rating. The programmatic and financial ratings are combined to establish the overall grant performance. The table below illustrates the Annual performance Rating of the CSS grant in 2021.

Annual Performance Rating	C – 3
Programmatic Rating: <i>(rated period: 1 January 2021 – 31 December 2021)</i>	C- Moderate performance
Financial Rating: <i>(cumulative rated period from beginning of the implementation period: 1 January 2021 – 31 December 2021)</i>	3- Moderate performance

Major Milestones in 2021

- 1 **Recruitment of working agents:** As a new Principal Recipient (PR) of the Global Fund, CHAG successfully advertised and selected Hope for Future Generation (HFFG) as a Sub-Recipient (SR) to HIV intervention implementation. The TB Voice Network and STOP TB Partnership were selected as Implementing Partners (IPs) to conduct contact tracing of index TB clients and community case finding respectively.
- 2 **Collaborations:** Major collaborations with the Ministry of Health/ Ghana Health Service were enhanced especially with the National AIDS/STI Control Program (NACP), National Tuberculosis Control program (NTP), Ghana AIDS Commission (GAC), the country offices of UNAIDS and WHO. Additionally, CHAG continued a collaboration with Africaid/Zvandiri from Zimbabwe that supports adolescent and young people's HIV interventions.
- 3 **Working aids and guides:** Under the period, CHAG developed Standard Operating Procedures (SOPs) to guide the engagement of HIV community cadres. This was done in consultation and partnership with the National Programs (NTP and NACP). All the community cadres were trained in the use of the SOPs. The development of a training manual for Community Peer Paralegals is anticipated in 2022.
- 4 **Acquisition of a software to manage data:** The story of the CSS intervention can best be told with data through program performance. CHAG engaged Africa Current Medical Research Journal to incorporate the HIV/TB program data processes through the Research Electronic Data Capture (REDCAP) for community cadre data collection. Additionally, Vantage was procured to provide analytic and visualization of programme oversight, performance monitoring and tracking. These were deployed to enhance achievement of the targets on the CSS intervention. In 2022, it is anticipated that the full scope of Vantage will be deployed to improve program oversight and performance monitoring for the cadres.
- 5 **Review and adoption of a Community Led Monitoring Intervention (CLM):** The CSS intervention saw the incorporation and roll out of the CLM model in 2021 for which monitors were recruited and trained to collect and analyze service utilization data.

Challenges Encountered in 2021

- 1 Transition of community cadres under the NFM2 to the NFM3
- 2 Delays in developing and harmonising community cadre work.
- 3 Delays and slow pace of adaptation of new reporting tools (manual and electronic).
- 4 Challenges in endorsing TB cases by district and health facilities.

Outlook for 2022

- 1 Continuous Stakeholder and Partner Engagement:** Stakeholder and partner engagement has proven key for the CSS interventions considering the gains made. The CSS interventions will enhance engagement with all stakeholders and partners to optimize achievement of national outcomes.
- 2 Joint Supportive Supervision:** The lessons learned in 2021 showed that the periodic monitoring of activities presented opportunities for further engagements with facilities and cadres. It also helped in identifying challenges and addressing them especially relating to reporting and cadre welfare. In 2022, CHAG will conduct joint supportive monitoring and supervision with the national programs and partners to implementing sites.
- 3 Actively participate in HIV Cascade Analysis with Partners:** TB data from 2021 showed significant contribution by the CSS intervention. There were, however, challenges in verification of the data in some districts. The plan for 2022 is to have better collaborations that will help in telling what is attributable to CSOs and NTP respectively through a sputum coding system.
- 4 Scale up Community Led Monitoring in 40 districts**
- 5 Complete recruitment and training of all outstanding community cadres:** There have been expansion into 31 new facilities because of the withdrawal from the Western, Western North and Ahafo regions. Having recruited the new cadres, there will be training of these new cadres in 2022.

Figure 3: Stakeholder Engagement towards the Implementation of the CSS Interventions



CHAG's COVID-19 and Institutional Capacity Building (CRIB) Project

CHAG's flagship programme on COVID-19, CRIB which sought to support government's efforts on COVID-19 response; build capacity of CHAG institutions to continuously provide basic and essential services; and share new knowledge on the novel COVID-19 virus through research, entered its second year of implementation in 2021. The project, funded by FCDO, was implemented in 15 out of the 16 regions and in 40 districts where CHAG facilities are the designated district hospitals.

The project made significant contributions to the national efforts in the 40 implementing districts. Critical needs related to COVID-19 for communities in the 40 districts in 2021 were addressed through the project. These needs include fears and anxiety, informational needs on COVID-19, COVID testing, Case Management, vaccine hesitancy, among others.

The Project addressed information needs, fears, and anxiety through radio education on COVID-19 routinely in all the 40 districts on monthly basis and organized press briefings to same communities. In many ways, through the radio education sessions, press briefings, community durbars, and citizens update, residents were offered the opportunity to engage and ask questions related to the COVID-19 pandemic. Towards the end of 2021 CHAG partnered the GHS to expand vaccine uptake in selected regions with low vaccine uptake. To support the exercise, 940 Samsung computer tablets funded by FCDO were donated to GHS to be given to five regions: Upper West, Bono East, Bono, Central and Western North.

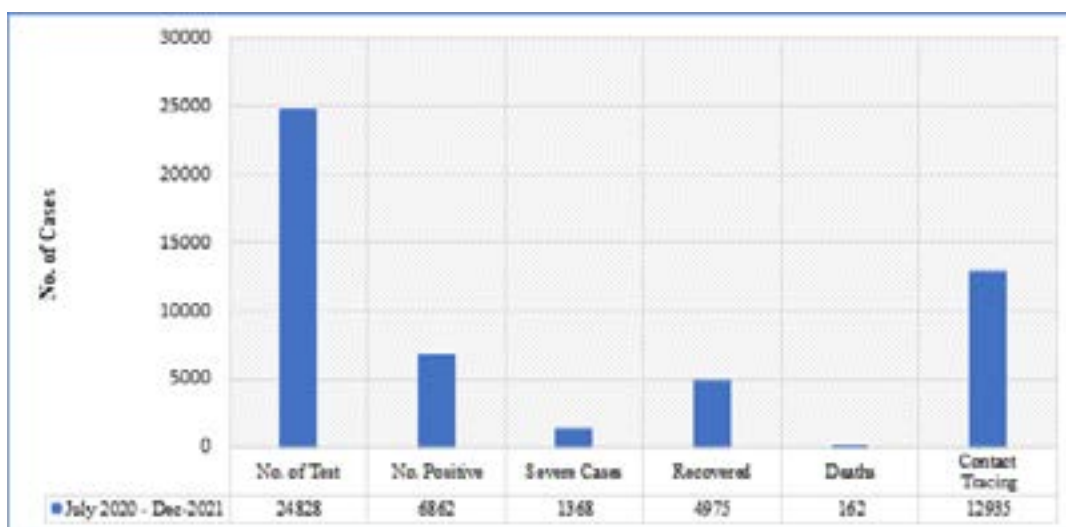
During the year, the project extended coverage of its testing to 40 districts with six (6) districts testing with PCR. From these 40 testing sites, 24,828 COVID-19 tests were conducted. As at the end of 2021, the project had trained cumulatively, 6,664 health care workers on Infection Prevention and Control, inventory management, quality improvement, amongst others. Several homes in rural areas were engaged with essential and factual messages on COVID-19 and thereby helping these rural communities to stay safe from COVID-19. One hundred and forty religious leaders were also trained on communication to address vaccine hesitancy.

FCDO funds supported the establishment of three (3) fully functional High Dependency Units (HDUs) in three facilities in three zones. The HDUs contributed to managing very severe COVID-19 cases in rural areas without referring them to National Treatment Centers. Additionally, forty (40) isolation units were created in the implementing facilities to allow suspected cases to be isolated whilst waiting for their laboratory results. The isolation units created were head resistant and bullet proof and could be repurposed to manage other infectious disease if COVID-19 pandemic is over. These services created by the CRIB Project, complemented government's efforts in containing the spread of COVID-19 disease.

To improve surveillance and data quality across the network, the project also funded the setting up a monitoring and evaluation tool (Vantage) and Health Information Management System, an electronic health records system for the network. This will be deployed in 2022.

The testing sites were also linked up with the National COVID-19 laboratory network and facilitated quality improvement programme for all the CHAG testing sites. Consequently, all the testing sites contributed data into the national database through the SORMAS.

Figure 4: Total Covid-19 Test and Traced Cascade (Jul 2020 – Dec 2021)



The Akomapa (Healthy Heart) Project

Non-communicable diseases (NCDs), especially cardiovascular diseases, are a leading cause of death in sub-Saharan Africa. In Ghana, approximately half of the population suffers from hypertension. Less than a third of those who are ill have been diagnosed, and just 22 per cent of patients are receiving treatment. About half of all deaths (43 per cent) are due to NCDs. Increasingly, common complications related to the absence of diagnosis and treatment are also a factor. A similar picture can be seen for diabetes.

In response to the situation, in 2021 CHAG began the “Akomapa” (healthy heart) project. focuses on improving the diagnosis, control, and treatment of patients with hypertension and/or diabetes to minimise life-threatening complications and increase the quality of life in rural Ghana. The project aims to improve the local diagnosis and treatment of these diseases in 85 facilities in rural communities to achieve the broadest possible delivery of health care. It concentrates on better and early diagnosis to prevent subsequent complications of the primary diseases. As at December 2021, the project had recruited nearly 8,000 clients with over 50% achieving good control. From January through to October 2022, the target is recruit 70,000 patients on the project and achieve good control for at least 50% of them.

Figure 5: TRAINING OF RELIGIOUS AND TRADITIONAL LEADERS ON COMMUNICATION TO IMPROVE VACCINE UPTAKE



Figure 6: FIELD VISIT TO FETENTAA REFUGEE CAMP FOR DHSC BFIW PROJECT



Figure 7: FIELD VISIT BY FCDO & CHAG HQ TEAM THE CRIB PROJECT SITES (ST ELIZABETH HOSPITAL ISOLATION UNIT AT HWDIEM)



Figure 8: FIELD VISIT TO CRIB FACILITIES IN THE WESTERN REGION



Performance Indicators

Key health service indicators showed an improved performance in 2021 compared to 2020. There was a total of 6,402,610 outpatient visits, compared to 5,716,794 in 2020. This represents an increase of 12% on the 2020 figures and a 5.6% average increase over a 5-year period (2016-2021). Total hospital admissions for the period under review also increased by 11.9% from 534,010 in 2020 to 597,623 in 2021. Over a 5-year period, there has been an average increase of 28.7% in admissions.

Among the people who were attended to in 2021, males formed 33.0% whereas females formed 67.0%. Health seeking behaviour which is generally perceived to be higher in females than males, may explain this figure. The highest proportion clients seen (27.1%) were within the 20 to 34-year old age group followed by 35 to 49 years (17.2%). The relatively high performance in 2021 could be attributed to the numerous interventions implemented by CHAG and its member institutions. Intervention such as the CRIB project, helped allay the fears, anxiety and panic that prevented majority of our clients from utilizing health care services in the previous year. The WASH IPC intervention implemented in 25 facilities helped improve the quality of services in the respective facilities. Staff training, the SafeCare quality improvement and skilled personnel at birth were other important contributory factors to the good performance for the year.

Total deliveries in 2021 were 139,531, a slight increase of 2.3% over that of 2020, and 2.1% over that of 2016. The number of Caesarian Sections (CS) were 28,718, which represents a decrease of 3.6% compared to that of 2020 but a 12.1% increase over a 5-year period. The proportion of CS cases to total delivery in 2021 was 20.3%, compared to 22.0% in 2020. These are both beyond the WHO recommended rate of 10-15%.

The number of children vaccinated for BCG increased from 120,734 in 2020 to 131,960 in 2021 representing an increase of 9.3%, while the bed-occupancy rate, improved from 49.6 to 53.0%.

The overall student intake at CHAG Health Training Colleges in 2021 was 5,794 for the twenty-two training schools. This represents 5.3% increase on the 2020 student's intake. Students pass rate was not released as at the time this report was published.

Table 5: Performance Indicators.

Performance Indicator	2016	2017	2018	2019	2020	2021	% Change 2020-2021	2-year Performance	% Change 2016-2021	5-year Performance	National 2021	Sub-Saharan Africa
Total Out-Patients	6,065,897	5,261,683	6,785,233	6,697,849	5,716,794	6,402,610	12.0	Increased	5.6	Increased	34,121,493	
Total Admissions	464,377	447,950	542,689	569,653	534,010	597,623	11.9	Increased	28.7	Increased	2,100,882	
No of Deliveries	136,669	110,109	143,242	144,180	136,460	139,531	2.3	Increased	2.1	Increased	782,595	
Total Caesarian Sections	25,612	23,894	33,232	34,459	29,795	28,718	-3.6	Improved	12.1	Worsened	100,860	
Caesarian Rate	19.0%	21.70%	23.2%	23.9%	22.0%	20.3%	-1.7	Improved	1.3	Worsened	12.8% ¹	2% ¹
Vaccination (BCG)	85,813	101167	113,513	131,817	120,734	131,960	9.3	Improved	54.1	Improved	1,226,187	
Bed Occupancy Rate	52%	49.20%	57.9%	58.6%	49.6%	53.0%	3.4	Increased	1.0	Increased	55.6	
Student Enrollment	2,878	2,800	2684	3003	5502	5,794	5.3	Increased	101.3	Increased		
Student Pass Rate	95.0%	84.0%	84.5%	79.0%	90.2%							

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

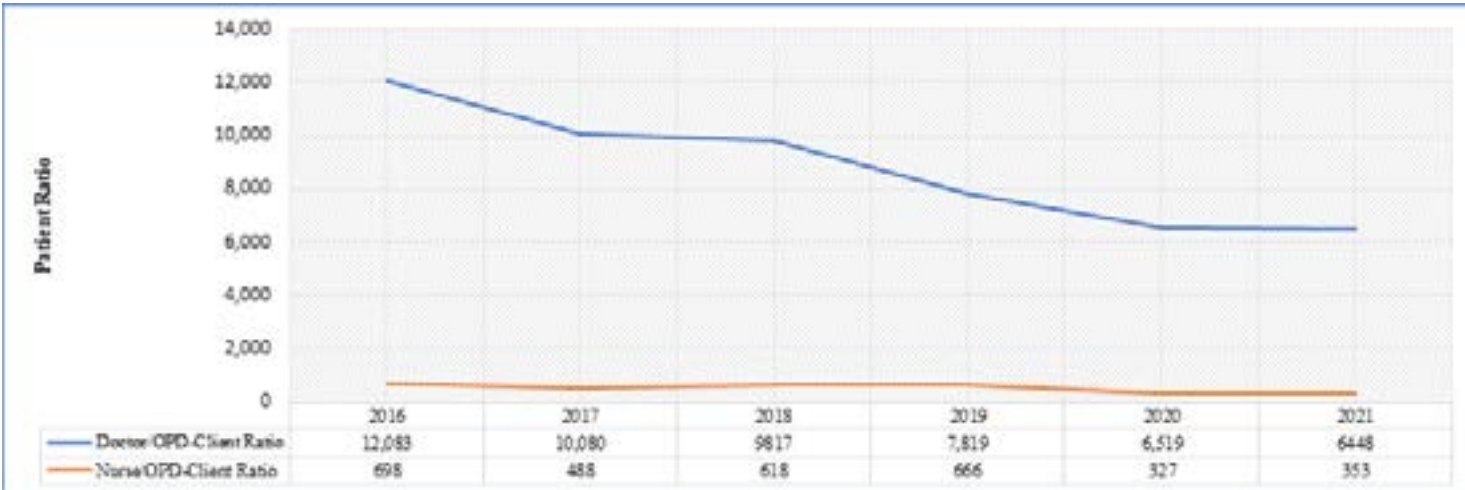
As shown in Table 6 and Figure 9, selected input indicators showed a considerable improvement in Human Resources. The staff strength of the CHAG Network as at the end of December 31st, 2021, was Forty-One Thousand, Two Hundred and Eighty-five (41,285). However, the number of CHAG employees on Government of Ghana payroll 34,915. Thus, the proportion of staff on GoG payroll as of December 31st, 2021, was approximately 84.6%. The details are indicated in table 27 below:

Doctor-to-Client ratio has seen continuous improvements from 2016 to 2021 as shown in Table 6 and Figure 9 below. The Nurse-to-patient ratio on the other hand slightly worsened. Improvements in the Doctor to patient and Nurse to patient ratios contribute to quality improvement. Within the CHAG network, the Doctor to population ratio in 2021 was 1:6,448, which is better than the national average of 1:10,000. Although the ratio in CHAG averagely appears better, there are regions with worse ratios. In Upper West region, the Doctor to population ratio is 1:26,605 In keeping with the government's UHC agenda, more doctors are needed in rural areas to guarantee to some level, the quality of health services delivered. The Nurse/Client ratio was 1:353 in 2021 compared to 1:327 in 2020. More health professionals transferred from CHAG to the Ghana Health Service. The situation calls for pragmatic measures to address the transfers whilst at the same time improve quality of care issues with the facilities that are in more deprived areas.

TABLE 6**Inpatient Indicators: 2016-2021**

Input indicators	2016	2017	2018	2019	2020	2021	% Change 2020-2021	1-Year Performance	% Change 2016- 2021	5 -Years Performance	WHO Standard
Total Mechanized Staff	12,584	15,942	20,099	20,344	26724	34,915	30.7	Increased	177.5	Improved	
% Clinical/non-Clinical Staff Ratio	60	64	69	79	83.5	83.2	-0.3	Declined	23.2	Increased	
Doctor/OPD-Client Ratio	1:12,083	1:10,080	1:9,817	1:7,819	1:6,519	1:6,448	5.0	Increased	-46.6	Improved	1:7,196
Nurse/OPD-Client Ratio	1:698	1:488	1:618	1:666	1:327	1:353	8.0	Increased	-49.4	Improved	1:8391

Figure 9: Trend of Doctors and Nurse /OPD Clients Ratio 2016 - 2021



Performance Outcome and Status for 2021

CHAG adopts the Health System Strengthening approach in its operations. These comprise:

- 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 2021. 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

For many years the services of CHAG have been characterized by quality and compassionate care. Since 2020 when the COVID-19 pandemic struck, it has been very challenging to keep services at the level that it requires. The implementation of the SafeCare Quality Improvement programme in 2021 has been very helpful in improving quality of care within CHAG network. Four (4) facilities achieved SafeCare level 4. In 2021, all the spectrum of health services was provided by the network. The interventions put in place to address COVID-19 in 2020 were continued in the reporting year. Given the government's priority to vaccinate 20 million Ghanaians, more attention was given to vaccine communication to address vaccine hesitancy. Despite the challenges, patronage of health services increased with remarkable improvements in the core health service indicators.

1.1

Out-Patient and In-Patient Services

In 2021, there was a total of 6,402,610 out-patient visits (old and new), and 597,623 admissions. Outpatient visits in 2021 thus increased by 12.0% compared to 2020. Admissions also increased by 11.9% compared 2020. Over a 5-year period, admissions increased by 28.7%. By inference, out of every 11 Out-patient visits, there were one (1) admission in CHAG Hospitals. About 84.2 % OPD and 83.1% IPD clients were insured. These represents 0.2% OPD and 0.1% IPD decline in NHIS insured coverage in 2021 compared to 2020 as shown in table 7 below.

TABLE 7**OPD, IPD Service Outputs and Health Insurance
Status of clients: 2016 – 2021**

Performance Indicator	2016	2017	2018	2019	2020	2021	2-Year Trend
OPD	6,065,897	5,261,683	6,785,233	6,697,849	5,716,794	6,402,610	Increased
OPD Insured	85%	94%	88.3%	87.8%	84.4%	84.2%	Declined
IPD	464,377	447,950	542,689	569,653	534,010	597,623	Increased
IPD Insured	82%	92%	83.6%	84.5%	83.2%	83.1%	Declined

1.1.2**The Contribution of CHAG to National
Outpatient and In-Patient Services**

In 2021, CHAG contribution to the National OPD and Admissions were 18.7% and 28.4% of respectively as shown table 8 and figure 10 below. CHAG has been contributing an average of 30% to National in-patient services since 2016 (refer to figure 10 below). CHAG's contribution to National OPD care has seen marginal decline over the past five years with actual numbers fluctuating. The average contribution since 2016 is 19.8%. The data shows increased access at the national level. Perhaps the various interventions including training and onboarding of facilities on the NHIS Claim-IT application. As at the end of 2021, there were 10,725 CHPS compounds in Ghana compared to about 6,000 in the previous year. Hence access has been created for more clients. It behooves on facilities to improve the quality of their services in order not to lose clients.

