PROJECTING CITIZENS' VOICES FOR HEALTH ACCOUNTABILITY

TRACKING MDGs 4&5
MDG4: Reduce child mortality
MDG5: Improve maternal health

Community Score Card Report 2014

Alliance for Reproductive Health Rights (ARHR)

The Alliance for Reproductive Health Rights (ARHR) is a Ghanaian NGO that promotes a rights-based approach and gender equity approaches to sexual and reproductive health.

The ARHR has a multi-tier structure comprising of 35 implementing NGOs, three zonal coordinating NGOs and a secretariat. The ARHR helps to protect the interests of Ghanaian people at regional, national and international levels through advocacy engagements, capacity-building and research to protect the rights of the poor, young and disadvantaged.

Consequently, ARHR engages in

- Building the capacity of members and other organizations by supporting, implementing, and monitoring projects with a rights-based approach to SRH;

- Monitoring the use of public funds and resources in the health sector as well as provisions to benefit the underprivileged, especially exemptions for the poor in the National Health Insurance Scheme;

- Promoting information and knowledge generation through:
  - Research: Conducting/commissioning research by/for the Alliance
  - Information dissemination: Monitoring and disseminating research findings

- Enabling an environment for SRH issues to be discussed by playing a lead role in the development of conferences and campaigns

- Exploring ways of encouraging members and NGOs/civil society to contribute to agenda setting for RH issues both at the national and international levels

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care/ clinic
ARH	Adolescent reproductive health
ARHR	Alliance for Reproductive Health Rights
CHN	Community health nurse
CHO	Community health officers
CHPS	Community Health and Planning Services
CSC	Community score card
CSO	Civil society organization
DHMT	District Health Management Team
DHOC	District Health Oversight Committee
FGD	Focus group discussion
FP	Family planning
GDP	Gross domestic product
GH¢	Ghana cedi
GoG	Government of Ghana
HIV	Human Immune-deficiency Virus
HRH	Human resources for health
IMM	Institutional maternal mortality
KEEA	Komenda-Edina-Eguafo-Abirem
MAF	Millennium Accelerated Framework
MCH	Maternal and child health
MDG	Millennium Development Goals
MoH	Ministry of Health
NDPC	National Development Planning Commission
NGO	Non-governmental organisation
NHIS	National Health Insurance Scheme
OPD	Outpatient department
PNC	Postnatal care
PRA	Participatory rural appraisal
RH	Reproductive health
SHP	School Health Programme
STD	Sexually transmitted diseases
TBA	Traditional birth attendants
WIFA	Women in fertile age

Executive Summary

Introduction

The Alliance for Reproductive Health Rights (ARHR) initiated participatory monitoring of Millennium Development Goals (MDGs 4&5) at the community level among the poor and vulnerable in 2007. This report is the fourth and final of the series conducted in four districts in the Central and Upper East regions, namely Agona East, Komenda-Edina-Eguafo-Abirem (KEEA) districts in the Central Region, and Bongo and Builsa districts. The report also provides a national context.

Purpose of the Report

The research findings are expected to provide useful lessons for enhancing engagement among actors in the health and related sectors and promote more responsive maternal and child health programming for the post-2015 development agenda.

Methodology

The study sought to examine the views, experiences and perceptions of ordinary citizens on the National Health Insurance Scheme (NHIS), maternal services, family planning and adolescent reproductive health care in four deprived districts, namely, Komenda-Edina–Eguafo-Abirem (KEEA) and Agona East in the Central Region, and Bongo and Bui1sa Districts in the Upper East Region. To these ends, the score card survey technique was adopted. The respondents included mothers and adolescent boys and girls who were involved in forty-eight (48) focus group discussions. Institutional and facility conditions were also examined.

