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UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH

**ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH
SERVICE DELIVERY AT ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY**

The watermark is a large, semi-transparent purple shield with a yellow border. At the top, there are three yellow downward-pointing triangles. In the center, there is a yellow decorative emblem consisting of two interlocking swirls with horizontal arrows pointing outwards. Below the emblem, the text 'BY SHAMSIYA ABDUL-RAHMAN (10508835)' is written in black. At the bottom of the shield, a purple banner contains the Latin motto 'INTEGRI PROCEDAMUS' in yellow capital letters.

**BY
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THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF

MASTER OF ARTS IN DEVELOPMENT STUDIES

DECEMBER, 2015

DECLARATION

I, hereby declare that this submission is my own original work towards the award of Master of Arts degree in Development Studies. To the best of my knowledge, this is not material previously published by another person for the award of any degree of the University or any other institution or for public consumption, except where due acknowledgement has been made in the text.

Signature.....

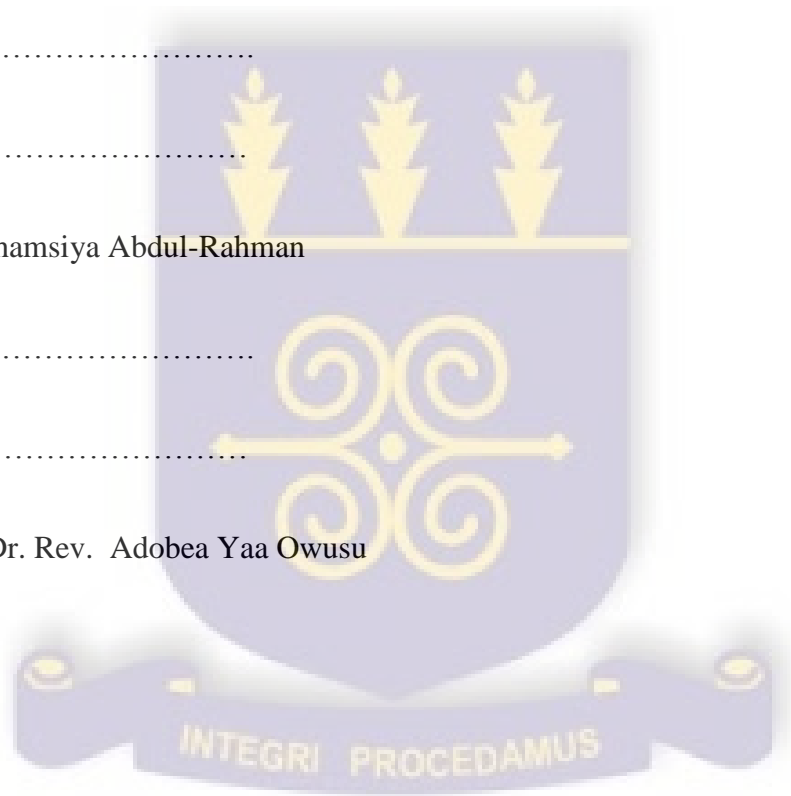
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DEDICATION

This work is dedicated to the Almighty Allah (SWT) for His numerous blessings and guidance throughout my life.



ACKNOWLEDGEMENT

I will like to extend my unconditional gratitude to some individuals for their contributions and efforts throughout this dissertation.

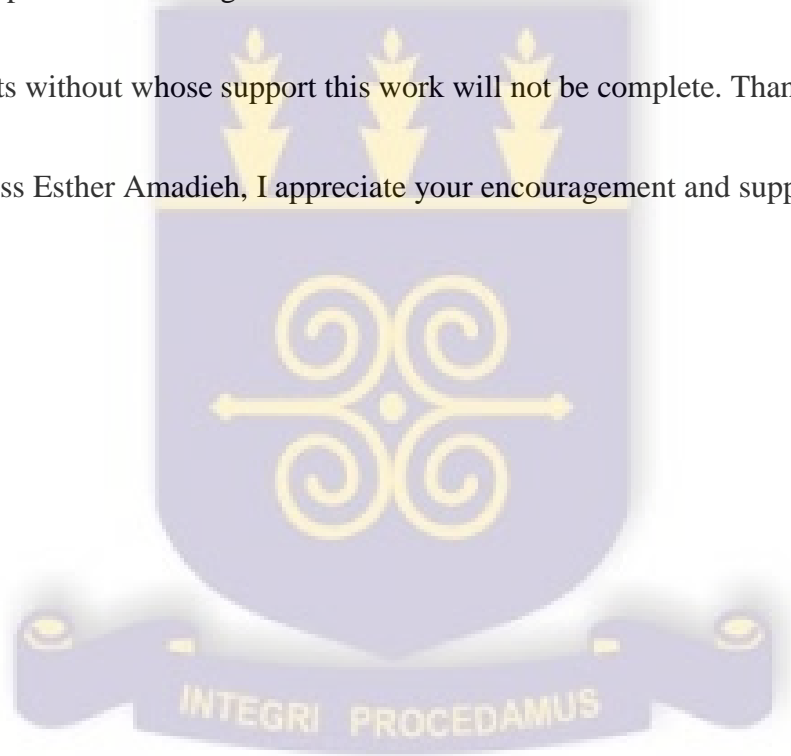
To Rev. Dr. Adobea Yaa Owusu, my supervisor, thank you for your guidance and support.

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To Ga East Muncipal Health Management Team for their time and assistance.

To my respondents without whose support this work will not be complete. Thank you!

To my mother Miss Esther Amadih, I appreciate your encouragement and support.



ABSTRACT

Accessibility is very critical to health service delivery. It includes financial, geographical and cultural accessibility. These factors inform the utilization of health services. The importance of accessibility and utilization of health services have been established in various studies globally. Yet in most developing countries and Ghana for that matter, accessibility to health care is limited in one way or the other. In Ghana, the implementation of the National Health Insurance Scheme in 2005 increased accessibility. However, accessibility and utilization of health services still remain a challenge for the country.

This study seeks to explore how accessible health care is at Abokobi in the Ga East Municipality and to what extent the service is used. The study design was a cross sectional survey using both quantitative and qualitative data with the use Questionnaires and in-depth interviews respectively. The target population were health service providers on one hand and the residents of Abokobi on the other hand. A purposive sampling was employed to sample the health service providers and stratified sampling was used to sample the respondents. The researcher collected all quantitative data with the help of one trained assistant. In depth interviews were conducted by the researcher only. The taped interviews were transcribed and the resulting texts analysed by using thematic analysis.

The study revealed that limited public facilities, inadequate health personnel like doctors, midwives and pharmacist at the Abokobi health center were major factors hindering accessibility and utilization of health service delivery. The income and educational status of respondents also affected accessibility and utilisation.

Below are some recommendations for the study; an effective monitoring and supervision of the operations of health facilities; the improvement of the NHIS services at the health facilities in Abokobi; the improvement and upgrade of equipment and logistics to ultra-modern in the health centres ones and the improvement of performance indicators to help the DHMT define and measure progress towards achieving its goals.



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ABBREVIATION/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CHAG	Christian Health Association of Ghana
CHPS	Community-based Health Planning and Services
DHMT	District Health Management Team
ENT	Ear Nose and Throat
FDB	Food and Dugs Board
GEMA	Ga East Municipal Assembly
GIPC	Ghana Investment Promotion Centre
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HNP	Health, Nutrition and Population
HIV	Human Immune Deficiency Virus
ISSER	Institute of Statistical, Social and Economic Research
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
MDGs	Millennium Development Goals
MHD	Municipal Health Directorate
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NAS	National Ambulance Service
NGOs	Non-Governmental Organisations
NHIS	National Health Insurance Scheme

OPD	Out-Patient Department
POW	Program Of Work
PPPIRC	Public-Private Partnership
PSPs	Private Sector Providers
RHA	Regional Health Administration
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TTH	Tamale Teaching Hospital
UN	United Nations
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organization
WIFA	Women In Fertility Age

CHAPTER ONE

INTRODUCTION

1.0: Background to the study

From time immemorial, the lives of a vast number of people have depended on health systems. Right from the point of delivery, to the point of providing quality care for the elderly, health has been of major relevance to society and its development. Existing literature has even proven that the general well-being of a populace determines the overall progress and development of a national economy as an enhanced quality of life means higher productivity. According to the Ministry of Health (MoH) in Ghana, improved productivity, a higher gross domestic product and sustainability in growth is only as a result of a healthy population (MoH, 2007). This has necessitated the espousal of various human rights provisions at the national and international levels to safeguard and enhance the basic needs of human kind including the right to adequate and quality health care. Article 25 of the United Nations' Declaration of Human Rights says among other things, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing ,medical care, and necessary social services".

According to the World Health Organization (1948), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p.100). This implies that, health is concerned with more of the psychological and social aspects of a person rather than the usual absence of illness or sickness. However, other definitions have also emerged and focused on other dimensions. Two scholars stand out. J. Bircher and R. Sarracci. Bircher (2005) for instance, defines health as "a dynamic state of well-being characterized by physical and mental potential, which satisfies the demands of life commensurate with age,

culture and personal responsibility”. Sarracci (1997) sees it as “a condition of well- being, free of disease or infirmity and a basic and universal human right”. Bircher (2005) is concerned with the changing health needs, placing emphasis on how age, culture and personal responsibility strongly influence a person’s health status, while Sarracci (1997) reiterates the WHO definition, but links it to contemporary issues of human of rights, equity and justice.

Health service delivery is an immediate output of the inputs into the health system, such as the health work force, procurement, and supplies and financing. Increased inputs should lead to improved service delivery and enhanced access to services (WHO 2010). This implies that the availability of health services to ensure a particular quality standard and the creation of access to them are key functions of a health system. Mental Health, child health and maternal health and child nutrition are some of the key areas captured within a health system. Nonetheless, the precise organization and content of health services differ from country to another.

The health system in Ghana is an elaborate network made up of three sectors; “the popular sector, the folk sector and the professional”. The professional sector encompasses the organized and legally sanctioned healing professions such as modern western scientific medicine or allopathy (Buor, 2004). The Ghana Health Service has been established with autonomous powers to administer the professional health services in the country. Health service delivery in Ghana is organized at three levels: primary, secondary and tertiary levels with four levels of management: central or national headquarters; regional; district and sub-district (WHO 2014). At the regional level, the administration of this level is in the hands of the Regional Health Management Team. And the regional health director is the chairman. The highest health institution at this level is the regional hospital which is supposed to be the final referral point within a region. There are three teaching hospitals in the country currently which serve as final

referral points; The Korle Bu Teaching Hospital (KBTH) in the Greater Accra region, the Komfo Anokye Teaching Hospital (KATH) in the Ashanti region and the Tamale Teaching Hospital (TTH) in the Northern region. Nonetheless, the facilities at the KBTH are more advanced and in more complicated situations, referrals are made from KATH and TTH to KBTH. The district level is under the administration of District Health Management Team (DHMT). The district is divided into sub districts or zones with a health center catering for the zone. All health facilities in the district are under the supervision of the health directorate which is headed by a district health director Buor (2004). Furthermore, in March 2014, the Cape Coast regional hospital was fully transformed into a Teaching Hospital to support the University of Cape coast School of Medical Science (UCCSMS).

In Ghana, there have been recent developmental interventions to eradicate factors that impede on adequate health service delivery. These impediments translates into high levels of ill-health, poor economic activities and production and poverty among others. In view of these challenges, Private Sector Providers (PSPs) role towards quality service delivery is recognized. PSPs of health care contribute to achieving public health goals in developing countries. According to Smith, Brugha and Zwi (2001), they are not under any form of control by the state and they are either for profit or non-profit. They include formally or informally trained pharmacists, doctors, nurses and midwives who provide health delivery services. Ghana has also witnessed both international and national commitment to improving health service delivery for quality care. One of such commitments by the Ghanaian government is the implementation and encouragement of the concept of the Public-Private Partnership (PPP). The core principles of partnership according to Raman & Bjorkman (2009) are;

- Relative Equality between partners

- Mutual Commitment to Health objectives
- Autonomy for each partner
- Shared decision-making and accountability
- Equitable Returns / Outcomes
- Benefits to the Stakeholders

Raman (2009) quickly notes that not all partnerships are PPP. This distinction helped to identify the type of partnership available in the research environment and how it affects the health delivery service there. Generally, the provision of public sector infrastructure and services has been portrayed as the sole responsibility of the government. However, the huge deficit in infrastructure cannot be met by the public sector alone through budget allocation. According to the Ministry of Finance and Economic Planning, Ghana's infrastructure deficit in general could require sustained spending of at least US \$ 1.5 billion per annum over the next decade (MOFEP 2011). The PPP intends to close the already existing gap and efficiently deliver infrastructure and services, especially those exclusive to promoting health service delivery. Strengthening health services have also been mentioned by the World Health Organization as the third objective among its five objectives with regards to PPP in health.

1.1: Problem Statement

Health is now a striking issue on the international agenda than ever before, and concern for the health of people is becoming a central issue in development. It is therefore not surprising that three out of the eight Millennium Development Goals (MDGs) declared by world leaders

following the Millennium Summit of the United Nations in the year 2000 are health related. This notwithstanding, many people do not seek health care due to cost of service, the remoteness of the health facility, and quality of service thereby bringing about low patronage of health services. Sociological studies have also revealed non-medical reasons which include financial and geographical access to health care which continue to be key challenges confronting the health sector of Ghana despite the National Health Insurance Scheme and the expansion of Community-based Health Planning and Service (*CHPS*) (WHO 2014).

Regardless of all the efforts by the Ghana Health Services, the Central Government and donor funding agencies to improve quality health service delivery in Ghana, there is still some essential but conspicuously missing elements in the process of quality health service delivery that have resulted in the current health situation in the country. According to Buor (2004), the population of Ghana has a high capacity to grow with an average annual population growth of 2.9%. This is high even within low income economies which have an average of 2.1% annum. He indicates that the high crude birth rate of 30 per 1000, and a relatively low crude death rate of 11 per 1000 reveal a high rate of natural increase. By virtue of these statistics, there is a high momentum for population growth which will further put pressure on the already inadequate health facilities. The World Bank (2002) also reports that health facilities with regards to physicians and beds are poor. The proportion of physicians per 1000 population is as low as 0.1 as against the average of 0.5 for low income countries and 2.9 for high income countries. Furthermore, health expenditure per capita is \$19 as against \$21 for low income countries with a Gross Domestic Product (GDP) per capita of \$400 for the year 1991. Ghana used 3.5% of her GDP on health for the same period. And this fell below the linear regression line (World Bank, 1993). Though in 2005, Ghana spent 6.2% of GDP on health care, approximately 34% of government expenditure, there is still

relative pressure on the sector. The sector's resource envelope also increased in absolute terms from GH¢ 439.23 million in 2007 to GH¢763.02 million in 2008 (MoH 2007).