1.1.3**1.1.3 CHAG Regional Contribution to National
OPD and IPD Services**

A review of the regional contributions of CHAG to IPD and OPD care, shows Bono Region with the highest establishment where CHAG contributes 50.3% and 28.5% IPD and OPD care respectively. The largest regional OPD contribution is the North-East with 34.6%. The second region where CHAG makes significant contribution to IPD and OPD is the Bono East with 50.2% and 23.5% respectively, followed by North East also with 42.0% IPD care. The regions with the least OPD and IPD recorded are the Greater Accra region with 13.9% and 9.3%.

¹ DHIMS2 Report on Number of CHPS Compounds (Accessed 16/04/2022)

TABLE 8**CHAG percentage CHAG Contribution to National OPD and IPD Services, 2021**

Output	2016	2017	2018	2019	2020	2021	2-years Trend
National OPD	29,948,878	28,451,871	30,849,769	32,846,118	29,357,906	34,183,672	Increased
CHAG OPD	6,065,897	5,261,683	6,785,233	6,697,849	5,716,794	6,402,610	Increased
CHAG % Contr. to National OPD	20%	18.7%	22.0%	20.4%	19.5%	18.7%	Declined
National IPD	1,532,839	1,523,653	1,688,050	1,774,724	1,675,972	2,106,939	Increased
CHAG IPD	464,377	447,950	542,689	569,653	534,010	597,623	Increased
CHAG % Contr. to National. IPD	29%	27.8%	32.1%	32.1%	31.9%	28.4%	Declined

Source: DHIMS 2 (retrieved February 22, 2022)

Figure 10: CHAG % Contribution to National OPD and IPD Services, 2016-2021

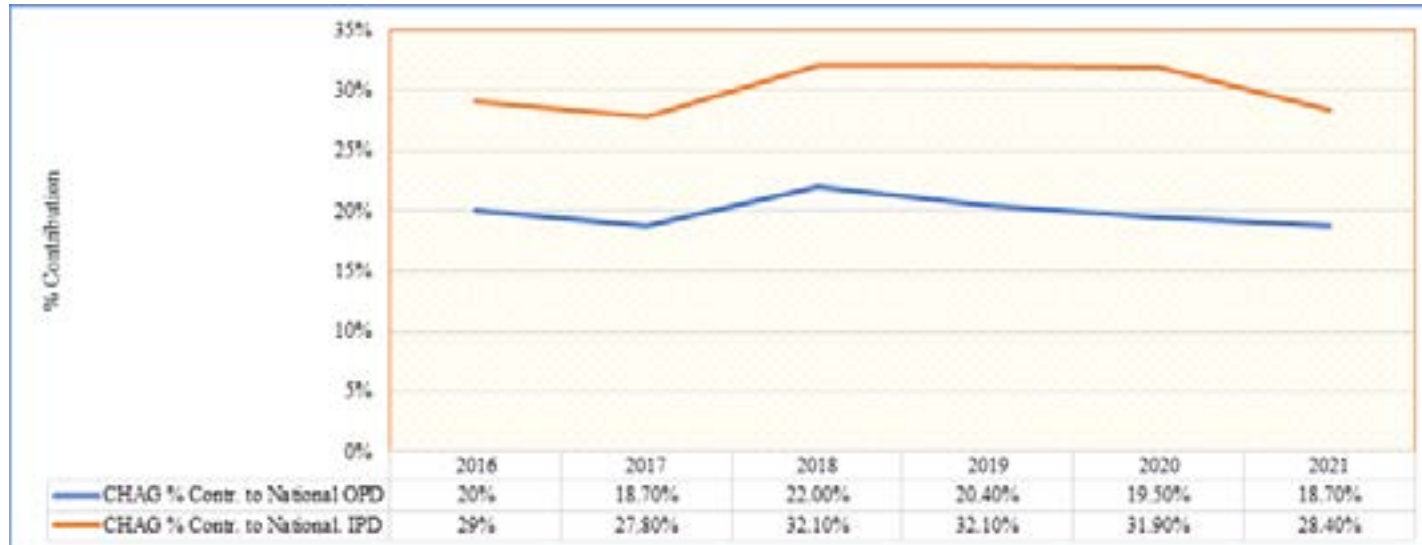


TABLE 9**CHAG's Contribution to Regional and National OPD and IPD, 2021**

Region	In-patients		Out-patients		Percentage (%) Contribution CHAG	
	National In-patients	Contribution by CHAG	National Out-patients	Contribution by CHAG	IPD	OPD
Ahafo	51,020	12,936	888,690	189,291	25.4%	21.3%
Ashanti	409,101	138,775	6,187,465	1,480,749	33.9%	23.9%
Bono	109,496	55,044	2,101,584	599,241	50.3%	28.5%
Bono East	96,751	48,558	1,630,874	383,486	50.2%	23.5%
Central	160,672	48,626	2,941,428	525,854	30.3%	17.9%
Eastern	210,552	48,744	4,416,375	764,164	23.2%	17.3%
Greater Accra	262,497	36,578	5,177,512	480,098	13.9%	9.3%
North East	49,036	20,601	502,067	173,495	42.0%	34.6%
Northern	194,653	27,866	1,282,450	190,461	14.3%	14.9%
Oti	31,631	8,735	544,461	85,395	27.6%	15.7%
Savannah	29,939	7,597	412,822	94,095	25.4%	22.8%
Upper East	99,325	22,697	1,745,575	345,530	22.9%	19.8%
Upper West	92,409	23,878	976,180	186,240	25.8%	19.1%
Volta	116,220	44,472	1,891,901	383,223	38.3%	20.3%
Western	130,857	37,894	2,486,947	345,333	29.0%	13.9%
Western North	62,780	14,622	997,341	175,955	23.3%	17.6%
National	2,106,939	597,623	34,183,672	6,402,610	28.4%	18.7%

Source: DHIMS 2 (accessed 14th February 2022)

1.1.4

Contribution to OPD by Church Denominational Health Services

IPD within the CHAG network. For the year under review, the NCHS contributed 53.8% to the overall CHAG OPD attendance followed by Ghana Adventist Health Services with 12.6%. Other Health Services that contributed more were the Presbyterian Health Service (10.6%), Methodist (4.1%), Pentecost (3.3%), and King of Kings (2.6%). The rest of the Health Services contributed 13.0% to CHAG OPD attendance in 2021 which is 0.54% less than that of 2020. Apart from the Catholic and Methodist health services which saw increase in their percentage contributions to the CHAG OPD attendance, the remaining coordinating units saw a decline in their percentage contributions. Despite the disruption of health services in Bawku and some portions of Upper East, the Presbyterian Health service maintained its second position as was seen in 2020. Table 10 and 11 below show 2021 percentage contribution to OPD and IPD by denomination respectively.

Table 10: OPD Contribution by Denominations, 2021

Position	Denomination	OPD Attendance	Percentage Contribution
1	Catholic	3,443,649	53.79%
2	Seventh Day Adventist	808,743	12.63%
3	Presbyterian	677,406	10.58%
4	Methodist	260,493	4.07%
5	The Church of Pentecost	211,061	3.30%
6	Kings of Kings	163,477	2.55%
7	Baptist Convention	127,701	1.99%
8	The Salvation Army	103,420	1.62%
9	Luke Society Missions	74,181	1.16%
10	Joint Anglican	61,649	0.96%
11	Church of Christ	60,965	0.95%
12	Saviour Church	59,945	0.94%
13	Assemblies of God	46,102	0.72%
14	Bryant Mission	41,253	0.64%
15	Church of God	39,627	0.62%
16	FAME	34,726	0.54%
17	Faith Evangelical Mission	27,530	0.43%
18	AME Zion	26,470	0.41%
19	Evangelical Presbyterian	25,826	0.40%
20	The Apostolic Church	24,244	0.38%
21	Manna Mission	18,316	0.29%
22	Harvesters Evangelistic Ministry	15,381	0.24%

23	ECG Mission	13,291	0.21%
24	Global Evangelical	11,763	0.18%
25	Siloam Gospel	7,434	0.12%
26	Powerhouse	5,348	0.08%
27	Baptist Mid West	4,134	0.06%
28	Theo Vision	2,870	0.04%
29	True Faith	2,382	0.04%
30	The Apostles Continuation	1,566	0.02%
31	Spring of Life	1,244	0.02%
32	WEC Mission	413	0.01%

Table 11: IPD Contribution by Denomination, 2021

No.	Denomination	Admissions	% Contribution
1	Catholic	337,968	56.6%
2	Seventh Day Adventist	80,186	13.4%
3	Presbyterian	46,262	7.7%
4	Methodist	25,313	4.2%
5	Baptist Convention	23,417	3.9%
6	Kings of Kings	16,449	2.8%
7	The Church of Pentecost	13,783	2.3%
8	Assemblies of God	10,782	1.8%
9	Saviour Church	6,484	1.1%
10	Luke Society Missions	5,603	0.9%
11	The Salvation Army	5,015	0.8%
12	AME Zion	4,594	0.8%
13	Manna Mission	4,065	0.7%
14	Church of God	3,498	0.6%
14	Bryant Mission	3,307	0.6%
15	WEC Mission	2,406	0.4%
16	The Apostolic Church	2,377	0.4%
17	Harvesters Evangelistic Ministry	2,201	0.4%
18	Church of Christ	1,512	0.3%
19	Global Evangelical	987	0.2%
20	Siloam Gospel	933	0.2%
21	Powerhouse	481	0.1%

The National Catholic Health Service contributed 56.6% to the CHAG IPD Client admissions compared to other Denominational Health Services. NCHS' contribution to CHAG's IPD in 2021 was however reduced by 7.8% compared to 2020. The contribution of GAHS in 2021 (13.4%) was high compared to 11.2% the previous year. The increase in IPD numbers is probably attributable to the critical role they played in the COVID-19 response in the Ashanti region. Kwadaso SDA hospital was one of the few facilities in the Ashanti region that opened its doors to all clients during the peak of the COVID infections in 2020 and 2021. While places like the Komfo Anokye Teaching hospital closed its OPD, Kwadaso was still receiving clients. The facility thus won the confidence of clients and consequently increased its attendance by over 5,000 compared to the previous year.

Table 12: High OPD Performing Facilities

Facility	2020	2021	%	% Contribution to CHAG OPD Attendance
Holy Family Hospital, Techiman	169,479	198,606	17.2%	3.1%
St. Patrick's Hospital, Offinso	138,079	153,818	11.4%	2.4%
St. Dominic Hospital, Akwatia	129,341	144,443	11.7%	2.3%
Presbyterian Hospital, Agogo	100,315	115,088	14.7%	1.8%
Pentecost Hospital, Madina	90,363	114,913	27.2%	1.8%
Presbyterian Hospital, Bawku	114,252	110,776	-3.0%	1.7%
Holy Family Hospital, Nkawkaw	92,728	110,620	19.3%	1.7%
Holy Family Hospital, Berekum	97,563	110,345	13.1%	1.7%
Presbyterian Hospital, Dormaa	86,920	98,791	13.7%	1.5%
St. Francis Xavier Hospital, Assin Fosu	83,698	98,401	17.6%	1.5%
St. Michael's Catholic Hospital, Pramso	87,125	95,788	9.9%	1.5%
Methodist Hospital, Wenchi	84,872	94,639	11.5%	1.5%
Our Lady of Grace Hospital, Breman Asikuma	84,059	93,445	11.2%	1.5%
St. Martin de Porres Hospital, Agomanya	63,075	92,594	46.8%	1.4%
St. Joseph's Hospital, Koforidua	83,277	92,273	10.8%	1.4%
Baptist Medical Centre, Nalerigu	83,173	89,143	7.2%	1.4%
St Elizabeth Hospital, Hwidiem	79,024	87,329	10.5%	1.4%
St. Mary Hospital, Drobo	83,195	85,501	2.8%	1.3%
St. John of God Hospital, Duayaw Nkwanta	79,789	85,191	6.8%	1.3%
SDA Hospital, Kwadaso	78,285	83,078	6.1%	1.3%
St. Martin de Porres Hospital, Eikwe	65,055	82,645	27.0%	1.3%
Catholic Hospital, Battor	74,721	82,246	10.1%	1.3%
Mathias Catholic Hospital, Yeji	55,690	80,721	44.9%	1.3%
SDA Hospital, Sunyani	61,170	79,910	30.6%	1.2%
St. Martins Memorial Hospital,	79,268	75,924	-4.2%	1.2%

Fr Thomas Alan Rooney Mem. Hospital, Asankragwa	69,253	71,261	2.9%	1.1%
SDA Hospital, Koforidua	66,422	69,536	4.7%	1.1%
St. Gregory Catholic Hospital	57,523	68,064	18.3%	1.1%
Margret Marquart Catholic Hospital, Kpando	54,656	61,181	11.9%	1.0%
St John of God Hospital, Sefwi Asafo	58,418	59,586	2.0%	0.9%

The facilities with high output include Holy Family hospital, Techiman, St Patrick's hospital, & St Dominic hospital, Akwatia and Presbyterian hospital, Agogo.

Table 13: Facilities with High Volume Admissions

Facility	2020	2021	%	% Contribution to CHAG IPD Attendance
Holy Family Hospital, Techiman	18,871	23,034	22.1%	3.9%
St. Patrick's Hospital, Offinso	16,187	18,052	11.5%	3.0%
St. Dominic Hospital, Akwatia	11,842	12,490	5.5%	2.1%
Presbyterian Hospital, Agogo	10,335	9,947	-3.8%	1.7%
Pentecost Hospital, Madina	5,472	2,640	-51.8%	0.4%
Presbyterian Hospital, Bawku	20,313	19,853	-2.3%	3.3%
Holy Family Hospital, Nkawkaw	7,765	8,816	13.5%	1.5%
Holy Family Hospital, Berekum	12,423	12,876	3.6%	2.2%
Presbyterian Hospital, Dormaa	6,769	11,255	66.3%	1.9%
St Francis Xavier Hospital, Assin Foso	11,099	12,080	8.8%	2.0%
St. Michael's Catholic Hospital, Pramso	5,915	6,042	2.1%	1.0%
Methodist Hospital, Wenchi	12,477	12,428	-0.4%	2.1%
Our Lady of Grace Hospital, Breman Asikuma	8,352	8,417	0.8%	1.4%
St. Martin de Porres Hospital, Agomanya	6,148	7,734	25.8%	1.3%
St. Joseph's Hospital, Koforidua	3,372	3,669	8.8%	0.6%
Baptist Medical Centre, Nalerigu	18,003	20,601	14.4%	3.4%
St. Elizabeth Hospital, Hwidiem	6,078	6,858	12.8%	1.1%
St. Mary's Hospital, Drobo	9,686	9,171	-5.3%	1.5%
St. John of God Hospital, Duayaw Nkwanta	5,823	6,078	4.4%	1.0%
SDA Hospital, Kwadaso	5,584	5,741	2.8%	1.0%
St Martin de Porres Hospital, Eikwe	13,694	15,232	11.2%	2.5%
Catholic Hospital, Battor	9,555	11,299	18.3%	1.9%
Mathias Catholic Hospital Yeji	9,996	12,734	27.4%	2.1%
SDA Hospital, Sunyani	5,167	6,477	25.4%	1.1%
St. Martins Memorial Hospital	7,159	6,810	-4.9%	1.1%

Fr. Thomas Alan Rooney Mem. Hospital, Asankragwa	7,119	7,034	-1.2%	1.2%
SDA Hospital, Koforidua	4,860	4,344	-10.6%	0.7%
St Gregory Catholic Hospital, Budumburam	6,043	6,629	9.7%	1.1%
Margret Marquart Catholic Hospital, Kpando	6,735	8,169	21.3%	1.4%
St John of God Hospital, Sefwi Asafo	8,055	7,756	-3.7%	1.3%

1.15 Bed Occupancy Rate (BOR) and Average Length of Stay (ALOS)

The proportion of beds utilized by inpatients per 100 beds in CHAG hospitals increased from 52% in 2016 to 53% beds in 2021. The two years performance also saw the BOR increasing from 49.6% reported in 2020 to 53.0% in 2021. At the national level, bed occupancy rate increased from 48.2% to 56.1%. The 7.1% increase in the CHAG bed occupancy rate is attributable to several factors including improved knowledge awareness of residents on COVID-19. The average number of days spent at hospital wards for CHAG hospitals were 3.1 days and this has remained fairly same since 2016.

This is approximately same as national average of 3.2 . The international standard average length of hospital stays, ranges from 3.9 (Turkey) to 16.5 (Japan) . Figure 11 below provides further details.

Figure 11: Trend of Bed Occupancy Rate and Average Length of Stay, 2016 - 2021



1.2

Reproductive and Sexual Health Services

In 2021, CHAG recorded very high deliveries. There were 139,531 supervised deliveries. This was 2.3% increase over that of 2021 and 2.1% more than that conducted five years ago (2016). Over twenty percent (20.3%) of all deliveries were performed under Caesarian Sections (CS). This is 7.0% lower than that of 2020, yet higher than the WHO approved CS rate of 10-15%. Moreover, the CHAG CS rate is above that of Ghana national target of 6.5% and that of Sub-Saharan Africa of 2%. Despite the improvement it is still high. The reasons could be delay in seeking care, late referrals from health facilities and homes, patient request and convenience. In many cases CS interventions are unavoidable. An enquiry is needed to show evidence of the reasons for the high CS deliveries. CS is a measure of the quality of maternal health and effectiveness of prenatal care. The higher rates suggest more work to be done on prenatal care and other public health interventions.

Table 14 below shows the trend of Sexual and Reproductive Health outputs, 2016 – 2021. From the table, a total of 117,920 pregnant women were registered at CHAG Reproductive and Child Health (RCH) units in 2021 for antenatal services (ANC), compared to 119,764 that registered in 2020. This represents a 1.5% decline compared to that of 2020 and 5.5% decline over the last 5 years (2016-2020). Health professionals have ascribed several reasons for the lower registrations of pregnancies in 2021. These include the establishment of several health facilities in many places and thus competing for the same number of pregnant women; changing patient choices and home deliveries.

More than 146,000 mothers were registered for Postnatal Care (PNC). The number of PNC registered increased by 3.0% in 2021 compared to 2020, and 2.9% over the five years period (2016-2021). The high PNC registrants could be attributed to confidence in the in the health facilities and quality improvement efforts by CRIB project and the SafeCare interventions which have yielded a lot of results. To a large extent, the fear, anxiety, and panic that characterized service utilization in 2020 reduced in 2021 hence the high utilization.

Table 14: Trend of Sexual and Reproductive Health outputs, 2016 – 2021

Performance Indicator	2016	2017	2018	2019	2020	2021	% Change 2020-2021	1-year Performance	% change 2016-2021	6-Year performance
Total Deliveries	136,669	110,109	143,242	144,180	136,452	139,531	2.26%	Slightly Increased	2.09%	Increased
Total C-S	25,612	23,894	33,232	34,459	29,795	28,718	-3.61%	Slightly declined	12.13%	Increased
C-S Rate	19%	21.7%	23.2%	23.9%	22.0%	20.40%	-1.6%	Improved	1.4%	Worsened
Total ANC Registrants	124,785	132,284	122,200	114,824	119,764	117,920	-1.54%	Slightly declined	-5.50%	Declined
Total ANC Attendance	641,554	684,800	748,657	730,960	714,469	768,707	7.59%	Increased	19.82%	Increased
ANC 4th Visit Rate	81%	81.3%	94.3%	90.9%	85.7%	84.70%	-1.17%	Declined	4.57%	Increased
Total PNC Registrants	142,704	151,707	144,760	150,660	142,541	146,785	2.98%	Increased	2.86%	Increased
MM Audit Rate	97%	87.5%	99.3%	97.9	95.0%	100.00%	5.0%	Increased	3.0%	Increased
MM Audit Rate	86%	97%	87.5%	99.3%	97.9	95.0%	3.0%	Declined	10%	Significantly improved

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

² WHO statement on Caesarean section rates; http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

1.3

Family Planning

During the year under review CHAG collaborated with STAR Ghana and conducted research on the impact of Covid-19 on FP services. The assessment showed that FP services were disrupted in some of the facilities that were selected for the study. Key recommendations and interventions were implemented by member institutions to help improve FP service delivery. There were however some facilities that recorded high utilization of family planning services. These facilities include the Baptist Medical Centre. The facility embarked on home service delivery for FP. This improved service utilization. The interventions resulted increase in FP new acceptors as depicted in figure 12.

