

# PRIMARY HEALTHCARE ADVOCACY PROJECT

## Report on 2017 Scorecard (Asante Akim Central Municipality and South Dayi District)

**Alliance for Reproductive Health Rights (ARHR)**

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The authors accept responsibility for any outstanding errors of interpretation.

## Acronyms and abbreviations

ANC	Ante-Natal Care
ARHR	Alliance for Reproductive Health Rights
CHC	Community Health Committee
CHN	Community Health Nurse
CHPS	Community-Based Health Planning and Services
CHV	Community Health Volunteer
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
CSC	Community Scorecard
CSO	Civil Society Organisation
CWSA	Community Water and Sanitation Agency
DA	District Assembly
Danida	Danish International Development Agency
DCE	District Chief Executive
DHA	District Health Administration
FDA	Food and Drugs Authority
FGD	Focus Group Discussion
GH¢	Ghana Cedi
GHS	Ghana Health Service
GWCL	Ghana Water Company Limited
JHS	Junior High School
KVIP	Kumasi Ventilated Improved Pit [latrine]
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
PAYD	Pay-as-you-draw
PHC	Primary Healthcare
PNC	Post-Natal Care
PRA	Participatory Rural Appraisal
TA	Traditional Authorities
VEReF	Volta Educational Renaissance Foundation
WRI	Water Resources Institute
YEA	Youth Employment Agency

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## Executive summary

### INTRODUCTION

This report presents the findings of a scorecard-based assessment of primary healthcare (PHC) access in four communities in the Asante Akim Central Municipality and South Dayi District of the Ashanti and Volta Regions respectively. Partner organisations within the Alliance for Reproductive Health Rights (ARHR) network employed community scorecard (CSC) techniques to elicit citizens' experiences of their healthcare services and related conditions in their respective localities. Having identified citizens' key concerns in respect of primary healthcare delivery, ARHR subsequently facilitated two engagement platforms at which citizen representatives met with officials from their respective District Health Administrations (DHAs), the district offices of the National Health Insurance Authority (NHIA), representatives of their District Assemblies (DAs) and their traditional leaders to dialogue about the issues raised. These dialogue sessions ended with some assurances by the service providers to address the concerns. ARHR partners will continue to assist the communities by further developing their capacity to continuously engage with their service authorities and advocate for improvements as necessary.

The assessment focused on citizens' experiences of Community-Based Health Planning and Services (CHPS) processes in particular, considering that the CHPS concept is the asserted cornerstone of Ghana's PHC system. In each community, the focus groups were asked to share their assessments on five specific indicators:

- \* universal accessibility – physical, receptiveness, promptness of service, health insurance services and availability of medicines;
- \* full community participation – citizens' involvement in making decisions about health services as well as in health promotion and in disease prevention;
- \* affordability of treatment – including cost of consultations and medicines;
- \* water service delivery – availability (e.g. flow rate, waiting time and year-round availability), affordability, accessibility and quality; and
- \* toilet services – availability at household level as well as accessibility and quality of public toilets.

### KEY FINDINGS

#### UNIVERSAL ACCESSIBILITY

- \* Citizens appreciate the concept of Community-based Health Planning and Services (CHPS), which aims to bring healthcare to their doorsteps. However, there are several areas in which planning processes and service delivery fall short of expectation.
- \* While CHPS facilities and water services may be physically accessible in all four communities visited, there are several other key considerations which affect patronage and which influence citizens to go for less orthodox options.
- \* In some cases (and particularly at Obenemase), participants complained about being treated insensitively when they report at their local facility sick. By contrast, when nurses are sensitive and act with urgency, clients are

encouraged to continue to participate in the on-site services offered – e.g. ante-natal and post-natal clinics, assisted deliveries (where available) and treatment.

- \* There are issues with staffing efficiency (with staff numbers exceeding outpatient flows) at some facilities. This has the potential of undermining the sustainability of the CHPS concept, with outreach services remaining sluggish owing to a range of logistical constraints and other factors.
- \* Citizens' expectations regarding the availability of medicines were not always realistic – when assessed against the typically low outpatient numbers. However, treatments for the most basic and most routine illnesses (e.g. malaria) ought to be more readily available, considering the tendency for patients to opt for unsafe alternatives when they cannot easily access the medicines prescribed by their formal healthcare providers. The alternative modes employed include unproven herbal concoctions, self-medication, short-dosing, spiritual interventions (including “*holy water*”) and seeking help from drugstores and “*foot pharmacists*” – who are often willing to dispense all kinds of medicine without proper diagnosis or prescription.
- \* Additionally, citizens deserve much better education on the health insurance policy, both to moderate their expectations as well as to facilitate their right to refunds when they are compelled to pay for prescribed medicines that are on the NHIS “*Medicines List*”.

#### FULL COMMUNITY PARTICIPATION

- \* Overall, traditional leaders have not been very successful in involving their citizens in making basic decisions affecting their health or in ensuring transparency in the selection of community health representatives. The outcome has been to undermine shared ownership of the agenda of community-based health promotion and disease prevention, with the youth feeling particularly excluded from decision-making processes. At Tsiyinu, the lack of consultation has provoked the youth into disengaging from collective processes.
- \* At Tsatee, the only community where the selection of community health volunteers (CHVs) was done transparently, the result has been much more impressive – with commendations from across the board for their active involvement in delivering public education and supporting staff of the health facility to deliver their public health mandates.

#### AFFORDABILITY OF TREATMENT

- \* Experiences vary, with some attesting to the value of the National Health Insurance Scheme (NHIS) as an effective safety net. However, the majority of subscribers had adverse assessments of the scheme. The frustrations include being compelled to make out-of-pocket payments for prescribed medicines (because the facilities often lack stocks) and challenges with renewing their subscriptions (following the introduction of biometric registration – presumably to control a previously high incidence of fraud). Biometric processing requires clients to be physically present at sometimes far-off centres, a requirement entailing high transport outlays for large households. To move

a five-person household at Tsiyinu or Tsatee to Kpeve (the registration centre and district capital) and back would cost GH¢90 just for transport.<sup>1</sup> As a result of these hurdles, many are failing to renew their subscriptions upon expiry.

- \* At Patriensa, there is a worrisome misalignment between the classification of the healthcare facility (Level A/ CHPS) and the calibre of staff posted there (Level B). The effect is that while the Physician Assistant (Level B official) at post is qualified to prescribe a broader range of medicines, patients who receive such prescriptions must pay for them because Level A facilities are ordinarily not entitled to claim reimbursements from the National Health Insurance Authority (NHIA) for such medicines. This situation breeds confusion and fuels needless mistrust between patients and facility staff.
- \* The free maternal care policy continues to be interpreted and applied unevenly, with charges as high as GH¢130 reported for a regular delivery at Tsatee.<sup>2</sup>
- \* Prospects for sustaining an effective NHIS at low cost will continue to be challenging for as long as the disease burden remains high. The assessment suggests that the disease burden is, in turn, affected by a myriad of factors such as:
  - poor sanitation behaviours;
  - lack of healthful toilet facilities;
  - pollution of aquifers by very unsafe artisanal mining practices;
  - reverting to uncapped wells, surface water sources and other easily contaminated supplies when there are long queues at public standpipes or when borehole facilities break down;
  - delayed reporting of diseases;
  - self-medication, short-dosing on their prescriptions, and the continued dependence on unlicensed herbal concoctions typically advertised as panaceas for some very diverse medleys of ailments

#### WATER SERVICE

- \* The overwhelming majority of respondents found the cost of water to be affordable, at around GH¢0.10<sup>3</sup> for a 34-litre bucket (or considerably cheaper where monthly tariffs were charged).
- \* However, perceptions of access were often better than suggested by the objective reality. For example, participants sometimes gave high scores for a borehole even though the level of access was well outside the national threshold of 300 citizens per borehole. Subsequent probing would then reveal the existence of long queues (with waiting times of up to an hour) at peak times, causing children to get to school late. Such long wait times sometimes compel residents to opt for unsafe sources such as uncovered wells and shallow surface waters. While most households do not intend to consume water from such sources in the form of a drink, it certainly poses a risk in households with children. Further, there are risks associated with its use in cooking and washing of dishes. Yet, citizens were entirely oblivious to these dangers.

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<sup>1</sup> Approximately US\$20

<sup>2</sup> This is equivalent to about US\$30

<sup>3</sup> About 2 US cents

Breakdowns also occur more often than expected because of the excessive stress on the facilities, compelling residents to fall back on unsafe sources.

- \* Quality also almost always got a high score, even though the supplies are rarely tested and/or disinfected. Many respondents also equated colourlessness with purity. At Tsatee, the youth believed that their stream was a better source of drinking water than the borehole, explaining that the river god had infused the stream with healing properties. These findings suggest that literacy on water hygiene is low.

### TOILET SERVICES

- \* Household toilets are rare in all four settlements, with most households left to rely on unsafe and undignified sanitation options. Everywhere, open defaecation is common, with its huge consequences for the disease burden. At Patriensa, women and men are compelled to share a communal latrine simultaneously. The sheer stench was reported to linger in users' clothing long after leaving the place. In at least three of the communities – Patriensa, Obenemase and Tsatee – snakes were a threat to people using the bushes for sanitation. Children too are allowed to defecate on the bare ground, after which the solids are gathered and disposed of either in nearby bushes or on the communal refuse tip. While people had issues with the lack of privacy and other inconveniences, they seemed less aware of the health implications of their poor sanitation practices.
- \* Apart from Tsatee, where the “*tippy tap*” has been widely adopted, no hand-washing facilities or arrangements were evident in the vicinities of any of the public toilets.

### POST-RESEARCH ACTIVITIES

Following the research phase, the four participant communities were assisted by the Civil Society Organisations (CSOs) who undertook the research to hold interface meetings with their respective DHAs and other service providers to agree on key actions to be taken on both sides (service providers and users) to improve on health outcomes. These actions will need ARHR's dedicated monitoring and support to ensure their faithful implementation.

