

**CHRISTIAN HEALTH ASSOCIATION OF GHANA
(CHAG)**

ANNUAL REPORT

June 2003

ACRONYMS

ALOS	Average Length of Stay
BOR	Bed Occupancy Rate
CHAG	Christian Health Association of Ghana
DA	District Assembly
DHMT	District Health Management Team
DPF	Donor Pooled Funds
ER	Emergency Room
GHS	Ghana Health Services
GOG	Government of Ghana
HMT	Hospital Management Team
HND	Higher National Diploma
IST	In-Service Training
LPO	Local Purchase Orders
MDA	Ministry, Departments and Agencies
MHO	Mutual Health Organizations
MI	Member Institutions
MOH	Ministry of Health
NGO	Non-Governmental Organizations
OPD	Out Patients' Department
PHC	Primary Health Care
POW	Program of Work
PPM	Planned Preventive Maintenance
PPRHAA	Peer and Participatory Health Appraisal and Action
QA	Quality Assurance
QC	Quality of Care
QoCWG	Quality of Care Working Group
RDF	Revolving Drug Fund
RDU	Rational Drug Use
SDA	Seventh Day Adventist
SP	Strategic Plan
TA	Technical Assistance
TOT	Trainer of Trainers
TUC	Trade Union Congress

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THE CHRISTIAN HEALTH ASSOCIATION OF GHANA

1.1 HISTORY AND COMPOSITION OF CHAG.

The Christian health Association of Ghana (CHAG) is made up of Christian health institutions. It was formed with the aim of fostering closer partnership between church related services and the Ministry of Health to promote competent total health care to the people being served. The association was founded in 1967 with the assistance of the World Council of Churches, the Catholic Bishops Conference and the Christian Council, known then as the Christian Hospitals Association of Ghana. It was registered as a non-profit Non-Governmental Organization (NGO) in 1968. On the introduction of Primary Health Care (PHC), the word "Health" was substituted for "Hospital" to become the "Christian Health Association of Ghana" (CHAG).

Although there were a few mission hospitals during the colonial era, (Agogo Presbyterian Hospital was built in 1931 and Breman Asikuma Catholic Hospital in 1943), the expansion of mission hospitals and clinics occurred after independence of Ghana in 1957 along with the public health sector¹. CHAG has grown from 25 health institutions in 1967 to 135 institutions in 2002. These institutions are 51 hospitals, 80 primary health care bodies and 4 health manpower-training centers in the country². See Table 1. Together, the members of CHAG cater for an estimated 35-40% of the national population, mainly in the rural parts of Ghana, thus making it second only to the government as the single largest provider of health care in Ghana. The hospitals and clinics have an aggregated total of about 6500 beds with an average of 60 beds per hospital.

Table 1: Break down of CHAG Institutions

Denomination	Hospitals	Clinics/PHC programs	Schools
Catholic	30	41	3 N +2M

¹ Christian Health Association of Ghana (C.H.A.G.) – Annual Report 1997-1998

² Christian Health Association of Ghana (C.H.A.G.) – Annual Report 2001-2002

Denomination	Hospital s	Clinics/PHC programs	School s
Presbyterian	4	7	1 N
Evangelical Presbyterian	1	5	
Anglican	0	7	
Methodist	2	2	
Salvation Army	0	8	
Baptist	1	0	
Assemblies of God	2	1	
World Evangelical Crusade	0	1	
Seventh-Day Adventist	5	2	
Church of Pentecost	4	3	
Church of God	0	1	
Church of Christ	0	1	
Siloam Gospel Mission	0	1	
AME Zion Mission	1	0	
E.P.Church of Ghana	1	0	
Total	51	80	4

Key: N= Nursing Training School. M=Midwifery Training School.
(Source: CHAG Annual Report 2001-June 2002)

These facilities are predominantly in the rural areas and are aimed at reaching the marginalized and poorest of the poor. A few are in big towns now but were built there when the towns were small and rural.

1.2 SERVICE PROVISION

Services provided by CHAG institutions cover the whole range of curative, preventive, promotive and rehabilitative services. Many of the mission hospitals in the rural areas providing primary level curative services also provide one or two specialized services such as eye care or specialist gynecological surgery for which clients would otherwise have had to travel long distances to bigger centers. Some of these hospitals have been

designated centers of good practices by government and are sites for training health professionals.

The primary health care services include immunization, family planning, maternal and child health services and health education.