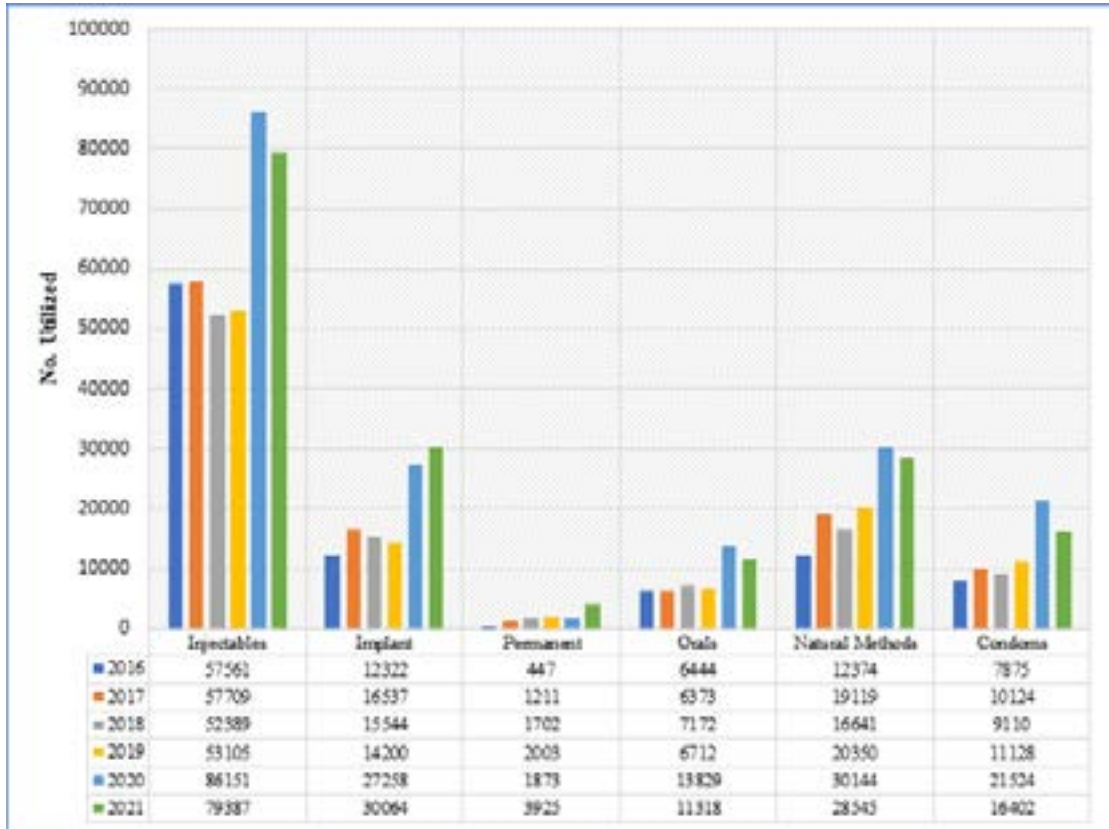
In 2021 new FP acceptors were 3.9% compared to 3.7% in 2020. The increase is attributed to the increase in PNC registrants and home service delivery implemented by some of the facilities. The number of continuing acceptors was higher in 2021 compared to the 5 previous years (2016-2021). Total FP acceptors in 2021 (3.8) is the second highest recorded since 2016. However, the percentage contribution by CHAG in 2021 declined by 7.3% compared to the contribution in the previous year.

Again, in 2021, the number of women who used injectables was quite low (79,387) compared to the previous year but high compared to 2016. The trend was the same for oral contraceptives, natural methods and condoms as shown in Figure 13 below. The number of couples who used permanent FP methods increased from 1,873 to 3,925 representing over 100% increase on that of 2020 as shown in figure 13. The year under review also saw a significant rise (10.3%) in uptake of implants.

Figure 12: Family Planning Services: New, Continuing and Total Acceptors (2016-2021)



Figure 13: Trend of Family Planning uptake by type, 2016-2021



1.4

HIV/AIDS Services

Because of the Global Fund CSS intervention, HIV/AIDS activities gained prominence in CHAG facilities for the year under review. Services provided on HIV/AIDS included testing at entry point, targeted testing for specific age and vulnerable groups, pre and post-test counselling, home care services and treatment. In 2021, a total of 150,635 clients were tested for HIV within specific age groups out of which 8.7% were positive as shown in table 15 below. This represents 28.0% of the national figures for 2021. The number of tests done for vulnerable populations increased from 111,303 in 2020 to 129,210 in 2021 with 6.4% positivity rate compared to 6.5% positives in 2020. Importantly, the number of tests done at entry points in 2021 also increased from 138,859 (2020) to 146,176 (5.3%) with 9,459 (6.5%) positive compared to 8,451 (6.1%) positives in 2020.

As shown in table 15 below, the number of clients linked to care among those tested within specific age group was 7,860 (representing 83.6%), that in general population was 6,942 (84.5%), while those linked from entry point testing were 7,868 (83.2%). The increase in the percentage of clients that were linked to HIV care could be attributed to several reasons including high commitment from facility HIV coordinators, CSO involvement in HIV care through the CSS intervention and active information sharing through rigorous health education, counseling.

TABLE 15

HIV Testing & Counselling Report (2020-2021)

Performance Indicator	National	CHAG	% Change 2020-2021	2-year Performance	2021 CHAG % Contribution to National Output
Number Tested for HIV (Age group)	155,991	150,635	-3.4%	Declined	14.3
Number Tested for HIV (Population)	111,303	129,210	16.1%	Increased	13.4
Number Tested for HIV (Entry point)	138,859	146,176	5.3%	Increased	14.3
Number (%) Tested HIV Positive (Age group)	9,690 (6.2%)	13,064 (8.7%)	34.8%	Worsened	28.0
Number (%) Tested HIV Positive (Population)	7,274 (6.5%)	8,215 (6.4%)	12.9%	Worsened	19.5
Number (%) Tested HIV Positive (Entry point)	8,451 (6.1%)	9,459 (6.5%)	11.9%	Worsened	21.0
Number Previously tested positive (Age group)	1,136	1,598	40.7%	Worsened	24.1
Number Previously tested positive (Population)	816	1,174	43.9%	Worsened	19.0
Number Previously tested positive (Entry Point)	982	1,376	40.1%	Worsened	22.6

Number (%) Linked into HIV Care (Age group)	7,964 (82.2%)	7,860 (83.6%)	-1.3%	Worsened	20.1
Number (%) Linked into HIV Care (Population)	6,012 \\ (82.7%)	6,942 (84.5%)	15.5%	Improved	19.2
Number (%) Linked into HIV Care (Entry point)	7,279 (86.1%)	7,868 (83.2%)	8.1%	Improved	20.8

TABLE 16**PMTCT Report (2020-2021)**

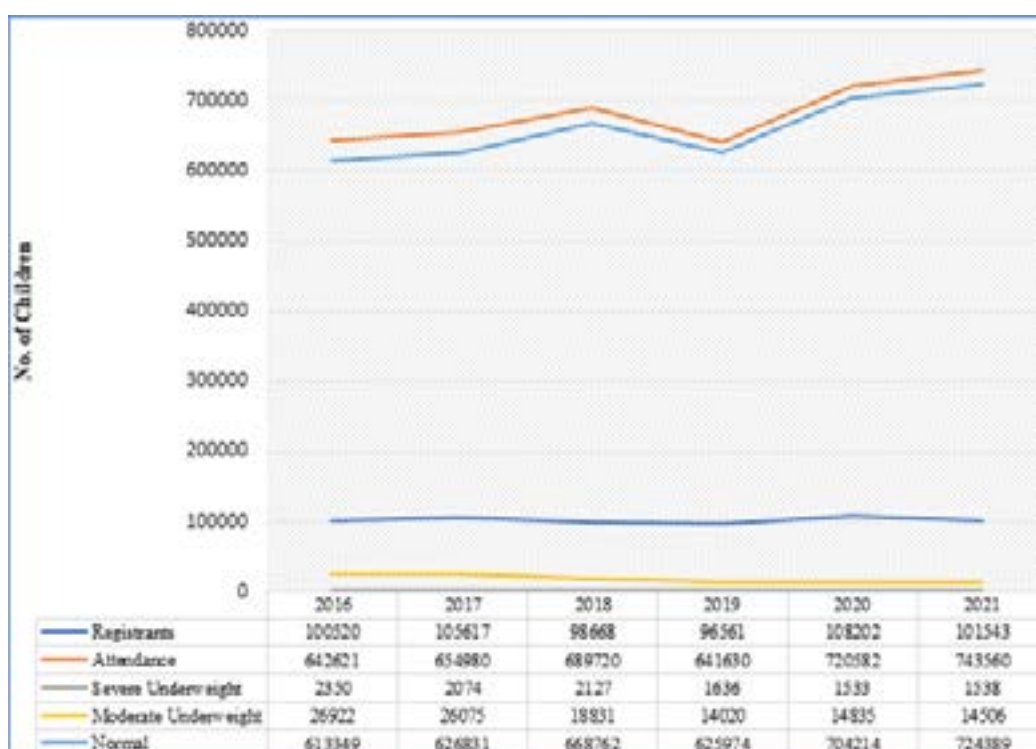
Performance Indicator	2020	2021	% Change 2020-2021	2-year Performance	2021 CHAG % Contribution to National Output
Number of Known HIV Positive before current pregnancy	2,368	1,131	-52.2%	Declined	17.6%
Number on ARV treatment before current pregnancy	1,966	895	-54.5%	Declined	15.7%
Number of known HIV Positive before current pregnancy newly put on treatment	278	170	-38.8%	Declined	18.6%
ANC registrants	119,419	117,920	-1.3%	Declined	12.0%
Number Initially tested	107,289	111,789	4.2%	Increased	12.1%
Number (%) Positive at initial testing	1,620 (1.5%)	2,345 (2.1%)	44.8%	Increased	26.5%
Number of negatives retested at 34 weeks	40,739	47,823	17.4%	Increased	15.1%
Number Positive after retesting at 34 weeks	339	222	-34.5%	Declined	15.3%
Number of new positives put on ARV	1,351	1,671	23.7%	Increased	18.9%
% Linked into HIV Care	83.4%	71.3%	-14.5%	Declined	18.9%

1.5

Child welfare Outreach Health Services

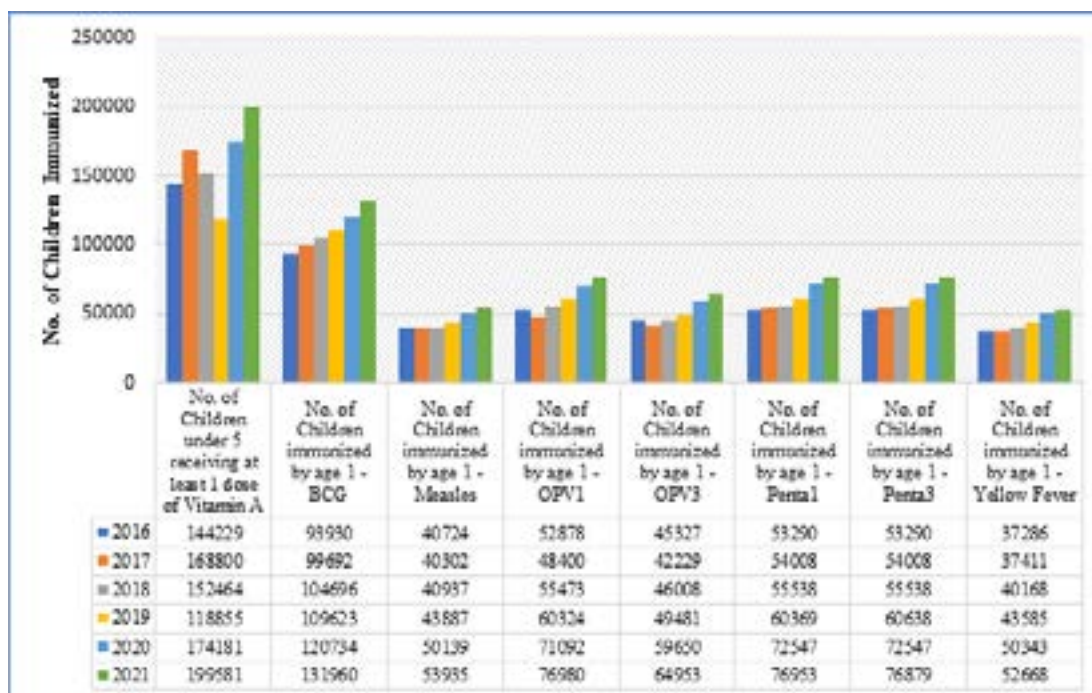
In 2021, CHAG facilities embarked on outreach services throughout the country. A total number of 743,560 children were reached through Child Welfare programmes. This was 3.2% higher compared to the previous year (720,582). The number of newly registered children in 2021 were 101,543 compared to 108,202 in 2020. This represents 6.2% decline compared to 2020. Children with normal weight were 724,389 compared to 704,214 in 2020 (-2SD to +2SD) whilst 14,506 were moderately underweight (-3SD to -2SD), and 1,538 severely underweight (<-3SD). The decline in the prevalence rate of underweight could be attributed to improved practice of Exclusive Breast Feeding (EBF). Figure 14 below shows the trend of Child Welfare and Outreach Services from 2016 – 2021.

Figure 14: Child Welfare Outreach Services from 2016- 2021



In 2021, approximately 200,000 (199,581) children under the age of 5 years were given at least one (1) dose of vitamin A (compared to 174,181 in 2020) whilst 131,960 children under 1 year were immunized against Tuberculosis (given BCG Vaccines) compared to 120,734 in 2020. Given that over 139,531 deliveries occurred in 2021, it presupposes that a significant number of babies (estimated 7,571) did not get the BCG vaccine. This poses danger for TB spread. Over 53,000 children were vaccinated against Measles while 52,668 children were vaccinated against Yellow fever. The increase in immunization coverage is attributed to improved education, improvement in supply chain system for vaccines and medicines in general. Over the period of five years, the most frequent vaccine given to children during outreaches remains Vitamin while the less frequent vaccine given is Yellow fever. Figure 15 below shows the trend of vaccinations within the CHAG network from 2016-2021.

Figure 15: Outreach Immunization Coverage and Vitamin- A Supplementation: 2016 – 2021



1.6

School Health Programme

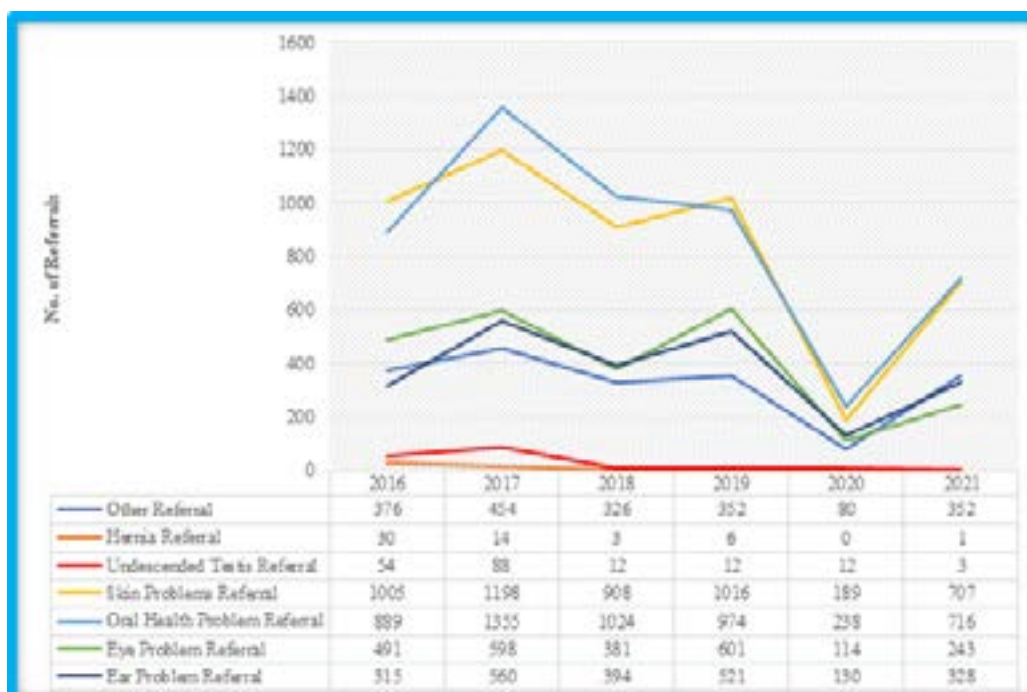
Over the period under review, schools were reopened throughout the year. Consequently, school visitations resumed. However, the number of students who were enrolled in SHEP were less (30,558) compared to the previous year (32,314). This represents 5.4% decline. The decline in the number of enrollments may be attributed to Covid-19 related fears among parents for schools. The number of students who were examined however increased from 27,983 in 2020 to 87,823 in 2021. This represents 213.8% increase. The high number of children examined in 2021 could be attributed to the perceived need to improve care for school children in the midst of the pandemic. Out of the students examined, 352 were referred to the next level of care compared 734 in the previous year. The decline in referral rates could be due to increase education on childhood illnesses, improved immunization coverage and improved school health programme.

Figure 16: School Health Programme from 2016- 2021



The common conditions seen in the school health programs were those related to oral health and skin. Eye and ear conditions were more compared to the previous year.

Figure 17: School Health Programme Diagnosed Conditions From 2016 - 2021



1.7

Summary Burden of Disease (Epidemiology)

The burden of disease is discussed in the sessions below

1.1.2

Morbidity

Over the year under review, Malaria was the commonest cause of OPD visit accounting for 9.3% as compared to 10.5% in the previous year. This was followed by Asthma/Bronchitis/URTI (6.5%) compared to 5.7% in 2020; Rheumatic/joint pains (6.2%) compared to 5.9% in 2020; and anaemia (4.1%) compared to 3.6 the previous year. The rest were Urinary Tract Infection (3.8%), Diarrhoea (2.6%), Acute Eye Infections (2.6%), Skin diseases (2.0%), respectively. In the previous year, respiratory tract infections were low largely because many people were using face-masks as part of compliance with Covid-19 protocols / restrictions that were introduced by the government. Table 17 below show the details of the top 10 conditions recorded in 2021.

TABLE 16

CHAG Top Ten (10) Causes of Morbidity for the Year Ending December 31, 2021

No.	Morbidity data for 2021	% Contribution	Morbidity data for 2021	% Contribution
1	Malaria	10.5	Malaria	9.3
2	Rheumatism / Other Joint Pains / Arthritis	5.9	Asthma/Bronchitis/URTIs	6.5
3	Asthma/Bronchitis/URTIs	5.7	Rheumatism / Other Joint Pains / Arthritis	6.2
4	Acute Urinary Tract Infection	3.8	Anaemia	4.1
5	Anaemia	3.6	Acute Urinary Tract Infection	3.8
6	Diarrhoea Diseases	2.9	Diarrhoea Diseases	2.6
7	Acute Eye Infection	2.6	Acute Eye Infection	2.6
8	Skin Diseases	2.2	Skin Diseases	2.0
9	Pregnancy Related Complications	2	Pneumonia	1.8
10	Hypertension	1.9	Gynaecological conditions	1.8
	Total % Contribution	41.1	Total % Contribution	40.8
	All Others	58.9	All Others	59.2
	Grand Total	100.0	Grand Total	100.0

1.7.2

Epidemiology of Wash-Related Diseases and Contaminants

In 2020 through to 2021, the health sector promoted hand hygiene, good nutrition, wearing of face mask and social distancing. These measures have yielded results. Aside their role in preventing the spread of COVID-19, they have helped reduce diarrhoea diseases, respiratory tract infections and malaria. For two consecutive years (2020 & 2021) no single case of cholera was reported within the CHAG network. Thus, hand hygiene has helped in abating cholera outbreaks that was so characteristic of Ghana's health system. The yearly combat for cholera can be dealt with by promoting hand hygiene at all levels. There was an increase in malaria cases by 5.6%; Diarrhoea diseases by 0.8%; typhoid fever by 29.8%, intestinal worms by 6.5% and schistosomiasis by 9.0%. CHAG in 2021 saw over 200% increase in Yellow Fever (YF).

The re-emergence of yellow fever and the rising typhoid fever cases may reflect the excessive resources channeled into COVID-19 management to the neglect of other basic and essential healthcare services.