Priority recommendations are itemised below:

#### *Recommendations for MoH, GHS and DHAs:*

- Ensure that healthcare workers honour the Patients Charter by treating clients with dignity and sensitivity. Related to this, invest more proactively in educating citizens on the contents of the Charter.
- Address inefficient staffing allocations at some CHPS facilities, in the interest of sustainability.
- Improve harmonisation between how a healthcare facility is classified and the calibre of staff allocated to the facility.
- Ensure that treatments for the most basic and most routine illnesses (e.g. malaria) are more readily available at all NHIA-accredited facilities.



*Recommendations for NHIA:*

- Invest in educating citizens effectively on the health insurance contract and the rights of policyholders.
- Set ceilings defining how long it should take for a client's NHIS application to be processed once they log in at the relevant NHIA office.

*Recommendations for FDA:*

- Enforce regulations on herbal medicine, especially the indiscriminate advertisement and sale of unlicensed products.

*Recommendations for YEA:*

- Collaborate closely with GHS to ensure that, in future, CHWs are selected through open and transparent processes at the community level.

*Recommendations for District Assemblies (DAs):*

- Work with civil society to actively promote appropriate CLTS solutions.
- Couple CLTS effort with sustained environmental inspections and enforcement of sanitation bylaws.

*Recommendations for ARHR/ civil society:*

- Going forward, prioritise effective public education, in collaboration with the outreach services of CHPS facilities to address hygiene practices and ensure greater attention to the kind of health literacy gaps identified in Section 6.3.
- Collaborate with the DHAs, DAs and traditional authorities (TAs) to promote appropriate CLTS strategies.

# 1. Introduction

## 1.1 BACKGROUND

The Alliance for Reproductive Health Rights (ARHR) has, since May 2016, been implementing the *Primary Healthcare Advocacy Project*, with funding from PAI,<sup>4</sup> a US-based non-governmental organisation that champions policies to put women in charge of their reproductive health. ARHR sought, through the project:

- \* to act as lead CSO convening agent of a coalition of in-country partners working collaboratively to advocate for primary healthcare (PHC) in Ghana; and
- \* to actively participate in the global advocacy working group convened by PAI.

**Between February and March 2017, ARHR conducted interviews with service users in four communities in two districts to elicit their experiences with Ghana's primary healthcare system.** The study sought to assess and understand the degree to which citizens access and utilise primary healthcare services. It also interrogated issues of service quality and relevance from the perspective of citizens, and identified challenges that ought to be brought to the attention of the state and/or which civil society should be prioritising more decisively.

## 1.2 PURPOSE OF REPORT

**This report presents the perceptions of citizens in the four communities regarding their experiences with the delivery of primary healthcare.** The key deficits and challenges identified will continue to be used as evidence in citizens' discussions with their service providers, District Health Administrations (DHAs) and National Health Insurance Scheme (NHIS) officials, with the view to jointly developing appropriate remedial actions to ensure that citizens receive the improved care they deserve.

## 1.3 METHODOLOGY

**The assessment was conducted using the community scorecard (CSC) as the main facilitating tool.** The method employs qualitative techniques such as scoring, semi-structured interviewing and probing. These techniques are all common to the participatory rural appraisal (PRA) research tradition. The conversational approach makes the scorecard particularly appropriate in assessments where participants' literacy levels are relatively low – as they are in the communities in which the study was conducted. Unlike most forms of traditional research, however, the scorecard goes beyond mere data collection, analysis and report production to actively facilitating citizen-provider engagement as a purposive strategy for strengthening citizen voice and fostering downward accountability.

The fieldwork was undertaken by facilitation teams from two district-based ARHR partner organisations – ABAK Foundation and Volta Educational Renaissance Foundation (VEReF), who operate in the Asante Akim Central Municipality and South Dayi District respectively. Supervision of the field research was jointly provided by

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<sup>4</sup> Formerly Population Action International

staff from the ARHR secretariat and an associate of ARHR with experience in the use of community scorecard techniques.

The leadership role assigned to the district-based partners was designed to help develop their capacity for continuous scorecard-based monitoring. The fieldwork was preceded by training for the research teams to enable them to facilitate the community-level discussions using a jointly designed tool. The tool was also piloted and reviewed by the team as part of the hands-on training process.

**The assessment was conducted with focus groups defined by gender and age.** For each community, three focus groups were constituted. The first comprised female youth from 15 to 29; the second was constituted of women between ages 30 and 49, and the final cohort was a mix of men and women aged 50 years and above. The two younger cohorts were deliberately restricted to women because they are the ones generally responsible for health in rural Ghanaian households – with roles such as accompanying sick children and the elderly to healthcare facilities, ensuring adequate supplies of domestic water, and maintaining sanitary conditions in the home. Taking each pre-identified priority marker in turn (see below), the facilitation team elicited participants' experiences and assessed their satisfaction with local PHC services and related processes.

**The study assessed five broad PHC priorities, namely:**

- \* *universal accessibility* – comprising issues of physical accessibility (indicated by how easy it is to reach and enter the facility), receptiveness of health workers, promptness of service (whether health workers arrive on time and attend to patients in a timely manner), health insurance services and availability of medicines (whether medicines prescribed are available at the health facility);
- \* *full community participation* – referring to citizens' involvement in making decisions regarding the siting of their Community-Based Health Planning and Services (CHPS) facility as well as in health promotion and in disease prevention (e.g. selection of community health volunteers/ community health workers);
- \* *affordability* of treatment – including cost of consultations and medicines;
- \* *water service delivery* – comprising availability of water at the primary source (e.g. flow rate, waiting time and year-round availability), its affordability (how much is paid for a standard bucket), accessibility (how long it takes to walk to the primary water source and draw one's requirements) and quality (especially for drinking purposes); and
- \* *toilet services* – referring to availability of toilets at household level as well as accessibility and quality of public toilets.

**The focus groups were facilitated, using a five-point satisfaction scale, to score their local PHC services on each of the assessment criteria.** Participants began by sharing their experiences with their other group members and the research team. The ensuing focus group discussions (FGDs) were often animated, as participants illustrated their experiences with some vivid examples. After several participants had described their individual experiences for an indicator, the facilitator would sum up and ask the group to give a score reflecting their assessment on that particular indicator. The

group was asked to try to agree on a common score, with scores of 1-2 indicating general discontent on the specific indicator, 4-5 suggesting broad satisfaction and 3 to signify “so-so”.

**As a final step in this assessment, ARHR facilitated two platforms at which citizen representatives met with officials from their respective service authorities** – the District Health Administrations (DHAs), the district offices of the National Health Insurance Authority (NHIA), representatives of their District Assemblies (DAs) and their traditional leaders to dialogue about the issues raised. These dialogue sessions ended with some assurances by the service providers to address the concerns. ARHR partners will continue to assist the communities by further developing their capacity to continuously engage with their service authorities and advocate for improvements as necessary.

TABLE 1.1: SUMMARY PROFILE OF PARTICIPATING COMMUNITIES

COMMUNITY	DISTRICT	APPROX. POPULATION	PRIMARY LIVELIHOOD	DISTANCE TO DIST. CAPITAL (KM)
Patriensa	Asante Akim Central Municipality	7,400	Farming	10
Obenemase	Asante Akim Central Municipality	2,825	Farming	c. 14
Tsiyinu	South Dayi District	300	Farming	c. 14
Tsatee	South Dayi District	860	Farming	c. 15

TABLE 1.2: COMPOSITION OF FOCUS GROUPS

COMMUNITY	COHORT 1		COHORT 2		COHORT 3	
	AGE	♀/♂	AGE	♀/♂	AGE	♀/♂
Patriensa	15-29	6/0	30-49	7/0	50+	5/3
Obenemase	15-29	7/0	30-49	7/0	50+	4/3
Tsiyinu	15-29	6/0	30-49	6/0	50+	3/4
Tsatee	15-29	6/0	30-49	6/0	50+	3/4

**The methodology is not without limitations.** The scorecard is principally a quick, simple and participatory action research approach designed to facilitate quick changes in service situations and is not primarily intended for rigorous academic analysis. The technique elicits citizens’ subjective experiences (and approximate assessments) as a basis for dialogue with service providers, as described above. While subjective, citizens’ perceptions and experiences are nevertheless invaluable in alerting service providers to the concerns of rights holders and facilitating their answerability to the latter. Most members of the research teams were using the methodology for the very first time and will, hopefully, become more adept in its use as they continue to apply the routines in other research and advocacy initiatives.

## 1.4 STRUCTURE OF REPORT

The report is in six sections. Following this introduction, Sections 2-5 report in turn on the detailed findings from each of the four study communities – Patriensa and Obenemase in Asante Akim Central Municipality, and Tsiyinu and Tsatee in South

Dayi District. The sixth and final section summarises the key challenges and actions which key actors including ARHR/civil society partners and various duty bearers ought to take to address the shortfalls unearthed by the research. Brief profiles of the four communities are provided at Annex 1.

## 2. Experiences of citizens at Patriensa

In general, citizens of Patriensa access their healthcare needs at a Community-based Health Planning and Services (CHPS) facility located on the outskirts of the settlement. Other health facilities patronised by residents include two orthodox healthcare providers in the district capital – Konongo Odumase Government Hospital (a public referral facility) and First Klass Hospital (a private facility) as well as several local herbalists and traditional healers. Many households also have an elderly woman who has traditional responsibility for preparing home-made herbal brews, based ostensibly on indigenous knowledge, for use within their households.