1.3 MEMBERSHIP

The association is opened to any Christian church-related medical institution in Ghana, which is recognized as such by the Ministry of Health. Its founding members are the Christian Council of Ghana and the Ghana Catholic Bishop's Conference. Institutional members are the hospitals and clinics, which belong to the founding members and share fully in the responsibilities and benefits of CHAG.

There are associate members who include other Church-related institutions which do not fall within the above mentioned category but share in the aims and objectives of the association and share only some limited benefits and responsibilities.

1.4 ORGANIZATIONAL STRUCTURE & FUNCTIONS

The organizational structure of CHAG³ has under gone changes recently and comprises of:

- The Council
- The Board
- Standing Committees
- Other Sub-Committees and
- Office of the Executive Secretary

The council is the highest governing body and is made up of representatives of the churches and institutions that make up the association. The council is responsible for top appointments at the secretariat, major disciplinary issues and financial investment policies. It meets once a year.

³ Constitution May 2002: Christian Health Association of Ghana.

The Board is the executive arm of the council and though with a composition similar to the council is much smaller. The board formulates policy including technical policy for the approval of the council and monitors the implementation of policies by the Secretariat and members. It meets three times a year.

The standing committee is a sub-committee of the GHAG board created to take urgent decisions. Other sub-committees of the CHAG board are those of Finance, development, Public relations, and the Advocacy sub-committee (the later is not in CHAG's constitution).

There is a CHAG Secretariat based at the national capital and is comprised of four officers; the Executive Secretary who is the leader, Deputy Executive Secretary, and a Finance Officer. The office of the executive secretary is subordinate to the CHAG board and is responsible for the day to day running of the affairs of the association.

CHAG Functions

In a recent workshop, members redefined the functions of the CHAG central organs as:

- Promotion of holistic quality and affordable health care based on good ethical and moral standards by, professionally competent, and motivated staff by member institutions
- Policy Analysis, Advocacy & Lobbying
- Capacity Building of Members: - Health Coordinators and Institutional Members
- Networking & Public Relations (or Public Image Building)
- Translating Government policies in operational terms for members to implement.

1.5 PARTNERSHIP AND RELATIONS

There are presently linkages (though not very strong and not formalized) with the communities being served, the District Assembly, other sectors, agencies and health related partners at all levels

The relation with MOH and CHAG has greatly improved at the central level. This is not always the case in all regional and district levels because there are no clear guidelines from the center to lower levels. Partnership between mission and government agencies at lower levels tends to depend heavily on the leaderships of both the government and CHAG agencies at that level.

Other important partners are NGOs such as the World Council of Global Consultation on Response to Challenges of HIV/AIDS in Africa, Africa Youth Alliance and Family Health International.

A couple of years ago, a memorandum of understanding was drawn between CHAG and the Government to institute a contracting system for services to areas not adequately covered by government health care services but this is yet to be implemented.

1.6. SOURCES OF FUNDING

In the sixties and seventies, the major source of funding for CHAG was external donations arranged by western missionaries who were then the major administrators of the mission health services. The donors provided equipment, vehicles, some infrastructure, drugs and money. As more and more facilities started being run by Ghanaians the donor component started steadily decreasing. A study of one mission hospital (St. Dominic's Hospital, Akwatia) in 1997 showed 50% of hospital funding is from user fees, 27% from Government subventions and 22% from donations¹. In many facilities, the donor component is much lower.

Besides the Government subventions, which go mainly to pay the salaries of health staff, a few Government health professionals such as doctors are sent on secondment to CHAG institutions. In recent times, Government also provides some limited funding from its donor-pooled funds to CHAG institutions but these are lower than those provided to government owned facilities. In some regions, refunds for exempted patients and Additional

Duty Allowances (ADHA) for health staff are paid by government to CHAG health facilities.