TABLE 18

Wash Related Diseases and Contaminants

Morbidity	2019	2020	2021	% Change 2020-2021	2-year Performance
Malaria	663,288	570,125	602,053	5.6%	Increased
Diarrhoea Diseases	203,952	168,038	169,303	0.8%	Slightly increased
Typhoid Fever	87,552	87,928	114,153	29.8%	Increased
Intestinal Worms	94,556	88,492	94,209	6.5%	Increased
Onchocerciasis	79	202	90	-55.5%	Declined
Yellow Fever (YF)	7	3	11	266.7%	Increased
Schistosomiasis (Bilharzia)	934	834	909	9.0%	Increased

1.7.3

Burden of Chronic Diseases and Neglected Tropical Diseases

Over the period under review, chronic diseases increased when compared to 2020. The major increases were lymphoma, rheumatism/arthritis, mental retardation, COPD, Hepatocellular Carcinoma, cardiac diseases, sickle cell diseases, hypertension, diabetes and ulcer. Meanwhile diseases like trachoma, autism, HIV related conditions, cerebral palsy, cancer and asthma saw a remarkable decline in 2021 as depicted in the table 19 below.

TABLE 19**Burden of Chronic Diseases**

Chronic Diseases	2019	2020	2021	% change 2020-2021	3-year Performance
Rheumatism / Arthritis	352,147	342,406	419,642	22.56%	Increased
Hypertension	98,148	109,622	117,775	7.44%	Increased
Ulcer	65,697	64,826	68,220	5.24%	Increased
Diabetes	30,117	36,957	38,929	5.34%	Increased
Asthma	18,254	19,372	18,639	-3.78%	Declined
Cardiac Diseases	14,158	15,332	18,218	18.82%	Increased
Sickle Cell Disease	9,488	9,846	11,809	19.94%	Increased
Cancer	16,990	10,485	9481	-9.58%	Declined
HIV/AIDS Related conditions	9,282	10,866	8,149	-25.00%	Declined
Stroke	5,876	6,148	7,111	15.66%	Increased
Epilepsy	4,977	5,644	6,097	8.03%	Increased
Lymphoma	241	297	768	158.59%	Increased
Cerebral Palsy	1,260	821	718	-12.55%	Declined
Trachoma	269	1,015	647	-36.26%	Declined
COPD	1,020	426	478	12.21%	Increased
Hepatocellular Carcinoma	282	241	273	13.28%	Increased
Mental Retardation	726	195	257	31.79%	Increased
Autism	92	126	87	-30.95%	Declined

TABLE 20**Burden of Neglected Tropical Diseases**

NTDs	2019	2020	2021	% change 2020-2021	3-year Performance
Schistosomiasis (Bilharzia)	934	834	909	8.99%	Increased
Onchocerciasis	79	202	90	-55.45%	Declined
Trachoma	269	1,015	647	-36.26%	Declined

1.7.4

Malaria Burden

In 2021, CHAG recorded 1,515,613 suspected malaria cases representing 30.9% of the total OPD cases. About 15.1% and 0.6% of the total CHAG admissions and deaths were attributed to malaria. Children under 5 years constituted 44.6% of the total malaria deaths within the CHAG network with a case fatality rate of 0.09. Although, the case fatality rate achieved by the network is less than the 0.2 national target, however, CHAG needs to put in key public health interventions in order to further reduce the case fatality rate.

TABLE 21

Malaria and Mortality, 2021

Indicator		Number Reported	Proportion of Cases Attributed to Malaria
Out Patient Department (OPD)	Total OPD Cases	4,900,242	
	Suspected Malaria Cases	1,515,613	30.9
	Tested Malaria Cases	1,453,414	95.9
	Confirmed Malaria Cases	602,053	41.4
	Suspected Malaria in Pregnancy Cases	64,890	4.3
	Tested Malaria in Pregnancy	63,676	98.1
	Confirmed Malaria in Pregnant Cases	16,566	26.0
Admission	Total Admissions (All ages)	597,623	
	Malaria Admissions (All ages)	90,424	15.1
	Under 5 malaria admissions	32,224	35.6
Deaths	Total deaths (All ages)	11,615	
	Total Malaria deaths (All ages)	65	0.6
	Under 5 Malaria deaths	29	44.6
	Under 5 Malaria CFR		0.09

In 2021, Malaria accounted for 12.2% of admissions compared to 13.1% in 2020. This was followed by Anaemia (7.2%), Urinary Tract Infections (5.5%), Gynaecological conditions (4.8%), and Pregnancy and related complications (4.2%). The decline in malaria admissions could be attributed to improved hygiene practices and improved health seeking behaviours of clients. The table below shows details of top 10 causes of admission for 2020 to 2021.

TABLE 22**CHAG Top Ten (10) Causes of Admission 2020-2021**

No.	Morbidity data for 2020	% Contribution	Morbidity data for 2021	% Contribution
1	Malaria	13.1	Malaria	12.2
2	Anaemia	7.0	Anaemia	7.2
3	UTI	5.6	Urinary Tract Infection (UTI)	5.5
4	Hypertension	5.5	Gynaecological Conditions	4.8
5	Pneumonia	3.9	Pregnancy and Related Complications	4.2
6	Sepsis	2.8	Asthma/Bronchits/URTIs	4.1
7	Gastroenteritis	2.6	Pneumonia	4.1
8	Asthma/Bronchits/URTIs	2.2	Gastroenteritis	4.0
9	Diarrhoea	2.1	Hypertension	4.0
10	Diabetes	2.1	Gastritis	3.0
	Total % Contribution	46.9	Total % Contribution	53.1
	All Others	53.1	All Others	46.9
	Grand Total	100.0	Grand Total	100.0

1.7.5**Mortality**

A total of 11,615 deaths occurred in 2021 in CHAG facilities compared to 10,827 in 2020. This represents a 7.3 % increase over that of 2020. Pneumonia was the commonest cause of mortality accounting for 12.0% of all deaths as compared to 7.5%. This was followed by Cerebro-Vascular Accident (6.5%); hypertension (5.7); anaemia (5.1%); and sepsis by 4.1%. It is possible that some of the pneumonia deaths were COVID-19 cases that were not detected /diagnosed. With increasing burden of non-communicable diseases, the high proportion of deaths due to CVA is not surprising. It has been reported by WHO and CDC that NCDs account for about 40% of deaths in Ghana. Towards the end of 2021, CHAG started the “Akomapa” (healthy heart) project that aimed at enrolling 70,000 people with hypertension and diabetes and helping them to achieve good control using technology led tool called “empower health”. In 2021, CHAG would continue leveraging on technology in the management of NCDs to reduce its incidence and hence CVAs. The actual causes of anaemia and sepsis would be investigated, and necessary interventions implemented to reduce the high incidence and mortalities recorded over the two years. table 23 gives details of the mortality

TABLE 23**CHAG Top Ten (10) Causes of Mortality for 2020-2021**

No.	Causes of Mortality (2020)	% Contribution	Morbidity data for 2021 (2021)	% Contribution
1	Pneumonia	7.5%	Pneumonia	12.0%
2	Septicaemia	7.2%	Cerebro-Vascular Accident (CVA)	6.5%
3	Cerebrovascular Diseases	6.6%	Hypertension	5.7%
4	Hypertension	5.8%	Severe Anaemia	5.1%
5	Anaemia	4.1%	Sepsis	4.1%
6	Asphyxia	3.7%	Asphyxia	3.4%
7	Diabetes Mellitus	2.4%	HIV/AIDS	3.4%
8	Pre-maturity	2.1%	Congestive Cardiac Failure (CCF)	2.9%
9	Sepsis	1.0%	Septicemia	2.7%
10	Protein Energy Malnutrition	0.8%	Diabetes Mellitus	2.5%
	Total % Contribution	41.2%	Total % Contribution	48.3%
	All Others	58.8%	All Others	51.7%
	Grand Total	100.0	Grand Total	100.0

1.7.6**Maternal Mortality**

Maternal and neonatal mortality rates have been priorities for the CHAG network over several years. For the period under reporting, institutional maternal mortality ratio reduced from 117/100,000 live births to 113/100,000 live births as shown in table 24 below. This represents an 3.1% decline. The institutional maternal mortality within CHAG is lower than the national MMR of 138/100,000 live births target set for 2021 by the MOH. The decline seen in the CHAG network may in part be attributable to the campaign against maternal deaths, institutional capacity building project sponsored by the FCDO and SafeCare Quality Improvement programme supported by PharmAccess. The WASH programme in selected institutions supported by Jhpiego was also very helpful

Pre-eclampsia, aspiration pneumonia, amniotic fluid, and haemorrhagic shock were the commonest causes of maternal deaths in CHAG institutions. Others included Post-partum haemorrhage, hypovolemic shock, puerperal sepsis, sickle cell disease and retained placenta. Table 24 below.

TABLE 24**CHAG Top Five (5) Causes of Maternal Mortality for 2021**

No.	Causes of Mortality, 2020	% Contribution	Causes of Morbidity 2021	% Contribution
1	Post-Partum Haemorrhage	23.8%	Pre-Eclampsia/Eclampsia	14.4%
2	Pre-Eclampsia	16.3%	Aspiration cardiogenic shock	9.1%
3	Haemorrhagic Shock	7.5%	Amniotic fluid	7.5%
4	Aspiration Pneumonia	4.4%	Haemorrhagic Shock	5.9%
5	Cardiac Arrest	4.4%	Pulmonary embolism	5.9%
6	Amniotic Fluid Embolism	3.8%	Post-Partum Haemorrhage (PPH)	5.3%
7	Respiratory Failure	3.8%	Hypovolemic Shock	4.8%
8	Pulmonary Embolism	3.1%	Puerperal sepsis	4.8%
9	Abortion	2.5%	Sickle cell diseases	3.7%
10	Pulmonary Edema	2.5%	Retained Placenta	2.7%
	Total % Contribution	71.9%	Total % Contribution	64.2%
	All Others	28.1%	All Others	35.8%
	Grand Total	100.0	Grand Total	100.0

CHAG will leverage on technology and enhance focused antenatal care through outreach antenatal screening and referral services to improve maternal health services to help address the present causes of maternal mortality in the institutions.

MOH POW, 2021

1.8

Summary Health Status Indicators

There were improvements in four key health status indicators over a 5-year period (2016 to 2021). These indicators include neonatal mortality, infant mortality, under five mortality rates and still birth rate. Specifically, in 2021, institutional maternal mortality reduced by about 3.1%, Infant mortality by 12.3% and crude death by 4.4%. Over a 5-year period, maternal mortality has worsened by 4.0%, infant mortality declined by 72.9%, under five mortality rates by 11.5%, neonatal mortality by 28.5% and stillbirth by 9.5%. crude mortality rate worsened by 2.1%. The decline in mortality rates is as a result of awareness, commitment, quality improvement programmes undertaken by CHAG.

The major challenge over the last 5 years is that while infant mortality is steadily declining, under 5 mortalities has been the reverse from 2018 until the year under reporting as shown in figures 18 & 19 below .

Figure 18: Trend of Infant Mortality 2016-2021



Figure 19: Trend of Under-5 Mortality, 2016-2021.

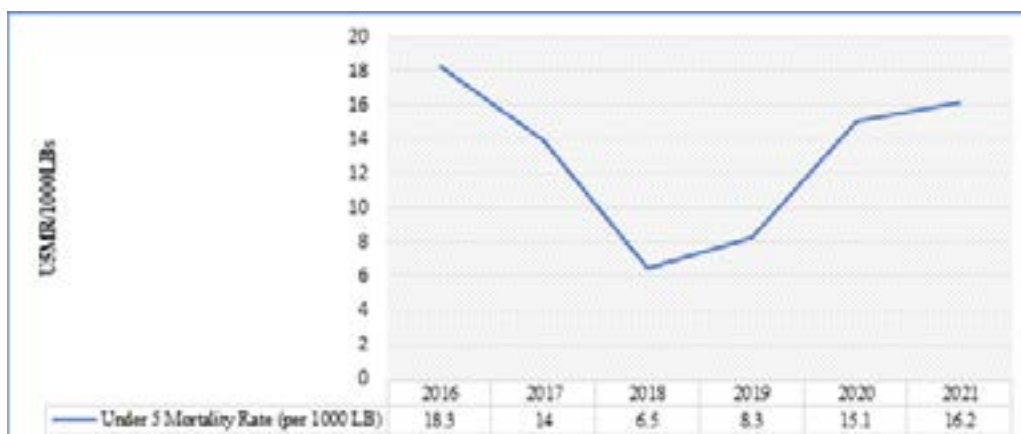


TABLE 24

CHAG Top Five (5) Causes of Maternal Mortality for 2021

Outcome Indicator	Year						% Change	2-years Performance	% Change	6-Year Performance	National	Developing Countries
	2016	2017	2018	2019	2020	2021	2020 - 2021	2020- 2021	2016 - 2021	2016 - 2021	2021	2016
Maternal Mortality Rate (per 100,000 LB)	109	152	124	123	117	113.4	-3.1	Improved	4.0	Worsen	1381	2394
Neonatal Mortality Rate (per 1000 LB)	13	9	8.2	9	9.3	9.3	0.0	Stabilized	-28.5	Improved	4.31	523
Infant Mortality Rate (per 1000 LB)	12.9	10.1	8.9	11.2	3.9	3.5	-12.3	Improved	-72.9	Improved	351	1073
Under 5 Mortality Rate (per 1000 LB)	18.3	14	6.5	8.3	15.1	16.2	7.3	Worsen	-11.5	Improved	501	1773
Still Births Rate (per 1000 LB)	20	19	19	17.9	18.1	18.1	0.0	Stabilized	-9.5	Improved	141	18.45
Crude Mortality Rate (per 1000)	19	19	17.5	14.5	20.3	19.4	-4.4	Improved	2.1	Worsen	21.31	163

¹ MOH POW, 2021

² GDHS & MICS, 2019

³ GDHS & GMHS, 2017

⁴ World Health Organization: Maternal Mortality Key facts 2015

⁵ 2015 worldwide estimates: WHO neglected tragedy of stillbirths

Figure 20: Trend of Crude Mortality Rate: 2016 – 2021

Crude mortality rate has been constant over the last five years with a slight decline in 2019. In the year under the reporting, crude mortality declined from 20.3 per 1000 admissions to 19.4 per 1000 admissions. This represents a 4.4% decline in the overall mortality rate.

1.9

Mental Health Services

1.1.2

Mentally ill Clients Seen at OPD and IPD.

In 2021, a large number of the mentally ill persons were attended to in CHAG facilities compared to the previous years. The number of new cases seen in 2021 were 13,044 compared to 8,622 in 2020 representing a percentage increase of 51.3%.

These cases were identified through active case search and at the various CHAG facility mental health units. Approximately 55%, (7161) of the clients seen were females as shown in figure 21 below. Patients who were seen for reviews in 2021 increased from 22,273 in 2020 to 35,123 representing a percentage increase of 57.7%. Out of the 35,123 mentally ill persons seen, 28,727 (81.8%) were on NHIS. The proportion of those on NHIS remained stable compared to those reported in the previous year (Ref=figure 24). The high number of cases recorded in 2021 indicates an increase in mental health illnesses. It also suggests improved accessibility and availability of mental health services in the CHAG network. Our findings from health facilities revealed an increase in mental health due to increased activities of the mental health units including screening and linking screened clients to services. Again, integration of mental health services in the mainstream maternal health services were done and proved helpful. It is suggested that the whole health system should adopt this approach.

1.9.1.1

Suicide Cases

The network recorded 27 suicide deaths. Out of the 27 deaths, 13 were females representing 48.1%. This suggests increase in suicidal deaths by 145.5% (n=27) in 2021 compared to 11 reported in 2020. Total suicide attempts also increased from 237 reported in 2020 to 293 in 2021 representing 19.1%. Females formed the highest (194) population to have attempted suicide with a percentage of 66.2%). Social related factors such as marital issues, inability to conceive a baby and poverty are said to be the leading cause of mental illness which ends in suicide. COVID-19 may also have triggered the rise in suicide cases. CHAG will conduct a survey on the epidemiology of suicide attempts within the network and come out with interventions to help reduce the high incidence of suicide.

1.9.1.2

Deaths

Mental health related death toll in 2021 declined from 197 to 148 (including 27 suicides) compared that recorded in 2020. This represents 24.9% decline. The decline as a result of increased utilization of health services as shown above. Males continue to form majority of deaths related to mental health illnesses across the network representing 66.2% (n=98), while 33.8% (n=50) of them were females.

1.9.1.3

Admissions and Discharges

The network admitted 1,974 mentally ill persons in 2021. This number is 15.6% increase on the 1,707 admissions reported in 2020. Out of the 1,974 mentally ill patients that were admitted, 1,037 (52.5%) were males while 937 (47.5%) were females. Over 90% of the admissions (1,826) were discharged home representing 92.5%. Males formed majority of those that were discharged representing 51% (n=932). Follow-ups and reviews were done for clients that were discharged home successfully to ensure total recovery of patients. Epilepsy, Schizophrenia, depression and substance use disorders were the commonest causes of admission as shown in figure 22 below.

Figure 21: New and Old Cases of Mental Clients seen in CHAG facilities by Sex, 2021

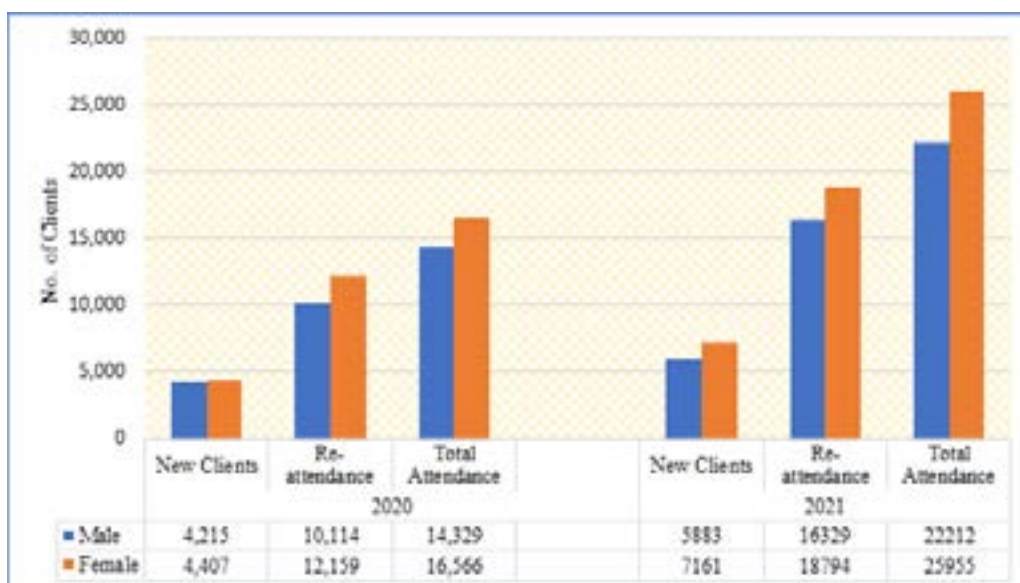


Figure 22: Admissions, Deaths and Discharges for Mentally Ill persons for 2020-2021