### 2.1 SCORECARD RESULTS, PATRIENSA

TABLE 2.1: SUMMARY OF SCORECARD RESULTS, PATRIENSA

Indicator	Age 15-29	Age 30-49	Age 50+
<b>UNIVERSAL ACCESSIBILITY</b>			
Geographical accessibility of PHC services	5	5	5
Respect accorded clients by service provider	5	5	5
Promptness of service	5	5	5
Availability of medicines	4	4	4
<b>FULL COMMUNITY PARTICIPATION</b>			
Community involvement in siting facility	1	1	5
Community involvement in health promotion	1	1	1
Community involvement in disease prevention	1	1	1
<b>AFFORDABILITY OF TREATMENT</b>			
Affordability of consultations	3	3	1
Affordability of medicines	3	1	2
<b>WATER SERVICE DELIVERY</b>			
Availability of water	5	5	5
Affordability of water	5	5	5
Accessibility of water	5	4	5
Quality of water	3	5	5
<b>TOILET SERVICES</b>			
Availability of household toilets			

#### 2.1.1 UNIVERSAL ACCESSIBILITY

As Table 2.1 shows, citizens of Patriensa are very satisfied with their ability to access services at their local health facility (a CHPS compound). The three focus groups interviewed were unanimous that the Patriensa CHPS compound is not only physically easy to reach, but that the geniality of its staff and the overall availability of drugs also encourage them to patronise the facility. In the view of two of the young women interviewed:

- \* “The [CHPS] facility is disability-friendly; ... there are no long staircases or drains [to cross, and] the veranda too is not high, [so] you ... enter without any difficulty”



- \* *“For me, the CHPS facility is very close; ... I do not have to worry about transport ...”*

However, a significant minority (two older women in the eight-person cohort of over 50s) said they were unable to access services at the CHPS facility because of aging-related challenges.



Focus group of 50+ year-olds interacting with assessment team at Patriensa Community; March 2017

**Participants were impressed with how sensitive and approachable staff of the CHPS compound are.** Regardless of age, all of the groups interviewed affirmed that they are treated with dignity when they attend the facility – whether for routine checks (e.g. ante-natal care and post-natal care) or when they are ill. Below is a selection of voices from the focus group discussions:

- \* *“when I got pregnant, I was [embarrassed and reluctant] to attend the ante-natal [clinic], but I gathered courage one day to go .... When I got there, I was [pleasantly] surprised by the way the nurses took care of me. They were very patient in explain[ing] things to me and really made me feel comfortable. So, since then, I always attend [their] ante-natal sessions” (female teenager)*
- \* Another respondent in the focus group composed of middle-aged women noted how *“the workers are very kind and lively; they make us laugh with their jokes ... and give our children sweets to calm them”*
- \* Comparing how she is received at the local CHPS compound with her experience with other healthcare facilities she has used, another participant from the same group observed: *“I have been to several hospitals [sic; implying healthcare facilities] and I will boldly say Patriensa nurses are respectful. Once when I misplaced my [health] insurance card, the nurses were kind [and] helped me look for it. They also gave me their number to call if I needed [further] help”*
- \* An older respondent from the over-50 cohort opined that *“their warmth and receptiveness served as ... medicine; ... they encouraged me and assured me of a speedy recovery”*.

**Nurses at Patriensa are also punctual to work and brisk when attending to clients.** The voices of several participants in the focus group demonstrate this:

- \* *“They are always around .... Even when you go around midnight, you are attended to”* (participant in age 50+ focus group)
- \* *“I usually visit early – around 6:30 a.m. – to avoid [getting stuck in] a long queue and I always find the workers at post”* (middle-aged woman)
- \* *“When I go for post-natal [care], it only takes some 30 minutes to get attended to. But, before, when I used to attend First Klass private hospital, it would take more than an hour because so many more people visit there”* (woman, aged 20)

**A closer scrutiny of human statistics associated with the CHPS facility (specifically staffing and outpatient numbers) suggests significant and quite costly inefficiencies in the operation of facility.** For a facility attending to some 70-80 clients per month (averaging only up to four outpatients daily), the professional staff roll of 11 (with a further six Community Health Workers (CHWs) and two other staff)<sup>5</sup> seems very high and difficult to justify – especially when most appear to be facility-bound. The DHAs explained that the situation has arisen partly because outreach services are constrained by deficits in logistical supplies. Indeed, some participants in the focus groups opined that the facility had a surplus of health workers and that some could be quite conveniently transferred to other facilities. This issue of staffing efficiency appears to cut across many CHPS compounds nation-wide and needs reviewing.



*Staff of Patriensa CHPS compound happy to provide health services to community members; March 2017*

**In terms of the availability of medicines, satisfaction fell slightly short of the optimum score,** across the different age cohorts. Generally, respondents wish all their prescriptions could be dispensed to them right there at the local facility. However, this has not always been so; and it may not be a realistic expectation, in light of the

<sup>5</sup> By contrast, the Tsatee facility is staffed by a midwife and two community health nurses



low outpatient numbers. However, treatments for the most basic and most routine illnesses (e.g. malaria) ought to be more readily available.

The following quotes illustrate respondents' experiences and capture their sentiments:

- \* *"Not all the drugs [which a client may be prescribed] are available. Usually, [those] like paracetamol, anti-malarial treatments, drugs for pregnant women, de-wormers and iron [supplements] are available. At times, I [choose to] visit Konongo Government Hospital [instead] because I know I will get all the drugs I need"* (adolescent female)
- \* *"When I ... do not get all the drugs I need, I ... rely on the little I [am] given"* (woman, aged 33)
- \* *"For me, I have observed that malaria drugs, drugs for pregnant women, paracetamol and tri-silicate are always available [when] I visit the facility. I think the availability of drugs depends on the type of illness. For example, the elderly who suffer chronic illnesses will not get all their drugs from the facility"* (middle-aged respondent)

**Some with valid NHIS subscriptions nevertheless observed that they were sometimes required to pay for selected medicines from the list of those prescribed and dispensed to them by the facility.** It appears that education has been suboptimal on the content of the health insurance scheme – specifically on what the benefit package entails and excludes. It is also the case that when the CHPS compound is unable to supply all the medicines it has prescribed, patients sometimes simply subsist on the few they have been given, undermining the effectiveness of the treatment.

### 2.1.2 FULL COMMUNITY PARTICIPATION

**The three focus groups differed widely on their satisfaction with their involvement in siting the CHPS facility.** While the two younger groups (ages 15-29 and 30-49 respectively) were entirely dissatisfied because they never heard of any community meeting to discuss the matter, the older cohort (of over-50s) affirmed that a community meeting was indeed organised for that purpose.

**It appears that traditional routines for sharing public information are inappropriate for this community of over 7,000 citizens.** Often, such public announcements (and community meetings) take place during working hours via the "gong-gong"<sup>6</sup> and other traditional broadcasting arrangements. However, as a settlement begins to urbanise, an increasing proportion of its members of working age become involved in the wage economy and hence tend to be away from the community during the day. As indicated in the community profile for Patriensa (Annex 1), many young men and women in this community have abandoned peasant farming and are now actively mining illegally for gold in pay-dirt pits in other parts of the district. Thus, while most respondents in the focus group of over-50s did hear the announcement inviting the community to a meeting to discuss where the new CHPS facility should be sited, absolutely no-one in either of the two younger focus groups even knew about it. Clearly, the system of making important public announcements needs adapting, in order to respond to the communication needs of those who work outside the community.

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<sup>6</sup> The gong-gong gets its name from the sound made by the traditional drum used for making public announcements in rural communities in southern Ghana

**The health service scored poorly in citizens' perceptions of efforts made to involve the community in health promotion and disease prevention.** The assessment was consistently low across the three cohorts interviewed. Ordinarily, one would expect to have a team of Community Health Volunteers (CHVs) or a Community Health Committee (CHC) appointed through some transparent arrangement to partner the CHPS staff in delivering health promotion and disease prevention initiatives (such as immunisations and public education), using peer-based processes. Curiously, while a team of such "volunteers" does exist, participants in the focus groups did not know of any such arrangement. Subsequent enquiries revealed that the volunteers were hand-picked by the leadership of the community in ways that fell short of the norms of transparency. The words of a 30-year-old respondent summarise the sentiments on community-owned health-related initiatives: "*... there is nothing like communal labour [in this community]*".

In addition to the community health volunteers, the research team met six CHWs at the CHPS facility. These had been recruited from outside Patriensa by the Youth Employment Agency (YEA) office in Konongo, and were receiving monthly allowances of GH¢240.<sup>7</sup> Not only does this finding raise serious questions about transparency; it also undermines shared ownership of the agenda of community-based health promotion and disease prevention.

### 2.1.3 AFFORDABILITY OF TREATMENT

**Participants' experiences regarding healthcare costs were quite mixed.** Some did experience the health insurance scheme as the safety net it was conceived to be. Overall, however, older respondents (over 50) had more adverse perceptions of consultation and treatment costs, as they were often trapped in the lowest income occupations (typically peasant farming). They scored the healthcare system a low 1 and 2 respectively on these related indicators, while the youngest cohort scored a more modest 3 on both indicators, suggesting that they neither find consultation costs expensive nor cheap. Even so, most respondents in these focus groups still had complaints about the effectiveness of the health insurance mechanism.

**Among the respondents interviewed, relatively few had active NHIS subscriptions.** The majority had either never subscribed at all or had not renewed their subscriptions upon expiry, as a result of frustrations experienced with the scheme. Many found the cost of annual renewal expensive, at GH¢22-25<sup>8</sup> per adult and GH¢5 for the aged (above 70 years). Some refused to renew their expired subscriptions because they had been compelled to make out-of-pocket payments while they were fully paid up. Respondents found these supplementary payments for medicines altogether surprising, as nobody had explained to them that not all medicines or treatments were covered under the insurance. Others too opt out because their preferred health service providers are not accredited by the National Health Insurance Authority (NHIA) and

<sup>7</sup> The YEA programme has recently been embroiled in allegations of fraud involving criminal payments of "allowances to thousands ... who do not work for the agency" (<http://citifmonline.com/2017/04/20/yea-suspends-allowances-over-fraudulent-payments/>). The programme has been criticised for serving as a channel of extortion, with recurrent allegations that it was employed as a tool of political patronage in the run-up to the 2016 General Elections

<sup>8</sup> Approximately US\$5-6 at the time of the field visits

so do not accept NHIS cards. Clients without active insurance cards said they pay GH¢5 for a facility card and an additional consultation charge depending on the sickness they present.

**Since the recent switch to a biometric mode of registration, citizens are finding the NHIS renewal process challenging.** This is because everyone renewing their subscription must now present themselves physically at a designated registration centre for their electronic portrait to be taken. This means that larger households are sometimes saddled with relatively high transport burdens. Poor telecommunication networks were noted to disrupt registration processes, often requiring clients to make multiple journeys to their district offices of the NHIA.