The Functionality of NHIS

Generally,most mothers and adolescents had valid NHIS cards in the Upper East Region compared to the Central Region. Access to services without paying cash at the point of service and the affordability of the premium are the main factors that account for the attractiveness of NHIS. However, several challenges are associated with accessing services under NHIS. These include poor physical access (road and means of transport) to health facilities; long periods of time spent waiting at health facilities and for registering and renewing NHIS card, health facilities charging other fees for services that are thought to be

provided free of charge, unavailability of drugs and poor attitudes of some nurses to patients. Similar concerns were raised in the 2011 monitoring survey report. The main coping strategies adopted by the communities included delays in seeking care from the health facilities, seeking of care only when conditions worsened, and/or dependence on drug stores and herbal treatment.

Antenatal Care (ANC), Delivery and Post Natal Care (PNC)

Overall, quality of ANC was rated highly in both regions; however, survey respondents in Upper East reported better levels of satisfaction with ANC services than those in the Central Region. Moreover, the level of satisfaction with ANC in selected communities in the region varied less than in the Central Region. The quality of delivery care was rated lowest of all the maternal services. A major concern was the lack of prompt action expected from nurses when pregnant women arrived at the health facility for delivery.

Access to PNC was rated high in all communities, except two (Namanruwa and Takunsa). Physical access to health facilities and poor attitudes of nurses were ranked high among the conditions that affected the quality of maternal services in this round of tracking as in 2011. Inadequate human resources at the health facilities accounted largely for poor quality of service in the communities. Only one or two doctors worked in each district between 2011 and 2013, serving whole district populations. Agona East District did not even have a doctor. Moreover, some CHPS compounds that could have ensured shorter distances to health facilities in the communities lacked requisite resources (for instance drugs) needed to deliver even basic services.

Access to Family Planning Services and Abortion Care

Access to family planning services and abortion care was limited and varied greatly among the communities in both regions. Generally, the Upper East Region again reported better access to family planning services, while those in the Central Region reported greater access for abortion care. However, lack of free choice of family planning methods; negative attitudes of relatives and the wider community; and stigma affected access to the services in both regions.

Adolescent Reproductive Health Care

Access to Contraceptives

Overall, access to contraceptives among the adolescents was better in the Upper East survey communities than in the Central Region communities. Differences were observed between districts. For example, adolescents in KEEA District reported better access than those in Agona East. Lack of recognition of adolescents' reproductive health needs in the communities and poor attitude of some service providers were major factors that limited adolescents' access to contraceptives.

Access to Adolescent Counseling Services

Access to adolescent reproductive health counseling services at health facilities was very limited in all the communities, with some adolescents rating access to this service below 40 percent. Counseling was, however, available under the School Health Programme (SHP). Vast disparities in access existed among the communities, districts and the two regions. Upper East adolescents indicated better access to counseling than those in the Central Region.

Youth-friendliness of Services

Most of the adolescents felt that the services at the health facilities were not youth-friendly and attributed this to having to join the same queue with adults; unfavourable hours of operation (they fall within school hours); a seeming lack of seriousness towards the health needs of the youth, poor/hostile attitudes of service providers and wider community to adolescents who seek reproductive health services. Those in the Central Region expressed greater dissatisfaction with the services than their counterparts in the Upper East Region.

Ability to Negotiate Safer Sex, Access to Abortion Care and Contraception

The majority of adolescents gave a low rating to their ability to negotiate safer sex. The main reasons included the desire to keep a sexual partner who wanted to have unprotected sex; and the ability to charge higher fees (by the girls) or the requirement to pay higher charges (boys/partners). Levels of stigma related to abortion care and use of contraception were extremely high in almost all the communities and accounted for restricted access to the services. It was instructive that all the obstacles to adolescents' access to reproductive health care observed in the 2014 survey had been present in the 2011 exercises and subsequent studies.