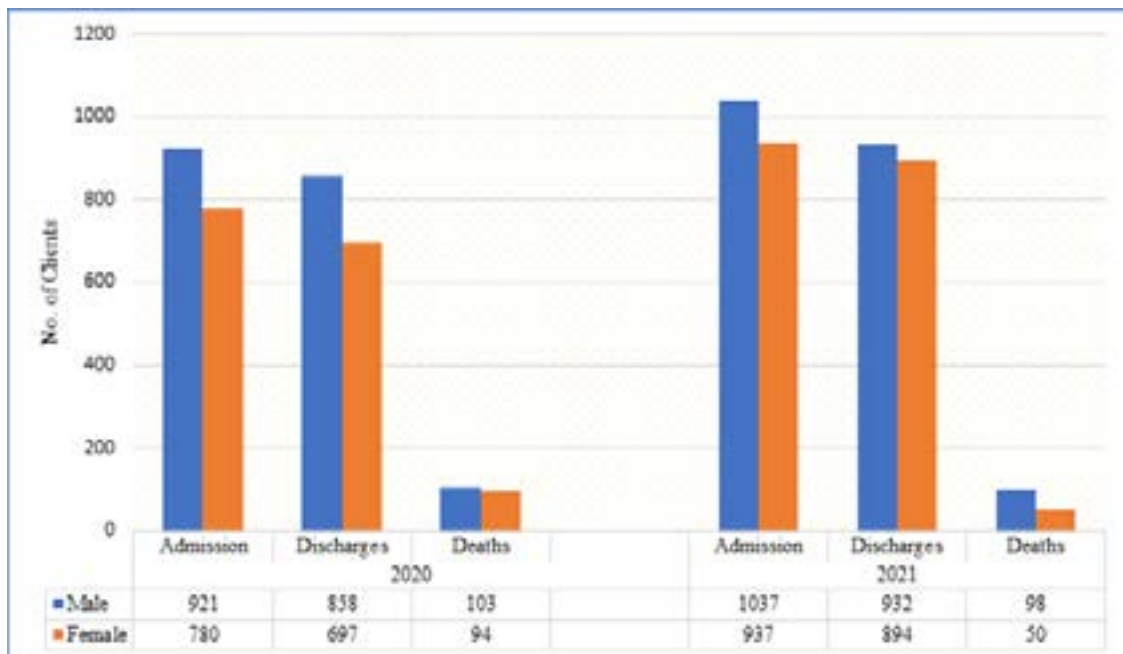


Figure 23: Common Mental Health Conditions for OPD Attendance, 2021

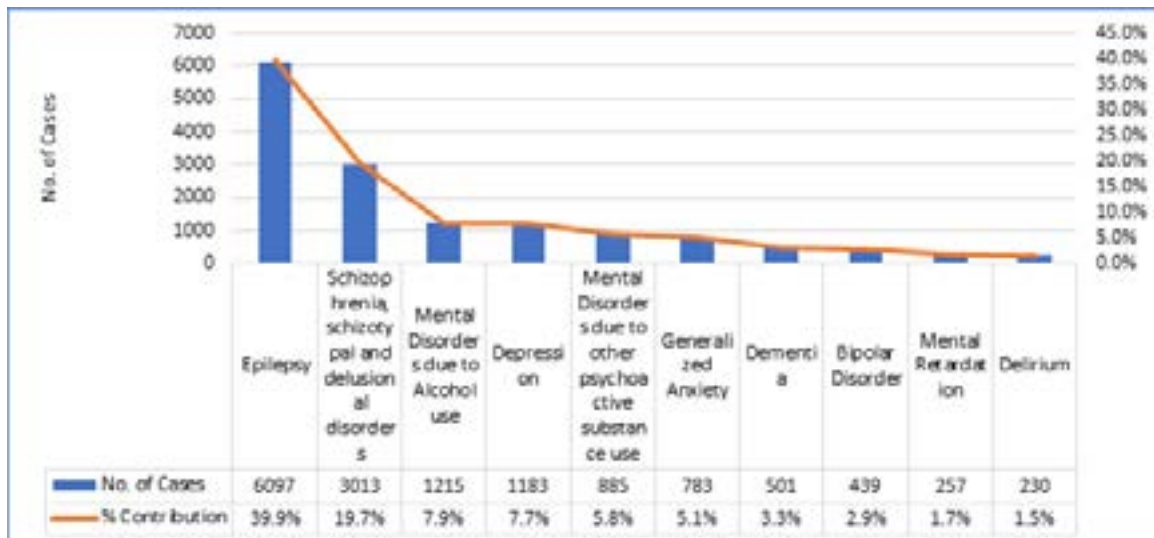
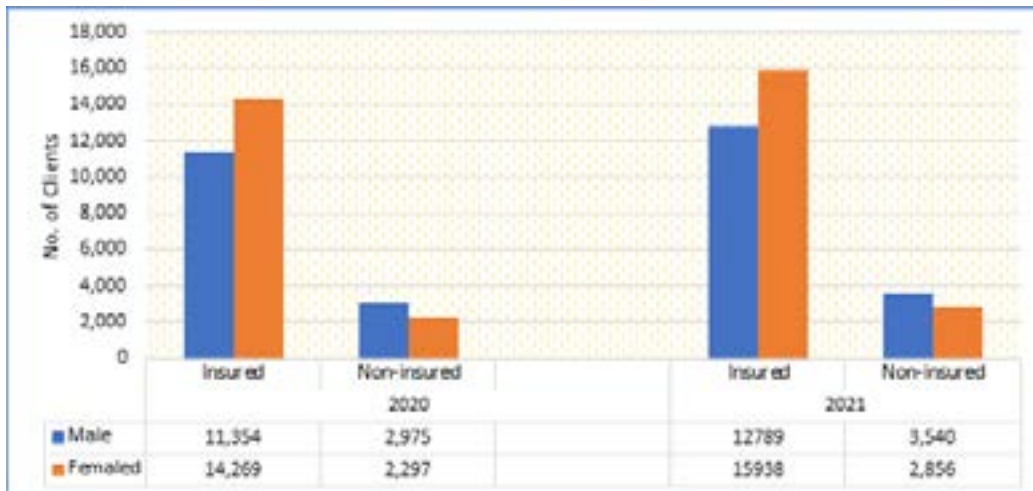


Figure 24: Insurance Status of Mentally Ill Persons seen in CHAG Facilities, 2021



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 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 using the CHAG Minimum Service Data Set (MSDS) bi-annually (January to June) and annually (January – December). 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 is also monitored and evaluated through the District Health Information Management System (DHIMS-2).

HEALTH INFORMATION OBJECTIVE FOR 2021

- 1 Scale up DHIMS 2 reporting for all CHAG facilities (including Health Centres, PHC Units & CHPS) and reduce parallel reporting.
- 2 Build capacity of Health Facility managers on the use of OPAT for facility assessment.
- 3 Harmonize data management and health information systems within the CHAG network.
- 4 Perform monthly data validation for selected key indicators with feedbacks to facilities.

ACHIEVEMENTS - 2021

- 1 Scaled up the number of facilities registered on DHIMS2 from 308 to 320.
- 2 Automated the CHAG Minimum Data Set.
- 3 Improved data quality through monthly data validation.
- 4 Improved data accessibility, availability, and integrity for Health Coordinating units.
- 5 Improved data submissions through DHIMS 2.
- 6 Set up Vantage, a performance management system that stores and analyses data and offers good visualization of performance.
- 7 Increased the number of HIO officers within the network.

Below are listed challenges faced within CHAG Network during the period under reporting.

HEALTH INFORMATION PRECARIOUS CHALLENGES

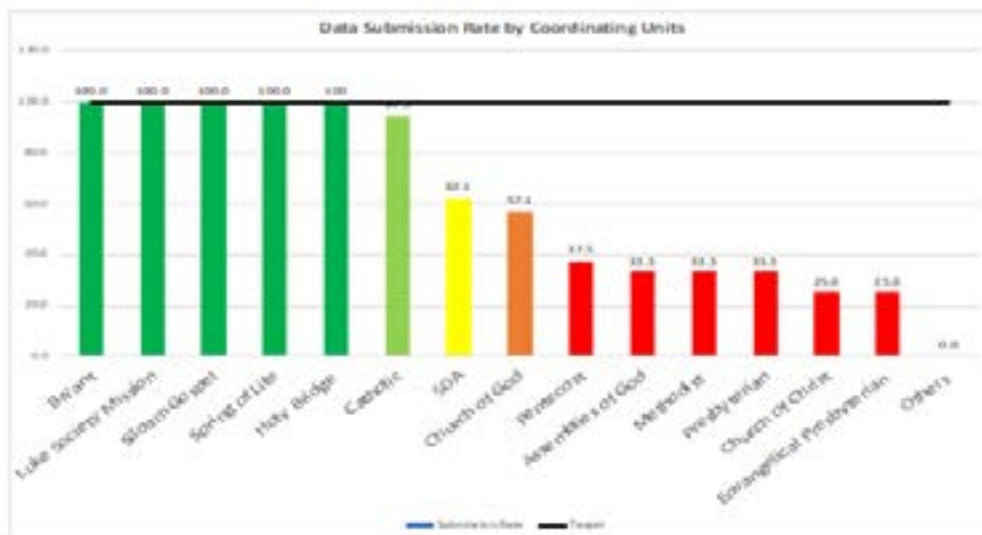
- 1 Absence of reliable data management tool / system in some facilities.
- 2 High cost in printing folders and in keeping patient records .
- 3 Diverse software versions that are not interoperable with DHIMS.
- 4 Difficulty in getting access to complete and system-wide data for decision-making.
- 5 Lack of data use by heads of health institutions.
- 6 Inability of DHIMS-II to provide disaggregated data on CHAG at all levels.

At the facility level, health service data are submitted to the government/MOH through DHIMS2. In 2021, 97.5% of CHAG Facilities submitted data to the DHIMS2 compared to 96.3% in the previous year. In 2022, the Secretariat will work on the development and implementation of CHAG Electronic Health Records which will ensure interoperability with existing systems. CHAG would further conduct research on evidence-based decision and build capacity for HIOs and Facility managers. The Secretariat will continue its normal routine activities and give feedback to health managers for improved decision making.

LEAGUE OF COORDINATING UNITS PERFORMANCE IN DATA SUBMISSION

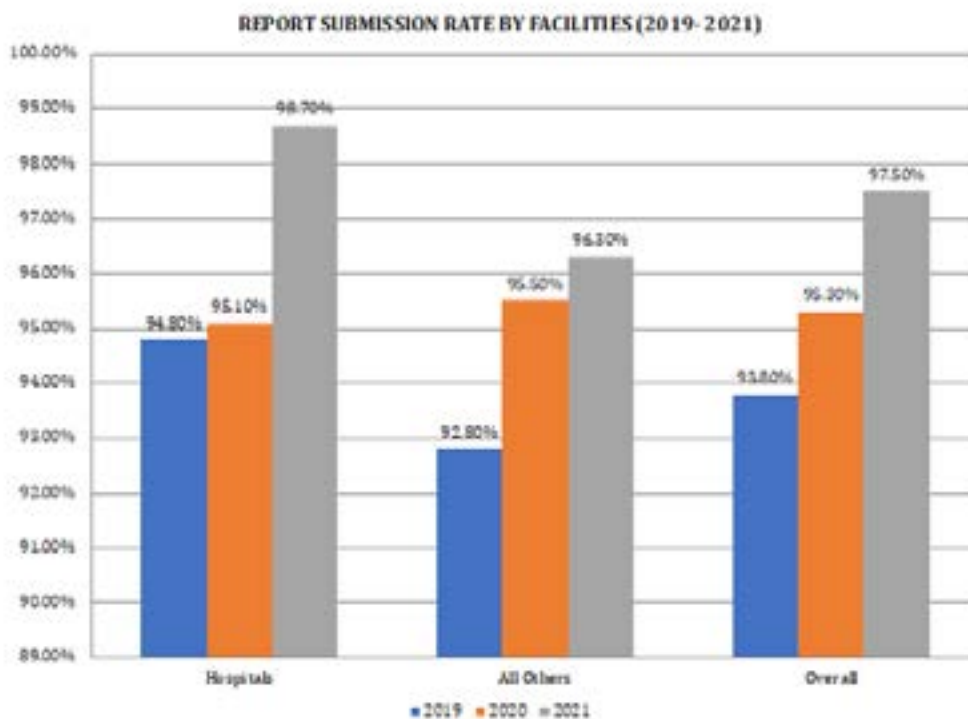
Performance Gauge (PG)				
Data Entry Via AUTOMATED CHAG MINIMUM DATA SET (%)				
> 95	95 - 80	70-60	50 - 40	< 40
A Excellent	B Very Good	C Good	D Satisfactory	E Unsatisfactory
SCORE				
4	4	3	2	1
Bryants Luke Society Mission Silvan Gospel Spring of Life Holy Bridge	Catholic	SDA	Church of God	Pentecost Assemblies of God Methodist Presbyterian Church of Christ Evangelical Presbyterian Others

Figure 25: Data Submission Rate by Church Health Offices



Bryant mission, Luke Society mission, Siloam Gospel, Spring of Life and Holy Bridge achieved 100% submission rate while NCHS achieved 94.5%, followed by SDA by 62.1% respectively.

Figure 26: Report Submission Rate by Facilities, 2021



3.0 LEADERSHIP AND GOVERNANCE

Leadership and governance relate to providing 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.

TABLE 26**Leadership and Governance in 2021**

Leadership and Governance in 2021 were similar to those experienced in 2020 and includes the following:

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

In 2021, CHAG established a 3-tier management system. The third tier looked at the implementation of the Global Fund CSS intervention. CHAG also engaged facility managers virtually on regular basis to address some key challenges and programmatic issues.

NATIONAL COMMITTEES ON WHICH CHAG SERVED

CHAG maintained its relevance in the health sector by active involvement in decision making and policy dialogue. Various Committees on which CHAG served at the National Level were same as those served in 2020: the National Technical Committee on COVID-19 (NTCC), COVID-19 Commodities Committee, Inter-Agency Leadership Committee, National Quality Strategy Technical Group, Health Sector Working Group, Ministerial Committee on Human Resources, Membership of the National AIDS Commission, HEFRA Advisory Committees, among others. The leadership of the Secretariat supported member institutions in ensuring that they were compliant with regulation. Consequently, the Secretariat supported registration of facilities with HeFRA, NHIA and Ghana Data Protection Agency

4.0 HUMAN RESOURCES

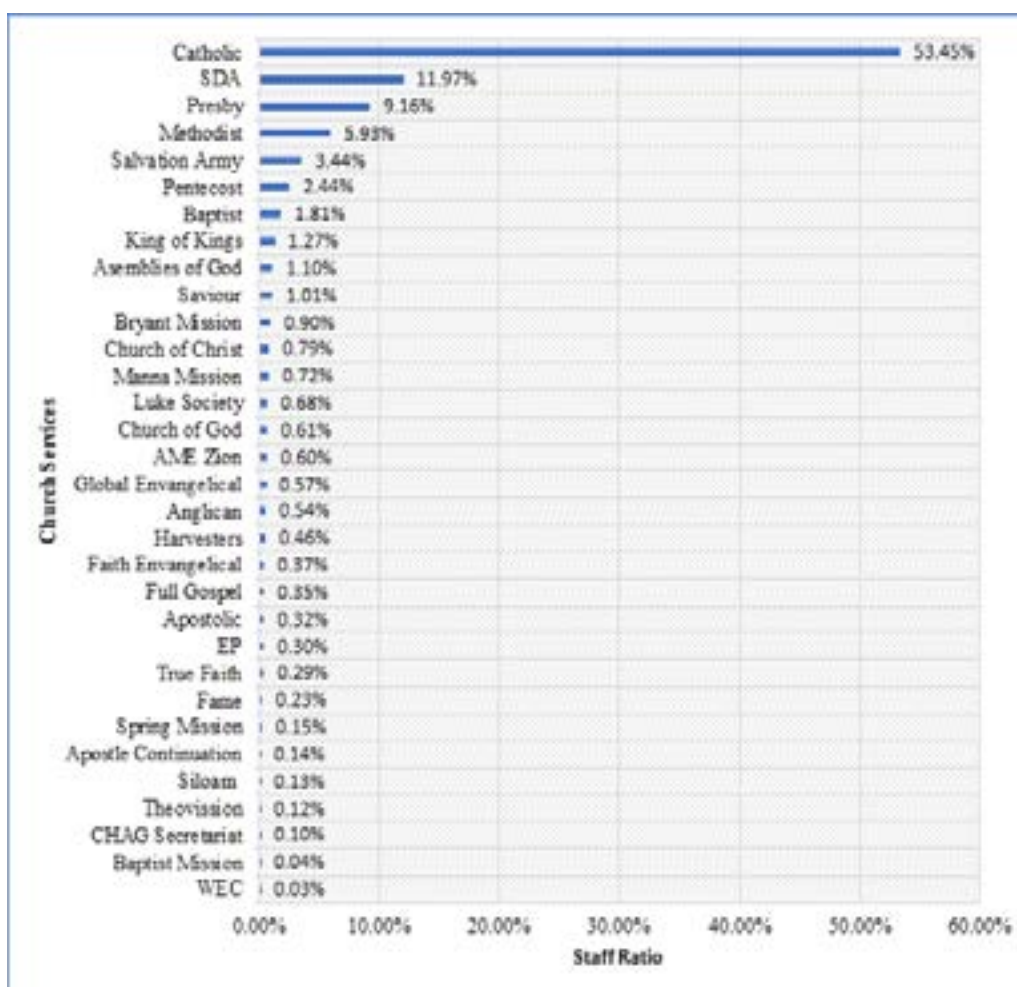
Human Resources for Health (HRH) relates to all aspects of availability, functionality, management, and performance of staff to attain optimum workforce productivity. The production, distribution, development, retention and utilization of a health workforce of the appropriate quantity, quality and the proper skill mix is essential to secure effective and quality health services. To this end, the Christian Health Association of Ghana (CHAG) regards human resource for health as central to achieving its mandate of contributing effectively to national health outcomes towards the achievement of universal health coverage and the sustainable development goal.

The staff strength of the CHAG Network as at the end of December 31st 2021 was Forty-One Thousand, Two Hundred and Eighty-Five (41,285). However, the number of CHAG employees on Government of Ghana payroll was 34,915 representing 84.6% of the total staff strength. The details are indicated in table 27 below:

TABLE 27**Trend of Number of Staff and Corresponding Salaries, 2016 - 2021**

Year	2016	2017	2018	2019	2020	2021
Salaries of CHAG staff on GoG payroll	218,886,709.56	306,668,966.00	516,064,162.50	544,530,126.00	793,625,820.90	1,126,880,746.20
% growth	14%	41%	40%	12.8%	24.02%	21.9%

As indicated in table 27 above, six thousand, three hundred and seventy (6,370) employees, representing 15.4% of the overall staff strength of CHAG were paid from the Internally Generated Funds (IGF). With the COVID-19 pandemic having additional the financial resources to paying staff amidst the delays in NHIS claims reimbursements was distressing for CMLs.

Figure 34: Percentage Distribution of Staff by Church Health Service, 2021

As can be seen in Figure 27 above, the National Catholic Health Service facilities have the highest proportion of CHAG staff with 53.45%. This is consistent with the highest number of facilities as well as the output of the NCHS to the total health services delivery of the CHAG network. However, the rate of the NCHS Has increased from 44.86% in 2019 to 53.45% in 2021; while GAHS 10.39% to 11.97%. Presbyterian Health services however declined from 11.03% to 9.16% in 2021. The proportion of staff in these three Church Health Services constitute about 75% of the total CHAG employees on GoG Payroll.

Conversely, the Church Health Services with least number of staff were Baptist Mid Mission, THEOVISION, Apostol Continuation and Spring Mission Health Services. The total staff strength of these four Church Health Services comprised 0.26% of the total number of CHAG employees on GoG payroll. The distribution of employees within the network during the period under review was largely influenced by the number of CMIs under each Denominational Health service, the need as determined by workload of the CMIs, and the location of the facilities. The staff strength of the Network has consistently seen an upward trend over the past 10 years; except in 2019 where it declined from 20,344 to 19, 537. Some further analysis will be required to establish the reason for the decline in the face of increasing number of CMIs.

4.1

Ratio of Professional to Auxiliary Nurses

The required proportion of professional and auxiliary nurses is 60% professional and 40% auxiliary. In 2021, the ratio of professional nurses and their auxiliary counterparts was 46.0% and 54.0% (figure 28). Specialised nurses were 9 in 2021 representing 0.1% out of the 8,333 professional nurses. This indicates that the CHAG network does not have the required proportion of clinical to non-clinical staff nurse; Efforts should be made to improve the rates as this has the potential of affecting effective health services delivery.