The voices below give a sense of the depth of dissatisfaction on the issue:

- \* *“The insurance is not affordable; at this age, I do not work so it [is] difficult ... to renew, considering the number of children I have; I have to pay [the associated] transport cost on top of the money meant for the renewal”* (middle-aged participant)
- \* *“Even though I have a valid insurance card, ... I am [sometimes] asked to pay”* (elderly man)
- \* *“For me the insurance is very important; [had I not been] on the scheme, it would have been very difficult to foot the medical bills when my daughter fell seriously ill”* (37-year-old woman)
- \* *“I was suffering from waist pains and visited Konongo Government Hospital for treatment. I had a valid insurance card, yet I was billed GH¢65<sup>9</sup> for [my] medicines. I didn't have money, so I came home relying on God's intervention. I thought I would die, but I didn't”* (woman aged 65)
- \* *“What is the essence of possessing a valid insurance card if you still have to pay so much for healthcare? I didn't renew [my subscription] because after going through all the stress, I would still [have had to] pay medical bills”* (25-year-old woman)
- \* *“Renewing the insurance is a major problem. I wake up as early as 4:00 a.m. to go to Juansa or Konongo and yet I am unable to renew it. Sometimes, I sleep over [just] to be able to renew it. Those who cannot sleep over would have to go home and return the next day. All of this requires additional money”* (28-year-old woman)

**Participants with active health insurance subscriptions still assessed the cost of treatment to be relatively high.** Many had experienced situations in which they were given written prescriptions to go and buy the more expensive medications outside the facility, on the pretext that their insurance policies did not cover such drugs. Others were charged for medicines they had expected their insurance policies to cover. By contrast, participants with no insurance cover said they were made to pay GH¢3 for malaria treatment, GH¢2.50 for a course of de-wormer and GH¢4 for tri-silicate if they attended the facility.<sup>10</sup>

**Subsequent engagements with staff of the facility revealed some anomalies with the grading of facilities and, related to that, the eligibility of the facility to offer certain services to premium holders without charge.** For example, certain medicines are not expected to be prescribed/ dispensed at CHPS facilities, that being the lowest

<sup>9</sup> Approximately US\$15

<sup>10</sup> These are equivalent to about 60-95 US cents.

level in the hierarchy of Ghana's formal health delivery system. Yet, at Patriensa, a Physician Assistant has been posted to the facility, with the capacity to prescribe a broader range of medicines, some of which are only reimbursable at the higher levels of the healthcare delivery chain. Thus, clients at Patriensa who are prescribed such medicines are compelled to pay cash for them, as CHPS facilities are ordinarily not entitled to be reimbursed for such costs.<sup>11</sup> This misalignment between health insurance and staffing practices clearly undermines transparency and fuels mistrust for facility staff.

#### 2.1.4 WATER SERVICE DELIVERY

**Citizens' assessments of the availability of water are good, but deeper reflections indicate some significant deficits.** Patriensa has seven bore holes (which works out to approximately one borehole per 1,000 population, with only two buildings having home connections). While this is well outside the national threshold of 300 citizens per borehole, residents gave the service top scores for sheer availability. They, however, qualified this by noting that waiting times can be very long at peak times (e.g. in the morning when people are hurrying to get to work and children are being prepared for school). Curiously, the oldest cohort (age 50+) had no issues with waiting times, while the other two groups complained bitterly. Some probing revealed, however, that citizens aged 50 and above almost never have to go to the borehole themselves as tradition requires their younger relatives to serve them. On the rare occasion when they do go in person to the borehole, the culture is again generous toward them and requires that they be made to jump the queue. Thus, their experience cannot quite be taken for the norm.



*Community member pumping water from a borehole at Patriensa Community; March 2017*

**Most respondents reported waiting times of about an hour at peak times.** At such times, those unable to wait are compelled to source water from the “*abrewa*”

<sup>11</sup> Also, while those CHPS facilities who have midwives are entitled to reimbursements for certain antibiotics, those without a midwife cannot make such claims.



(uncovered, hand-dug well). They noted, however, that water from the well is not drunk, but rather used for washing, showering and cooking. A 20-year-old opined that a mere look inside the well was enough to provoke a bout of nausea, inferring that the water was visibly polluted and unwholesome for drinking. Thus, while the average household may not plan to drink it, even the limited uses mentioned entail some quite significant dangers if local staples such as *fufu* are made with it or food bowls rinsed with it. Surprisingly, residents were entirely uninformed concerning these dangers.

**Assessments of the flow rates and year-round dependability were mixed.** Participants explained that availability tends to dip when the harmattan season is harsh, with sluggish flow rates during the period. Further, because of the stress on the boreholes (given the high population per facility ratios), the boreholes tend to break down quite frequently. During such times, the pay-as-you-draw (PAYD) user fees charged for drawing water are used to expedite repairs. Further, the seven facilities across the community do not break down simultaneously, so citizens seem reasonably comfortable with their ability to manage during such downtimes.

**All three focus groups considered the cost of water affordable**, at GH¢0.10<sup>12</sup> for a 34-litre bucket. The unit cost is even lower for households who opt to pay a monthly charge of GH¢1.<sup>13</sup> Most households opt for the latter tariff.

**Citizens were also entirely satisfied with the accessibility of water services.** Their assessment was explained by the fact that most households can reach a borehole within a two-minute (maximum, five-minute) walk.

**Despite a lack of regular testing, respondents were satisfied with the quality of their water.** However, the younger cohort observed that a film of dirt settles to the bottom when the water is stored for about a week. Others reported occasionally seeing a film of oil on the water. Both of these they attributed to a high iron content – though, without proper laboratory testing, there is no way of properly identifying the contaminant. It could well be dust from the wind or from daily sweeping that ends up in the water after it has been brought home, or there might be all manner of other pathogens that are not visible to the naked eye. Suggestions that their leaders drop alum into the borehole occasionally have no scientific basis. Instituting a systematic regime of inexpensive quarterly testing (and treatment, when necessary), along with proper public education on water hygiene, would be helpful. This could be done in collaboration with the district office of Ghana Water Company Limited (GWCL), which is the relevant state agency.

### 2.1.5 TOILET SERVICES

**Household toilets are rare at Patriensa.** Most households share the community's seven public pit latrines. A woman in the middle-aged focus group had this observation on the stench emanating from the communal latrine in her quarter of the community: *"... to visit that toilet, you must first strip naked [to avoid trapping the lingering*

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<sup>12</sup> About 2 US cents

<sup>13</sup> About 25 US cents

*stench in your clothing] and take your bath immediately afterwards.”* Respondents were unanimous in their scathing criticism of the latrine, which attracts a 20-pesewa charge for each use. This raises clear accountability questions as well, as nobody appears to be questioning the use to which the user fees are put.

**As a result of the unsatisfactory state of the communal latrines, community members often resort to practising “free range” (a euphemism for open defaecation).**

The excerpts below highlight some experiences recounted in the focus groups:

- \* *“Because the condition of the public toilet is so bad, most of us go to the bush. [Just] imagine men and women ‘doing it’ together”* (participant in focus group of middle-aged women)
- \* *“We go [simultaneously] with the men; we have no choice [but] to squat in the same place with the men”* (woman aged 31)
- \* *“Our children ... use the refuse dump; [but] because of [the threat of] snakes ..., most of them defecate at home; then we collect it and throw it into the bushes”* (33-year-old woman)

Curiously, citizens seemed much less aware and concerned about the adverse health implications of their sanitation situation and related practices. No effective hand-washing facilities or arrangements were evident in the vicinities of the public toilets seen by the research team.

#### 2.1.6 COPING STRATEGIES

**Those unable to afford the costs of formal healthcare opt for traditional options.** The most patronised of the traditional healers, “Auntie Yaa”, is consulted with wounds, boils, chronic headaches, breast problems, impotence and several other health issues. No fee is demanded when indigenes seek her services. However, they are expected to “show their appreciation” through whatever gifts they can afford after they have experienced healing. Residents believe that a client who attempts to outsmart Auntie Yaa will suffer a relapse of the initial illness in a more severe manifestation. Unlike indigenes, non-native clients are charged an all-inclusive fee of GH¢5<sup>14</sup> when they consult her. Others who have failed to maintain their health insurance subscriptions (or who cannot afford to purchase the full course of medications prescribed for them) may resort to self-medication or simply buy short quantities of the prescribed medicines.

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<sup>14</sup> About US\$1.20

### 3. Experiences of citizens at Obenemase

Obenemase has a CHPS facility within the settlement. However, patronage is mixed, with many opting for alternative providers within and outside the community (Section 3.1.1). Mainly, these include the larger and better-equipped formal healthcare facilities in the district capital, practitioners of herbal medicine and drugstores who dispense all manner of medicines without prescriptions. Affordability of treatment and perceptions of the quality of care emerged as major considerations in people's health-seeking decisions.

#### 3.1 SCORECARD RESULTS, OBENEMASE

TABLE 3.1: SUMMARY OF SCORECARD RESULTS, OBENEMASE

Indicator	Age 15-29	Age 30-49	Age 50+
<b>UNIVERSAL ACCESSIBILITY</b>			
Geographical accessibility of PHC services	3	5	5
Respect accorded clients by service provider	2	2	5
Promptness of service	3	1	3
Availability of medicines	3	1	4
<b>FULL COMMUNITY PARTICIPATION</b>			
Community involvement in siting facility	1	2	5
Community involvement in health promotion	1	1	1
Community involvement in disease prevention	1	1	1
<b>AFFORDABILITY OF TREATMENT</b>			
Affordability of consultations	1	1	3
Affordability of medicines	3	1	3
<b>WATER SERVICE DELIVERY</b>			
Availability of water	2	3	5
Affordability of water	5	5	4
Accessibility of water	5	3	5
Quality of water	3	4	5
<b>TOILET SERVICES</b>			
Availability of household toilets			

##### 3.1.1 UNIVERSAL ACCESSIBILITY

**Perceptions of *de facto* access to the services rendered at the local health facility differ, but are largely poor.** In terms of proximity of the health facility, an overwhelming majority of participants in all three age cohorts were entirely satisfied.