Buor (2004) has indicated that the increasing threats of health hazards are as a result of poor access to facilities to promote good health. Poor and inadequate health delivery translates into alarming health conditions of people. The trend in Abokobi is not different as it is recognized as one of the 216 districts in Ghana. According to the Ga East Municipal Assembly profile (2013), the Doctor to population and Nurse to population ratios are 1: 40,246 and 1: 2,012 respectively. Even though Tuberculosis is one of the priority diseases in the Ghana, the case detection rate is low due to reasons like stigmatization and misconceptions about the disease among others. It is important to note that malaria continues to be the major cause of Out-Patients Department (OPD) attendance in the Ga East Municipality. It accounts for about 40.8% of morbidity. Frequent outbreaks of cholera in the municipality are also of great concern. Poor environmental sanitation is a major contributory factor. The health sector is challenged by lack of office accommodation for the Municipal Health Directorate. It is accommodated in rented premises, lack of a municipal hospital to cater for cases referred from the poly Clinics and Health Centres, Lack of public facilities at Dome and Taifa sub municipalities, lack of NHIS secretariat in the municipality, inadequate space in the facilities, inadequate logistics, lack of some caliber of staff and low maternal health indicators. It is worth noting that the polyclinics in the Ga East Municipality which were health centres, were elevated to the present status in 2008 without any infrastructural expansion. These structures can no longer cope with the ever increasing population who access services from them.

In today's world of complication and haste, it is almost impossible to do anything unaided. This is particularly evident in health where constantly rising prices, changing disease patterns, and

increasing use of sophisticated technology for diagnosis and treatment have made it virtually impossible to imagine any single party providing services without some type of established partnership. The engagement of the private sector by the state to help in infrastructure and service provision is the remedy to the existing deficits. It is therefore in this light that, the study attempts to assess the participation of private agencies and government in health service delivery. Generally, efforts to address the health situation have not been encouraging. This study hopes to make contributions to fill up the gaps regarding health delivery in Abokobi in the Ga East Municipal Assembly.

1.2: Aim

The study aimed at exploring and assessing the level of participation of both the private and government facilities with regards to adequate health service delivery and how to improve the service delivery at Abokobi in the Ga East Municipal Assembly.

1.3: Objectives

- 1) To determine the availability and accessibility of health facilities in Abokobi.
- 2) To assess the contribution of the government and the private sectors in health care delivery at Abokobi.
- 3) To identify the factors that impede the delivery of quality health services at Abokobi.

1.4: Research Questions

Some questions that the study attempted to answer included

- 1) How accessible and available are the health facilities at Abokobi to the average inhabitant?
- 2) What is the proportion of both private and public participants in health service delivery in Abokobi?
- 3) What is the level of partnership between the government and private participants with regards to health services delivery in Abokobi?
- 4) What are the barriers to the delivery of quality health care in Abokobi?

1.5: Significance of The Study

The availability and accessibility of health service delivery is a prerequisite for attaining a quality health status. Everyone needs to be healthy for a sound life without any form of inequities and deprivation. Therefore, no one should be denied of a quality health service as being healthy has been argued by the likes of Sarracci (1997) as a basic and universal human right. This study revealed how both the private and the government participants interplay in achieving the ultimate goal of the provision of efficient health service delivery as well as how the relationship between both parties has evolved over time. The results of this study attempts to assist stakeholders and policy makers in the health sector to identify the strengths and weaknesses in health service delivery of government and private facilities that are engaged in service and possibly build on the weaknesses to ensure quality health care. Furthermore, this study also attempted to add on more knowledge to already existing knowledge in the field of health.

1.6: Organization of the Study

The study is divided into five chapters. Chapter one includes the general introduction to the study, the problem statement, objectives, research questions and significance of the study. Chapter two is concerned with existing and relevant literature to the study as well as the conceptual framework, while chapter three includes the profile of the study area and the methodology. The analysis and discussions are presented in chapter four. And the last chapter covers the findings and conclusions.

CHAPTER TWO

LITERATURE REVIEW

2.0: Introduction

Like many countries across the globe, health delivery in Ghana and in Ga East to be specific appears to be minimal as a result of several factors. However, certain indicators have shown that this could get better. The big idea in this research is to assess how the Government on one hand participates together with the private sector on the other to promote health delivery. Relevant literature on how the government and private sectors participate to facilitate accessible health care delivery and quality services is critically reviewed. The research issues arising from these reviews informed the formulation of the objectives of the study.

2.1: Definition of Terms

Participation

Participation, in the development context, is a process through which all members of a community or organization are involved in and have influence on decisions related to development activities that will affect them (Chambers, 1994). For the purpose of this study, participation is concerned with recognition of power differentials between the private and government service providers and how power is redistributed to promote the mutual goal to provide quality health services.

Public-Private Partnership (PPP)

According to the Public-Private Partnership (PPP) in Infrastructure Resource Center (PPPIRC) of the World Bank (2014), PPP refers to “arrangements between the public and private sectors whereby part of the services or works that fall under the responsibilities of the public sector are provided by the private sector, with clear agreement on shared objectives for delivery of public infrastructure and or public services”.

Private Sector Providers (PSPs)

PSPs are health care providers who work outside the direct control of the state. In developing countries, those describing PSPs often include both for-profit and not-for-profit providers. PSPs may be formally trained (pharmacists, doctors, nurses, midwives and even some Non-Governmental Organisations (NGOs)) or informally trained; they may work on their own or in institutions, and they may provide health care or other products such as drugs and contraceptive supplies (Smith et al. 2009).

Health System

It consists of all the organizations, institutions, resources and people whose primary purpose is to improve health care. This includes efforts to influence determinants of health as well as more direct health-improvement activities (WHO, 2010).

Availability

It is an aspect of comprehensiveness and refers to the physical presence or delivery of services that meet a minimum standard. It is usually tailored towards the needs of the target population.

Services delivered include preventive services, curative services and health promotion services (WHO, 2010).

Accessibility

It is the comprehensive measurement of access that requires a systematic assessment of the physical, economic, and socio-psychological aspects of people's ability to make use of health services. Services are directly and permanently accessible when there are no undue barriers of cost, language, culture, or geography. Health services are close to the people when there is a routine point of entry to the service network at the primary care level (not at the specialist or hospital level). Services may be provided in the home, the community, the workplace, or health facilities as is appropriate (WHO, 2010).

Coverage

Coverage of health interventions is defined as the proportion of people who receive a specific intervention or service among those who need it. Service delivery is designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups. Universal health coverage is defined as ensuring that everyone has access to needed preventive, curative and rehabilitative health services of sufficient quality. It also means safeguarding that people do not suffer financial constraints when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO (WHO, 2010).

Utilisation

It is often defined as the quantity of health care services used. It is related to the availability and accessibility of health services as well as the culture of users (WHO, 2010).

Quality Health Care

The meaning of quality healthcare can be cladded in so much controversy. Quality in health care takes many dimensions. According to Gill (1993), medical quality consists of a mixture of hard technical elements such as correct diagnosis, appropriate intervention and effective treatment as well as soft elements such as good communication, patients' satisfaction and consideration for the patients' preferences. Quality is the ultimate goal for any service performance. And it is no exception for health delivery service. It has been argued that there is a structural connectivity between quality health care services and other sectors of the economy. "Thirty years ago, an important World Bank (1975) policy paper on health demonstrated a clear link between economic growth and the health and nutritional status of the labour force" (Midgley, 2014, p.96). This has necessitated the need for a system of continuous quality improvement committed to providing better medical services as a surest way of ensuring quality health care delivery.

2.2: Global Trend of Health Service Delivery

According to Berman et al. (2011), effective, equitable, and efficient health service delivery is a priority for the World Bank and its clients working in human development. The World Bank's (2007) Health, Nutrition and Population (HNP) Strategy emphasizes the importance of strengthening health systems. Service delivery is universally acknowledged as one of the core

instruments through which health systems produce better health, financial protection, and client satisfaction.

In recent years there has been a significant increase in global and national attention toward improving health outcomes; thus, there has been dramatic progress in a number of areas. However, in many low and middle-income countries there is evidence that progress could be greater and more rapid. Many countries are not on the pathway to meet the health-related global objectives such as the Millennium Development Goals 1. To eradicate extreme poverty and hunger, 4. To reduce child mortality, 5. To improve maternal health, and 6. To combat HIV/AIDS, malaria, and other diseases (UNDP 2015), which include outstanding HNP-related targets. Funding for these priorities has increased, and efficacious technologies that can rapidly improve health have been made available. However, weak performance in service delivery affecting access, quality, and cost is often a cause of lagging health system performance.

Health systems are one of the key instruments created by human societies to help achieve the above stated goals. Health systems help raise and channel resources and manage the service delivery mechanisms that bring effective health-improving technologies to the people who need those (Berman et al, 2011). Service delivery is a critical link in this chain; the locus at which money and technology are transformed into health-improving interventions. Despite much progress, the gap between need and effective action is still enormous. More resources, further development of cost-effective interventions, and better health financing schemes are certainly needed. But it is also striking that even the funds and technologies that are available are often not being used effectively. Berman et al. (2011) further indicate that, in many countries one encounters health facilities with shockingly few patients, communities with low levels of coverage in life-saving services even where capacity exists to provide that coverage, or trained

workers missing from their assigned posts and empty shelves for drugs and supplies when workers have been paid and supplies purchased. Clearly, having money and technology are not sufficient conditions for impact. Even with more money and better technologies, a major challenge remains: improving the delivery of health services. Without improvement in the performance of the organizations that deliver health services, potential gains in health outcomes from increased funding and better technologies will not be achieved. In India for example, the government is the major financier for the child immunization program at relative levels across the states. Yet, according to a recent national survey, the level of coverage with DPT3, a good indicator of overall immunization, ranged from 28.7 in the lowest performing state to 95.7 percent in the highest (WHO, 2013). Within states across this performance range one can also find similar large variations across districts; within districts, differences persist across the catchment areas of health facilities. With relatively similar levels of resource availability, what accounts for these differences? In Kenya, procedures of service volume for three main services were collected for public health centers, a facility type suggesting similar levels of infrastructure and staffing. The average number of these services delivered in each facility was approximately two thousand visits per year, or five to ten visits per day. Yet some health centers reported almost no delivery of these important services, while others reported output levels five-to-six times the average (Berman et al. 2011).

In many low and middle-income countries, the overall level of health service delivery performance is not what it ought to be. For example, the Countdown to 2015 on Maternal, Newborn, and Child Survival in its decade report (2000–10) by the World Health Organization and United Nations Children’s Fund (2010) noted that, out of the sixty- eight countries monitored for progress in priority infant and young child mortality goals, nineteen were on track

to achieve Millennium Development Goal 4. But forty-nine countries were not on track, and twelve countries had experienced slowdown in their progress. And even within an existing average performance level for a particular country, performance gaps across organizations and facilities are also widespread. In many settings, substantial differentials exist between low-performing health service delivery organizations and their high-performing peers. Berman et al. (2011) posit that in rural India, most antenatal care is delivered by government workers in district-level, health service delivery organizations. Across the country, district coverage with full ANC averaged 18 percent but ranged up to 94 percent.

In the Tigre region of Ethiopia, high-performing health service delivery organizations provided eight times more family planning services and treated about eight times more malaria cases than average-performing organizations. In Serbia, high-performing health centers reported more than four times as many outpatient visits per capita per year as low-performing facilities. In Egypt, higher-output urban health units report treating more than six times more sick children annually than the average for similar facilities.

In Namibia, inpatient occupancy rates in district hospitals ranged from 18 percent to well over 100 percent. Even in well-performing Sri Lanka, inpatient occupancy rates in a sample of medium-size government hospitals ranged from 21 to 95 percent. Around the world, high-performing health service delivery organizations demonstrate the better outcomes their peers could achieve within the same health systems and with similar resource levels. If the overall performance of health service delivery systems were raised and performance gaps between the higher-performing and lower-performing organizations were closed or reduced, health outcomes in low and middle-income countries could improve significantly. The observation that health outcomes would be better if the delivery of health services were improved is widely shared

(Berman et al. 2011). All these bottlenecks accounted for in health service delivery translates to inaccessibility of the service delivery.

2.3: A Review of The Health Sector In Ghana

The Ministry of Health is responsible for stewardship of the entire health sector and ensuring equity and efficiency in the sector activities in Ghana. It exercises this function by providing overall policy directions, institutional development, coordinating the activities of agencies, partners and stakeholders involved in health and ensuring performance and accountability within the sector (MoH, 2007). In addition, MOH coordinates planning, resource organization, budget implementation, human resource development and the overall monitoring and evaluation of the health sector performance. The Ghana Health Service (GHS) was established under Act 525 to promote access to health services at the community, sub-district, district and regional levels (MoH, 2007).

Christian Health Association of Ghana (CHAG) is an umbrella group of faith based organization that contributes in improving the health status of the people of Ghana. Member Institutions are mostly situated in the interior with a few in urban slums and are therefore positioned to provide services to the poor and marginalized in fulfillment of Christ's Healing Ministry. There are One Hundred and Eighty-three (183) member institutions located in all the ten regions of Ghana. Our members are involved in the provision of health care and training of health professionals. Established in 1967, the Association currently consist of sixty-one hospitals and a polyclinic, 113 health centres, clinics and primary health care centres and nine health training health-training institutions. Membership has gone up from 25 in 1967 to 183 in 2011 (CHAG 2012). Regulatory

Institutions such as the Food and Drugs Board (FDB), Pharmacy Council, are mandated to regulate the activities of the various collaborators and stakeholders in the health sector. Training Institutions are charged with the production of health professionals and it is the shared responsibility of the Ministry of Education, the Ministry of Health and the private sector and quasi government organizations. The National Ambulance Service (NAS) has the mandate of providing transportation and pre hospital care. Actually it promotes access to emergency care. The Private Hospitals and Maternity Homes Board was established to assist in the provision of appropriate regulations relating to private health care practice and the delivery of appropriate services by approved private hospitals and maternity homes. However, the laws and acts governing health service provision and public health protection are disjointed and insufficient in promoting quality and efficiency in the private sector.

According to the Ghana Health Service, the ultimate goal of the health sector in Ghana is to ensure a healthy and productive population that reproduces itself safely (GHS, 2007). ISSER (2014) indicates that in spite of all the significant attention given the health sector by the state in Ghana, the question of access to health is still very problematic. However more efforts are still invested by both the government and donor organizations towards achieving quality health delivery services, one way to arrive at this is the National Health Insurance Scheme. Out-patient utilization of healthcare services increased from 0.6 million in 2005 to 25.5 million in 2011. However, in 2012, outpatient utilization decreased to 23.9 million (NHIS, 2012).

For the past decade, financing the annual Programme of Work (POW) within a budget constraint whilst managing the hope of rapidly scaling up the delivery of health interventions to meet the MDGs remains a big challenge for the health sector in Ghana. Moreover, the sector will have to take a critical look at the relatively high wage bill without concurrent increases in resources from

the consolidated fund for services and investments. At the same time financing through the National Health Insurance system is increasing (MoH, 2007). Currently, the health sector is faced with urban and peri-urban areas as well as deprived rural areas increasingly demanding for health services. At the same time existing health infrastructure are deteriorating and equipment are fast becoming obsolete thus undermining quality of care (GHS 2007)

The development within the health industry has not been recognized and analyzed. The capacity of the local manufacturing industry is under-utilized and the potential of Ghana's herbal and traditional medicines is largely untapped. The role of this industry in wealth creation is in sustaining health services and creating jobs. The national health vision is to attain middle income status with 1000 USD per capita by the year 2015 by creating wealth through health (GIPC 2014).