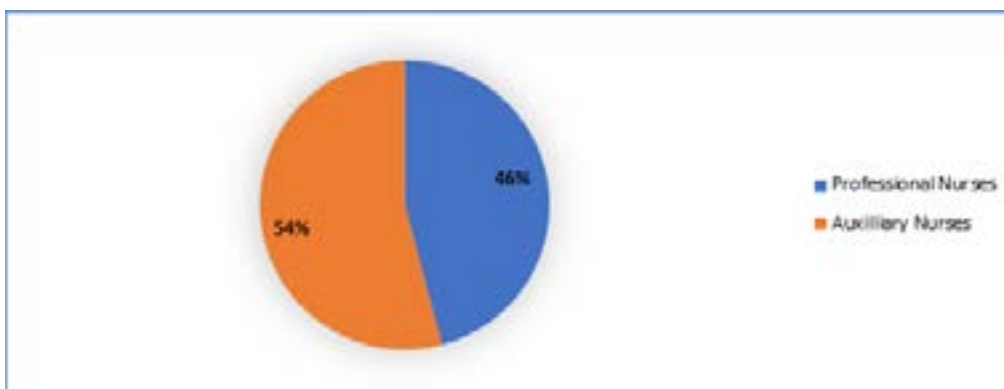
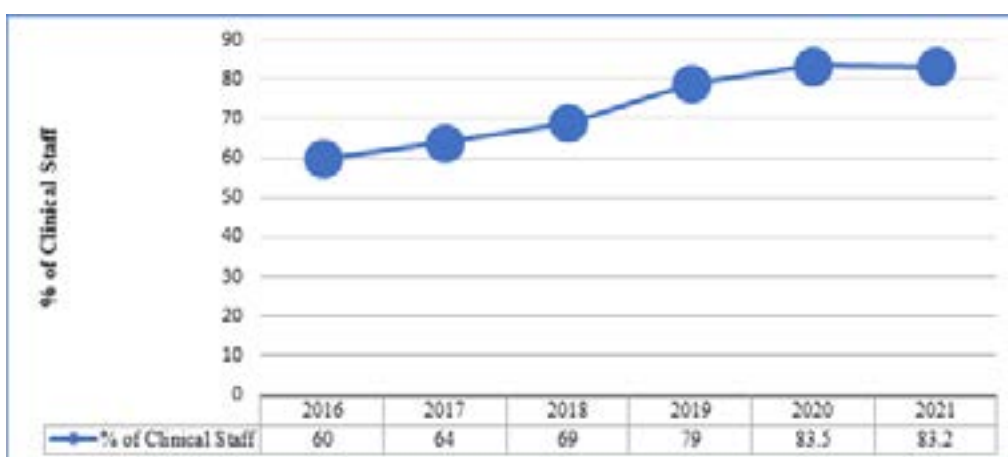


Figure 28: Ratio of Professional to Auxiliary Nurses in CHAG, 2021

Source: CHAG 2021 HR Data.

Figure 29: Trend of Clinical to non-clinical staff, 2016 - 2021



From figure 29 above, the rate of clinical staff in the network is on the upward trend, while the rate of the non-clinical staff is on the decline. This reflects Governments focus of granting financial clearance to clinical staff. A strong advocacy is required to improve the proportions of non-clinical professional staff; such as Biostatisticians, Health Service Administrators, Epidemiologist, Human Resource Managers and Information Technology Managers among others; to ensure effective strengthening of the health system.

4.2 Doctor to Patient ratio

In 2021, there were 875 Medical Doctors including specialists within the CHAG network. Doctor out-patients’ ratio recorded in CHAG in 2021 was thus 1:6,448. Each Medical Doctor saw 6448 out-patients during 2020 with an average of 18 patients per day in CHAG. The Doctor out-patient Patient ratio has increased in the year under review relative to the previous year, which recorded the rate of 1:6,519.

4.3 Nurse to Population Ratio

Nurse out-patient ratio in 2021 was 1:353 compared to 1:327. This ratio is still better for effective patient care.

Figure 30: Trend of Doctor and Nurse to Patient Ratios 2016 – 2021



4.4 Summary of Key HR Performance Indicators 5-Year Trend

Figure 30 provides information on some key human resource performance indicators over a five- year period across the CHAG network. These include the total number of mechanized staff, and Doctor to Outpatient and nurse to outpatient ratios. This has seen continued improvement over the past 5 years (2016-2021).

4.5

Promotions and Upgrades

As part of the health sector's efforts at recognizing and motivating employees in their work, for improved performance and productivity, the Ministry of Health of Ghana and by extension CHAG promotes eligible employees who meet set criteria in the performance of their duties.

Accordingly, total of two thousand, four hundred and thirty-nine (2,439) employees of the network were promoted in 2021 compared to over 4,000 promotions in 2021. This represents nearly a 50% decrease compared to 2020. The increase notwithstanding, the number of employees promoted constitutes 8% of the total staff strength of the CHAG Network; an indication that promotion activities have been generally low within the network. A survey will be required to establish the reasons for the low promotion activities. Table 28 below provides details of the Promotions.

TABLE 28**Promotions and Upgrades**

PROMOTIONS	
CHURCH HEALTH SERVICE	NO
A.G. Care	35
AME Zion Health	21
Joint Anglican	21
Baptist Convention	27
Bryant Mission Health	44
The Church of Pentecost	11
Church of Christ Mission	23
Church of God Mission	22
Evangelical Presbyterian	1
Faith Mission	5
Ghana Adventist Health	275
Global Evangelical	8
Harvester's Evangelistic Ministry	8
King of Kings	17
Luke Society Mission	2
Manna Mission	49
Methodist	113
National Catholic Health	1,204
The Church of Pentecost	92
Presbyterian	398
Saviour Church	50

Siloam Gospel	7
Grace Spring Mission	1
Theovision International	1
WEC Mission	4
Total	2,439

4.6 Inter-Agency Transfers

The Ministry of Health policy on transfer allows inter-agency transfer of staff. During the period under review, CHAG recorded six hundred and sixty-six (666) transfers, an increase of about 26% compared to that of 2021. Four hundred and twenty-three (423) were intra CHAG transfers (transfer from one Church Health Service to another); the remaining two hundred and forty-three (243) are transfers to and from other Agencies of the Ministry of Health; an increase of about 141% on the inter-agency transfers. The major receiving agency of transfers from CHAG is the Ghana Health Service; receiving one hundred and thirty-one (131) during the period.

4.7 Key HR Interventions Undertaken During the Year

Human Resource Information and Management System

CHAG continued the operationalization of HR Information and Management System (HRIMS). This intervention aimed at providing accurate comprehensive HR data and information for CHAG in particular and the health sector in general. These interventions undertaken in 2021 have the potential of building capacity of institutional managers for timely and informed decision making, HR investment, effective planning management, as well as HR advocacy. These will further strengthen CHAG HR system and practices for effective and efficient management of human resources for improved performance and productivity

4.8 HR Outlook for 2021

In 2022 several HR interventions will be carried out to further improve the HR system and practices for improved performance and productivity to enhance CHAG's contribution toward Ghana's achievement of Universal Health Coverage (UHC). The following are some of the interventions earmarked for 2019:

- 1 Organization of HR Conference.
- 2 Development of Equity index and staff rationalization estimate for facilitate redeployment of staff with the CHAG network.
- 3 Full operationalization of HRIMS for effective decision making, planning, management, advocacy and investment.
- 4 Development of composite Strategic HR plan for the network.
- 5 Electronic (online) recruitment system for timely and effective recruitment to enhance equitable distribution of health professionals.
- 6 Retention study to inform strategies to improve retention of health professionals in all CHAG facilities.
- 7 Complete the Facilitation of strategic plans development for all CHAG health training institutions for improved management and performance of the institutions.
- 8 Resourcing the Training and Development department of the CHAG HR Directorate for improving performance and productivity.

4.9

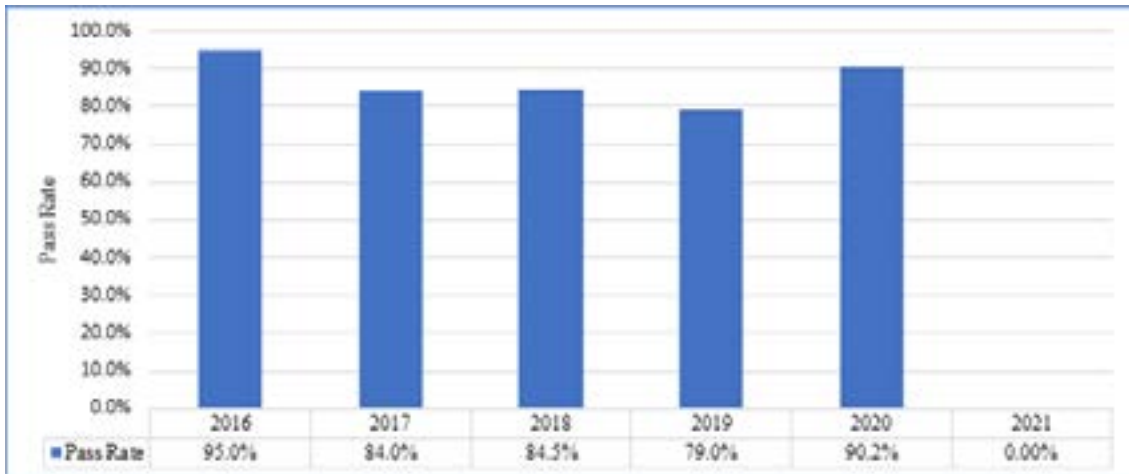
Health Training Institutions

Investment in pre-service training and continuous professional education of staff is a considerable measure for retaining staff to improve quality of services. CHAG therefore continued its investment in pre-service training during the period under review. The network has twenty-two CHAG Health training institutions. These Health Training Institutions have performed creditable over the years. At the time of publishing this report, the pass rates of CHTIs were not available, however, it is expected that performance of the institutions will exceed 90%. The graphs in figure 31 below give the trend of intake of CHAG facilities over the past five years. The overall student intake at CHAG Health Training Colleges in 2021 was 5,794 for the twenty-two training schools.

Figure 31: Trend of Student Enrolment: 2016-2021



Figure 32: Trend of Student Pass Rate in CHAG Training Institutions, 2016-2021



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 the table below.

TABLE 29
Critical Network Challenges: Health Technology

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

Presently, the CHAG network accounts for 6.0% of the total health infrastructure in the health sector. To deliver on its mandate and to contribute meaningfully to health outcomes, there is the need to retool a lot of the facilities. ICT infrastructure needs planning and coordination in the coming years. COVID-19 has brought to bear the indispensable nature of ICT for health services delivery. Post COVID-19, we need to take advantage of ICT to improved services

5.1

Prices of Medicines

Owing to the situation of COVID-19, prices of medicines reached all-time high in 2021. Access to these medicines was a challenge for several reasons: delayed NHIS payment, low utilization of services in the previous year leading to low claims, uneconomic NHIS tariffs among others. Feasible measures need to be put in place to ensure access to medicines at a reasonable price that will allow facilities to continuously serve clients on NHIS

5.2**Digital Supply Chain System for Medicines (Med4All)**

Most leading causes of discomfort, disability and premature death can be prevented, treated, or alleviated with cost effective good quality medicines. Unfortunately, this very important commodity of health is not accessible in many parts of the global community especially in the Sub-Saharan Africa and other LMICs where disease burden is greatest. In order to create access to affordable, high quality medicines in Ghana particularly in unreached segments of Ghana, CHAG and PharmAccess established the Med4All platform in 2019. The Med4All platform is a highly digitalized medicines supply chain system that bring health service providers and pharmaceutical suppliers together on a single platform. Med4All aims at finding solution to complex problems of substandard and counterfeit medicines, high medicine prices and inadequate medicines availability within CHAG member institutions and beyond.

During the year under review, Med4All made a bold step of setting up funding for facilities to access and be able to secure medicines. The funds are accessed free of interest and replaced after six (6) months when NHIS pays the facilities. This was done to cushion the facilities in the light of the difficulties in the pharmaceutical industry.

Last year, from a pilot of 29 facilities the programmed scaled up to 59 facilities. CHAG / PharmAccess also worked with FDA to guarantee the quality of medicines that are traded on the platform. Consequently, all the 430 different medicines and brands on the Med4All platform passed FDA post market surveillance quality test. A digital spectrophotometric device called TrueScan, was used in post market surveillance for medicines that were procured through the platform. The platform presently hosts 13 reputable pharmaceutical suppliers and 430 brands of medicines on the Med4All platform

5.3**Secondary Status for CHAG Facilities**

In 2021, one additional facility, the Holy Family Hospital in Berekum was granted secondary status by the NHIA. This brought to two (2) the number of CHAG hospital that had been credentialed as regional/secondary hospitals within the CHAG network. In the coming year, CHAG will work with the NHIA to credential some additional facilities as secondary facilities to attract realistic tariffs that befits the services they provide to their communities.

6.0 HEALTH FINANCING

6.1 Claim-It Uptake

CHAG adopted and implemented the electronic claims processing system known as claim-It. The number of CHAG facilities using claim-It increased to three hundred and twelve (312) constituting over 95% of CHAG facilities. This makes CHAG the Agency with the highest number of facilities submitting electronic claims. The system helped in the timely processing of claims and facilitated the identification and correction of basic errors. Furthermore, the high cost of printing claims and the cost of travelling to submit claims at Claims Processing Centers has also been removed especially for facilities that are located in hard-to-reach areas.

6.2 Costing of Health Services as Basis for Tariffs Setting

Since the inception of the National Health Insurance Scheme, tariff setting has been done by consultants who collate data from providers and later seek the buy in of providers and other stakeholders for their proposed work. Cost data is collected by independent consultants is often based on their own perspectives. This process has not been acceptable to providers, and leaves room for omissions of the views and challenges of providers. For the first time, the latest costing conducted was done using experts from the NHIA, the MOH, GHS, CHAG and the SPMDPs. The decision to adopt this approach was to help secure buy in from the onset and to consider the perspective of all stakeholders. The other benefit of this approach is to institutionalize the process of costing as a routine feature of the operations of health facilities.

TABLE 30

Upgrade of Facilities to Secondary Level Status

S/N	Name of Facility	Location	Denomination
1	Holy Family Hospital	Techiman	Catholic
2	Holy Family Hospital	Berekum	Catholic
3	St. Dominic Hospital	Akwatia	Catholic
4	Presbyterian Hospital	Agogo	Presbyterian
5	St Elizabeth Hospital	Hwidiem	Catholic
6	St Patrick Hospital	Offinso	Catholic

The table above shows the number of CHAG facilities granted secondary status by HeFRA. Among these, Holy Family Hospital, Techiman and Holy Family Hospital, Berekum were further credentialed by the NHIA to operate as Secondary level facilities by the NHIA. This recognition means higher tariffs commensurate with the extra cost of providing care at that level.

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 31).

TABLE 31**Critical Network Challenges: Partnership for Health**

- 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.
- Collaboration with NGOs and other partners.

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 31).

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 32).

TABLE 32
Critical Network Challenges: Health Research

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

8.1
Research Works

In an attempt to improve research and generate evidence for informed decision making, CHAG's Institutional Review Board was set to facilitate research for health workers within and without the CHAG network. The IRB formed in 2018 comprised individuals with the following expertise: researchers / scientists (2 from Noguchi – with one chairing the Board), legal, health systems, general administration and public health.

The IRB's mandate is to ensure the safety and protection of research subjects, as well as the ethical conduct of research that involves human subjects. The Board reviews research protocols submitted by researchers and either exempts them from review, gives expedited review or full review for approval.

As at the end of the year, the IRB had received 78 research protocols out of which 73 (93.6%) had been reviewed and 70 (89.7%) approved. Nineteen percent (19%) research protocols received were on Biomedical Science while 81% were on social / behavioural science. The details of the research proposals received in 2021 are indicated in the table 33 below. The IRB is currently receiving high number of applications for sectors that are distinguished including the Ghana College of Physicians and Surgeons.

TABLE 33**2021 Research Proposals Received**

No.	Topic	Principal Investigator	Institution
1	Exploring Social Media Adoption by Nurses for Nursing care in the North Tongu District of the Volta Region, Ghana.	Mr. Nathan Gamor	School of Nursing and Midwifery College of Health Science, University of Ghana.
2	Early Identification and Management of New Born Danger Signs among Women in Southern Ghana: A Participatory Action Research.	Mr. Mary Ani Amponsah	Maternal and Children Health Department School of Nursing and Midwifery College of Science. University of Ghana.
3	Knowledge Attitude and Practice Related to umbilical cord care in Savannah, North and North East regions.	Mr. Selase Adjei	Total Family Health Organization
4	Identification of Pathology in Chemically Exposed Agricultural Workers.	Mr. Wilson Kuhlör	SDA Hospital Gbawe, Accra
5	Assessment of Research of Nurses to Respond to Emergencies at the Paediatric ward SDA Hospital, Koforidua.	Miss Justina Banahene	SDA Hospital- Koforidua
6	Use of Malaria Rapid Diagnostic Test (RDT) and Prescribed Treatment Practice.	Mr. Christian Ayin	St. Luke Catholic Hospital, Apam
7	Exploring the Determinants of Effective Paediatric Patients /Family Education: A Study Among Nurses Working at the Kings Medical Centre.	Mr. Titus Abaah	Kings Medical Centre. Bontanga, Tamale
8	Perception of Nurses on Paediatric Pain Management: A Study at Nagel Memorial Adventist Hospital, Takoradi-Western Region.	Miss Portia . A .Hanampong	Nagel Memorial Adventist Hospital, Takoradi
9	Experience of Nurses Quarantined During the COVID-19 Pandemic. A Study at Magaret Marquart Catholic Hospital, Kpando.	Miss Evelyn Bless Degbey	Ghana Collage of Nurses and Midwives
10	Assessment of the Effectiveness of SP in Prevention of Malaria among Women: A Study in three Major Hospitals, Ahafo Region.	Mr. Justice Isaac Addo	Catholic University Collage of Ghana
11	Assessment of Healthcare Professionals and Facility Readiness towards Implementation of Eletronic Medical Records.	Mr. Emmanuel Kwarku	University of Cape Coast (UCC)

12	Tuberculosis and HIV Related Stigma and Discrimination Assessment in Selected Health Facilities in Ghana.	Mr. Benjamin Cheabu	CHAG -Global Fund
13	Health System Factors that Affects the Practices of Basic Life Support in two CHAG Facilities in the Gomoa East District, Ghana.	Mr. Patrick Bediako	Catholic University College of Ghana, Sunyani
14	Financial Health of Mission Hospitals and Medical Outcomes in the Eastern Region of Ghana	Rev. Ebenezer Abban	St. Dominic Hospital- Akwatia
15	Knowledge and Practices of Self Medication among Young People in Amansaman, Greater Accra Region.	Ms. Caroline Badzi	University of Ghana -School of Nursing and Midwifery
16	Knowledge and Perception of Adolescents on the use of Emergency Contraceptive among Senior High School Girls at Dormaa Ahenkro, Ghana.	Ms. Hannah Nsarko	Catholic University College, Sunyani
17	Assessing the Association between the National Health Insurance Scheme and the Health Seeking Behaviours of Expectant Mothers in the Techiman North District, Bono East Region, Ghana.	Dr. Alfred K. Ampofo	Catholic University College, Sunyani
18	The Experience of Nurses on Paediatric Pain Assessment Management at the Akomea Memorial SDA Hospital.	Ms. Sarah Osei	Ghana Collage of Nurses and Midwives
19	Breastmilk for Life - Operationalization of Ghana's Breastfeeding Policy	Dr Sodzi Sodzi-Tettey	UBORA Institute
20	Antecedents of User Adoption and Continuous Use of Technology: An Examination of the Med4All System in Selected Health Facilities in Ghana	Dr. Gordon Abeka-Nkrumah	Public Administration and Health Service Management, University of Ghana
21	Assessment of The Implementation of TB/HIV Collaborative Activities and Performance on Integration at the Manna Mission Hospital in Ledzokuku Municipal District	Mrs. Gloria Maud Ninepence	School of Public Health, University of Ghana
22	Patients safety Culture among Community Pharmacists in Ghana.	Dr. Gordon Abeka-Nkrumah	Public Administration and Health Service Management, University of Ghana
23	Case Report: Snakebite Envenomation with persistent coagulopathy requiring continuous dosing of Snake Antivenom in a primary care Hospital in Kpando	Dr. Eric Gyamfi	Margret Marquart Catholic Hospital, Kpando

24	Child Maintenance as a Tip of the Iceberg: Exploring the Limitation of Case Assessment Approaches in Ghana	Mr. Alhassan Abdullah	University of Hong Kong
25	The National Health Insurance Scheme and Health Needs of the Poor	Mrs. Harriet Nuamah Agyeman	School of Public Health, University of Ghana
26	Snake Bite Incidence Treatment and Effects in Ghana (SnakebiTE)	Dr. John Humphrey Amuasi	Kwame Nkrumah University of Technology
27	Determinant of COVID-19 Vaccine acceptance and Lived Experiences among Ghanaians: A qualitative Study	Mrs. Lawrence Aggrey-Bluwey	School of Public Health, University of Ghana
28	Quality of Life of HIV Peer Service Providers in Ghana.	Mr. Benjamin Spears Cheabu	CHAG - Global Fund
29	Assessment of Cervical Lesions among HIV Positive Women using Mobile Colposcopy in Bator-Ghana	Ms. Ethel Tekpor	School of Public Health, University of Ghana
30	Enablers and Barriers to the Uptake of Family Planning Methods by Healthcare Workers at the SDA Hospital Sunyani.	Sarah Osei- Amankwaa	Catholic University College, Sunyani
31	Quality Assurance Practices among Health Training Institutions: The Case of Holy Family Nursing and Midwifery Training College in the Bono Region	Emmanuella Muna Atiah	Catholic University College, Sunyani
32	Nurses Experience on Paediatric procedural pain assessment and management: A study at Hawa Memorial Hospital.	Janet Owusu Hema	Hawa Memorial Hospital, Osiem
33	: Nurses knowledge and Practices on Oxygen Therapy and Delivery Devices: A study at the SDA Hospital, Kwadaso	Gifty Yeboah Brefo	SDA Hospital Kwadaso
34	Postpartum Depression Identification and Management among Women: A study in Wenchi, Bono region.	Deborah Aba Eteru	Catholic University College, Sunyani
35	Hand hygiene practice in reducing the spread of COVID-19 among Nurses and Midwives in health facilities in Western Region of Ghana.	Valentine Ziem	Catholic University College, Sunyani
36	Tuberculosis and HIV related Stigma and Discrimination Assessment in Selected Health Facilities in Ghana.	Benjamin Cheabu	CHAG - Global Fund

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

The Organizational Performance Assessment Tool (OPAT), which is CHAG's M&E tool is helping the health facilities to periodically assess their organizational capacity 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 34 and 35). CHAG uses the OPAT for consolidated reporting and strategic capacity development of the individual members and the network as a whole. For the year under review, no monitoring was done at the facility level due to funding challenges. It is hoped that in the coming year, facilities will be assessed on the use of the OPAT.