CHPS facility at Obenemase; March 2017

However, while the older respondents (over 50s) were satisfied that they were respected when they visited the facility, their younger counterparts had very unsatisfactory experiences. Uncertainty about how sensitively they will be received and attended to has affected citizens' appetite for patronising the services available at the facility.

Participants' experiences with staff of the facility include:

- \* *"The nurses are respectful. They ... take care of us even when we do not have money"* (woman over 50)
- \* *"The nurse who took care of me respected me and also even gave my son a biscuit when he was crying. This calmed him down"* (woman in middle-aged group)
- \* However, another mother from the same group observed thus: *"the nurses talked rudely to me, they behaved as if I was not human"*
- \* *"This batch of nurses don't respect human beings at all; the previous nurses ... were better. ... I sent my wounded son to the facility and after [he had been treated], I pleaded for a reduction [in the charge]. One of the nurses said that if I wanted a reduction I should go to the market [where I could haggle over prices]"* (35-year-old mother)
- \* A 28-year-old woman complained: *"I am a seamstress and my madam asked me to take her son to the hospital. When I got there, the nurses told me I was late. [She] refused [to treat the boy] and drove me out. I went back to [inform] my madam [who] personally took her son to the facility [but] she too was [driven out]"*
- \* *"For me, because of the attitude of the nurses, I always go to town for health care. I will never go to that facility for them to [treat me with] disrespect"* (28-year-old woman)

All three focus groups were patently unimpressed with the urgency with which frontline staff attend to them at the local facility. Those in the 30-49 age bracket (who have greatest responsibility for caring for children) had the worst accounts, scoring the service a low 1 for promptness. According to participants:

- \* *"[A] woman was [seriously ill] at night and when we visited the facility to wake the midwife up, she refused to attend to the client and told us to wait until morning. It was only God who saved the [sick] woman"* (50-year-old woman)
- \* Another woman from the 30-49-year group shared a similar view: *"sometimes [when] you ... visit the facility, [you do] not meet a single soul there. They sometimes*



*close the facility. This happens mostly on Saturdays. To save me from walking there and meeting no-one, I rather go to Konongo or Agogo to receive proper care"*

- \* *Another from that group added, "some of them are not punctual to work; you [sometimes] wait till 10 am before they [show up] and attend to you"*
- \* *"... for promptness, they are very poor; you have to wait for them to complete whatever they are doing before they attend to you" (middle-aged woman)*
- \* *"Sister, I think this facility should be closed down so that we will know at least we don't have any facility here because the nurses don't do anything here. Recently a woman I share a house with lost her 10-month-old baby. The baby [suddenly took ill] at dawn so the mother went to one of the nurses [who] told the woman to wait till morning. The mother had no option but to wait anxiously for morning to come. She waited and waited [only for] the nurses [to] finally arrive around 10am and subsequently refer her to a bigger hospital. When she got there, her baby was dead" (29-year-old woman)*
- \* *"The nurses come to work late and close before 6pm; ... they are not reliable at all, which is why I don't even go there ..." (woman aged 26)*

**Participants' experiences on the availability of medicines varies, with an overall picture of erratic supplies.** Even the most basic medicines like paracetamol were said to run out at times. When prescribed medicines are not available at the facility, clients purchase their supplies from private drug stores in the district capital, Konongo. Others resort to the use of traditional medicines or consult with local traditional healers (e.g. Opanin Kwasi Atta or Agya Moses) for treatment. However, the facility believes the issue of unavailability of drugs has now been resolved.

### 3.1.2 FULL COMMUNITY PARTICIPATION

**Overall, citizens' scores were lowest for this indicator, suggesting little involvement of the community in health governance.** As with Patriensa, only the oldest had any prior notification about the establishment of a CHPS facility. Even so, a 50-year-old noted: *"there was nothing like a forum where we could give our opinions, [though] we were informed about the idea to convert the old post office to a CHPS [facility]."* Other participants in the focus group discussions only heard about the facility when it was about to be commissioned. None of those interviewed were aware of any community health volunteers. Neither were they involved in any communal activities specifically organised with the aim of preventing diseases.

### 3.1.3 AFFORDABILITY OF TREATMENT

**The two younger cohorts found formal healthcare expensive to access.** Their counterparts in the over-50 group also mostly felt the costs were high. One member noted: *"with farming as my source of livelihood, I can't afford the insurance."* Below are other experiences shared with the study team:

- \* *"I have so many children to fend for and don't have spare funds to purchase drugs" (middle-aged woman)*
- \* *A peer from that focus group added: "The cost involved in travelling to Juansa or Konongo to renew my [health insurance] card does not motivate me to do so because, in addition to [paying for] the insurance, I also have to find additional money for food and transport. So now whenever I am sick, I [just] go the drugstore to describe my condition, and they sell me drugs"*

- \* *“For me since the pharmacy is there, I don’t worry myself; I just go to the pharmacy shop each time I am not feeling well and they give me drugs ... or I stick with traditional medicine for treatment. About a month ago, I was getting acute headaches and I consulted a herbalist who smeared my head with some herbs and within a few days, I was fit again” (58-year-old)*
- \* *“Why should I have insurance and at the same time pay for all my medicines?” (middle-aged woman)*
- \* *On a more positive note, a respondent from the over-50s group opined: “even though some of the medicines are expensive, I do not have to pay for all my medicines because the insurance takes care of some of [them]”*
- \* *“I have an insurance but recently when I went for a check-up, I was asked to purchase a drug which cost GH¢90.<sup>15</sup> I am a student who got pregnant so I could not afford to buy that drug. The doctor told me the drug was important for the safety of both my unborn child and me. Since I could not buy it, I had to practice self-medication” (18-year-old woman)*
- \* *“Affordability of the health insurance depends on one’s job; ... for those [of us] who are living from ‘hand to mouth’, ... even affording one meal a day is very difficult, let alone getting GH¢25<sup>16</sup> for an insurance card” (49-year-old woman)*

### 3.1.4 WATER SERVICE DELIVERY

**Perceptions of water services at Obenemase vary, but tend to be least satisfactory for the youngest cohort of women, who have direct responsibility for ensuring that households’ water requirements are met.** Of the community’s seven bore holes (most of which are over 22 years old), two had broken down at the time of the study visit. Only an insignificant minority have direct connections to their homes. Geographical accessibility is also a challenge for households living in Ward 3 of the settlement. According to one woman in the middle-aged group, *“it takes those living in Ward 3 about 10-15 minutes to get to the water source and 30 minutes to get to ‘Nana Amosua’ [a surface water source].”* The following comments from the focus group discussions capture participants’ impressions of the utility:

- \* *“The water flows well but it takes a lot of strength to pump it out” (female teenager)*
- \* *“See my biceps [showing them to the team]. Some of the men ... say we scare them with our muscles – thanks to our ‘macho’ bore hole” (25-year-old woman)*
- \* *“The bore holes flow well but it is not easy to pump; because of that there is always a long queue” (20-year-old woman)*

**Respondents also said they are often delayed at the boreholes, sometimes queuing for one hour or more, thereby compelling those who cannot wait to opt for less safe sources.** The quote below, from a 24-year-old woman, is illustrative of the water-seeking behaviour of many at Obenemase:

- \* *“When there is a long queue, I sometimes go to fetch water at ‘Nana Amosua’ [a nearby surface water source]. During the harmattan [i.e. dry season], the boreholes do not flow very well”*
- \* *Another observed: “it takes about a month to repair the borehole each time it breaks down” (48 years)*

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<sup>15</sup> Approximately US\$20

<sup>16</sup> Approximately US\$6

Water is priced at GH¢0.10 for a 34-litre bucket. Virtually all of those interviewed found this affordable. However, there was less unanimity around the question of quality. While the oldest respondents tended to believe that the quality of their water is entirely satisfactory (equating its colourlessness with purity), the two younger groups mentioned some issues with the quality of supplies. However, even they demonstrated weak literacy in respect of water quality. Some voices from the focus groups are captured below:

- \* *“About a year ago, we experienced itching and rashes when we drank the water. We complained and some ‘doctors’ came to add some ‘alum’ to the water, so there are no more issues”* (28-year-old woman).
- \* *“Recently they have dropped some ‘alum’ in our bore holes so we are now safe”* (middle-aged woman)

### 3.1.5 TOILET SERVICES

**Very few homes in Obenemase have household toilets.** There is a single public toilet for the nearly 3,000 residents, and it is dilapidated and largely disused. As one 19-year-old woman observed disturbingly, *“if you want to [use it], you first have to throw stones onto the roof to scare away a snake [that has made a home there]”*. Right next to the toilet is a refuse disposal point – which is a perfect breeding place for vermin – and, thus, an attractive habitat for snakes.

Another 25-year-old woman noted: *“the toilet is not accessible to those living in Ward 3, so most of them use the cemetery”*. When asked who keeps the toilet clean, a respondent from the over-50s focus group had this to say: *“Auntie Mercy volunteers to clean the toilet, but because of that people [avoid] the food she sells”*. Another 38-year-old woman reported: *“the toilet is ... very old ... more than 33 years. Since it was built, there has not been any form of maintenance ... and because there is no caretaker, it is not properly managed”*.



*Toilet facility at Obenemase, adjacent to garbage disposal site; March 2017*

### 3.1.6 COPING STRATEGIES

As observed in Section 3.1.3, it is common for citizens to rely on unorthodox healthcare options such as self-medication or consulting drugstore keepers for prescriptions.

## 4. Experiences of citizens at Tsiyinu

Residents of Tsiyinu generally access healthcare services at a CHPS facility located in their community. However, they also use the Peki Government Hospital upon referral or when they perceive their illness to be serious. Herb use is widespread, while some also explore spiritual services when they are ill.

### 4.1 SCORECARD RESULTS, TSIYINU

Residents of Tsiyinu were largely satisfied with their CHPS facility, except for the effectiveness of the NHIS.