1.7 ACHIEVEMENTS & CHALLENGES

1.7.1.Achievement

Christian mission institutions have over the years achieved a number of successes and good reputations including the following:

- Recognition as credible health service providers in the country – being places patients can always be assured of sensitive care. They are also health stations where services are always available at no extra charge when government facilities are on industrial strikes. In a study conducted by Amuah et al in 1997, clients identified mission institutions as providers of better quality of services than other types of facilities in the country.
- Over a period of less than half a decade, services have increased from only a few institutions to cover about 35% of services in the country, located in areas of the most need; and CHAG has become a big contributor to the national health care goals.
- With its 3 health manpower training institutions, CHAG has also contributed to producing health professionals for the country. Not only are the professionals from these institutions well disciplined, but they have also tended to show willingness to work in hardship areas. Some CHAG institutions, because of the high quality of specialized services they provide, have become national centers of good practices for training of doctors.
- CHAG institutions have facilitated the development of many towns and communities where these facilities are situated. Hence towns such as Agogo, Dodi Papasi and Nalerigu are often associated with the mission hospitals situated in these towns than with any other infrastructure in these towns.

- CHAG has pioneered major health system changes such as PHC and community health insurance and have paved the way for the development of these health care strategies by the government of Ghana.

1.7.2 Challenges

Working within its own guiding principles, mission institutions are located in poor rural areas. Over the years, the incomes of users in these rural areas have steadily reduced with increasing cost of health resources. The proportion of people who are unable to pay for their health care needs has been rising steadily while funding from donors in the North have continued to dwindle. CHAG institutions therefore find themselves with inadequate funding to run services for populations who need these services the most. They also have no reliable sources of funding for capital costs. Even though CHAG caters for about 36% of the population, Government only provides CHAG with 20% of the health budget.

Because the mission health care services are located in deprived areas, with few socio-economic amenities, health professionals are often unwilling to work in health institutions and programs. There is therefore a chronic shortage of skilled trained health staff. The small numbers are inadequately paid and staff morale is usually low. The few professionals seconded from the government health services are often difficult to control because of unclear allegiances. These factors and the inadequacy of quality assurance systems have considerably affected the quality of service provision to clients.

The facilities are often under managed. Managers are basically health staff with little management capacity, working within unclear and rather archaic health management systems. Human resource, financial, equipment and information management systems are therefore weak and not very efficient and effective. This is compounded by unclear and weak standing relationships with other stakeholders in health care at the regional, district and community level such as district health management teams, RHMTs, church parishes and district assemblies.

At the national coordinating level, the CHAG secretariat, the challenges mirror those of member institutions:

- Member institutions some times complain of loss of confidence in the Secretariat because of its inadequate capacity to support members through its stated core business of advocacy, networking, translating and influencing government policy, and promotion of public relations on behalf of members. The secretariat is not effective in mobilizing resources for it self and for members, and this is thought to be the cause of decreased willingness of members to pay their subventions to the Secretariat and the cause of rifts among the different Christian denominations that form the association.

2.0 VISION, FEARS AND PERCEIVED BARRIERS OF CHAG

CHAG sees itself as an important partner (not a competitor) with Government and other stakeholders in the provision of health care to the people of Ghana. This is reflected in CHAG's vision.

2.1 Vision

The Vision of CHAG is to be a dynamic partner in the health sector development of Ghana recognized for creativity and excellence in delivering holistic quality services that meets members' and other partners' expectations.

Delivering holistic quality health services to clients' expectations in fulfillment of Christ healing ministry and collaborating with other partners by professionals with integrity, who are transparent and accountable.

More specifically, CHAG envisions addressing the following:

- Providing clients with both (spiritual & physical needs) – holistic needs
- Reaching the un-reached
 - The very poor
 - The marginalized
 - Deprived
- The provision of services that ensure that no client walks away without services because of cost (cost should not be a barrier to health care)
- Improving equity of resource allocation to member institutions and service provision
- Improving efficiency in the use of resources by reducing waste and becoming more cost-effective and cost controlled.
- Ensuring maximal collaboration and participation of all stakeholders
- Changing cultural barriers and improving access to services through collaboration with traditional authorities, communities and other stakeholders.

2.2 Fears and Barriers

Although CHAG's visions are in consonance with those of the current governments, she still has some fears. These include

- Fear of losing its Christian identity in the partnership with Government and other stakeholders.
- The current close relation with government may one day change, as it did during the first republic, and that government would withdraw seconded staff, funding or even nationalize its institutions.
- The brain drain that is affecting all sectors of the country may adversely affect CHAG and derail its visions and objectives.
- There appears to be asynchrony between the new Ghana Health Service and the Ministry of Health and CHAG fears being caught between the two.

Beside these fears, there are also still some risks and barriers that confront the provision of good health by CHAG.

CHAG operate in rural and hard to reach areas where far too many people fall into the lowest economic quintile. The economic environment does not favor the majority of CHAG's clients who are mainly subsistence farmers and depend largely on natural rainfall for farming activities. Health care provision under these conditions is trying.