2.4 Public Private Partnership (PPP)

PPPs are typically medium to long term arrangements between the public and private sectors whereby some of the service obligations of the public sector are provided by the private sector, with clear agreement on shared objectives for delivery of public infrastructure and/ or public services. Tain and Bendamane (2001) indicated that in the context of health, a wide variety of initiatives can take the form of Public-Private Partnerships (PPPs). These include:

- private sector involvement in product development or distribution programs within public health systems
- joint initiatives by a government and the private sector to strengthen specific health programs

- contracting by the public sector of private sector service delivery organisations.

Public-private partnerships (PPP) can achieve positive public health results and at the same time meet the individual organizational goals of the partners. Such partnerships allow considerable leveraging of each partner's resources and unique strengths, and results are often attained in less time, at lower cost, and with greater sustainability than efforts by any single partner. Between 1996 and 1999, public, private, and donor organizations in Guatemala, El Salvador, Costa Rica, and Honduras formed the Central American Handwashing Initiative. Together, four soap companies and two projects supported by the U. S. Agency for International Development (USAID) designed an advertising and promotional campaign for effective hand washing with soap aimed at reducing diarrheal disease in children. They collaborated with ministries of health and education and other development organizations in the region to carry out the campaign. These efforts led to improvements in hand washing behavior and decreases in diarrheal disease. Ten percent of mothers in the study sample in Guatemala improved their hand washing practices, and the percentage of mothers using optimal practices doubled. Another result was that a sustained involvement of the private sector in social programs emerged (Tain and Bendamane, 2001)

In many parts of Africa faith-based organisations are responsible for delivering essential health services to large proportions of the population. Ghana is one country in which this is the case. Here, the Christian Health Association of Ghana (CHAG), which comprises a number of member institutions, caters for the health care needs of an estimated 35 to 40 per cent of the population. Established in 1967, CHAG has evolved over the last 40 years to become a major player in Ghana's health sector. Its accomplishments to date mean that it is widely viewed within

Sub-Saharan Africa as being the best-performing organisation in the faith-based health sector (CHAG, 2012)

2.4.1: Private Sector Providers

In many developing countries, when people first seek diagnosis and treatment for an illness they visit a private pharmacist, nurse, midwife, a drug seller or traditional practitioner. People use these private sector providers (PSPs) because they are often nearer, open for longer hours, and are seen as more considerate and sometimes less expensive than their public sector counterparts. PSPs are often a significant part of the health system in developing countries. Consequently they are an important focus for governments which aim to improve the performance of their health system. Poor people in particular visit PSPs for diagnosis and treatment of illness, including those illnesses which contribute most to the population disease burden, such as malaria, sexually transmitted infections, diarrhoea and tuberculosis. They often pay out of their own pockets for health services and products from PSPs as they are not generally members of pre-paid health schemes. Poor people are thus both vulnerable to draining their resources resulting from ineffective treatment and to the sometimes catastrophic costs of serious illness. Both may lead to further impoverishment (Smith, Brugha and Zwi 2001).

Aljunid (1995) argues that the reasons for consulting PSPs are ease of geographic access, shorter waiting periods, longer or more flexible opening hours and greater availability of staff and drugs. New anti-malarial such as the artemisinins, on which future malaria control strategies will rely on are widely found in private retail outlets long before reaching the public sector. Greater confidentiality in dealing with diseases such as tuberculosis (TB) and sexually transmitted infections (STIs) which carry social stigma, especially where notification of STIs by public

sector services is mandatory, perceptions are that PSPs are more considerate, caring and sensitive to client concerns.

Smith et al. (2001) argued that both informal and formal user charges may be levied in the public sector, making public sector services equally or more expensive. Perceptions in some settings are that private sector services are technically superior continuity of care and in the case of doctors, a belief in the value of the 'family-doctor' relationship. Financial inaccessibility is not the only challenge to accessing healthcare but also the nature of the health service must be acceptable by the social structure of the setting to promote utilization.

Swan and Zwi, (1997) advice that there is the need to study the nature of Private Sector Providers (PSPs). They argue that the technical quality of care provided by private providers is often poor. PSP practices have been under-researched and few of the available studies compare public and private sector quality of care. However, the available evidence reveals serious technical weaknesses in the services supplied by many for-profit providers. Shortcomings in private sector TB care include failure to test sputum, reliance on X-ray diagnosis alone, use of incorrect drugs or drug dosages, and failure to educate patients.

In India, almost half of the TB patients attending private health facilities failed to complete the treatment (Uplekar et al. 1998). Recent studies in Vietnam have shown similar patterns of health care provision for TB by PSPs: little use of appropriate diagnostic tests, delays in establishing the diagnosis and commencing treatment and poor referral to the best available public sector services (Lönnroth 2000). Studies of pharmacy, general practice and specialist Sexually Transmitted Infections services have shown poor quality management of STIs by for-profit PSPs. In a study

from Thailand, even where users recognised that government services were technically superior, they sometimes chose a PSP to minimise embarrassment (Benjarattanaporn et al., 1997).

Inadequate information and failure to make decisions about the technical quality of the accessible types of health care information asymmetry is a major limitation when people acquire care. They may find PSPs more responsive, but may not recognise their inadequacies. Poor prescriptions, dispensing and self-medication practices waste scarce resources, harm individuals and contribute to the spread of infectious diseases. Where incomplete courses of drugs are dispensed or people fail to complete the treatment, resistance to the drugs that are essential for controlling infections is promoted (Smith et al. 2001).

According to Venkant (2009), the virtual breakdown of public health system and unfettered rapid expansion and dominance of private health sector have translated into the poor being forced to seek services from expensive and unregulated private sector. And 80% of expenses from Out-of-Pocket by the service beneficiary resulting in debilitating effects on the poor in India. This attracted the Concern regarding unbridled commercial behavior of the private sector.

Juxtaposing the respective strengths and weaknesses, neither the public nor the private sector is in full capacity to deliver health care. Therefore it is by virtue of this circumstance that there is the need for some collaboration between the two. While this study is concerned with the four concepts mentioned earlier (availability, accessibility, utilization and coverage) to assess the service delivery, Venkant (2009), extends his study to financing health delivery. Hypothetically, he outlines the intended benefits of the collaboration between the public sector and private sector in health care. And they include improved access and reach , improved equity (reduce out of pocket expenses), better efficiency , opportunity to regulate and accountability, improve quality,

rational practice, imbibe best practices and augment Resources and Funds, technology and human resource. By the end of my study I hope that some of these outcomes will be obtained from the study area.

According to a review on China's health care delivery by Eggleston et al (2008) in a paper submitted to the World Bank, the study looked at the factors that underpin the poor performance of the health sector and revealed that there was more work to be done with regards to cost, equity, personnel, efficiency and urban bias. However, they indicated that it did not really depend on the efforts of either the private or the public sector. The outcomes of the study indicated that the poor performance of the health sector in China was as a result of the following factors: some inappropriate interventions by the government which includes poor regulation, the issue of advertising hazardous products to health and the behaviour of insurance. Other factors were the health care markets such as pricing mechanisms, confidentiality with regards to patients and the issue of not making necessary information available to tackle market failure problems like information asymmetry. Another problem was the quality of the health workforce in China especially in the rural areas. China found it relevant to increase the health workforce however the major challenge that emerged was the issue of the quality of the personal. Eggleston et al., (2008) posit that, a study conducted in 2001 revealed that about 70% of health workers in the rural areas had high school education as the highest level obtained and had just gone through medical training for about 20 months only. The health sector also fell short of management and other key groups necessary for the course on quality health care delivery.

2.5: Private Sector Health Care in Developing Countries

The huge and mostly unregulated private health sector in low-income countries raises serious concerns. According to a review in the latest issue of the Bulletin of the World Health Organization, the quality of drugs, advice and care sold privately is often dangerously poor. Especially for major diseases such as tuberculosis, malaria, and sexually transmitted infections, this has consequences for the individuals treated, for disease transmission and the development of drug resistance (WHO, 2002).

An article by Professor Anne Mills and colleagues in the Health Policy Unit at the London School of Hygiene and Tropical Medicine indicates how the private sector functions, and how it could be influenced in order to help meet national health objectives (WHO 2002).

Though it contains extreme diversity, ranging as it does from large commercial companies to shopkeepers and itinerant drug sellers, private enterprise has a strong common characteristic: it needs to sell its services and products profitably. In order to do so, it may ignore good technical standards of treatment such as correct drugs and dosages, especially where these are not readily affordable to its customers. For poor people such services are often the only option. In Sierra Leone, for example, the price of purchased drugs was almost a third of the cost of treatment at a public health centre. Private services are often more easily accessible as well, with drugs sold in general shops with convenient opening hours (WHO 2002).

People in low-income countries often lack knowledge about effective means of treating and preventing illness and are dependent on providers for information such as an interpretation of their symptoms (WHO, 2002). This can make them vulnerable to inadequately qualified

practitioners providing care of very poor quality, with little chance of redress when they have been victims of malpractice or negligence.

Direct consumer education could help inform patients about what constitutes good quality care for many common medical procedures. Price information could help patients when they seek providers, and social marketing could prove useful in publicizing such information.

Governments should use a range of approaches when working with private providers rather than relying on single strategies. The improvement of knowledge and skills is a necessary starting point. Most private providers receive no guidance from the public sector on diagnosis and treatment. Consequently, their practices are determined by biased information from pharmaceutical companies. Therefore, training is central to most approaches (WHO, 2002). It has improved the diagnosis and counseling practices of informal providers in India, the provision of antimalarials by shopkeepers in Kenya, and the management of diarrhoea and acute respiratory infections by private medical practitioners in Mexico (WHO 2002).

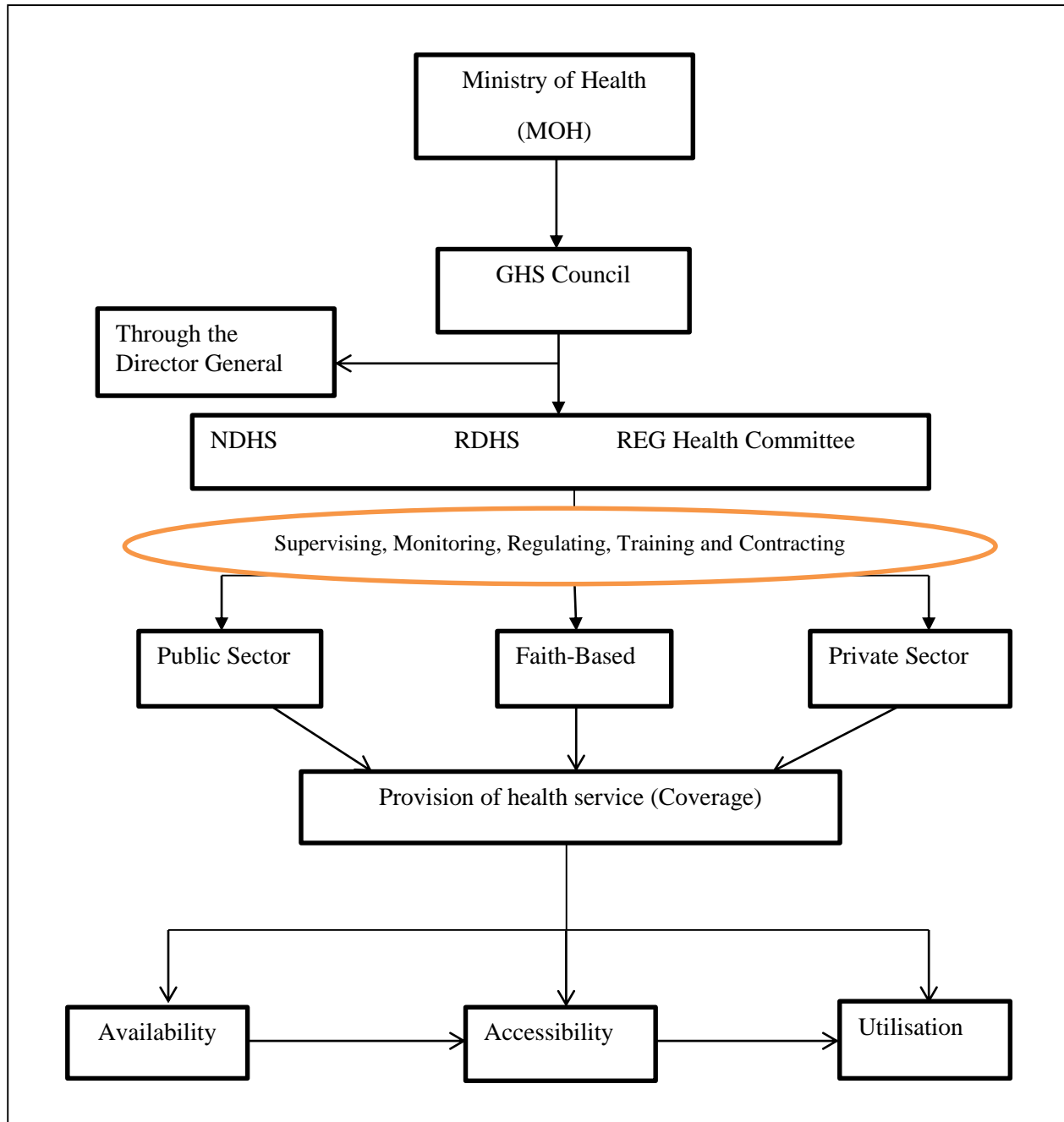
Governments should regulate the private sector, but putting regulation into effect has proved extremely difficult, especially in sub-Saharan Africa. For example, at present, many antibiotics and antimalarials, including those most recently released, are readily available from shops and peddlers, hence, ways must be found to influence the private sector in favour of public health.

2.6: Conceptual Framework for the Structure of Health Care Delivery in Ghana

This section deals with the concepts that underpin the study. Many efforts have been put to study and possibly improve on the health service delivery by numerous researchers. However, WHO (2010) has frequently used some conceptualized outcomes to assess health service delivery

globally. According to WHO (2010), these concepts are relevant and remain part of the key characteristics of a health service delivery system. This study attempted to adopt some of these concepts. Among them are accessibility, availability, utilization and coverage. Figure 1 gives an over view on how health care is organized, regulated and delivered by the various service providers.

Figure 1: A Conceptual Framework of the Institutional Arrangements and Supervisory Structure of the GHS and Health Service Providers.



Source: Author's construct, 2015

NB: GHS – Ghana Health Service

NDHS- National Directorate of Health Services

RDHS- Regional Directorate of Health Services

DHD- District Health Directorate

This conceptual framework looks at the various health service providers considered for this study and the institutional arrangement that binds them in executing the common goal of delivering quality health care services. With a mission ‘to contribute to socio-economic development and the development of a local health industry by promoting health and vitality through access to quality health for all people living in Ghana using motivated personnel’, the MoH is tasked by the government with the provision of effective and efficient policy formulation, resource mobilization, monitoring and regulation of delivery of health care by different health agencies in Ghana (MoH, 2012).

The MoH is headed by the Minister of Health. The Ghana Health Service is an independent Executive Agency in-charge of the implementation of national policies under the control of MoH through its governing Council - the Ghana Health Service Council. The GHS depends largely on public funds and thus remain within the public sector. At the regional level, the regional hospitals, the District Health Management Team (DHMT) as well as the Public Health division of the regional hospitals provides curative services and public health services respectively. The Regional Health Administration or Directorate (RHA) provides supervision and management support to the districts and sub-districts within each region (GHS, 2015).