TABLE 4.1: SUMMARY OF SCORECARD RESULTS, TSIYINU

Indicator	Age 15-29	Age 30-49	Age 50+
<b>UNIVERSAL ACCESSIBILITY</b>			
Geographical accessibility of PHC services	5	5	5
Respect accorded clients by service provider	5	5	5
Promptness of service	4	5	5
Availability of medicines	4.5	3	3
<b>FULL COMMUNITY PARTICIPATION</b>			
Community involvement in siting facility	1	5	5
Community involvement in health promotion	1	1	1
Community involvement in disease prevention	--	--	--
<b>AFFORDABILITY OF TREATMENT</b>			
Affordability of consultations	1	1	1
Affordability of medicines	1	1	1
<b>WATER SERVICE DELIVERY</b>			
Availability of water	5	5	5
Affordability of water	5	5	5
Accessibility of water	5	5	5
Quality of water	5	5	5
<b>TOILET SERVICES</b>			
Availability of household toilets			

#### 4.1.1 UNIVERSAL ACCESSIBILITY

**In all three groups, respondents were unanimous in perceiving their CHPS facility as being highly accessible geographically** (Table 4.1). At the maximum, it takes residents 15 minutes to reach the facility, and everyone travels there on foot. Citizens were also satisfied that the facility is disability friendly.





*Female youth at Tsiyinu during community scorecard assessment activity; March 2017*

**Residents of Tsiyinu also perceive that they are accorded respect when they visit the facility.** When asked for their assessment, participants responded with expressions such as “*they love us*”, “*they treat us with dignity*” and “*they don’t yell at us*”. The youth focus group observed the health workers’ patience in trying to identify and understand their illnesses whenever they visited the facility. In the words of a young mother who participated in that focus group, “*the nurses bath our sick babies for us when we take them to the CHPS [facility]; this [demonstrates] that they respect us and have love for our children.*”

**Respondents were equally satisfied with the punctuality of the facility workers and the promptness with which they were attended to by staff.**<sup>17</sup> The youths noted how they were sometimes delayed because the nurses tended to take particularly detailed case histories when they had to deal with elderly women. The middle-aged group also noted that the facility spends more time on “*serious cases*” (e.g. labour and machete injuries). Notwithstanding these observation, respondents were clearly understanding, adding that it only took five to ten minutes for them to be seen at other times. Respondents also observed how the nurse voluntarily forgoes her lunch break when there are lots of patients waiting to be seen.

**The focus groups were less satisfied with the availability of medicines,** scoring between 3 (the two older groups) and 4.5 (the youth). Participants explained that there were no chemist shops locally and so they had to travel to other communities like Asikuma (10 minutes’ drive, GH¢6 return fare), Juapong (about 30 minutes’ drive, GH¢10 return fare) or Kpeve (GH¢18 return fare)<sup>18</sup> to purchase any medicines the facility was unable to supply. An older participant who was nursing a urinary tract infection indicated that he had to travel to Ho (the regional capital, about an hour away) to buy his prescription drugs. Some also noted that basic antibiotics like amoxicillin and metronidazole were not available at the facility.

<sup>17</sup> Staff were said to be at post by 8:00 a.m. every day.

<sup>18</sup> These fares equate to between US\$1.40 and US\$4.20

#### 4.1.2 FULL COMMUNITY PARTICIPATION

**It appears that youth are not adequately involved in decision-making processes, provoking them to disengage from collective processes.** While the two older groups scored full marks to indicate their satisfaction with their involvement in the decision about siting the CHPS facility, the youths scored just one point to reinforce their disappointment at their voice not being respected in the process.

On the issue of community health volunteers, most of **the youth interviewed were unaware of any such volunteers or activities undertaken by them.** However, the two older groups again suggested that there had *previously* been two volunteers who had supported Community Health Nurses (CHNs) with their immunisation and outreach initiatives.

**Community involvement in health promotion was scored a low 1 by all three focus groups, with some even wishing the scoring scale had room for a zero.** Presumably, the “volunteers” have been non-functional for over three years. The interviews indicated that the “volunteers” had expected to be paid and when no such compensation was forthcoming, they had lost interest in serving their community. This has, unfortunately, become the new normal in many “volunteer” settings in Ghana, fuelled by a heedless trend of paying all manner of allowances to self-help groups, mindlessly threatening the tradition of genuine selfless giving within collectives.

#### 4.1.3 AFFORDABILITY OF TREATMENT

**The three focus groups at Tsiyinu were unanimous in their perception that the costs of formal care are high.** Some older members interviewed said they had been compelled to call their children working in Accra and elsewhere to assist them meet their NHIS subscription costs of GH¢22.<sup>19</sup> Respondents said it typically costs around GH¢15-20<sup>20</sup> to consult at a formal healthcare facility without an active NHIS card, and an elderly man described how he was made to pay GH¢80<sup>21</sup> for treatment because his subscription had lapsed.

Further, **since the introduction of biometric registration (ostensibly to minimise impact of fraud on public funds), the expense entailed in renewing an expiring NHIS subscription has gone up significantly,** as agents no longer go around the communities offering to renew such subscriptions. Thus, citizens of Tsiyinu must now make the journey to their district capital, Kpeve, to renew their subscriptions. At GH¢18 for a return fare per person, it would cost a five-person household GH¢90 just on transport alone.<sup>22</sup> Yet, judging from responses by participants in the focus groups, there is no guarantee that one’s renewal transaction will be completed in one visit, owing in large part to an erratic internet network.

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<sup>19</sup> About US\$5.20

<sup>20</sup> About US\$3.50-4.70

<sup>21</sup> About US\$19

<sup>22</sup> Over US\$20

#### 4.1.4 WATER SERVICE DELIVERY

**Tsiyinu's households are fully satisfied with their water services.** The community is connected to a mains supply constructed with funding from Danida. Households access the supply via three standpipes conveniently situated within the settlement. All three focus groups interviewed described the flow rate as good. Respondents said they did not have to queue and that they only spent a maximum of five minutes at the tap. A middle-aged respondent from the adult group noted: *"you could even put food on the fire and go to the tap side and return without [the food] getting burnt, because it takes no time for the container to fill."*

**Residents also enjoy reliable year-round access, except occasionally** when the pipeline gets blocked by tree roots along the supply pathway from the source in the nearby mountains. When this happens, it usually takes a maximum of three days to restore supplies.

**With households paying a flat monthly levy of GH¢2,<sup>23</sup> they also find the service very affordable.** Households pay this amount regardless of their varied sizes. This is intended to address the unbudgeted usage associated with various social events that take place in households – e.g. funerals, outdooing and marriage ceremonies – which tend to use much water. The levy is used by the local water committee to finance repairs as well as to support various communal projects such as the construction of a library structure with support from Adanu, a non-governmental organisation (NGO).

**The focus groups were also fully content with the quality of their water,** which they described as "colourless" and *"better than Voltic [bottled mineral water]"* – which some of the researchers had carried to the community for their personal use. They opined that if the researchers drank their water, they would not want to revert to the Voltic brand.

**Citizens cope with the downtime in supplies by resorting to an alternative traditional source, the Tsawe river, about forty minutes' walk away.** Unsurprisingly, some of the individuals interviewed reported getting stomach upsets when they drink from that water source.

#### 4.1.5 TOILET SERVICES

**Apart from the single KVIP<sup>24</sup> structure intended for students of the basic school, there are no toilets in Tsiyinu.** The youths related that they rely on the bushes, covering up their excrement after relieving themselves. Some in the older cohorts said they use the school KVIP. Children under five generally use chamber pots, with the contents emptied onto the communal refuse dump. Older children use either the bushes or the KVIP. Cleaning of the KVIP facility is shared between the students (who do the routine cleaning) and the community – who organise communal labour occasionally to weed around the structure.

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<sup>23</sup> About 50 US cents

<sup>24</sup> Kumasi Ventilated Improved Pit [latrine]

#### 4.1.6 COPING STRATEGIES

People explore a range of unorthodox healthcare options when they are unable to access or afford formal consultation and treatment. To treat malaria, some rely on herbal infusions brewed from fresh leaves harvested from neem (*azadirachta indica*) and guava (*psidium guajava*) trees or from roots dug up from acacia trees. Prayer is another avenue explored by the sick. These options are employed not only because residents perceive them to be credible cures but even more because they find the costs of orthodox medication and the related transportation costs (to other communities with chemist shops) prohibitive. For clients without NHIS subscriptions, consultation costs were said to range typically between GH¢15 and GH¢20.<sup>25</sup> Two-way transport costs to Asikuma and Juapong (the nearest communities with reliable drugstores) are a further GH¢6 and GH¢10 respectively,<sup>26</sup> whereas the herbal alternatives are often free and available right within the community. As the youth explained, “*herbs cost us virtually nothing as we just obtain them from the [surrounding] bush*”.

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<sup>25</sup> About US\$3.50-4.70

<sup>26</sup> About US\$1.40 and US\$2.30 respectively



## 5. Experiences of citizens at Tsatee

In addition to the CHPS compound in their community, residents of Tsatee also access healthcare services at a number of larger facilities in nearby towns. Dependence on herbal concoctions and spiritual services (including buying “holy water”) are also common, influenced mainly by a general lack of medicines at the CHPS facility.

### 5.1 SCORECARD RESULTS, TSATEE

TABLE 5.1: SUMMARY OF SCORECARD RESULTS, TSATEE

Indicator	Age 15-29	Age 30-49	Age 50+
<b>UNIVERSAL ACCESSIBILITY</b>			
Geographical accessibility of PHC services	5	5	5
Respect accorded clients by service provider	5	5	5
Promptness of service	4	5	5
Availability of medicines	2	1	2
<b>FULL COMMUNITY PARTICIPATION</b>			
Community involvement in siting facility	5	5	5
Community involvement in health promotion	5	5	5
Community involvement in disease prevention	5	5	4
<b>AFFORDABILITY OF TREATMENT</b>			
Affordability of consultations	2	1	2
Affordability of medicines	4	5	4
<b>WATER SERVICE DELIVERY</b>			
Availability of water	3	5	5
Affordability of water	4	5	4
Accessibility of water	1	1	2
Quality of water	3	5	5
<b>TOILET SERVICES</b>			
Availability of household toilets			

#### 5.1.1 UNIVERSAL ACCESSIBILITY

All three groups interviewed were fully satisfied with the geographical accessibility of their CHPS facility. Even from the farthest house, it only takes about fifteen minutes to get to the facility on foot. In the words of a youth: “even a cripple (sic) could arrive at the facility within a short period of time”.