The poverty interferes with access to health care affordability for service and cost of transport to health care facilities. Illiteracy is rampant, contributing to poverty, and will take a long time to address. Underdevelopment of these areas confounds the problems of access – poor roads, lack of public transport, good drinking water and limited electrical power.

3.0 THE HEALTH POLICY ENVIRONMENT AND OPPORTUNITIES

Since the early nineties, the health sector in Ghana has been undergoing many reforms, some of it cutting new paths for other African countries. A medium Term Health Strategy (MTHS) and a Health Sector Program of Work (POW) was developed for the period 1997-2001. By means of a Sector Wide Approach Program (SWAP), Government and the major donors came together under common management arrangements and a common financing basket. The first 5-Year Program of Work has since been completed, evaluated and a second Five-Year Program of Work for the period 2002-2006 drawn. The evaluation, described in the "Health of the Nation", identified significant gains in public health delivery such as

increased immunization coverage and improved child and maternal mortality.

The new POW aims at bridging the gaps in access to quality health and nutrition to poor and deprived areas and groups, vulnerable people such as women, children and the disabled. This objective is the same as that of CHAG. It aims to do this through:

- Improving health worker performance
- Improving responsiveness to client needs
- Improving geographical, financial and socio-cultural access to health
- Improving health planning, management and administration
- Improving partnerships with
 - Households and communities
 - Private and public sector providers
 - Other Ministries, Departments and Agencies (MDAs)
- Expanding relationships with development partners.
- Increasing public expenditure on the poor and vulnerable.

The second POW, unlike the first, is very strong on the private and non-governmental health sector and provides the environment for CHAG to contribute to the improvement of health for the poor and vulnerable in Ghana.

The POW provides very good opportunities for the attainment of CHAG visions:

- A political commitment to the health sector reforms is high and government is committed to its policy of strengthening the private sector.
- Government is currently engaged in a strong Poverty Reduction Strategy (PRS), a strategy that CHAG has been implementing since the inception of its first health program in the country.
- There is a stable political environment and a government committed to providing the health needs of its people.
- Recent governments see CHAG as an important partner and not a competitor unlike those of the not too distant past in the history of the country.
- MOH/donor policies are in favour of linking/strengthening private partners

- CHAG with service coverage of about 35%, and many specialized skills, has become big enough to influence health policy in the country.
- Current government policy is the decentralization of resources in favour of lower levels, and this where many CHAG health care services are located.
- There is Increasing recognition of CHAG and accreditation of CHAG institutions
- General improvement of socio-economic infrastructure in the rural areas favours the working of CHAG.
- District Assemblies, Zonal and Town Development Committees have brought governance to lower levels. These bodies are strongly agitating for development at their levels and these can only provide opportunities for CHAG.
- Recent evaluations in Ghana by government and the NGO community have appreciated the potential of CHAG and its contribution to the health of the nation.

4.0 STRATEGIC PLAN

4.1 RATIONAL

This strategic plan aims at overcoming and/or reducing the challenges stated above within the current favorable health policy environment, good opportunities and strong commitments. It is intended to strengthen member institutions and CHAG secretariat to contribute more meaningfully to the national strategic plan. It also hoped that this would enable CHAG position itself towards sustainability at playing its roles and strengthening its corporate identity. It is derived from the second health sector program of work and includes what CHAG thinks it can feasibly implement within the next five years.

The strategic plan will clearly define CHAG's strategic direction for the next five years and enable CHAG identify priorities towards solving some of her constraints. The assumption is that CHAG will implement the strategic plan with support from MOH, and other stakeholders and that this will result in improvement in the health status of the project beneficiaries.

4.2 Objectives and Strategies

4.2.1 Goal (Overall Objective)

The goal of the strategic plan is:

To improve the health status of people in Ghana, especially the marginalized and the poorest of the poor, in fulfillment of Christ healing ministry.

4.2.2 Purpose (Intermediate Objective)

To improve the delivery and use of health services by all people living in Ghana, especially the poor and marginalized.

4.2.2 Immediate Objectives

- To strengthen the management of CHAG health facilities and programs, especially financial, human resource and organizational structures and systems towards more effective and efficient service delivery.
- To improve the quality of services and financial access for users of primary health care and hospital services especially for the very poor and the deprived.
- To strengthen CHAG secretariat to perform its core functions (advocacy, networking and public relations, resource mobilization, support to member institutions, monitoring and evaluation) on behalf of member institutions.