At the district level, curative services are provided by district hospitals many of which are mission or faith based. Public health services are provided by the DHMT and the Public Health unit of the district hospitals. The District Health Administration (DHA) provides supervision

and management support to their sub-districts (GHS, 2015). The situation is not different in Abokobi as the community health center delivers curative services under the supervision of the Municipal Health Directorate (MHD). The MHD delivers preventive services within the community through programmes such as disease control and nutrition.

As mentioned earlier, the arrangements that bind these partners and agencies are contracts, supervision and monitoring as well as regulation. In the case of the private participants, there is a limit to the extent at which the Municipal Health Directorate (MHD) can supervise their work. For example the MHD is limited to only clinical areas of a private facility where as administrative, financial and procurement area no go areas for the MHD. According to the Municipal Health Directorate in Abokobi, the Abokobi Health Center is public and automatically falls under its authority, it also supervises all the private facilities within the catchment area to ensure that the required standards are met. Among the standards checked, supervised and monitored are; a nominal role, procurement, triage desk and all implemented programmes among others. Aside supervision, available nurses are also contracted to the private facilities that at any point in time fall short of nursing personnel. The study then revealed that partnership between government and private health service providers is not a regulated one. However, there is some sort of collaboration existing between the aforementioned categories of service providers that help in promoting health care services for the utilisation of the people of Abokobi.

However three key interrelated concepts in the provision of health care are availability, accessibility and utilisation as outlined in the conceptual framework. As it is arranged in the conceptual framework from left to right, each concept needs to be fulfilled and achieved before the next one can be conceived and achieved. According to WHO (2010), availability refers to the physical presence of the facility. However it is not enough for facilities to be available but they

should be sufficiently enough in regard to numbers, locations and proximity for them to be accessible to the people. It is only in these regards that the people are enabled to utilize the facilities. Other concepts have been captured by literature in promoting quality service delivery. For example Tanahashie (1978) includes affordability and acceptability in the concepts mentioned above. He posits that a health facility or health service should be affordable and acceptable. Which means that services provided should be reasonably priced. In other words it should be inexpensive to the recipient of the service. He argued that for a health facility or service to be acceptable, the nature of the service should be suitable and satisfactory to the recipient. Or social, cultural, religious and ethnical factors do not discourage the recipient from acquiring healthcare.

CHAPTER THREE

METHODOLOGY

3.0: Introduction

Both quantitative and qualitative methods were used for the study. The Abokobi township was chosen as the study area because of the presence of the District Health Directorate (DHD), the Community Health Center and the presence of some private sector providers which include two pharmacies, some herbalists and a Traditional Birth Attendant. Various instruments were employed to assess the accessibility and utilization of health care delivery in the municipality.

3.1 Profile of Ga East Municipal Assembly Area

The Ga East Municipal Assembly (GEMA) is one of the eight (8) districts in the Greater Accra Region of Ghana. The area is located to the north eastern part of the region and is one of the newly created districts carved out of the former Ga District (GEMA 2015).

3.2 Demographic Characteristics

The 2010 National Population and Housing Census put the Municipal Assembly's population at 198,220 with an inter-censal growth rate of about 4.2%. Women In the Fertile Age (WIFA) (15-49 years) formed 28.5% of the total population. The 2010 population figure yields a density of 1,214 persons per sq km much higher than the national density of 79.3 and the regional density of 895.5 persons per sq. km. This indicates a great pressure of population on land and resources or what the land can generate (GSS, 2014).

Abokobi in particular had a population of 1,095 as at 2010 but was projected to reach 1,764 by 2013. Abokobi is the capital of the Ga East District. The district is bordered on the north by the Akwapim South District in the Eastern Region and on the west by the Ga West district, on the south by Accra Metropolis and Ga South and on the east by the Adenta Municipal area. There are thirty four (34) communities in the Ga East Mncipal Assembly comprising mixed settlements, urban, peri-urban and rural areas with about 82% of the entire Municipal Assembly settlement being urban (GEMA, 2013).

The Ga East Municipal Assembly has a great deal of opportunities for both private investment and joint ventureship with the public sector. This is due to the enabling factors for development coupled with the infrastructure set-up and the district's proximity to the nation's capital, Accra.

There are four main economic activities in the District which are commerce, agriculture, service and industry. The economic activities include Public Services and trading, these are the dominant occupations in the municipality, followed by craftsmanship or artisanship with few engaged in subsistence farming. There are a few who are employed in small and medium scale enterprises as factory hands or casual workers. Some are engaged in hawking in goods for companies for some form of daily commission (GEMA, 2013).

About 63.6% of the population of the Ga East Municipality falls within the economically active age group. The dependency ratio shows the relative predominance of persons in dependant ages (persons less than 15 and those above 65) and those in the productive ages (i.e. 15-64 years). The 0-14 year group is the children population; 15-64 constitute the working population and 65 plus forms the aged group. The current dependency ratio is estimated to be 1:0.52 or 52%, which means that for every 100 people aged 15-65 years, there are approximately 52 people depending

on them for survival. In other words, each person within the working age group has less than one additional person to cater for. Dependency ratio in the Municipality is less in urban localities (52.0) than in rural localities of (53.3). This translates into the high poverty level and for that matter their inability to pay for the health care services offered (GSS, 2014).

The district is a Ga community but could be said to be heterogeneous since it is made of a mix of many of ethnic groups in Ghana but with Ga –Adangbes, Akans, Ewes and people from the three northern regions of Ghana forming the majority. Two major festivals are celebrated in the district, namely Dokobi which is celebrated by the inhabitants of Sessemi and Homowo celebrated by the people of Boi, Teiman and the other Ga communities in conjunction with the people of Teshie and La.

The Ga East Municipal Health Management Team (MHMT) is responsible for all health service delivery in the entire municipality. The municipality is divided into four sub municipalities for the organization and distribution of primary health care services. These sub municipalities are Abokobi, Dome, Taifa and Haatso.

Each sub municipal health management team has the responsibility for the delivery of health services to defined areas and has a center with either one or two community clinics. There are trained Traditional Birth Attendants (TBAs) and other care providers such as chemical shop dealers, maternity homes and traditional healers in the municipality. The doctor to population and nurse to population ratios are given as follows:

- Population to doctor ratio is 1 : 40,246
- Population to nurse ratio is 1 : 2,012

One important fact worth noting is that Abokobi is one of the initial settlements of the Basel missionaries in Ghana and is therefore an important landmark of the Presbyterian Church of Ghana. It is the political seat of the district and therefore has the Municipal Assembly as well as other decentralised departments including the Municipal Health Directorate (MHD). The town is well planned with quite good environmental sanitation and has a serene environment. The Ghana Atomic Energy Commission is located at Kwabenya (Taifa sub-district); the largest Psychiatric Hospital in Ghana is located at Pantang (Abokobi sub-district) which has two Nurses Training Schools (GEMA, 2013).

The district has a total of about forty-three (43) health facilities made up of 6 public facilities (13.3%), One (1) quasi government, Ghana Atomic Energy Commission (GAEC), one (1) faith based hospital, Christian Health Association of Ghana (CHAG) and the remaining 35 (81.4%) are private facilities. There is one Community Health based Planning and Services (CHPS compound) located at Akpormang-Boi in the municipality. All these health facilities render outpatient curative care services but only eight (8) have skilled delivery facilities. There is collaboration between the District Health Management Team (DHMT) and some of the private health care providers. Twenty five (25) of the private facilities send monthly reports to the Municipal Health Directorate. There is no district hospital but the Pentecost Hospital which is a Faith based hospital situated at Madina serves as the first referral point for emergency obstetric care. The Greater Accra Regional Hospital (Ridge Hospital) which is about 22 km away serves as the next referral level for emergency obstetric care. The municipal area has no ambulance but falls on one from the Pentecost Hospital (GEMA, 2013)

The major health problems in the district are malaria, poor sanitation and lack of potable water with malaria ranking first among the first ten top diseases. The Ga East Municipal Assembly

collaborates with the health directorate to have quarterly review meetings to identify health problems and come up with strategies to address such problems. There are plans underway to provide more public health facilities especially within the Taifa and Dome sub districts where there are none in order to improve health services within the district. The School of Public Health of the University of Ghana is in collaboration with the MHD in supporting the CHPS programme in the district. Non-Governmental agencies such as 'Focus Region' also support the MHD with logistics and finance.

All the government health facilities are rendering services to NHIS clients; however, the municipality does not have a separate scheme to manage NHIS. The Municipality is managed by the Ga Mutual Health Insurance Scheme at Amasaman. Although the municipality has agents, processing of documents is handled by the scheme at Amasaman. This greatly affects access to service delivery. There is the need to create a separate scheme in Ga East Municipality to manage the community members (GEMA 2013).

3.3 Research Design

Descriptive case study

The study was a case study. It was focused and detailed, in which propositions and questions on the topic were carefully scrutinized and expressed at the outset (Tobin, 2010). It was concerned with collecting information without altering the environment. The case study, like other research strategies, is a way of exploring an empirical topic by following a set of pre specified procedures. These procedures will largely dominate the remainder of this study (Yin 2003).

3.4 Population

The inhabitants who reside in the area and personnel at the health directorate, the community health center and private health service providers in Abokobi in the Ga East Municipality were the entire population of the study. The target population was stratified into two strata; the health service providers and the residents (respondents).

3.5 Sampling

This was an attempt to draw a number from the population for the study. A non-probability sampling method called the purposive sampling method was utilized to draw a sample of two facilities from the private facilities. Non-probability samples are convenient and have relatively low cost per unit studied (Kumekpor, 2002). Maxwell (1997) further defined purposive sampling as a type of sampling in which, “particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices” (p. 87). Purposive sampling is based on the postulation that the researcher wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned.

Stratified random sampling technique was used for the selection of households of the respondents. This stratification was based on spatial features with the community being grouped into three (3) clusters according to the 2010 population census (GSS, 2014). Simple random sampling was used to further select the households from the clusters. Structured questionnaires administered to the respondents sought to answer questions related to financial and geographical accessibility, utilization, quality of health service, health insurance and universal coverage of

health as well as the educational levels as these helped the researcher achieve the objectives of the study.

3.6 Sample size

A sample size was drawn from the Abokobi catchment area which has a household population of four hundred and forty (440). A confidence level of 95% with an error term of 10% was employed in yielding a sample size of eighty-one (81) respondents by Yamane's (1967) mathematically derived formula. However, due to the issue of no response, the researcher added 20% (16) of the optimal sample size to make a total sample size of ninety-seven (97). The respondent households were obtained using a systematic sampling method. From the main entry of each cluster as the name suggested, every third 3rd house was selected for the study.

The optimal sample size (n) is therefore calculated from the equation as follows;

$$\{n = N / (1 + N(e)^2)\}$$

$$n = (440) / (1 + (440) * (0.1)^2)$$

$$n = (440) / (1 + 4.4)$$

$$n = 440 / 5.4$$

$$n = 81.481$$

Therefore the desired sample size was 81. Nonetheless, the researcher added 20% of the sample size to cater for unresponsive households.

$$20/100*81=16$$

$$n=81+16=97$$

hence the total sample size =97

Three representatives were randomly selected from the purposively sampled health service providers to obtain qualitative data. They were each from the Municipal Health Directorate, the Community Health Center and a pharmacy. Two herbalists and a TBA were also interviewed as well as three respondents who utilise their services; one for each of these health service providers.

3.7 Data Collection

Since the objective of the research was to assess the level of participation of both private and government partners in health delivery, it required a detailed data. It required multiple forms of data collection. This included conducting in-depth interviews with the private service providers aforementioned, a representative of the community health center as well as a representative of the Municipal Health Directorate. The interviews provided the opportunity to obtain in detail the contribution of the various categories of health service providers in Abokobi. Primary data from the residents of the study environment was also collected quantitatively with the use of structured questionnaires.

Two key informants contacted for the study were the Assembly man and the Administrative assistant at the District Health Directorate. This was to help the researcher to gain insight into the history of the community and also to authenticate information gathered from other respondents.

Secondary data from the 2010 Population and housing Census: District Analytical Report, District Health Directorate Reports, Ghana Health Service and Ministry of Health aided in assessing health outcomes from both the private sector and public sector in health service delivery.

The researcher also attempted the use of direct observation to complement the other methods aforementioned.

3.8 Data processing/Analysis

The Statistical Package for the Social Sciences (SPSS) was utilized in the analysis of the quantitative data collected from the households. Descriptive statistical tools used included frequency tables and pie charts to summarise the findings of the study. Cross tabulation was used to analyse how the dependent variables affect the independent variable. Some demographic characteristics of the population studied were considered possible covariates of health service delivery and utilisation and are therefore considered as the independent variables of this study. These include age, level of education, marital status, number of offspring, ethnicity, health insurance coverage, and employment history. Pearson's chi square was further used to observe the significance of the differences between the independent variables and the dependent variables. The study also utilized thematic analysis to interpret the qualitative data. Content

analysis of literature was employed as well. This approach is sometimes referred to as a quantitative analysis of qualitative data (Morgan 1993).

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF DATA

4.0 Introduction

As discussed in the previous chapter, the study uses primary data to assess private and government participation in health service delivery at Abokobi in the Ga East Municipal Assembly. To effectively achieve the objectives of the study, the researcher employed an eclectic approach of quantitative (through descriptive statistics, frequency tables and graphs) and unstructured in-depth interviewing as a qualitative methodology. The chapter covers presentation and discussion of the primary data collected from the field.

4.1 Socio-demographic Characteristics of Respondents

A total of 97 people were interviewed from selected households using structured questionnaires. Out of this, 51% was classified as adults with ages ranging from 35-60 years as seen in Table 4.1.1. Out of the respondents interviewed, 44% were married and 24% had never married. Those who were divorced, widowed, or separated were 30%. The largest proportion of 44% was married.

Literacy was quite high among the respondents as 92% of them reported they could read and write and could therefore give an independent assessment of the service delivery by the various targeted service providers.

Concerning employment, 42.41% were unemployed and 57.29% were employed. Traders formed 41% of the respondents and about 13% were farmers. One can agree with the Ga East Municipal Profile as it describes the community as a farming community.

The survey revealed that 54.02% of respondents earn a monthly income below 200 Ghana Cedis. Abokobi is a peri urban town and most of the residents are considered to be low income earners however, at this income level, most of the residents earned above the annual national average income of 1,314 Ghana Cedis as reported by the Ghana Statistical Service (2013).

It is worth knowing that, the total number of responses on some variables fell short of the optimal sample size of 97. This was as a result of some respondents' inability to answer such questions. Age, employment, educational level, profession and income are the areas that suffered the deficit. Therefore the estimated frequencies are based on responses by respondents only not taking account of missing values.