Participants in the Tsatee focus groups also noted that they are treated sensitively and with civility by the facility staff. Unlike the situation at Obenemase, youths at Tsatee see their nurses as sincere carers who do not make them feel inferior when they call at the facility with health issues. Participants described their nurses entertaining women who go to the facility to deliver, in an effort to lighten their anxieties. Some of the over-50s spoke fondly of how some nurses who have been posted to other stations occasionally come back just to visit.

**The nurses were also reported to arrive punctually at work and to be brisk when attending to patients.** An elderly woman described a time when she hurt herself on her farm and called the phone of a health worker who arrived promptly to carry her to the facility for treatment. Another said, “*if we were permitted to give a score greater than 5, we would have [awarded that]; even at night, they are quick to [respond] and provide care.*” When there is no pressure at the facility, it only takes about ten minutes to be attended to. However, it can take over half an hour when the nurses are occupied with cases that need more attention, particularly with elderly patients.



*A member for the Community Scorecards Assessment team engages a focus group in a discussion at Tsatee Community; March 2017*

**As with most of the other sites, participants were unhappy with the poor medicine situation at their facility.** Too often, they found prescribed medicines to have run out. Even basic medicines like analgesics and anti-malarial treatments are often unavailable at the facility, compelling patients to travel to other communities to purchase their supplies. This they found troubling, as the roads around Tsatee are rough and very dusty. For some elderly, the concern was mainly about the non-availability of anti-hypertensive drugs (which cost them around GH¢30 for a month’s supply).<sup>27</sup> In all three focus groups, participants also complained about the lack of anti-snake serums and observed that lives had been lost as a result of snake bites.

### 5.1.2 FULL COMMUNITY PARTICIPATION

**Only at Tsatee were all three focus groups united in their satisfaction with their involvement in siting the health facility.** A community gathering had been properly advertised and facilitated inclusively for the purpose. Unsuitable options (such as a location in a flood-prone depression and another that was assessed to be deficient on accessibility) were rejected during the discussion. The land for the construction was donated by the local Presbyterian church as a gift to the community. **Tsatee demonstrates the value of communal decision-making.** While it is, of course, possible for a suitable site to be identified through non-inclusive processes (as in

<sup>27</sup> About US\$6.80

several of the sites visited), the evidence suggests that **there is greater overall satisfaction and fuller cooperation when such decisions are made inclusively.**

**The health volunteers were, likewise, chosen by the community through a transparent forum.** Their primary role has been to assist during immunisation efforts, educating the community on child nutrition and personal hygiene (including good hand-washing routines), promoting the use of bed-nets to minimise the incidence of malaria, and supporting the staff of the health facility during regular post-natal clinics. Through their persistence, most homes now have an improvised technology (the “tippy-tap”) for hand-washing after visiting the toilet.<sup>28</sup> Participants in the FGDs told of how the volunteers had advised them to clear bushy areas around their homes as a measure to control the breeding of mosquitoes, as well as to avoid eating cold meals to minimise the risk of contracting cholera. Two of the five volunteers were reported to demonstrate a passion for the work they do, even though it is purely voluntary.<sup>29</sup> This contrasts with the situation at Tsiyinu, where all volunteers quit when they realised that there was no compensation attached to the position. Tsatee was also the only site where the selection process was assessed to be fully transparent. **While it did not fully rule out the chances of insincere candidates slipping through the net, the openness of the selection process did improve the odds of identifying truly dedicated volunteers, with very positive outcomes.**



*Community member excitedly operates the “tippy tap” to wash her hands in Tsatee community; March 2017.*

### 5.1.3 AFFORDABILITY OF TREATMENT

**All three cohorts complained about the cost of maintaining their NHIS subscriptions.** They noted that the process often entails several journeys to Kpeve (the District capital, located about 30 minutes’ drive away). The reason they are often compelled to make multiple trips is because of poor internet connectivity, creating delays and long queues at the biometric registration centre. With each member of the

<sup>28</sup> The “tippy-tap” is promoted by UNICEF ([https://www.unicef.org/ghana/media\\_9677.html](https://www.unicef.org/ghana/media_9677.html)) and was first introduced to the community by the District Chief Executive (DCE).

<sup>29</sup> The other three abandoned the position because there is no allowance attached to it.



household having to pay GH¢18 for the return journey to Kpeve,<sup>30</sup> participants observed that the cost quickly adds up.

**On the cost of medications, the key complaint for those with health insurance policies was the additional expenditure and discomfort they endure because they have to travel on very bad roads to procure drugs from Boso and Peki.** Further, some with NHIS subscriptions said they were still asked to pay GH¢9 or GH¢28 for amoxicillin and amoxiclav respectively to treat respiratory infections.<sup>31</sup> For those without active NHIS subscriptions, malaria treatment can cost about GH¢25-30.<sup>32</sup> Those who cannot afford such costs (or who find the journey to other towns challenging) opt for herbs, which are widely accessible. Participants mentioned treating malaria and other ailments with various leaves, roots and barks (e.g. of acacia and teak trees), concocted with peelings from pineapples.

**The free maternal care policy continues to be interpreted and applied unevenly,** with some women asserting that it costs the uninsured GH¢130 to deliver at the CHPS facility.<sup>33</sup> How much of that cost is made up of items not directly available to the facility is unclear, as the cost was not explained to the mothers involved.

#### 5.1.4 WATER SERVICE DELIVERY

**Residents of Tsatee now obtain their drinking water supplies primarily from a borehole some 25-40 minutes' walk from the community.** On top of this is an additional waiting time of close to an hour at the pump, which often causes children to be late for school. A more centrally located solar-powered borehole has broken down, leaving residents to rely on the one on the outskirts of the settlement. All groups perceived the distance they have to travel to get water to be excessive. Even though participants acknowledged that the borehole is reliable (as a year-round source of water), they noted that the journey to the facility is along a dusty feeder road, which causes dust to settle on the water, affecting its suitability for drinking. Due to these disincentives, some households simply rely on an alternative source – the Loglovu stream which runs by the community. However, virtually all households revert to using the borehole in the dry season when the stream dries up.

Participants perceived the price of water to be largely affordable – at GH¢0.10 for a so-called “*Kufuor gallon*” with a capacity of approximately 20-25 litres. However, some with large households said they feel the pinch. Teachers and nurses are exempted from paying, in appreciation for the services they render to the community.

**Perceptions of the quality of the water vary greatly and are partly based on myth.** While the older cohort felt that water from the borehole was perfect for drinking, the youngest group complained that the borehole is never treated and found the taste to be salty. They preferred the stream water for drinking, perceiving the stream water to have healing properties bestowed by the river god. They also complained that water from the borehole is hard, undermining its suitability for laundry. An elderly

<sup>30</sup> About US\$4.20

<sup>31</sup> About US\$2.10 and US\$6.60 respectively

<sup>32</sup> About US\$6-6.80

<sup>33</sup> About US\$30

woman was excited that rice cooked with water from the borehole ends up with a yellowish tint, which she found attractive. Whether this is attributable to a high iron content or to the film of dust which settles on the water as it is transported by head along the dusty feeder road or to some other contaminant is unclear and has not been investigated by the community.

#### 5.1.5 TOILET SERVICES

**As with all the other communities visited for this assessment, Tsatee has very few household toilets.** Indeed, apart from the chief and the assemblyman, no other household appears to have a private toilet facility. A public water closet facility constructed in 2013 still cannot be operated because of the lack of running water. An old communal pit latrine is now largely dysfunctional and the majority of the inhabitants of the community use nearby bushes as a place of convenience. Occasionally, people have been bitten by scorpions and snakes while using the bushes, with some fatalities. Children either use chamber pots or the bare ground, after which the excreta is collected in polythene bags and disposed of at the communal refuse dump. With few choices available to them, some citizens now use the KVIP<sup>34</sup> toilets at the community's basic schools (primary and JHS<sup>35</sup>) when they think nobody is watching.

#### 5.1.6 COPING STRATEGIES

As noted above, various herbal remedies are employed by those unable to finance the cost of orthodox healthcare (including insurance cover and transportation to towns with drugstores). However, hardly any of these treatments have been tested or licensed by the Food and Drugs Authority (FDA).

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<sup>34</sup> Kumasi Ventilated Improved Pit

<sup>35</sup> Junior High School

## 6. Synthesis of findings

### 6.1 UNIVERSAL ACCESSIBILITY

Residents of the communities assessed appreciate the fact that CHPS seeks to bring healthcare closer to their doorsteps. However, there are several areas in which planning processes and service delivery fall short of their expectations.

There are several factors which influence patronage of local healthcare facilities and determine citizens' healthcare choices. When frontline care workers treat patients with sensitivity and act with urgency, clients feel encouraged to continue to participate in the on-site services offered – e.g. ante-natal and post-natal clinics, assisted deliveries (where available) and treatment. By contrast, when clients feel disrespected and emotionally abused (e.g. at Obenemase), or when prescribed medicines are routinely unavailable at the facility, clients tend to opt for alternative solutions such as unproven herbal concoctions, self-medication, short-dosing, spiritual interventions (including “*holy water*”) and seeking help from drugstores and “*foot pharmacists*” – who are often willing to dispense all kinds of medicine without proper diagnosis or prescription.

There are issues with staffing efficiency (with staff numbers exceeding outpatient flows) at some facilities. This has the potential of undermining the sustainability of the CHPS concept. In some situations (such as Patriensa), it is clear that the existing labour resource could be applied more efficiently – for example by increasing attention to public education services, which are sorely needed (see Section 6.3). Such an arrangement would entail a more deliberate shift in priority away from facility-based care to taking vital preventive services (such as hygiene and sanitation education, together with sustained environmental inspections) into the community.