TABLE 34

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

TABLE 35**Health Facility Outcomes and Impacts**

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, Region and Denomination

No	Facility Name/Location	Type	Region	Denomination
1	Abrafi Memorial Clinic, Brahabebome	Clinic	Ashanti	Church of God
2	Adventist Hospital, Breman	Hospital	Ashanti	Seventh Day Adventist
3	Akoma Memorial SDA Hospital, Kortwia-Abodom	Hospital	Ashanti	Seventh Day Adventist
4	All Saints Clinic, Piina	Clinic	Upper West	Catholic
5	Anfoega Catholic Hospital, Anfoega	Hospital	Volta	Catholic
6	Angela Memorial Catholic Clinic, Yawmatwa	Clinic	Western North	Catholic
7	Anglican Clinic, Sefwi-Bonzain	Clinic	Western North	Anglican
8	Anglican Clinic, Yelwoko	Clinic	Upper East	Anglican
9	Anglican Eye Hospital, Jachie	Hospital	Ashanti	Anglican
10	Anglican Health Centre, Tano-Odumase	Health Centre	Ashanti	Anglican
11	Assemblies of God Health Centre, Nakpanduri	Health Centre	North East	Assemblies of God
12	Assemblies of God Hospital, Saboba	Hospital	Northern	Assemblies of God
13	Atiaba Memorial Baptist Medical Centre	Hospital	Upper East	Baptist
14	Ave Maria Clinic, Bepoh	Clinic	Western	Catholic
15	Bachabordo Catholic Clinic, Mion	Clinic	Northern	Catholic
16	Baptist Medical Centre, Abuakwa	Hospital	Ashanti	Baptist
17	Baptist Medical Centre, Nalerigu	Hospital	North East	Baptist
18	Benito Menni Hospital, Dompoease	Hospital	Ashanti	Catholic

19	Bishop Charles Kweku Sam Memorial Clinic, Amuni	Clinic	Western	Catholic
20	Bishop Ackon Mem. Christian Eye Centre, Cape Coast	Eye Clinic	Central	Anglican
21	Bishop Anglonby Memorial Clinic, Sefwi-Bodi	Clinic	Western North	Anglican
22	Br. Tarcisius Prosthetics & Orthotics Training College, Nsawam	Training Institution	Eastern	Catholic
23	Bryant Mission Hospital, Obuasi-Adansi	Hospital	Ashanti	Bryant Mission
24	Calvary Baptist Micro-Clinic, Cape Coast	Clinic	Central	Baptist
25	Calvary Charismatic Baptist Medical Centre, Atwima Mim	Hospital	Ashanti	Baptist
26	Catholic Clinic And Maternity, Akim Swedru	Clinic	Eastern	Catholic
27	Catholic Clinic, Oku Ejura	Clinic	Ashanti	Catholic
28	Catholic Clinic/PHC, Salaga	Clinic	Northern	Catholic
29	Catholic Hospital, Battor	Hospital	Volta	Catholic
30	Central Charismatic Baptist Hospital, Gynase	Hospital	Ashanti	Baptist
31	Church of Christ Mission Clinic, Yendi	Clinic	Northern	Church of Christ
32	Church of Christ Mission Hospital, Bomso	Hospital	Ashanti	Church of Christ
33	Church of God Clinic & Maternity Home, Asempanaye	Clinic	Ashanti	Church of God
34	Church of God Clinic, Ahwerewa	Clinic	Ashanti	Church of God
35	Church of God Clinic. Apaaso	Clinic	Ashanti	Church of God
36	Church of God Hospital, Essienimpong	Hospital	Ashanti	Church of God
37	Church of God Hospital, Banda Nkwanta	Hospital	Savanna	Church of God
38	Dabaa Hope Hospital, Dabaa	Hospital	Ashanti	Harvesters Evangelistic Ministry
39	Don Bosco Clinic, Tainso	Clinic	Bono	Catholic

40	Donald Richard Memorial Health Centre, Nakwabi	Clinic	Savanna	Catholic
41	Dormaa Presby Phc , Dormaa-Ahenkro	Primary Health Care	Bono	Presbyterian
42	Dzodze Ghana Mission Clinic	Clinic	Volta	Church of Christ
43	E. P. Church Clinic, Dzemeni	Clinic	Volta	Evangelical Presbyterian
44	E. P. Church Clinic, Hatorgodo	Clinic	Volta	Evangelical Presbyterian
45	E. P. Church Clinic, Wapuli	Clinic	Northern	Evangelical Presbyterian
46	E. P. Church Dan Moser Memorial Clinic, Dambai	Clinic	Volta	Evangelical Presbyterian
47	E. P. Church Health Centre, Ho	Health Centre	Volta	Evangelical Presbyterian
48	Emmanuel Eye/ Medical Centre, East Legon	Hospital	Greater Accra	Luke Society Missions
49	Ep Church Clinic Maternity Home, Blajai	Clinic	Northern	Evangelical Presbyterian
50	Ep Church Clinic, Adaklu Waya	Clinic	Oti	Evangelical Presbyterian
51	Episcopal Clinic, Nyankamam-Enchi	Clinic	Western	Anglican
52	Evangelical Church of Ghana Hospital, Kpandai	Hospital	Northern	Wec Mission
53	Faith Evangelical Mission Hospital, Bubuashie	Hospital	Greater Accra	Faith Evangelical Mission
54	Fame Clinic, Akplale	Clinic	Oti	FAME
55	Fame Clinic, Benwoko	Clinic	Upper East	FAME
56	Fame Clinic, Ekumdi	Clinic	Northern	FAME
57	Fame Clinic, Loagri	Clinic	Northern	FAME
58	Fame Clinic, Makango	Clinic	Northern	FAME
59	Fame Clinic, Tobali/Tatindo	Clinic	Northern	FAME
60	Fame Clinic, Yezesi	Clinic	Northern	FAME

61	Fr. Cuniberto Clinic And Maternity Home, Lume.	Clinic	Volta	Catholic
62	Fr. Thomas Alan Rooney Memorial Hospital, Asankragwa	Hospital	Western	Catholic
63	Global Evangelical Mission Hospital, Apromase	Hospital	Ashanti	Global Evangelical
64	Good Shepherd Health Centre, Tuna	Health Centre	Savanna	Catholic
65	Grace Spring Mission Hospital, Effia	Hospital	Western	Spring of Life Mission
66	Hart Adventist Hospital, Ahinsan	Hospital	Ashanti	Seventh Day Adventist
67	Hawa Memorial Saviour Hospital, Akim-Osiem	Hospital	Eastern	Saviour Church
68	Holy Bridge Clinic And Maternity Home, New Mmai	Clinic	Greater Accra	The Apostles Continuation
69	Holy Child Catholic Hospital, Fijai	Hospital	Western	Catholic
70	Holy Child Clinic, Egyam	Clinic	Western	Catholic
71	Holy Cross Maternity Home And Clinic, Sambuli	Clinic	Northern	Catholic
72	Holy Family Hospital, Berekum	Hospital	Bono	Catholic
73	Holy Family Hospital, Nkawkaw	Hospital	Eastern	Catholic
74	Holy Family Hospital, Techiman	Hospital	Bono East	Catholic
75	Holy Family Nursing And Midwifery Training College, Berekum	Training Institution	Bono	Catholic
76	Holy Family Nurses Training College, Nkawkaw	Training Institution	Eastern	Catholic
77	Holy Family Nursing and Midwifery Training College, Techiman	Training Institution	Bono East	Catholic
78	Holy Rosary Health Centre, Amankwakrom	Health Centre	Eastern	Catholic
79	Holy Spirit Clinic & Maternity Home, Kwasi Fante	Clinic	Eastern	Catholic
80	Holy Spirit Clinic, Dantano	Clinic	Ahafo	Catholic
81	Hope Christian Hospital, Gomoa Fetteh	Hospital	Central	Church of Christ

82	HopeXchange Medical Centre, Santasi	Hospital	Ashanti	Catholic
83	St. Anne Catholic Hospital, Damango	Hospital	Savanna	Catholic
84	Immaculate Conception Clinic, Kaleo	Clinic	Upper West	Catholic
85	Immaculate Conception Health Centre, Kongo	Health Centre	Upper East	Catholic
86	Infant Jesus Catholic Clinic, Kasoa	Clinic	Central	Catholic
87	Janie Speaks A.M.E Zion Hospital, Afrancho	Hospital	Ashanti	Ame Zion
88	Jirapa Community Health Nursing Training School, Jirapa	Training Institution	Upper West	Catholic
89	Jubilee Catholic Children Hospital, Apowa	Hospital	Western	Catholic
90	Kayeresi Clinic, Kayeresi	Clinic	Upper East	Catholic
91	Koni Health Centre, Kpassa	Health Centre	Volta	Wec Mission
92	Kumasi Academy Clinic, Asokore	Clinic	Ashanti	Baptist
93	Kuwani Health Centre, Kuwani	Health Centre	Savanna	Presbyterian
94	Lighthouse Mission Hospital, North Kaneshie	Hospital	Greater Accra	Lighthouse Mission
95	Living Spring Baptist Medical Centre, Atasomanso	Hospital	Ashanti	Baptist
96	Madonna Health Centre, Besease	Clinic	Ashanti	Catholic
97	Manna Mission Hospital, Teshie-Nungua	Hospital	Greater Accra	Manna Mission
98	Margaret Marquart Catholic Hospital, Kpando	Hospital	Volta	Catholic
99	Margret Marquart Catholic Nursing Training College, Kpando	Training Institution	Volta	Catholic
100	Martyrs of Uganda Health Centre, Bole	Health Centre	Savanna	Catholic
101	Martyrs of Uganda Health Centre, Sirigu	Health Centre	Upper East	Catholic
102	Mary Ekuba Ewoo Memorial Adventist Clinic, Akwidaa	Clinic	Western	Seventh Day Adventist

103	Mater Ecclesiae Hospital, Sokode	Hospital	Volta	Catholic
104	Mathias Catholic Hospital, Yeji	Hospital	Bono East	Catholic
105	Mercy Women's Hospital, Mankessim	Hospital	Central	Catholic
106	Methodist Hospital, Ankaase	Hospital	Ashanti	Methodist
107	Methodist Health Training Institute, Afosu	Training Institution	Eastern	Methodist
108	Methodist Hospital, Aburaso	Hospital	Ashanti	Methodist
109	Methodist Hospital, Wenchi	Hospital	Bono East	Methodist
110	Methodist Medical Centre, Zanzugu Yipala	Clinic	Northern	Methodist
111	Methodist Medical Centre, Adjoafua	Clinic	Western North	Methodist
112	Methodist Medical Centre, Adum Kumasi	Clinic	Ashanti	Methodist
113	Methodist Medical Centre, Amakom	Clinic	Ashanti	Methodist
114	Methodist Hospital, Apagya	Hospital	Ashanti	Methodist
115	Methodist Medical Centre, Asuakwa	Clinic	Bono	Methodist
116	Methodist Medical Centre, Bebu - Anyiaem	Clinic	Ashanti	Methodist
117	Methodist Medical Centre, Brodekwan	Clinic	Ashanti	Methodist
118	Methodist Medical Centre, Dayyamen	Clinic	Bono	Methodist
119	Methodist Medical Centre, Gwira Eshiem	Clinic	Western North	Methodist
120	Methodist Medical Centre, Hweehwee	Clinic	Eastern	Methodist
121	Methodist Medical Centre, Kwakuanya	Clinic	Bono	Methodist
122	Methodist Medical Centre, Kwawu	Clinic	Western	Methodist
123	Methodist Medical Centre, Kyerekyewere	Clinic	Bono	Methodist

124	Methodist Medical Centre, Lawra	Clinic	Upper West	Methodist
125	Methodist Medical Centre, Nyameani	Clinic	Ashanti	Methodist
126	Methodist Medical Centre, Benyin	Clinic	Western	Methodist
127	Methodist Medical Centre, Osuben	Clinic	Eastern	Methodist
128	Methodist Medical Centre, Senchi	Clinic	Ashanti	Methodist
129	Methodist Medical Centre, Tafo	Clinic	Ashanti	Methodist
130	Methodist Medical Centre, Takoradi	Clinic	Western	Methodist
131	Methodist Medical Centre, Yawsae	Clinic	Bono	Methodist
132	Mother of God Clinic, Esaase Bontefufuo	Clinic	Ashanti	Catholic
133	Nagel Memorial Adventist Hospital, Takoradi	Hospital	Western	Seventh Day Adventist
134	Nativity of Our Lady Health Centre, Ko	Clinic	Upper West	Catholic
135	Nazareth Healing Complex, Vane Avetime	Clinic	Volta	Evangelical Presbyterian
136	New Life College, Tamale	Training Institution	Northern	WEC Mission
137	Notre Dame Clinic, Nsawam	Clinic	Eastern	Catholic
138	Presbyterian Nursing & Midwifery Training College, Agogo	Training Institution	Ashanti	Presbyterian
139	Nzema Baptist Hospital, Nvellenu	Hospital	Western	Baptist
140	Orthopaedic Training Centre, Adoagyiri	Clinic	Eastern	Catholic
141	Our Lady of Fatima Health Centre, Abease	Clinic	Bono East	Catholic
142	Our Lady of Grace Hospital, Breman-Asikuma	Hospital	Central	Catholic
143	Our Lady of Lourdes Clinic, Yagha	Clinic	Upper West	Catholic
144	Our Lady of Rocio Health Centre, Walewale	Health Centre	North East	Catholic

145	Pentecost Hospital, Ayanfuri	Hospital	Central	The Church of Pentecost
146	Pentecost Clinic, Enchi	Clinic	Western	The Church of Pentecost
147	Pentecost Clinic, Kasapin	Clinic	Bono	The Church of Pentecost
148	Pentecost Clinic, Kpassa	Clinic	Oti	The Church of Pentecost
149	Pentecost Clinic, Yawmatwa	Clinic	Western North	The Church of Pentecost
150	Pentecost Community Clinic, Twifu Agona	Clinic	Central	The Church of Pentecost
151	Pentecost Hospital - Tarkwa	Hospital	Western	The Church of Pentecost
152	Pentecost Hospital, Madina	Hospital	Greater Accra	The Church of Pentecost
153	Pope Francis Clinic, Komfourkrom	Clinic	Bono East	Catholic
154	Pope John Paul II Medical Centre, Jamasi	Hospital	Ashanti	Catholic
155	Power House Hospital, Old Tafo	Hospital	Ashanti	Powerhouse
156	Presbyterian CHPS Compound, Amonie	CHPS	Western	Presbyterian
157	Presbyterian CHPS Compound, Tolla	CHPS	Upper East	Presbyterian
158	Presbyterian Clinic, Abasua	Clinic	Ashanti	Presbyterian
159	Presbyterian Clinic, Antwirifo	Clinic	Bono	Presbyterian
160	Presbyterian Clinic, Buokrukruwa	Clinic	Bono	Presbyterian
161	Presbyterian Clinic, Fooshegu	Clinic	Savanna	Presbyterian
162	Presbyterian Clinic, Gyankufa	Clinic	Bono	Presbyterian
163	Presbyterian Clinic, Namolgo	Clinic	Upper East	Presbyterian
164	Presbyterian Clinic, Ohiamatuo	Clinic	Western	Presbyterian
165	Presbyterian Clinic, Papueso-Enchi	Clinic	Western	Presbyterian

166	Presbyterian Clinic, Tanoboase	Clinic	Bono	Presbyterian
167	Presbyterian Clinic, Yaakrom	Clinic	Bono	Presbyterian
168	Presbyterian Health Centre , Kwamebikrom	Health Centre	Western	Presbyterian
169	Presbyterian Health Centre, Assin Nsuta	Health Centre	Central	Presbyterian
170	Presbyterian Health Centre, Jenjemireja	Health Centre	Bono	Presbyterian
171	Presbyterian Health Centre, Kwahu Praso	Health Centre	Eastern	Presbyterian
172	Presbyterian Health Centre, Kyeremasu	Health Centre	Bono	Presbyterian
173	Presbyterian Health Centre, Aboabo	Health Centre	Bono	Presbyterian
174	Presbyterian Health Centre, Enchi	Health Centre	Western	Presbyterian
175	Presbyterian Health Centre, Kwadwokumikrom	Health Centre	Bono East	Presbyterian
176	Presbyterian Health Centre, Kwamesua	Health Centre	Bono	Presbyterian
177	Presbyterian Health Centre, Langbinsi-Gambaga	Health Centre	North East	Presbyterian
178	Presbyterian Health Centre, Loloto	Health Centre	North East	Presbyterian
179	Presbyterian Health Centre, Obregyima	Health Centre	Eastern	Presbyterian
180	Presbyterian Health Centre, Siniensi	Health Centre	Upper East	Presbyterian
181	Presbyterian Health Centre, Suma Ahenkro	Health Centre	Bono	Presbyterian
182	Presbyterian Health Centre, Sumaduri	Health Centre	Upper East	Presbyterian
183	Presbyterian Hospital, Agogo, Ashanti-Akim	Hospital	Ashanti	Presbyterian
184	Presbyterian Hospital, Assin Praso	Hospital	Central	Presbyterian
185	Presbyterian Hospital, Bawku	Hospital	Upper East	Presbyterian
186	Presbyterian Hospital, Donkorkrom	Hospital	Eastern	Presbyterian

187	Presbyterian Hospital, Dormaa-Ahenkro	Hospital	Bono	Presbyterian
188	Presbyterian Midwifery Training School, Dormaa Ahenkro	Training Institution	Bono	Presbyterian
189	Presbyterian Midwifery Training School, Duayaw Nkwanta	Training Institution	Bono	Presbyterian
190	Presbyterian Nursing And Midwifery Training College, Bawku	Training Institution	Upper East	Presbyterian
191	Presbyterian Orthopaedic Hospital, Bawku	Hospital	Upper East	Presbyterian
192	Presbyterian PHC , Agogo, Ashanti-Akim	Primary Health Care	Ashanti	Presbyterian
193	Presbyterian PHC, Bawku	Primary Health Care	Upper East	Presbyterian
194	Presbyterian PHC, Bolgatanga	Primary Health Care	Upper East	Presbyterian
195	Presbyterian PHC, Salaga	Primary Health Care	Northern	Presbyterian
196	Presbyterian PHC, Sandema	Primary Health Care	Upper East	Presbyterian
197	Presbyterian Primary Health Centre, Tease	Primary Health Care	Eastern	Presbyterian
198	Presbyterian Regional Eye Centre, Bolgatanga	Eye Clinic	Upper East	Presbyterian
199	Presbyterian Health Centre, Widana	Health Centre	Upper East	Presbyterian
200	Presbyterian Health Centre, Abetifi	Health Centre	Eastern	Presbyterian
201	Presbyterian Health Centre, Ekye	Health Centre	Eastern	Presbyterian
202	Presbyterian Health Centre, Garu	Health Centre	Upper East	Presbyterian
203	Presbyterian Health Centre, Kom- Aburi	Health Centre	Eastern	Presbyterian
204	Presbyterian Health Centre, Woriyanga	Primary Health Care	Upper East	Presbyterian
205	Queen of Peace Clinic, Sabuli	Clinic	Upper West	Catholic
206	Rev. Walker Mission Hospital, Fumesua Kokobra	Hospital	Ashanti	The Apostolic Church
207	Richard Novarti Memorial Hospital, Sogakope	Hospital	Volta	Catholic