Table 4.1.1: Socio-demographic characteristics of respondents in Abokobi

Characteristic	Proportion Frequency (%)	Characteristic	Proportion Frequency (%)
Age		Employment Status	
Youth (18-34)	31 (32.98)	Employed	55 (57.29)
Adult (35-60)	48 (51.06)	Unemployed	41 (42.71)
Aged (60+)	15 (15.96)		
Total	94 (100)	Total	96 (100)
Marital Status		Educational level completed	
Never Married	24 (24.74)	Never being to school	8 (8.60)
Married	43 (44.33)	Primary	18 (19.35)
Separated	10 (10.31)	Secondary	46 (49.46)
Divorced	6 (6.19)	Tertiary	15 (16.14)
Widowed	14 (14.43)	Adult Education	6 (6.45)
Total	97 (100)	Total	93 (100)
Household Size		Length of stay in Abokobi	
Less than 4	18 (19.35)	Less than 3 yrs	7 (7.53)
4-6	42 (45.16)	3-5 yrs	18 (19.35)
7-9	24 (25.81)	6-8 yrs	14 (15.06)
10+	9 (9.68)	8+ yrs	54 (58.06)
Total	93 (100)	Total	93 (100)
Profession		Monthly Income	
Farmer	13 (15.12)	Below GHC200	47 (54.02)
Petty Trader	41 (47.67)	GHC201-GHC400	19 (21.84)
Salary Worker	20 (23.26)	GHC401-GHC600	10 (11.49)
Other	12 (13.95)	GHC601-GHC800	3 (3.45)
		GHC801-GHC1000	4 (4.60)
Total	86 (100)	Above GHC1000	4 (4.60)
		Total	87 (100)
Gender			
Male	57 (58.76)		
Female	40 (41.24)		
Total	97 (100)		

Source: Author's Field Survey, July 2015

4.2 Profile and contribution of both government and private health service providers at Abokobi

The Abokobi Community Health Center is a government facility which has existed for about 18 years. According to the Senior Physician Assistant in charge, the land on which it is situated was allocated by the Presbyterian Church to put up the facility to cater for the health care needs of the people of Abokobi and its environs. The center lacks a theater, ear, nose and throat (ENT) department, an x ray department and attends to less than 12,000 patients a year'. A medical officer is not available and the center is managed by a senior physician assistant. 'I am the in-charge' says the senior physician Assistant at the Abokobi Health Center). The facility delivers services including general Out Patient Department (OPD) services and reproductive and child health (ante natal and post natal delivery, weighing of babies, family planning counseling and immunization). It was discovered that an increase in the number of people who accessed the facility was one of its achievements. While the facility aims at increasing the current number of people who access it, there is also the aspiration to be the best health center in Greater Accra region as well as expanding to attain a polyclinic status.

With regards to the two categories of health service providers considered for this study, the community health center which is a public facility and is more utilized by household members than the private service providers. These private service providers include a pharmacist, herbalist and Traditional Birth Attendant (TBAs). As observed in Table 4.1.12 below, 69 out of 97 household members use the community health center where as the remaining 8 members opt for the private service providers. This trend has earlier been attributed to various variables including age, educational level and income in the previous discussion. The contribution of these two service providers towards health delivery in Abokobi is being assessed in this work. According

to the Administrative manager of the Ga East Municipal Health Directorate in an interview, diverse programs are implemented and run by various units at both the municipal health directorate and the community health center. ‘We have some programs run at the directorate level and some too at the facility level’ says the Administrator. He indicated that some programs like disease control, nutrition and health information were run at the directorate and psychiatry was a typical example of a facility level program. He further revealed that, the directorate also played supervisory and monitory roles to ensure that both the public and private facilities operated within ‘acceptable standards’.

The private service providers on the other hand also serve as source of health care to the community. In an interview with an attendant at the pharmacy, dispensary services on both orthodox and herbal medicine are delivered. According to the attendant, patients with severe cases are advised to go to the community health center as well as those seeking delicate drugs without prescription. Examples of such drugs mentioned were anti biotics. It was discovered that though the directorate did not have any sort of relationship with the operating pharmacies, they were supervised periodically by the Ghana Pharmacy council.

A herbalist in Abokobi who has practiced for close to fifty years added that people from the community and its environs utilize his services. Some major ailment he treats include ‘all kinds of fever’, piles, fibroid, severe headaches known as ‘Atifa’ in the Ga dialect and snake bites as well as extracting all kinds of poison. The cost for treatment for an episode of treating these ailments aforementioned ranged between 20.00 to 500.00 Ghana cedis. The duration for treating such ailments according to him was three days to two weeks within an episode of ailments. This depends on the nature and intensity of the ailment. He revealed that his clients reach him through the references by people he has previously treated. ‘Those I treat make advert for me’. According

to the herbalist, herbal medicine is mainly made from ‘leaves, roots and the backs’ of plants. Apart from drinking these herbs, one major way of treatment is known as ‘chukomor’ in Ga. Chukomor according to the herbalist is the act of laying over a very hot concoction while covered with a heavy cloth to enable the vapour get into your body through one’s pores.

Concerning partnerships, various forms of collaboration existed between the public health service providers and the private health service providers. According to the municipal health administrator, the Municipal Health Directorate plays monitoring and supervisory roles in all facilities. Actually, it controls every activity at the public facility. However, it is limited to supervising and monitoring clinical areas only at private facilities. Non-clinical areas such as administration, accounts and procurement among others are ‘no go areas’ for the municipal directorate. Another relationship that existed was one that existed between the health center and the National Health Insurance Authority (NHIA). The senior physician assistant described it as one that ‘was not smooth at all’. She lamented bitterly on the NHIA’s inability to reimburse the health center on time after it provides services to clients on the scheme. This trend negates the outcome of the service delivery as well as the Internally Generated Funds (IGF) of the facility which eventually affects development. It was discovered that the NHIA was indebted to the facility from August 2014 to the time of the study (July 2015). One may argue that, it is probably the reason the Abokobi Pharmacy is not subscribed to provide services for the health insurance beneficiaries.

With regards to human resource and how it contributes to service delivery, the study revealed that it was a vital component. However it was discovered that, there was inadequate number of personnel especially at the facility level. The senior physician assistant indicated that the units that suffered most in terms of inadequate personnel were the laboratory and the pharmacy. Hence

the facility hired casual workers at its own expense. She also admitted that the total of four physician assistants was woefully inadequate as four were not enough to get someone to run the evening shift. This meant that, even though the facility was opened and accessible to the residents anytime, at night, the service of a physician assistant was not available, making it inaccessible. Furthermore the study discovered that, the inadequate personnel who were available received little incentive as motivation to work. Presently personnel provided for themselves logistics which were previously provided by the government. Uniforms and accommodation were examples. Meaning, personnel live far from the facility and this affected punctuality and regularity at work.

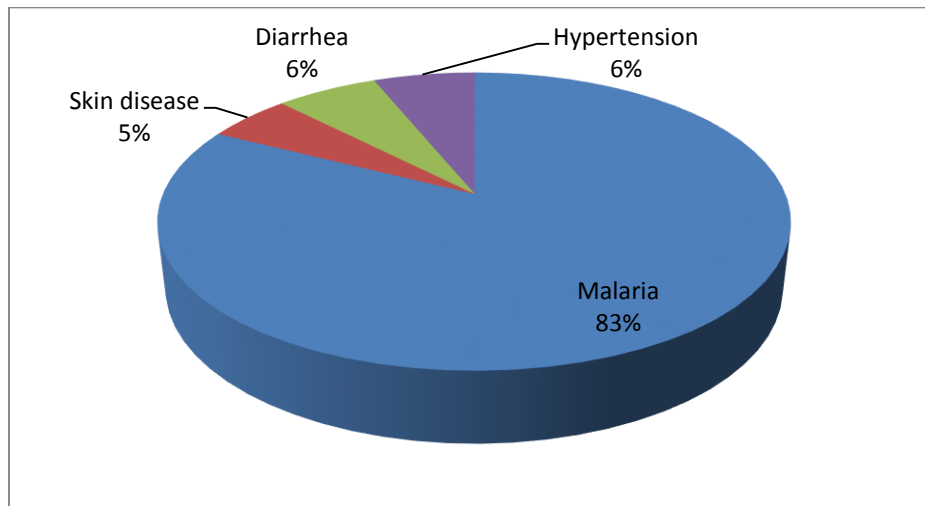
The private service providers aforementioned revealed that all the herbalists within the community came together to form association which was registered at the Ga East Municipal Assembly. The association is regulated by rules. The community health center also organises training sessions for the Traditional Birth Attendants in Abokobi as well as equipping them with the appropriate and necessary equipment. The usage of herbal medicine is increasing and this has called for its integration into the modern health system as well as regulation. This can explain the efforts by the community health centre to train and improve the skills of TBAs as well as providing them with the necessary kits for delivering.

In a nutshell, the contributions of the private and government sectors resulted in mixed reactions. Whereas the presence of the facility meant that health service was available, accessibility was quite limited to an extent. Funds, logistics, human resources and some institutional weaknesses posed as challenges to accessibility and utilization of health service delivery. According to the senior physician assistant, affordability was ensured to promote financial accessibility. On the

other hand, the private service providers were relatively more affordable and accessible and valued by their clientele.

4.3 Frequency of Illness and Disease Prevalence

Individual household members in Abokobi are not immune to sicknesses and diseases. Just like other peri-urban areas in the Greater Accra Region, individuals in Abokobi suffer from all kinds of sicknesses ranging from malaria, skin diseases, diarrhea and hypertension. While 58 percent of the 97 respondents sampled for the quantitative study indicated they rarely fall sick, about 26 percent, 8 percent and 3 percent said that they often fall sick once in 6 months, once in 3 months and once in a month respectively. The most common disease suffered in Abokobi community is malaria (Figure 2) with 27 percent and 16 percent of the respondents for the quantitative study reporting having had 1 and 2 members of their household respectively affected by diarrhea and malaria in the past month. The private service providers and most of the respondents who utilize their services agreed that fever and malaria were the commonest diseases that affected them. Hence respondents who utilise both service providers agreed on the commonest disease in Abokobi.

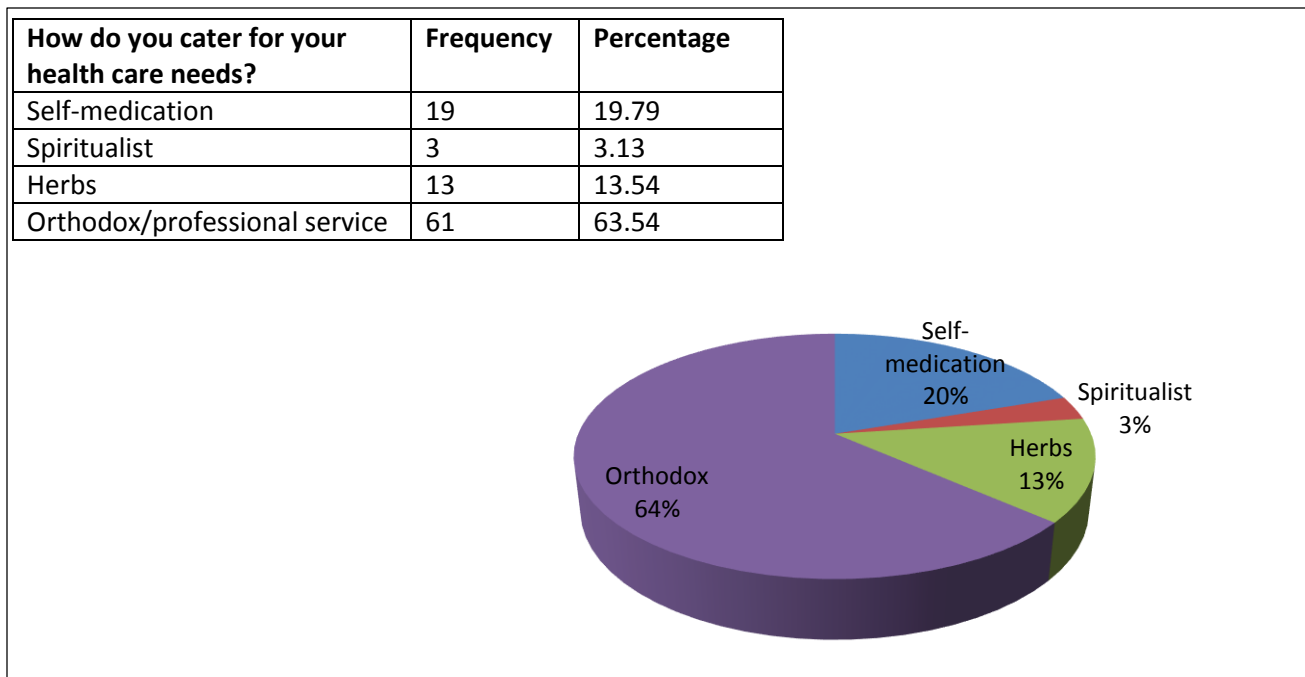
Figure 2: Percentage of common diseases in Abokobi as reported by respondents

Source: Author's Field Survey, July 2015

4.4 Sources of Health Care

The prevalence of all kinds of sicknesses with malaria being on top in the Abokobi community and the frequency of occurred cases necessitate health care availability. The rate of accessibility then becomes a crucial issue since inaccessible health facility is synonymous to unavailable health facility. Respondents in Abokobi seek all kinds of means for their health care needs. The data indicated that about 20 percent of the respondents rely on self-medication for their health needs. Some 3 percent consult spiritualists while 14 percent rely on herbalists or herbal medications. Some 64 percent however rely on professional or orthodox medical services for their health needs (Figure 3). The proportion of those who depend on the orthodox services give an indication of the availability and accessibility of a health facility or facilities in the community. According to Meise et al. (1996) a study in Australia found an inverse relationship between the utilization of available facilities by patients and the distance from their home.

Figure 3: Various sources of health care needs for respondents in Abokobi



Source: Author’s Field Survey, July 2015

From Figure 3, health care facilities seem highly accessible to the community members as almost 64 percent of respondents rely on professional health care services. With respect to gender, about 73 percent of males depend on orthodox medical services while 14 percent and 13 percent of males respectively depend on self-medication and herbs. About 50 percent of females also depend on orthodox/professional health care services. About 28 percent of females rely on self-medication while 15 percent depend on herbs (Table 4.1.2). The difference in sourcing health care needs among male and female respondents in Abokobi community is significant at 5 percent from the chi square test.

Table 4.1.2: Percentage distribution of sources of health care by gender of respondents

Gender of HH Head	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Male	14.29	0	12.5	73.21	100
Female	27.5	7.5	15	50	100
Pearson chi2 = 8.3453			P = 0.039		

Source: Author's Field Survey, July 2015

Both the youth and the adult populations in the community often depend on orthodox health services. About 68 percent of the youth and 64 percent of adults rely on orthodox/professional health services for their health care needs. For the aged population however, about 27 percent rely on self-medication while 20 percent rely on herbs. Close to 47 percent of the aged seek the professional/orthodox medical services for the health care needs (Table 4.1.3). These differences among the various age groups are however not statistically significant, based on the chi square test.

Table 4.1.3: Percentage distribution of sources of health care by age of respondents.