Citizens' expectations regarding the availability of medicines are not always realistic – when assessed against the typically low outpatient numbers. However, treatments for the most basic and most routine illnesses (e.g. malaria) ought to be more readily available, considering the tendency for patients to opt for unsafe alternatives when they cannot easily access the medicines prescribed by their formal healthcare providers.

Additionally, citizens deserve much better education on the health insurance policy, both to moderate their expectations as well as to facilitate their right to refunds when they are compelled to pay for prescribed medicines that are on the NHIS “Medicines List”.

### 6.2 FULL COMMUNITY PARTICIPATION

The community health worker (CHW) concept is increasingly becoming a key pillar in Ghana's drive towards universal health coverage. As community representatives, CHWs are supposed to be selected from within their CHPS zones through open and transparent arrangements, to support the formal health service in delivering health

education and promotion services through regular visits to households.<sup>36</sup> It must, thus, be a source of concern that, across the communities visited, citizens interviewed had no knowledge of how CHWs and other volunteers had been selected or, often, even if any existed. The assessment found that CHWs are instead being selected at the district level, without proper consultation, and households are certainly not receiving the expected health promotion visits. Unsurprisingly, community involvement in health promotion and disease prevention were consistently among the lowest scoring indicators. By contrast, in the average savannah community where CHWs are operating, they are very well known (having been selected through open processes) and their services are highly appreciated (owing to their diligence, visibility and effectiveness – particularly in collaborating with the local health facilities to address malnutrition, malaria and diarrhoea cases).

### 6.3 AFFORDABILITY OF TREATMENT

Most clients have only a limited understanding of their entitlements under the terms of their contract with NHIA. As a result, they are mostly unaware of what reimbursements they are entitled to, and many pay twice for the same service – through the premiums and again at the point of purchase. This injustice – which many experience in poor communities – completely undermines the social protection basis of the NHIS. Closely related to this (and citizens' reluctance to renew their NHIS subscriptions) are the challenges in the rollout of the biometric registration arrangement, which significantly increase the real cost of subscription.

The anomalous situation in which a facility is staffed at one level – say a Level B (health centre) while officially classified as a Level A (CHPS) (as is the case at Patriensa) – creates needless confusion for clients and breeds mistrust for health service providers. While equipping a CHPS facility with a Physician Assistant may provide patients in provincial settlements with access to more competent staff, it is problematic as the facility cannot then claim reimbursements for medicines dispensed outside the medicines list for Level A.

On the affordability of care (more broadly – along with prospects for sustaining an effective NHIS at low cost), it is important to appreciate more proactively that this will remain a challenge for as long as the disease burden is high. The assessment suggests that the disease burden is, in turn, affected by a myriad of factors such as:

- \* poor sanitation behaviours;
- \* lack of healthful toilet facilities;
- \* pollution of aquifers by very unsafe artisanal mining practices;
- \* reverting to uncapped wells, surface water sources and other easily contaminated supplies when there are long queues at public standpipes or when borehole facilities break down;
- \* delayed reporting of diseases;
- \* self-medication, short-dosing on their prescriptions, and the continued dependence on the likes of “Auntie Yaa”<sup>37</sup> – with their unproven herbal

<sup>36</sup> Key areas which CHWs are expected cover under that agenda include environmental sanitation, immunisation, family planning, ante-natal care (ANC), exclusive breastfeeding and nutrition.

<sup>37</sup> Ref Section 2.1.6

concoctions typically advertised as panaceas for some very diverse medleys of ailments.

Yet citizens in the communities visited remain largely oblivious to the adverse health implications of their hygiene practices and health-seeking behaviours. For example, poor hygiene (including the persistent failure to wash hands with soap after visiting the toilet) is known to be a major contributor to preventable diseases. The abuse of heavy metals such as mercury and arsenic in small-scale mining has been reported by WRI<sup>38</sup> and other scientists to pose serious threats not only to local groundwater resources but also the fish and food crops sold in Ghanaian markets. Too many citizens also appear to believe that water is safe simply because it is colourless or because the source has been treated with alum – when all the alum does is merely to force the suspended particulates to settle to the bottom. For many diseases, early reporting and referral can make a big difference to a patient's treatment outcomes and yet, it is still routine for patients to first try all manner of unorthodox remedies before finally reporting at a formal healthcare facility. When potent antibiotics such as amoxiclav are bought and used recklessly without prescription because patients are unhappy with their care providers or with the NHIS, it fuels antibiotic resistance in the population. Only an insignificant proportion of herbal remedies are certified, and the long-term effects on the liver and other organs must be a matter of concern for sector practitioners and advocates. However, the Food and Drugs Authority seems to have turned a blind eye to the production, widespread advertisement and indiscriminate sale of such products. Clearly, better public education will be needed to address these largely ignored priorities.

#### 6.4 WATER SERVICE DELIVERY

Instituting a systematic regime of inexpensive quarterly water testing (and treatment, when necessary), along with proper public education on water hygiene, would be a worthwhile effort. This could be guided by Community Water and Sanitation Agency (CWSA) in collaboration with the Ghana Water Company Limited (GWCL).

#### 6.5 TOILET SERVICES

Despite the high incidence of diarrhoea and dysentery reported by the health facilities visited, nowhere did the research team find any evidence of an active and effective promotion of the concept of community-led total sanitation (CLTS). Neither was it evident that citizens realised the importance of good handwashing routines or appreciated what such practices entail. These observations are somewhat surprising, given the relatively large number of CHWs and outreach staff at the typical CHPS facility visited. While the staff are largely working to ensure better health for citizens, significant gaps remain in the effectiveness of the public education effort.

#### 6.6 COPING STRATEGIES

In all four communities sampled, the study reveals a heavy reliance on herbal remedies – either as alternatives or as supplements to modern medication. Reasons vary, but poverty, illiteracy and inappropriate attitudes of healthcare workers all contribute to the high level of dependence on herbs. This makes it imperative for

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<sup>38</sup> Water Resources Institute



greater attention to be paid to monitoring and regulating the quality and distribution of herbal medicines on the market. For now, there are too many herbal “remedies” being bandied about (on the streets and in the media) without proper regulation by the relevant state agency, the Food and Drugs Authority (FDA).

## 6.7 RECOMMENDATIONS AND NEXT STEPS

Following the facilitated engagements between citizens and their District Health Administrations and other service providers, ARHR and its partners should assist their stakeholder communities to monitor the commitments made by duty bearers. Specific priorities agreed at the engagement meetings are itemised below:

### *Recommendations for MoH, GHS and DHAs:*

- Ensure that healthcare workers honour the Patients Charter by treating clients with dignity and sensitivity. Related to this, invest more proactively in educating citizens on the contents of the Charter.
- Address inefficient staffing allocations at some CHPS facilities, in the interest of sustainability.
- Improve harmonisation between how a healthcare facility is classified and the calibre of staff allocated to the facility.
- Ensure that treatments for the most basic and most routine illnesses (e.g. malaria) are more readily available at all NHIA-accredited facilities.

### *Recommendations for NHIA:*

- Invest in educating citizens effectively on the health insurance contract and the rights of policyholders.
- Set ceilings defining how long it should take for a client’s NHIS application to be processed once they log in at the relevant NHIA office.

### *Recommendations for FDA:*

- Enforce regulations on herbal medicine, especially the indiscriminate advertisement and sale of unlicensed products.

### *Recommendations for YEA:*

- Collaborate closely with GHS to ensure that, in future, CHWs are selected through open and transparent processes at the community level.

### *Recommendations for District Assemblies (DAs):*

- Work with civil society to actively promote appropriate CLTS solutions.
- Couple CLTS effort with sustained environmental inspections and enforcement of sanitation bylaws.

### *Recommendations for ARHR/ civil society:*

- Going forward, prioritise effective public education, in collaboration with the outreach services of CHPS facilities to address hygiene practices and ensure greater attention to the kind of health literacy gaps identified in Section 6.3.
- Collaborate with the DHAs, DAs and traditional authorities (TAs) to promote appropriate CLTS strategies.

## Annex 1: Community profiles

### Patriensa

Patriensa is one of 26 settlements in the Asante Akim Central Municipality and about 10 minutes' drive from the district capital, Konongo-Odumasi. Projecting from the 2010 population census with an estimated annual growth rate of 3%, Patriensa currently has a population in the region of 7,400. The community is relatively poor, with livelihoods dominated by food-crop farming. Many of its young men and women are adversely incorporated into the local economy, eking out a living by engaging in illegal artisanal mining (typically referred to as "*galamsey*"). The community is served by a recently opened CHPS facility, with residential accommodation for the midwife, and offering a 24-hour service. Respiratory problems (including tuberculosis and asthma) are among the most common complaints reported to the health facility. Staff of the CHPS facility attributed the high incidence of such diseases to the unrelenting pollution of the atmosphere and aquifers arising from the unsafe methods applied across the illegal artisanal mining industry.

### Obenemase

The district estimates the population of Obenemase to be a little over 2,800. By public transport, Obenemase is about 20 minutes' drive from Konongo-Odumasi. From most parts of the settlement, it only takes about five minutes on foot to reach the health facility, which has nine health workers. As with other provincial settlements, a large section of Obenemase's citizens sustain themselves by farming food crops – mainly plantain and cassava – but also the cocoa cash crop. Many of its youth also participate in illegal ("*galamsey*") artisanal mining activities. Diarrhoea/dysentery and upper respiratory tract infections are among the topmost diseases that patients report to the CHPS.

### Tsiyinu

Tsiyinu is a small, mono-ethnic community in the South Dayi District. The current population of the community is projected at 300 by the district assembly. Poverty is rife among its citizens and the overwhelming majority of its homes are built of mud. Livelihoods are dominated by food crop farming (for men) and retailing of groceries (for women). A CHPS facility located in the community serves a wider catchment.

### Tsatee

The majority of Tsatee citizens are subsistence farmers. Poverty is rife in the settlement and many of its households barter their farm produce for other items at the local market. The community has a population of about 1,000 people. Roads into the community are in very poor condition. As a result, citizens often use the services of commercial motorbikes when they need to access services in nearby towns. The Tsatee CHPS facility, which is shared by several other communities, is staffed by a midwife and two community health nurses, which appears to be more efficient than at Patriensa.