4.3 STRATEGIES

4.3.1 Strengthening Institutional Management

Institutional management would be strengthened by initiating management reforms. This would be started by getting a clear understanding of the existing systems, practices, procedures and capacities in health institutions and programs through participatory appraisals. To ensure ownership and sharing of good practices across facilities, the assessments would be conducted by facility managers themselves and their peers from other CHAG institutions. The peers would include those from the CHAG secretariat to enable them understand by first hand, the problems of member institutions. The assessment would become the monitoring

mechanism for CHAG implementation programs and would be aimed at identifying weaknesses and strengths in

- Patient Care Management
- Service performance outputs
- Internal facility management
- External linkages with other stakeholders in the health care sector
- Financial management
- And the management of equipment and infrastructure.

The appraisals would pave the way for developing more modern management systems and practices that are appropriate to CHAG institutions and the environment in which they operate. Effective systems for health management information, the management of physical facilities, plants, basic equipment and the physical environment would be priorities.

Financial management systems would be strengthened in facilities for them to meet the financial criteria set by MoH. The improvement of financial systems would include the computerization of the major CHAG hospitals to allow easy access of reliable financial information for the use of hospital managers in decision-making.

A performance based human resource management systems, including support, supervision, appraisal systems and suitable gender and skill mix of staff would be instituted.

4.3.2 Improving Quality of Services and Financial Access for Users

Patient and client focused quality improvement systems would be set where they do not exist and strengthened where they have been initiated in collaboration with communities. Professional quality would be strengthened with particular reference to:

- Diagnosis
- Use of standard evidence-based treatment
- Rational use of drugs
- Monitoring of outcomes
- More effective IEC
- Maintaining clinic environments that are conducive and safe to clients and providers.

Higher Professional training (including long and short term fellowships) for health staff would be facilitated.

To ease the present financial burden to the very poor, more effective systems for exemptions and deferral payments would be explored and implemented.

4.3.3 Strengthening CHAG Secretariat.

The CHAG secretariat would be strengthened to perform its core functions of advocacy for its members, facilitating networking of its members and partners, resource mobilization, monitoring and evaluation. This would be done by recruiting staff with the above skills into the CHAG Secretariat and re-training existing staff at the Secretariat, the Regional CHAG's and managers at the level of health institutions.

Networking among members would be improved through the following:

- Setting up internet communications with all members and a CHAG website
- Facilitation of the establishment of regional CHAGs
- Instituting a bi-annual CHAG News Letter
- Initiating quarterly meetings of all the health coordinators of the different Christian denominations who make up CHAG for information sharing and coordination of health programs.

The CHAG Secretariat would facilitate operations that would elucidate and allow attainments of the CHAG mission, such as increasing access to the poor and the marginalized, and increasing staff motivation to work in rural areas of the country. This would be done by setting aside funds for beneficial operational research and pilot implementations.

Proposals would be made to other partners in area such as:

- A comprehensive HMIS strategy for CHAG
- Staff motivation schemes
- Setting up a wide-area network for CHAG and its members
- Human Resource Development including postgraduate fellowships.

To adequately support member institutions, the office of the CHAG secretariat would be provided with the necessary essential office equipment such as computers, printers and photocopiers. The equipment would include a suitable transport vehicle for monitoring visits to member institutions.

4.4 STRATEGIC APPROACH

The strategic approach is based on the following principles:

- The plan is complimentary to the national health sector Five-Year Program of work.
- Ownership of the strategic plan by CHAG and its member institutions.
- Implementation would be geared towards institutional building and reforms which would improve sustainability at the end of the current plan.
- The implementation process shall be integrated into CHAG existing system. The planning and implementation will be related to CHAG goals and vision and shall take place in all member institutions.
- There will be participatory joint implementation of CHAG and other stakeholders such as RHMT, DHMT, Sub-districts and other partners in health. Avenues will be created for involving communities, the marginalized and the very poor.
- There will be capacity building of staff and stakeholders to improve implementation. The capacity strengthening will also bring about improvement in managerial skills in CHAG member institutions and Secretariat. Awareness will be created in CHAG, MOH and other stakeholders.

5.0 ANNEXES

ANNEX 1: MAP OF SELECTED HOSPITALS