Age category	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Youth (18-34 yrs.)	25.81	0	6.45	67.74	100
Adults (35-60 yrs.)	14.89	4.26	17.02	63.83	100
Aged (60+ yrs.)	26.67	6.67	20	46.67	100
Pearson chi2 = 5.844			P = 0.441		

Source: Author's Field Survey, July 2015

It is also evident from the data that a high proportion of respondents who suffer from malaria seek orthodox/professional health care services (69.62%) while 15 percent and 14 percent of malaria cases are attended to by self-medication and through herbs, respectively. About 40 percent of skin disease cases report to orthodox medical centres while 20 percent each are attended to by self-medication, spiritualist and herbs respectively (Table 4.1.4). Many diarrhoea cases (50%) are attended to by self-medication with only 17 percent relying on the orthodox/professional health services. Fifty percent of hypertension cases are reported at professional/orthodox health centres while 50 percent of the cases also rely on self-medication. The difference in sourcing health care with regards to common diseases in the community is statistically significant at 5 percent from the chi square test in Table 4.1.4. Those who fall sick most frequently seek health care services from orthodox/professional sources than those who do not fall sick frequently. Almost all respondents who fall sick once in every month seek orthodox health services while about 71 percent of those who fall sick once in every 3 months also visit the orthodox health facilities (Table 4.1.5). Hence the difference in sources of health care and the

frequency at which respondents fall sick is statistically insignificant at 5 percent from the chi square test in table 4.1.5.

Table 4.1.4: Percentage distribution of sources of health care by the prevalent diseases in Abokobi.

Common diseases	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Malaria	15.19	1.27	13.92	69.62	100
Skin diseases	20	20	20	40	100
Diarrhoea	50	16.67	16.67	16.67	100
Hypertension	50	0	0	50	100
Pearson chi2 = 19.678			P = 0.020		

Source: Author's Field Survey, July 2015

Table 4.1.5: Percentage distribution of sources of health care by the frequency of falling sick of the respondents

Frequency of falling sick	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Rarely	15.09	1.89	13.21	69.81	100
Once in 6 months	41.67	4.17	20.83	33.33	100
Once in 3 months	14.29	14.29	0	71.43	100
Once in 1 month	0	0	0	100	100
Pearson chi2 = 18.048			P = 0.114		

Source: Author's Field Survey, July 2015

Except for respondents who are widowed, majority of married, separated, divorced and those who never married attend orthodox/professional medical centres for their health service needs. About 43 percent of household members whose head is widowed depend on self-medication while about 29 percent of them each rely on herbs and orthodox/professional health services (Table 4.1.6). The different health care needs sought by married, separated, divorced, widowed and those who are never married is statistically significant at 5 percent from the chi square test in Table 4.1.6.

Table 4.1.6: Percentage distribution of sources of health care by marital status of respondents

Married Status	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Never married	25	0	8.33	66.67	100
Married	7.14	7.14	11.9	73.81	100
Separated	30	0	0	70.0	100
Divorced	16.67	0	33.33	50.0	100
Widowed	42.86	0	28.57	28.57	100
Pearson chi2 = 21.557			P = 0.043		

Source: Author's Field Survey, July 2015

The rate of dependence on self-medication and herbs generally decreases with increasing levels of education while the rate of dependence on orthodox/professional services increases with increasing education. For respondents who have never been to school, about 38 percent rely on self-medication, 12 percent on herbs while 50 percent use orthodox services. For respondents who completed primary school level, about 17 percent rely on self-medication while 78 percent consult orthodox services. For respondents who completed secondary schools, 22 percent rely on self-medication while 7 percent of those who completed tertiary education do likewise (Table 4.1.7). About 33 percent of respondents who completed adult/non-formal education resort to spiritualists for their health care needs with 50 percent consulting orthodox services. The difference in health care sources for respondents with different educational backgrounds is statistically significant at 1 percent from the Pearson's chi square test and its probability value in Table 4.1.7.

Table 4.1.7: Percentage distribution of sources of health care by the educational level of respondents

Educational level attained	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
Never been to school	37.5	0	12.5	50.0	100
Primary school	16.67	0	5.56	77.78	100
Secondary school	22.22	0	17.78	60.0	100
Tertiary school	6.67	0	13.33	80.0	100
Adult/non formal education	0	33.33	16.67	50.0	100
Pearson chi ² = 35.88			P = 0.000		

Source: Author's Field Survey, July 2015

Generally, the data indicate decreasing self-medication and increasing orthodox/professional health care dependence as the respondents' monthly income increases. About 36 percent of respondents with less than GHC 200 as their monthly income depend on self-medication for their health care needs, 13 percent depend on herbs and 57 percent depend on orthodox services. For respondents with monthly income between GHC200 and GHC400, 16 percent each depend on self-medication and herbs while 68 percent rely on orthodox services. For respondents with monthly income above GHC600, more than 70 percent depend on the orthodox/professional health services (Table 4.1.8). Based on the chi square test, the difference in sources of health care and monthly income levels of respondents is statistically insignificant at 5 percent.

Table 4.1.8: Percentage distribution of sources of healthcare needs by the range of monthly income of respondents.

Monthly income category	Sources of health care				Total
	Self-medic	Spiritualist	Herbs	Orthodox	
Below GHC 200	26.09	4.35	13.04	56.56	100
GHC200-GHC400	15.79	0	15.79	68.42	100
GHC401-GHC600	10	10	30	50	100
GHC601-GHC800	0	0	0	100	100
GHC801-GHC1000	25	0	0	75	100
Above GHC 1000	0	0	25	75	100
Pearson chi2 = 9.786			P = 0.833		

Source: Author's Field Survey, July 2015

4.5 Health Care Financing

Despite the rate of self-medication and the reliance on herbs for health care needs among respondents with relatively low monthly income in the Abokobi community, a significant proportion still rely heavily on the orthodox/professional health services in and around the community. This could be explained from the rate of involvement, participation, effectiveness and adoption of the National Health Insurance Scheme (NHIS) among respondents with relatively low monthly income in the community. Out of the 97 respondents interviewed quantitatively, 74 respondents representing about 76.29 percent were registered on the NHIS while the remaining 23.71 percent were not (with 12 respondents claiming not interested, 4 had no money to pay the premium while 6 had other reasons). From the chi square test in table 4.1.9,

the difference in monthly income levels and NHIS usage is statistically insignificant at 10 percent. About 67.42 percent of respondents registered on the NHIS reported that the scheme is effective while the remaining 32.58 percent who feel otherwise (ineffective NHIS) tied it to the fact that the scheme does not cover serious ailments.

It is clear from the above analysis that a fair proportion of respondents in Abokobi are enrolled on the NHIS and a fair proportion feels it is effective as well. Table 4.1.9 below indicates that about 54.55 percent of respondents with less than GHC200 monthly income are on the NHIS and 24.24 percent of respondents with monthly income between GHC 200 and GHC 400 are also on the NHIS. This explains why a significant proportion of respondents with relatively low monthly income rely on orthodox/professional health services in the community. As evident from Table 4.1.10, about 70 percent of respondents active on the NHIS attend to their health care needs from orthodox/professional sources yet, close to 21 percent of such NHIS members still rely on self-medication. For respondents not on the NHIS, about 17.4 percent rely on self-medication, 13 percent on spiritualists, 26 percent on herbs and 43.5 percent on orthodox services for their health care needs (Table 4.1.10). The difference in various sources for health care needs for NHIS members and non-NHIS members is statistically significant at 1 percent from the Pearson chi square test (15.04) and its probability (0.002) in Table 4.1.10. On the other hand, respondents who utilize the services of the private service providers (spiritualist, herbalist, pharmacy and TBAs) barely paid for the services except to pay for the herbs which are now hard to come by as a result of the increase in the depletion of the forest reserve according to the study. The study revealed that most of the practitioners acquired the knowledge and skill through spirits and inheritance. With this inclination, they believe they are to serve humanity.

Table 4.1.9: Percentage distribution of NHIS usage and income status of respondents

On/Off NHIS	Monthly Income of Respondents						Total
	<200	200-400	401-600	601-800	801-1000	>1000	
On NHIS	54.55	24.24	9.09	3.03	4.55	4.55	100
Not on NHIS	52.38	14.29	19.05	4.76	4.76	4.76	100
Pearson chi2 = 2.25			P = 0.813				

Source: Author's Field Survey, July 2015

Table 4.1.10: Percentage distribution of sources of health care by the adoption of the National Health Insurance

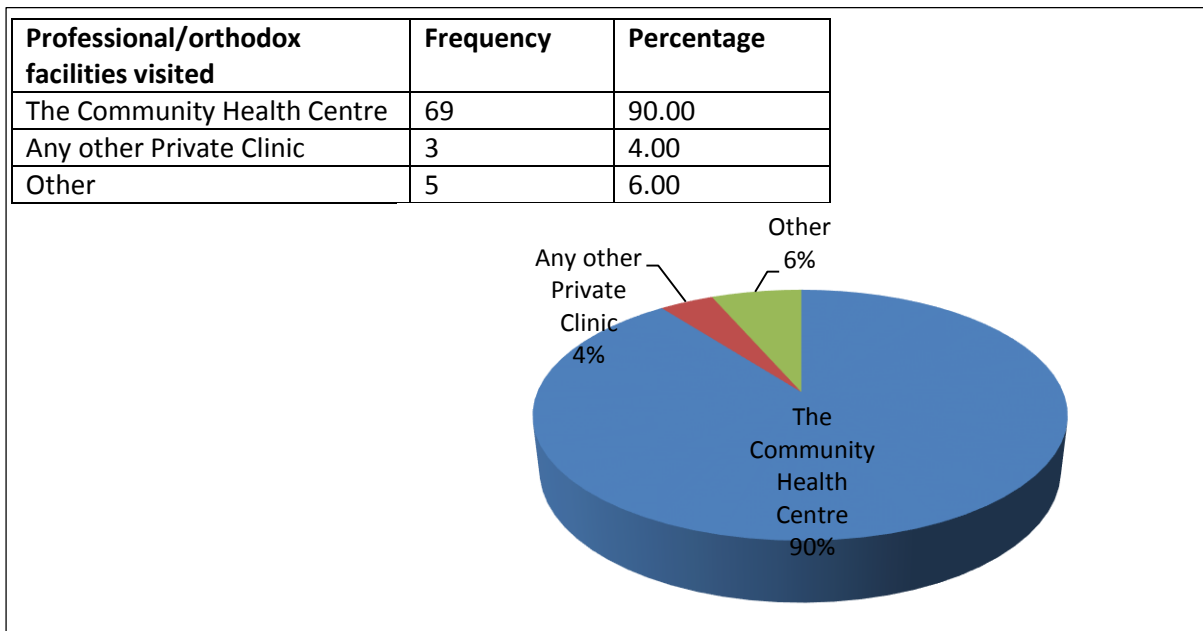
On/Off NHIS	Sources of health care				Total
	Self-medication	Spiritualist	Herbs	Orthodox	
On NHIS	20.55	0	9.59	69.86	100
Not on NHIS	17.39	13.04	26.09	43.48	100
Pearson chi2 = 15.04			P = 0.002		

Source: Author's Field Survey, July 2015

For respondents who accessed professional/orthodox facilities, about 85 percent went to the Community Health Centre, 3.7 percent went to any other private clinic while 6 percent sought the other private service providers captured by the study (Figure 4). The major reasons for the choice of the facilities are affordability and proximity. These two factors are indicative of the financial and geographical accessibility of the health facilities to the respondents in Abokobi. The percentage distribution of respondents' different reasons for the choice of a facility by the

various facilities is represented in Table 4.1.11. The difference in acquiring orthodox care and reason for its choice is statistically insignificant at 5 percent based on the chi square test and its probability (0.992) in Table 4.1.11.

Figure 4: Professional/orthodox health facilities visited by respondents in Abokobi



Source: Author’s Field Survey, July 2015

Table 4.1.11: Percentage distribution of orthodox/professional facilities visited by the reason for the choice of facility (%)

Orthodox facility visited	Reasons for the choice of facility					Total
	Quality of service delivered	Warm attitude of workers	Affordability	Proximity	Other	
Community Health Centre	27.94	10.29	30.88	29.41	1.47	100
Other Private Clinic	50	0	50	0	0	100
Other	20	20	20	40	0	100
Pearson chi2 = 3.40			P = 0.992			

Source: Author's Field Survey, July 2015

For those who visit the Community Health Centre in Abokobi for their health care needs, close to 31 percent make such choice based on the affordability of the facility while about 29 percent also visit the Community Health Centre due to its proximity to them (Table 4.1.11). It is therefore evident that a community health centre is available in Abokobi and it is geographically and financially accessible to household members in the community. About 28 percent and 10 percent of household members who visited orthodox medical centres chose the Community Health Centre due to the quality of service delivery and the warm attitude of health workers respectively (Table 4.1.11). For respondents who also visited orthodox facilities, 50 percent chose other private clinics because they are affordable and 50 percent also feel private clinics provide quality health services (Table 4.1.11). On the bases of affordability, other private clinics are also accessible to household members in Abokobi. The differences between the orthodox facilities visited due to various reasons assigned for the choice of facility are not statistically significant at 5 percent based on the chi square test in Table 4.1.11.

Many respondents also access these orthodox health facilities because of the attitude of service providers. According to the data, 14.49 percent of respondents who visited the Community Health Centre in the community felt the service providers were very friendly while 44.93 percent, 30.43 percent and 10.14 percent felt the service providers were friendly, not too friendly and rude respectively (Table 4.1.12). Clearly, the positive attitude of service providers attracted lots of respondents to the community health centre. For those who visited other private clinics, about 67 percent and 33 percent of respondents felt service providers were very friendly and friendly respectively (Table 4.1.12). The difference between visits to either the community health center or a private facility and the attitude of the service provider is statistically significant at 5 percent based on the chi square test.

4.6 Availability, Accessibility, Utilization And Quality Of Service

Table 4.1.12 and the discussion beneath it explain how the attitude of personnel at orthodox facilities influences respondents' usage of the facility.

Table 4.1.12: Percentage distribution of orthodox facilities visited by respondents by the perceived attitude of service providers

Orthodox facility visited	Attitude of service providers				Total
	Very friendly	Friendly	Not too friendly	Rude	
Community Health Centre	14.49	44.93	30.43	10.14	100
Private Clinic	66.67	33.33	0	00	100
Other	20	60	20	0	100
Pearson chi2 = 8.926			P = 0.444		

Source: Author's Field Survey, July 2015

About 26 percent of respondents rated the performance of the community health centre at Abokobi as poor while 32 percent and 39 percent respectively rated the performance of the community health centre as satisfactory and good (Table 4.1.13). In support of this, about 31.34 percent of respondents who visited the Community Health Centre reported that health education, maternal health and laboratory are available at the Community Health Centre (Table 4.1.14). For those who visit other private clinics, 67 percent of respondents rated the private clinics as poor while 33 percent rated their performances as good (Table 4.1.13). Hence the difference in visiting an orthodox facility and the perceived performance of the facility is statistically insignificant at 5 percent in Table 4.1.13 based on the chi square test.

On the qualitative findings, the study discovered that there was only one public facility at Abokobi Township against two pharmacy shops and other private and traditional service providers including herbalists, Traditional Birth Attendants and some medicine vendors. However, the entire Ga East district possessed two public centers against 15 private facilities and one quasi government facility. The study indicated that the services delivered by the private service providers in Abokobi is indigenous to the community and it is still accessed and utilized by the people amidst the presence of the public health center. Respondents revealed that these service providers usually acquire their skill through ancestral spirits and so most of their services are for free. They added that these service providers are effective and it is usually from satisfied clients that they heard about the service provider.