208	Sacred Heart Health Centre, Bepoase	Health Centre	Ashanti	Catholic
209	Sacred Heart Hospital, Weme-Abor	Hospital	Volta	Catholic
210	Salvation Army Clinic, Adaklu-Sofa	Clinic	Oti	The Salvation Army
211	Salvation Army Clinic, Akim-Wenchi	Clinic	Eastern	The Salvation Army
212	Salvation Army Clinic, Anum	Clinic	Eastern	The Salvation Army
213	Salvation Army Clinic, Begoro	Clinic	Eastern	The Salvation Army
214	Salvation Army Health Centre, Ajumako-Ochiso	Health Centre	Central	The Salvation Army
215	Salvation Army Hospital, Agona-Duakwa	Hospital	Central	The Salvation Army
216	Salvation Army Hospital, Wiamoase	Hospital	Ashanti	The Salvation Army
217	Salvation Army Polyclinic, Baa	Polyclinic	Central	The Salvation Army
218	Samuel Seidu Memorial Clinic, Bayiri	Clinic	Upper West	Baptist Mid Mission
219	Santa Maria Clinic, Krisan	Clinic	Western	Catholic
220	Saviour Church Clinic, Bonwire	Clinic	Ashanti	Saviour Church
221	Saviour Church Clinic, Subriso	Clinic	Ashanti	Saviour Church
222	Saviour Church Nursing And Midwifery Training College, Osiem	Training Institution	Eastern	Saviour Church
223	Sda Valley View Hospital, Oyibi	Hospital	Greater Accra	Seventh Day Adventist
224	Seventh Day Adventist Hospital, New Gbawe	Hospital	Greater Accra	Seventh Day Adventist
225	Seventh Day Adventist Clinic And Maternity, Sefwi Punikrom	Clinic	Western North	Seventh Day Adventist
226	Seventh Day Adventist Clinic, Anyinasuso	Clinic	Ashanti	Seventh Day Adventist
227	Seventh Day Adventist Clinic, Apaah	Clinic	Ashanti	Seventh Day Adventist
228	Seventh Day Adventist Clinic, Dadieso	Clinic	Western	Seventh Day Adventist

229	Seventh Day Adventist Clinic, Dominase	Clinic	Central	Seventh Day Adventist
230	Seventh Day Adventist Clinic, Kofikrom	Clinic	Western North	Seventh Day Adventist
231	Seventh Day Adventist Clinic, Konkoma	Clinic	Ashanti	Seventh Day Adventist
232	Seventh Day Adventist Clinic, Nobewam	Clinic	Ashanti	Seventh Day Adventist
233	Seventh Day Adventist Clinic, Sefwi Amoaya	Clinic	Western North	Seventh Day Adventist
234	Seventh Day Adventist Clinic, Wa	Clinic	Upper West	Seventh Day Adventist
235	Seventh Day Adventist Clinic, Wassa Nkran	Clinic	Western	Seventh Day Adventist
236	Sda Nursing And Midwifery Training College, Asanta	Training Institution	Western	Seventh Day Adventist
237	Seventh Day Adventist Hospital, Asamang	Hospital	Ashanti	Seventh Day Adventist
238	Seventh Day Adventist Hospital, Dominase	Hospital	Ashanti	Seventh Day Adventist
239	Seventh Day Adventist Hospital, Koforidua	Hospital	Eastern	Seventh Day Adventist
240	Seventh Day Adventist Hospital, Kwadaso-Kumasi	Hospital	Ashanti	Seventh Day Adventist
241	Seventh Day Adventist Hospital, Namong	Hospital	Ashanti	Seventh Day Adventist
242	Seventh Day Adventist Hospital, Obuasi	Hospital	Ashanti	Seventh Day Adventist
243	Seventh Day Adventist Hospital, Sefwi-Asawinso	Hospital	Western	Seventh Day Adventist
244	Seventh Day Adventist Hospital, Sunyani	Hospital	Bono	Seventh Day Adventist
245	Seventh Day Adventist Hospital, Tamale	Hospital	Northern	Seventh Day Adventist
246	Seventh Day Adventist Hospital, Wiamoasi-Ashanti	Hospital	Ashanti	Seventh Day Adventist
247	Sda Midwifery Training School, Asamang	Training Institution	Ashanti	Seventh Day Adventist
248	Sda Nursing And Midwifery Training School, Kwadaso	Training Institution	Ashanti	Seventh Day Adventist
249	Siloam Gospel Clinic, Bonyere	Clinic	Western	Siloam Gospel

250	St. Alban's Clinic(The Refugee Camp Clinic), Fetentaa	Clinic	Bono	Catholic
251	St. Andrew's Catholic Hospital, Kordiabe	Hospital	Greater Accra	Catholic
252	St. Anne Hospital, Damongo	Hospital	Upper East	Catholic
253	St. Anne's Polyclinic, Tagadzi	Clinic	Volta	Catholic
254	St. Anthony Ann Hospital, Donyina	Clinic	Ashanti	Catholic
255	St. Anthony Clinic, Sikaman	Clinic	Ashanti	Catholic
256	St. Anthony's Clinic, Anyinasu	Clinic	Ashanti	Catholic
257	St. Anthony's Clinic, Badu	Clinic	Bono	Catholic
258	St. Anthony's Hospital, Dzodze	Hospital	Volta	Catholic
259	St. Catherine of Sienna Health Centre, Jirapa	Health Centre	Upper West	Catholic
260	St. Christoper Clinic, Dapuori	Clinic	Upper West	Catholic
261	St. Dominic Health Centre, Cherembo	Clinic	Bono East	Catholic
262	St. Dominic Hospital, Akwatia	Hospital	Eastern	Catholic
263	St. Edward's Hospital, Dwinyama	Hospital	Ashanti	Catholic
264	St. Elizabeth Hospital, Hwidiem	Hospital	Ahafo	Catholic
265	St. Evarist Clinic, Ullo	Clinic	Upper West	Catholic
266	St. Francis Clinic, Saviefe Agorkpo	Clinic	Oti	Catholic
267	St. Francis Xavier Hospital, Assin-Fosu	Hospital	Central	Catholic
268	St. George's Polyclinic, Liatu	Clinic	Volta	Catholic
269	St. Gerhardt Health Centre, Fielmuo	Health Centre	Upper West	Catholic
270	St. Gregory Catholic Hospital, Gomoa Budumburam	Hospital	Central	Catholic

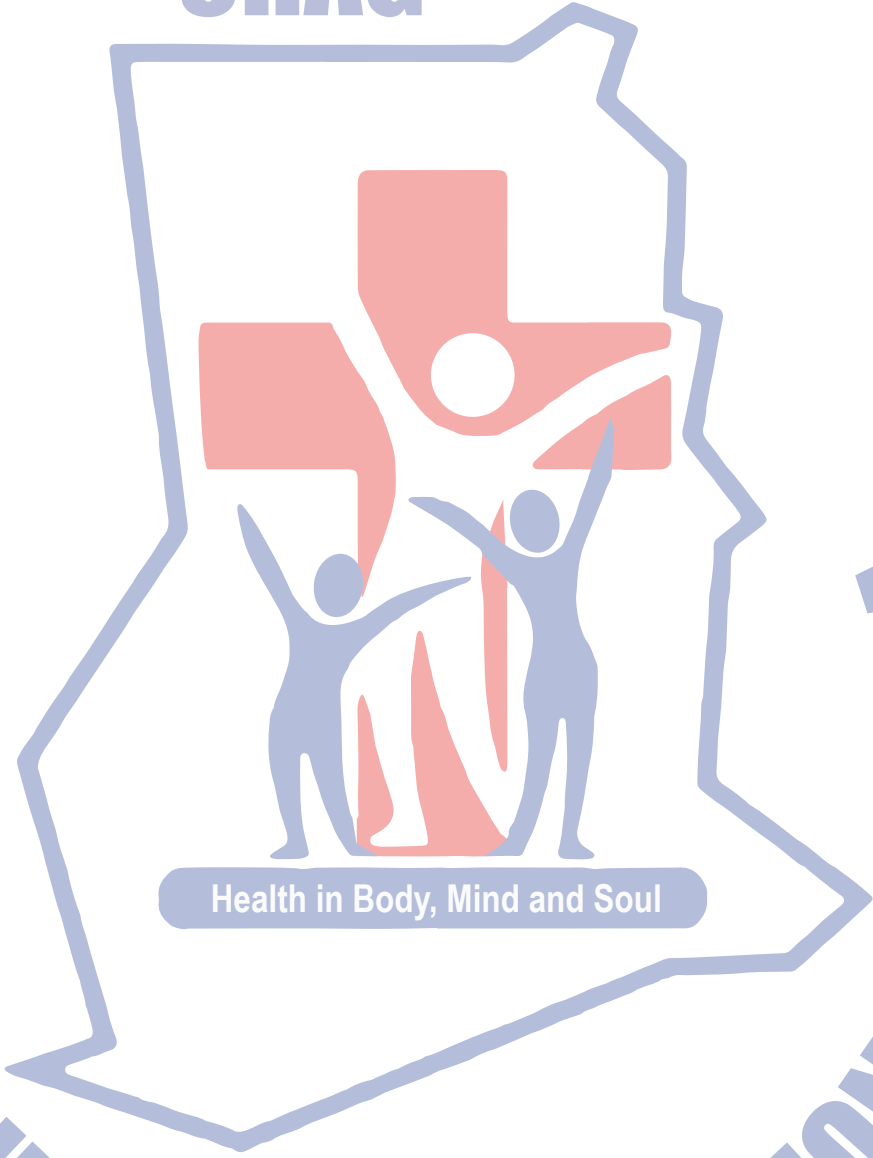
271	St. Gregory's Clinic, Nanvilli	Clinic	Upper West	Catholic
272	St. Ignatius Clinic, Lasia Tuolu	Clinic	Upper West	Catholic
273	St. Jame's Clinic, Abesim	Clinic	Bono	Catholic
274	St. John of God Clinic, Amrahia	Clinic	Greater Accra	Catholic
275	St. John of God Clinic, Oseikojokrom	Clinic	Western North	Catholic
276	St. John of God College Of Health, Duayaw Nkwanta	Training Institution	Bono	Catholic
277	St. John of God Hospital, Duayaw-Nkwanta	Hospital	Bono	Catholic
278	St. John of God Hospital, Sefwi-Asafo	Hospital	Western North	Catholic
279	St. John's Clinic, Funsu	Clinic	Upper West	Catholic
280	St. John's Clinic/Maternity, Akim Ofoase	Clinic	Eastern	Catholic
281	St. John's Health Centre, Domeabra	Health Centre	Ashanti	Catholic
282	St. Joseph Clinic & Maternity Home, Chamba	Clinic	Northern	Catholic
283	St. Joseph Clinic & Maternity Home, Kwahu-Tafo	Clinic	Eastern	Catholic
284	St. Joseph Health Centre, Nakolo	Health Centre	Upper East	Catholic
285	St. Joseph The Worker Clinic, Guabuliga	Clinic	Upper East	Catholic
286	St. Joseph's Clinic, Abira	Clinic	Ashanti	Catholic
287	St. Joseph's Clinic, Bechem	Clinic	Bono	Catholic
288	St. Joseph's Clinic, Wenchi Koasi	Clinic	Bono	Catholic
289	St. Joseph's Health Centre, Kalba	Health Centre	Savanna	Catholic
290	St. Joseph's Hospital, Jirapa	Hospital	Upper West	Catholic
291	St. Joseph's Hospital, Koforidua	Hospital	Eastern	Catholic

292	St. Joseph's Hospital, Nkwanta	Hospital	Oti	Catholic
293	St. Joseph's Midwifery Training College, Jirapa	Training Institution	Upper West	Catholic
294	St. Joseph's Nurses' Training College, Jirapa	Training Institution	Upper West	Catholic
295	St. Louis Health Centre, Bodwesango	Health Centre	Ashanti	Catholic
296	St. Lucy Hospital, Tamale	Hospital	Northern	Catholic
297	St. Luke Catholic Hospital, Apam	Hospital	Central	Catholic
298	St. Luke's Clinic, Chinderi	Clinic	Volta	Catholic
299	St. Luke's Health Centre, Seniagya	Health Centre	Ashanti	Catholic
300	St. Luke's Hospital, Kasei Via Ejura	Hospital	Ashanti	Luke Society Missions
301	St. Mark's Anglican Clinic, Subiri	Clinic	Western North	Anglican
302	St. Martin de Porres Clinic, Eremon	Clinic	Upper West	Catholic
303	St. Martin de Porres Hospital, Eikwe	Hospital	Western	Catholic
304	St. Martin Memorial Hospital, Ashaiman	Hospital	Greater Accra	King Of Kings
305	St. Martin Memorial Hospital, Dansoman	Hospital	Greater Accra	King Of Kings
306	St. Martin Memorial Hospital, Shukura	Hospital	Greater Accra	King Of Kings
307	St. Martin's de Porres Hospital, Agomanya	Hospital	Eastern	Catholic
308	St. Martin's Hospital, Agroyesum	Hospital	Ashanti	Catholic
309	St. Martin's PHC/ Maternity Clinic, Biu	Clinic	Upper East	Catholic
310	St. Mary's Anglican Clinic, Apinkra	Clinic	Ashanti	Anglican
311	St. Mary Theresa Hospital, Dodi-Papase	Hospital	Oti	Catholic
312	St. Mary's Clinic, Yapesa	Clinic	Ashanti	Catholic

313	St. Mary's Hospital, Drobo	Hospital	Bono	Catholic
314	St. Matthews Hospital, Ampenkro	Hospital	Bono	Catholic
315	St. Michael's Catholic Clinic/Maternity, Ntronang-Akim	Clinic	Eastern	Catholic
316	St. Michael's Hospital, Pramso	Hospital	Ashanti	Catholic
317	St. Michael's Nursing and Midwifery Training College, Pramso	Training Institution	Ashanti	Catholic
318	St. Monica's Clinic and Maternity, Akim Sekyere	Clinic	Eastern	Catholic
319	St. Patrick's Clinic, Wulungu	Clinic	Upper East	Catholic
320	St. Patrick's Hospital, Maase-Offinso	Hospital	Ashanti	Catholic
321	St. Patrick's Nursing and Midwifery Training College, Maase-Offinso	Training Institution	Ashanti	Catholic
322	St. Paul's Clinic, Kundungu	Clinic	Upper West	Catholic
323	St. Pauline Clinic, Accra	Clinic	Greater Accra	Catholic
324	St. Peter's Clinic, Donkorkrom	Clinic	Bono	Catholic
325	St. Peter's Clinic/Maternity Home, Ntobroso	Clinic	Ashanti	Catholic
326	St. Peter's Hospital, Jacobu	Hospital	Ashanti	Catholic
327	St. Stella's Clinic, Karne	Clinic	Upper West	Catholic
328	St. Theresa Health Centre, Zorko	Health Centre	Upper East	Catholic
329	St. Theresa's Clinic, Nope, Nope - Obayentoboase	Clinic	Ashanti	Catholic
330	St. Theresa's Hospital, Nandom	Hospital	Upper West	Catholic
331	St. Theresa's Hospital, Nkoranza	Hospital	Bono East	Catholic
332	St. Thomas General & Maternity Clinic, Hiaa	Clinic	Ashanti	Catholic
333	St. Vincent's Clinic, Drobonso	Clinic	Ashanti	Catholic

334	Tanoah Memorial Baptist Health Centre, Opuniase	Health Centre	Ashanti	Baptist
335	Tatale District Hospital, Tatale	Hospital	Northern	Catholic
336	Tease Presby Health Centre, Afram Plains	Health Centre	Eastern	Presbyterian
337	The Kings Medical Centre, Bontanga	Hospital	Northern	Assemblies Of God
338	The Salvation Army Anidasofi Clinic, Kokomlemle	Health Centre	Greater Accra	The Salvation Army
339	The Salvation Army Rehabilitation Centre, Begoro	Rehabilitation Centre	Eastern	The Salvation Army
340	The Salvation Army Rehabilitation Centre, Duakwa	Rehabilitation Centre	Central	The Salvation Army
341	Todah Hospital, Obuasi	Hospital	Ashanti	Church Of God
342	Tree of Life Medical Centre	Clinic	Greater Accra	Theo Vision
343	True Faith Hospital, Bethel Juaben	Hospital	Ashanti	True Faith
344	True Faith Hospital, Kumawu Bodomase	Hospital	Ashanti	True Faith
345	Urban Aid Health Centre, Mamobi	Health Centre	Greater Accra	The Salvation Army
346	Valley View University Hospital, Techiman	Hospital	Bono East	Seventh Day Adventist
347	Villa Regina Maternity Clinic, Gwenia	Clinic	Upper East	Catholic
348	Wa Diocese PHC Project	Primary Health Care	Upper West	Catholic
349	Word Alive Community Health Nursing Training School, Esiama	Training Institution	Western	Word Alive

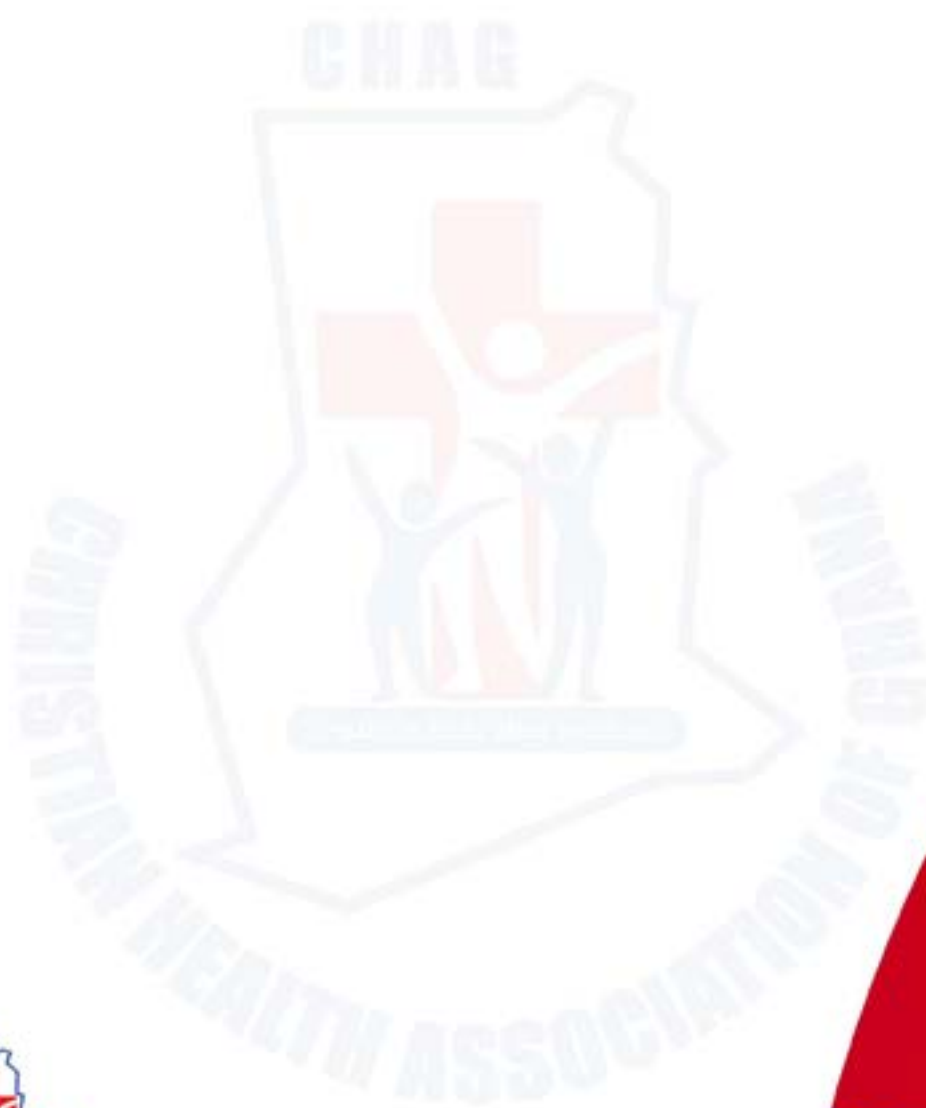
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Health in Body, Mind and Soul

CHRISTIAN HEALTH ASSOCIATION OF GHANA





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