Table 4.1.13: Performance distribution of orthodox facilities visited by respondents by the perceived performance of the health facility

Orthodox facility visited	Perceived performance of the health facility				Total
	Poor	Satisfactory	Good	Very Good	
Community Health Centre	26.09	31.88	39.13	2.90	100
Other Private Clinic	66.67	0	33.33	0	100
Other	60.0	40.0	0	0	100
Pearson chi2 = 6.87			P = 0.651		

Source: Author's Field Survey, July 2015

Table 4.1.14: Percentage distribution of orthodox facilities visited by respondents by the services available at the health facility

Orthodox facility visited	Services available at the health facility				Total
	Health Education	Maternal Health	Laboratory	Child Health	
Community Health Centre	31.34	31.34	31.34	5.98	100
Other Private Clinic	33.33	33.33	33.33	0	100
Other	20	20	0	60	100
Pearson chi2 = 25.55			P = 0.012		

Source: Author's Field Survey, July 2015

4.7 Challenges Encountered In Accessing and Delivering Health Care

Factors impeding the delivery of quality health services at Abokobi

Delivering quality health service to all Ghanaians irrespective of location, income status and gender is a top priority of the government and enshrined in the health sector policies of Ghana. Besides, delivering accessible and quality health service to all is one of the Millennium Development Goals that government is committing resources into towards its achievement. Despite the efforts by the government in areas of service extension and quality controls, supervisions and monitoring, personal improvement and increments, increasing enrolments on the NHIS and improvements in the scheme among others, through the Health Ministry, Health Directorates and the Ghana Health Service, service delivery still falls short and not without challenges according to the data gathered from Abokobi in the Ga East Municipality. The following factors have been ascribed as impeding efficient and effective health service delivery

in health facilities in and around Abokobi. The estimated frequencies below were based on responses only.

When asked about the constraints that respondents in Abokobi face in accessing health service from the health facilities they visit often, about 30 percent of the respondents pointed fingers towards issues of finance (Table 4.1.15).

Table 4.1.15: Constraints faced by respondents in Abokobi in accessing health service in health facilities

	Frequency	Percentage
Long Distance	16	17.98
Financial	27	30.34
Attitude of the personnel	14	15.73
Long waiting hours	26	29.21
Other	6	6.74
Total	89	100

Source: Author's Field Survey, July 2015

As encountered in the preceding section, about 76 percent of respondents in Abokobi are on the NHIS and some of the respondents who are not on the NHIS cited issues of affordability as the reason they are not on the scheme (about 18 percent). For those on the NHIS, about 33 percent hold the view that the scheme is not very effective and various reasons were ascribed to their claims (Table 4.1.16).

Table 4.1.16: Reasons ascribed to the ineffectiveness of the NHIS

	Frequency	Percentage
Because it doesn't cover very serious ailment	20	80
There is too many complaints about it	1	4
I don't know	4	16
Total	25	100

Source: Author's Field Survey, July 2015

The outstanding reason is the scheme not covering very serious ailments. In effect, respondents even on the NHIS get to make high expenses on medications as far as such medications are not covered by the NHIS. As shown in Table 4.1.16, about 38 percent of respondents spent between GHC21 and GHC50 the last time they visited the health facility. About 30 percent spent GHC 20 while 14 percent and 10 percent spent between GHC51 and GHC80 and GHC80 plus respectively for the last time they visited the health facility (Table 4.1.17). About 65 percent of the respondents reported that they spent such amounts on drugs (presumably those not covered by the NHIS for those on the NHIS) while about 26 percent also reported spending such amounts on consultations (Table 4.1.18). About 81 percent of respondents who visited the community health center for orthodox treatment claimed to have paid such amount themselves while about 16 percent claimed the bills were paid by family members according to the data.

Table 4.1.17: Range of amounts spent by respondents the last time they visited the health centre

	Frequency	Percentage
GHC20	29	30.21
GHC21-GHC50	36	37.50
GHC51-GHC80	13	13.54
GHC80 plus	10	10.42
None	8	8.33
Total	96	100

Source: Author's Field Survey, July 2015

Table 4.1.18: Health services on which the money was spent on by respondents during their last visit to the health centre

	Frequency	Percentage
Consultations	23	26.14
Drugs	57	64.77
Bed user fee	4	4.55
Other (Laboratory)	4	4.55
Total	88	100

Source: Author's Field Survey, July 2015

These expenses depend very much on the financial status of the respondent. Hence respondents with limited income especially those with less than GHC 200 monthly income find it difficult to access effective health services from the service providers once they are not able to afford medications not covered by the scheme. For such reasons and other complaints about the scheme, some respondents (about 18 percent) choose to have a different health insurance scheme

apart from the NHIS and most of such members (about 75 percent) believed that the private health insurance scheme is effective.

Aside financial challenges, another constraint identified by respondents as impeding effective health service delivery is the long hours of waiting at the health centre to be attended to. About 29 percent of respondents reported having to wait for long hours to be served at the health centre (Table 4.1.15). According to some of the respondents, the processes involved in clearing NHIS card holders to receive service can take long hours and can also be exhaustive because of the large numbers of NHIS card holders. Consequently, they spend long hours to get through to the service providers.

About 18 percent of the respondents also reported on the long distance to the health centres as a hindering factor to effective accessibility to health service from the facilities. Meanwhile about 16 percent also reported on the attitude of health personnel as impeding health service delivery at the health facilities. As reported earlier in the previous section (Table 4.1.12), some respondents regarded the attitude of health workers in the facilities (especially the Community Health Centre) as not very friendly and rude. This, they believe also impedes delivery of quality health service in Abokobi.

Presented in Table 4.1.18 are various responses given when respondents were asked what they will change about health service delivery in general in Abokobi if given the chance. Only 3.16 percent of respondents reported that they will not change anything because everything is fine. This implies that clearly lots of people wish they could change things around the health facilities. This further implies that certain factors impede smooth delivery of efficient health services in Abokobi. Among the various reasons ascribed, three clearly stand out. About 47 percent of

respondents wished they could build an ultra-modern health facility (Table 4.1.20). This could be explained from the fact that either the facilities available at the health centre are inadequate or there are no modern facilities to enhance efficient delivery of quality health services.

There are also inadequate health personnel at the health facilities in Abokobi and surrounding communities. Next after building an ultra-modern facility, about 25 percent of respondents wish they could increase highly trained doctors and nurses in the health facilities to ensure better health service delivery in general in Abokobi. Coupled with inadequate personnel in the health facilities, negative attitude of some personnel towards customers and patients is believed to hinder or impede quality health service delivery in Abokobi. About 18 percent of the respondents interviewed pointed out that they will not hesitate to change some personnel of the health centres noted for their bad attitudes towards patients if given the chance.

The Municipal Health Directorate added that, the major challenge it faced was financial. The administrator lamented on the inadequate funds that they receive from government leading to the delay in starting programs as well as limiting coverage of such programmes. A coordinator of a program currently hit by financial constraints admitted that, the Millennium Accelerated Framework (MAF) is aimed at accelerating MDG goal five. The targeted goals under this program include increasing family planning acceptance rate, skilled delivery and emergency obstetric neonatal care. ‘We haven’t even achieved half of the set target and 2015 is almost over’ because ‘there is no money’.

Amongst the private service providers, the two herbalist captured by the study both complained about the unavailability of some particular herbs and the difficulty encountered in getting them as a result of the depletion of the forest. Especially, now that estate developers have encroached

the Abokobi area. The TBA also lamented the unwillingness of the younger generation to learn the skill to continue the service. The octogenarian bemoaned that the health center might be the only avenue for deliveries very soon.

4.8 Proposed Solutions by Respondents

Respondents suggested some ideas to resolve the challenges facing health service delivery in Abokobi. These solutions are captured in the table and discussion below.

Table 4.1.19: What respondents are most likely to change about health service delivery in general in Abokobi if given the chance

Suggested changes for improvement	Freq.	Percentage of responses
I will build an ultra-modern health facility	45	42.45
I will provide more laboratory equipment and beds	7	6.60
I will provide accommodation for health personnel	5	4.72
I will make generators available	3	2.83
I will set up a private facility to care for the community	1	0.94
I will increase doctors and nurses who are highly trained	24	22.64
I will change some of the personnel because of their attitude and ensure discipline in the hospital	17	16.04
Too much is being charged. I will make it affordable	1	0.94
I will not change anything. Everything is fine	3	2.83
Total	106	100

Source: Author's Field Survey, July 2015

In close agreement with the above table (Table 4.1.19), similar views were expressed by respondents as what they feel must be done to ensure efficient and effective health service

delivery in Abokobi. The top most reason yet again is providing modern facilities in the hospital and possibly changing the status of the health facility from its current status to a polyclinic (about 44 percent of respondents hold this view). This further drives home the fact that modern facilities are either inadequate in the hospital presently or non-existence hence impeding efficient and effective health service delivery at Abokobi.

About 24 percent of respondents also expressed the view that highly trained professionals must be posted to the health facility at Abokobi (Table 4.1.20). This implies that, currently, the number of well trained personnel at the health facility is regarded as inadequate and could be impeding efficient and effective delivery of health service in the health centre. There is also perceived lack of supervision of the activities in the health centre, attitude of workers, and overall performance of the hospital hence supervision is highly recommended by respondents to ensure efficient health service delivery.

Ambulance services at the health facilities are non-existence or in limited supply. About 15 percent of respondents in Abokobi expressed views that providing ambulance services in the health facilities will ensure efficient and effective health service delivery. About 12 percent of respondents also believe providing generators at the health facilities will ensure effective health service delivery. Clearly, the current shortfall in electricity supply that has bedeviled the entire country is having its toll on health service deliver in Abokobi as well. Without generators, major activities of the facilities that depend on power cease to run when there are blackouts. Delivering services become a big challenge hence provision of a power generator plant could rescue this predicament to some extent.

Table 4.1.20: In the view of respondents, what must be done to ensure efficient and effective health service delivery in Abokobi

Suggested changes for improvement	Frequency	Percentage of responses
Highly trained professionals must be posted to Abokobi and well supervised	22	19.30
Modern facilities should be provided and the status of the health facility must be changed to a polyclinic	41	35.96
Nurses must be humble and treat patients with respect	6	5.26
Generators must be available	11	9.65
The laboratory should be extended	2	1.75
An ambulance service must be provided	14	12.28
Good customer relations	12	10.53
The services of the NHIS should be improved	4	3.51
Everything is fine	2	1.75
Total	114	100

Source: Author's Field Survey, July 2015

4.9 The Findings And The Conceptual Framework

The study resulted in outcomes discussed above. The conceptual framework was a reflection of what the study sought to achieve. Key findings of the setup of health systems in Ghana from the national level (MoH) down to the municipality where health facilities are supervised and set standards are ensured fitted in the author's conceptual framework. Furthermore the determination of collaboration between the public health service providers and private health service also fitted

in the conceptual framework as there was both formal and informal collaboration between both categories of health service providers. However, the study revealed the absence of faith based health care providers in the study environment as captured by the conceptual framework. Challenges were also revealed by the study which the conceptual framework failed to consider. These challenges were essential to the study as they promoted efficient policy recommendations in the subsequent chapter. In a nutshell the major findings regarding the structural set up of the health sector in Abokobi and Ghana and how its performance translates into adequate accessibility, coverage and utilization of health care fitted in the conceptual framework and its core concept.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter concludes the study and presents a summary of the findings. Relevant recommendations are drawn out of the findings for policy recommendations. Summary of the study is presented first followed by a brief conclusion to the study. Finally, policy recommendations are presented at the later end of the chapter.

5.1 Summary of findings

The study discovered that quality health service delivery is essential. It is sought after daily. And existing literature has proven a direct relationship between quality health care and both social and economic progress. However, most people fail to utilise health service delivery as a result of financial and geographical inaccessibility which has translated into the current challenging health situation in Ghana. Among such challenges are alarming health conditions, an ailing population and even poor sanitation (Buor 2004). Hence, availability, accessibility, utilization, coverage and affordability of health service delivery have become of critical concern to stakeholders (NHIS 2013).

A review of literature indicated that researches on private and government efforts towards health service delivery in Africa and Ghana were limited compared to what was done in the Western World (WHO 2013). Hence, the emphasis of the research work on assessing the private and government participation in health service delivery. Furthermore, the literature urged that critical

attention should be given to the activities of the private sector, especially the Private Service Providers (PSPs) which happen to be a major source of health services for the poor (Smith et al. 2009).

The conceptual framework that underpinned this study was constructed by the author using set standards and outcomes conceived by the World Health Organization to assess performance of health service providers. Pertaining to the fact that the content and organization of service delivery differ from one country to the other, the framework laid emphasis on the channel and mode of organization from the Ghana Ministry of Health to the Municipal Health Directorate and Sub Municipal Health Directorate.

The study sought to determine the availability and accessibility of health facilities in Abokobi, to assess the contribution of the government and the private sectors in health care delivery at Abokobi and also to identify the factors that impede the delivery of quality health services at Abokobi.

In respect of the availability and accessibility of health facilities in Abokobi, the data reveals that health facilities are available in the Abokobi community since about 64 percent of the respondents reported to cater for their health care needs through the orthodox/professional health services. The proportion of male respondents going for orthodox medical services is high; the study revealed that more females than males rely on self-medications and herbs. Also the aged (above 60 years old) rely on self-medication and herbs than the youth (18-34 years) and the adult (35-60 years) populations in Abokobi. The study also found that those who fall sick quite frequently (once in 3 months and once in 1 month) often rely on orthodox/professional health services while those who rarely fall sick have increasing proportions relying on self-medications.

Education and monthly income of respondents play key roles in the health care respondents tend to seek. The proportions of self-medication and herb treatments decrease with increasing educational levels completed. Similarly, the proportions of self-medication and herb treatment decrease with increasing household monthly income.

For the available orthodox/professional health facilities in and around Abokobi, about 85 percent of respondents visit the Community Health Centre, 3.7 percent visit other private service providers and 6 percent visit other facilities outside Abokobi. Among the determinant factors for the choice of facilities, affordability and proximity stand out clearly. About 31 percent and 29 percent of respondents reported that they go to the Community Health Centre for their health care needs because of the affordability and proximity, respectively. In other words, the Community Health Centre is both financially and geographically accessible to the people in Abokobi according to the data collected. Nonetheless, the challenge of inadequate health personnel is an impediment to accessibility as well.

In respect of the contribution of the government and the private sectors in health care delivery at Abokobi, an in-depth interview with the administrative manager at the Municipal Health Directorate and two other representatives from the public and private service providers revealed that the directorate served as a regulatory entity to the service providers. The directorate ensures that acceptable standards are met by the health service providers.

Further exploration of the data uncovered various factors that impede the delivery of quality health services at Abokobi. Financial issues were rated atop of the constraints faced by respondents at Abokobi in accessing quality health service delivery from the health facilities in the community. Despite majority of the people in Abokobi being enrolled on the NHIS (about 76

percent), various expenditures covering drugs and consultations are made any time they visit the hospital. This, according to them, is because the NHIS does not cover serious ailments hence they have to finance such expenditures themselves. With majority spending between GHC20 and GHC80, it is considered to be expensive given that Abokobi is a peri-urban community with lots of low income respondents receiving up to about GHC600 per month. While few respondents complained about the long distance to the health facilities, majority complained about waiting for long hours upon reaching the hospital before being attended to. They claim these constraints them from receiving quality health services.

Only 3.16 percent of respondents reported that they will not change anything at the health facilities as they are now because everything is fine. Majority however wish lots of things could be changed to ensure effective and efficient health service delivery at Abokobi. According to their responses, limited ultra-modern facilities at the hospital, limited well-trained personnel and poor attitude of some health workers towards patients and customers are identified as the factors that impede the delivery of quality health services at Abokobi.

5.2 Conclusion of the Study

The data revealed that respondents in Abokobi mostly rely on orthodox /professional health services for their health care needs. While majority go to the Community health Centre, which is a public health institution, some also visit other private service providers in or around the Abokobi community. This implies that both the public and private health sectors are participants and contribute significantly to health service delivery in Abokobi. The facilities are accessible to the community members in terms of both financial and geographical means. While majority of the respondents rated the performance of the service providers as satisfactory and good and also reported that various services such as health education, maternity health and laboratory services

are available at the health facilities, they also pointed out certain factors that are hindering quality health service delivery at Abokobi. Among such factors are limited NHIS services, limited modern facilities at the health centres, limited well-trained health personnel and poor attitude of some health workers towards patients. Respondents who utilise other private service providers especially the herbalist complained about the increasing cost of acquiring services. Further exploration revealed that the increase in cost of acquiring herbal services is as a result of the depletion of the forest reserve translated into difficulty in finding herbs which are mainly used for treatment. A TBA indicated that one major challenge she faces in her line of work is the issue of breeched birth. Based on these findings, some recommendations are outlined in the subsequent section for consideration.

5.3 Recommendations

Based on the analysis done in the preceding chapter from the extensive exploration of the data collected in the Abokobi community, the following ideas are recommended for consideration to improve upon quality health service delivery in the health facilities in and around Abokobi community:

- Improve supervision: one of the major changes recommended by a significant proportion of respondents is not only to increase well-trained personnel in the health facilities but also to improve supervision of all activities in the health facilities. Supervision should not be limited to only private health facilities but should include public facilities as well. To effectively monitor and supervise the operations of health facilities, short surveys can be carried out by the monitoring teams involving staffs of the health facilities at all levels as

well as the patients or customers of the facilities. Sensitive questions should be asked such as diagnosis and treatments administered to patients, how health workers behave towards patients, among others. With these approaches, activities of the health facilities will be better monitored to prevent unwanted errors and lackadaisical attitudes from health workers.

- Improve upon the NHIS services at the health facilities in Abokobi. This is more of a national campaign rather than to just health facilities in Abokobi. According to the respondents, serious ailments are not covered by the scheme hence they mostly finance drugs that are not covered themselves. The responsible authorities should review the details of the health facilities, the most common reported cases at the facilities, the most common treatment drugs administered to such cases such that, even if not all, most of such drugs can be included on the NHIS covered list to lessen the expenditure of these peri-urban folks. The National Health Insurance Authority must also endeavour to reimburse the service providers on time.
- An ambulance service and standby generators should be provided by the government to the Abokobi health center. Rendering health services become stiffly challenging in times of blackouts without standby generators. All activities almost come to a standstill hence standby generators will certainly improve upon health care delivery at Abokobi. Unavailability or limited ambulance service in the health facilities in Abokobi makes it difficult in handling emergency cases. Provision of this service will go a long way to improve upon health service delivery in Abokobi.

- Aside increasing the number of well-trained health personnel in the health facilities to manage the ever increasing patient demands, there is also the need to improve and upgrade on the facilities of the health centres to modern facilities. This will ensure effective and efficient delivery of quality health services in the health facilities in and around Abokobi. As a matter of fact, well-trained personnel need modern facilities to operate effectively at maximum level otherwise, they become white elephants and operate inefficiently as untrained personnel.
- The private service providers should be regulated by the respective authorities to ensure that set standards are achieved. Regulation will go a long way to promote hygiene and improved skills as they deliver services. This will further translate into wider accessibility and coverage of the service providers.

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APPENDIX

APPENDIX 1: QUANTITATIVE SURVEY INSTRUMENT

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

**ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH
SERVICE DELIVERY IN ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY**

HOUSEHOLDS ONLY

QUESTIONNAIRE

The series of statements and questions in this questionnaire was designed to obtain individuals' views on health service delivery by both the private sector and the public sector in Abokobi.

Kindly indicate your opinion by ticking the appropriate option of your choice (if provided).

Please answer all questions freely but objectively. The information is for academic purpose only and will be treated with the strictest confidentiality.

Thank you.

Shamsiya Abdul-Rahman

MA development studies, Student

SECTION A: SOCIO DEMOGRAPHICS

1. Name of interviewee
2. Age
3. Marital Status: [1]Never Married [2]Married [3]Separated [4]Divorced [5]Widowed
4. Highest educational level attained: [1] Never been to school [2]Primary [3]Secondary [4]Tertiary [5]Adult education
5. Household size: [1] Less than 4 [2] 4-6 [3] 7-9 [4] 10 and above
6. How long have you stayed in this area? [1]Less than three years [2]3-5years [3] 6-8years [4] More than eight years
7. Are you employed? [1] Yes [2] No
8. What work do you do? [1]Farmer [2]Petty trading [3] Salaried worker [4] Other
9. Monthly income level of your household in Ghana cedis:
[1] Below 200.00
[2] 200-400
[3] 401-600
[4] 601-800
[5] 801-1000
[6] above 1,000
10. Sex of household head:[1]Male [2]Female

**SECTION B: THE AVAILABILITY AND ACCESSIBILITY OF HEALTH FACILITIES
IN ABOKOBI**

11. What are the common diseases in this community?

- 1) Malaria
- 2) Skin disease
- 3) Diarrhoea
- 4) Hypertension
- 5) Other, Please Specify.....

12. How often do you fall sick?

- 1) Rarely
- 2) Once in 6 months
- 3) Once in 3 months
- 4) Once in 1 month
- 5) Other Please Specify.....

13. How many members of your household got malaria or diarrhea in the last month?

.....

14. How do you cater for your health care needs?

- 1) Self-Medication
- 2) Spiritualist
- 3) Herbs
- 4) Professional or Orthodox medical care

14. If it is professional care which of the facilities do you visit for your health care needs?

- 1) The Community Health Centre
- 2) Any other private clinic

3) Others, Please Specify.....

15. What informs your choice of the facility?

- 1) Quality of service delivered
- 2) Warm attitude of health workers
- 3) Affordable
- 4) Proximity
- 5) Others, Please Specify.....

16. How would you describe most of the service providers in this center

- 1) Friendly
- 2) Not too friendly
- 3) Very friendly
- 4) Rude

17. Do you have the National Health Insurance?

- 1) Yes
- 2) No

<<<<<**If yes, skip to 19**>>>>>

18. If no why?

- 1) Have not heard about it
- 2) Not interested
- 3) No money to pay the premium

4) Others please specify
.....

19. Do - mj you think the National Health Insurance Scheme is effective?

- 1) Yes
- 2) No

If no why

20. Do you have a different health insurance apart from the National Health Insurance?

- 1) Yes
- 2) No

21. If yes, do you think it is effective?

- 1) Yes
- 2) No

If no why?

22. How much money did you spend the last time you visited the hospital

- 1) 20.00 GHS
- 2) 21.00-50.00
- 3) 51.00-80.00
- 4) 80.00 and above
- 5) None

<<<<<If none, Skip 23 and 24>>>>>

23. What specifically did you pay for?

- 1) Consultation
- 2) Drugs
- 3) Bed user fee
- 4) Other, please specify.....

24. Who paid the bill?

- 1) My self
- 2) My family
- 3) Others please specify

25. What services are available at the health facility?

- 1) Health Education
- 2) Maternal health
- 3) Laboratory
- 4) Child health
- 5) Other

26. What are the constraints that you face in accessing health service in this facility?

- 1) Long distance
- 2) Financial

- 3) Attitude of the personnel
- 4) Long waiting hours
- 5) Others, please specify

27. Do you think the health facility in your community has brought other development?

- 1) Yes

What are they?

- 2) No

Why not?

28. How do you assess the performance of the health facility?

- 1) Poor
- 2) Satisfactory
- 3) Good
- 4) Very Good

29. Why?

.....
.....
.....
.....

30. What would you change about health service delivery in general in Abokobi if you had the power to do so?

.....
.....
.....

31. What in your view must be done to ensure effective and efficient health service delivery in Abokobi?

.....
.....
.....

APPENDIX 2: QUALITATIVE SURVEY INSTRUMENT FOR PUBLIC SERVICE

PROVIDER

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

**ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH
SERVICE DELIVERY IN ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY**

INTERVIEW GUIDE FOR THE PUBLIC SERVICE PROVIDER

This interview guide is designed to help the researcher elicit information on the participation of the private and government sectors in health service delivery at Abokobi.

1. Name of health facility
2. Position of respondent
3. How long has this facility served this area?
4. Brief background of the facility.
5. What services are available at the facility
6. Give an estimated cost of most sought services.
7. What are the major health development goals? (Areas of operation and primary focus)
8. Is there any partnership between you and any of other health facility?
9. What are the major achievements of this facility
10. What are the constraints that the facility faces which hinders the process of health care delivery?

11. What is the average number of patients per month?
12. What is the doctor patient ratio and nurse patient ratio in this facility?
13. What benefits do you think this facility has brought to Abokobi?

**APPENDIX 3: QUALITATIVE SURVEY INSTRUMENT FOR MUNICIPAL HEALTH
DIRECTORATE**

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

**ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH
SERVICE DELIVERY IN ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY**

INTERVIEW GUIDE FOR THE MUNICIPAL HEALTH DIRECTORATE

This interview guide is designed to help the researcher elicit information on the participation of the private and government sector in health service delivery at Abokobi

1. Position of respondent
2. How long has the directorate served this area?
3. What is the major role of the directorate in the health sector?
4. What are the programmes put in place to promote quality health service delivery.
5. How are these programmes implemented?
6. How effective and efficient are these programmes ?
7. Is there a provision made for contingencies and how effective is that?
8. What is the proportion of both private and public participants in the health service delivery in Abokobi?
9. Is there any form of partnership that exists between the private facilities and the public facilities?

10. Are the available facilities well sourced up to the required standards?
11. What are the most recorded diseases in the Abokobi?
12. How does the directorate ensure that health service is accessible?
13. What is the doctor patient ratio in Abokobi?
14. What are the factors that impede health service delivery?
15. How does the directorate intend to solve these challenges?

**APPENDIX 4: QUALITATIVE SURVEY INSTRUMENT FOR BENEFICIARIES OF
PRIVATE SERVICE PROVIDER**

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

**ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH
SERVICE DELIVERY IN ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY**

**INTERVIEW GUIDE FOR RESPONDENTS WHO UTILIZE HEALTH SERVICES
PROVIDED BY THE PRIVATE SECTOR.**

This interview guide is designed to help the researcher elicit information from the perspective of respondents who utilize private sector health service at Abokobi

1. Background of respondent (name, sex, age, education, marital status, number of dependents, name of the service provider you use, average monthly income, how long you have lived in Abokobi and telephone number)
2. What are the main ailments that you have taken to this service provider for treatment?
3. On the average, what is the cost for treatment for an episode of each ailment you mentioned?
4. On the average, what is the duration for treatment for an episode of each ailment mentioned?
5. How do you reach this service provider?
6. Does the provider make follow ups during treatment?
7. Why do you utilize this and not the other means of treatment for your health care needs?

8. What is your perception of this private sector service and this service provider?
9. Have you ever been advised by this provider to go to the community health center or any other form of orthodox treatment for care?
10. What is your perception of the orthodox healthcare?
11. How do you think the services of this private sector service provider have impacted on the entire health service delivery process in Abokobi?
12. What are the challenges you have encountered in the process of utilizing this private sector service and this private service provider?

APPENDIX 5: QUALITATIVE SURVEY INSTRUMENT FOR PRIVATE HEALTH CARE PROVIDER

UNIVERSITY OF GHANA

INSTITUTE OF STATISTICAL, SOCIAL AND ECONOMIC RESEARCH (ISSER)

ASSESSING PRIVATE AND GOVERNMENT PARTICIPATION IN HEALTH SERVICE DELIVERY IN ABOKOBI IN THE GA EAST MUNICIPAL ASSEMBLY

INTERVIEW GUIDE FOR THE PRIVATE HEALTHCARE PROVIDERS.

This interview guide is designed to help the researcher elicit information on the participation of the private sector in health service delivery at Abokobi.

1. Background of the respondent (name, sex, age, level of education, average monthly household income and telephone number)?
2. Name of the service provided
3. How long have you lived in this community?
4. How long have you been in practice?
5. Brief background of the work and service (how the skills were acquired).
6. What main ailments do you usually treat?
7. How many people on the average visit you for health service in a week?
8. What is the average cost incurred when accessing services within an episode of the ailments mentioned above?
9. On the average, what is the treatment duration within an episode of ailment for each ailment mentioned?
10. How are you reached by clients?
11. How do you reach your clients?
12. Is there any form of collaboration between you and the Abokobi Health Center?
13. What is the form of collaboration, if any?
14. Is there any form of collaboration between you and the Municipal Health Directorate?

15. What is the form of collaboration, if any?
16. Are there any instances where you have advised patients to go to the Abokobi Health Center or pharmacy in the last six months? (probe)
17. Are there any instances where you patients have been advised to come to you from the Abokobi Health Center or the Pharmacy in the last six months
18. What is your own perception about your provision of health care services?
19. Do you think you have made impact on the health service delivery in Abokobi?
20. Do you think your clients value your service? Why or why not?
21. What are the challenges you face in this practice?

**APPENDIX 6: DETERMINATION OF THE OPTIMAL SAMPLE SIZE OF HOUSES
SELECTED FOR THE SURVEY AT ABOKOBI**

The formula for calculating the optimal sample size of houses is based on the work done by Yamane (1973). This formula is widely used for its simplicity and given as follows:

$$\{n = N/1+N (e)^2\}$$

$$n = (440)/(1+(440)*(0.1)^2)$$

$$n = (440)/ (1+4.4)$$

$$n = 440/5.4$$

$$n = 81.481$$

Therefore the desired sample size was 81. Nonetheless, the researcher added 20% of the sample size to cater for unresponsive households.

$$20/100*81=16$$

$$n=81+16=97$$

hence the total sample size =97

**APPENDIX 7: THE POPULATION OF HOUSES AND RANDOMLY SELECTED
NUMBER OF HOUSES FOR EACH OF THE THREE GHANA STATISTICAL
SERVICE (GSS) CLUSTERS AT ABOKOBI BASED ON THE CLUSTER SAMPLING
METHOD.**

GSS-based cluster	Name of GSS-based cluster	Number of houses in the GSS-based cluster	Number of houses selected based on the optimal size of 81	Actual number of respondents who were interviewed
1.	Abokobi Presbyterian Church area	128	29	
2.	Abokobi Agricultural Project area	125	28	
3.	Abokobi Clinic area	187	34	
Total		440	81	