Key Recommendations

1. A new understanding of the right to health service[or the right to SRH service?] is required, and this must go beyond just providing health facilities to include ensuring reliable and efficient transportation systems and infrastructure that connect communities with health facilities as well as providing adequate human resource for service delivery.
2. Human capacity building for improved service delivery should address nurses' and service providers' attitudes, while establishing incentives for good performance.
3. Strong civil society advocacy to promote effective service-provider–client relationships as a right should be accompanied with sensitization of patients to this end. This is in line with the post-MDGs rights-approach paradigm.
4. A new perspective of adolescent reproductive care should be based on adolescents' views and definition of youth friendliness: including separating adolescent service points from that of adults and providing adolescent services beyond school hours.
5. Tackling poverty in deprived communities should be a priority for reducing poor adolescent girls' tendency to have sex, including unprotected sex, to meet their material needs.

1.0 Introduction

1.1 Background

The eight Millennium Development Goals (MDGs) set at the 2000 United Nations summit have guided the human development activities of countries worldwide over the past decade and a half. The health implications of these goals and, particularly sexual and reproductive health issues, have ranked high on the international agenda on human development over the period. Civil society, non-governmental organizations (NGOs) and other advocates have contributed to ensuring that these issues remain central to human development activities of less developed countries (UNDP 2010).

In the pursuit of its human development goals, Ghana has adopted several health policies and implemented programmes in response to its commitments. Apart from the MDGs, key commitments include the Abuja Declaration that requires governments to allocate adequate resources (15 percent of their national budget) to health; and the Every Woman Every Child (EWEC) initiative that seeks to address funding, quality and coverage of implementation of health programmes, health system, and accountability issues. However, Ghana has not made sufficient progress towards achieving the MDG 4 (reducing child mortality) and MDG 5 (improving maternal health) nor in the implementation of these commitments. Increases in antenatal care attendance and rise in skilled deliveries coverage resulting from the free maternal care policy introduced in 2003 have been the greatest achievements so far.

In spite of the introduction of NHIS to improve access to health services, particularly for the poor, bottlenecks have plagued its implementation as well as other health programmes and policies. Except for two years (2005 and 2007), budget allocation to the health sector has been less than 15 percent of the total national budget despite various governments' commitment to the Abuja Declaration (Burke and Sridha, 2013). Again, more than 50 percent of Ghana's health budget is spent on salaries. Access to skilled delivery is still limited among the poor though they are entitled to free maternity care. Even though NHIS has yielded some good results, registration has been poor [%?]. Inefficiencies in the health system, including the management of the NHIS as well as associated corruption, costs the health sector highly and contributes to poor service

delivery and the lack of progress in improving mothers' and children's health. Poor data and monitoring of health system administration are also major challenges to improving health service delivery in Ghana. A review of the various Ghana Demographic and Health Surveys (GDHS) indicates that there is a strong correlation between poverty, socio-economic and geographic factors (physical access) and availability and access to basic health services.

Since 2007, ARHR has been supported by Cordaid to implement the Citizens' Action and Health MDGs (CAH-MDGs) project. ARHR has conducted surveys and produced three reports on perspectives of ordinary citizens in selected deprived areas on maternal and child health services and outcomes with respect to Ghana's progress towards achieving MDGs 4 and 5. The objective has been to document the progress made towards attainment of the goals. The 2007 and 2009 round of surveys focused on maternal and child health, sanitation, potable water, communicable diseases and the role of non-medical factors associated with health outcomes for the poor. The third survey round addressed a set of priorities that were not examined in the previous two rounds ─ service satisfaction and access to the National Health Insurance Scheme (ARHR, 2011).

This report is the fourth and final of the series of surveys. It is on the findings of the views, experiences and perceptions of ordinary citizens in selected deprived areas on access to sexual and reproductive health services in the four study districts in Central and Upper East regions. It also provides a review of national level context and trends of health indicators in the districts.

1.2 Ghana's Progress towards Achieving the MDGs

Ghana has been committed to the implementation of the MDGs since 2001 when, as part of the 189 member states of the UN that endorsed the MDGs, it began to monitor the activities and programmes that aimed at achieving the goals. As part of these efforts, the country mainstreamed the MDGs into its key public policy and strategy documents, namely, the Ghana Poverty Reduction Strategy (GPRS) I, GPRS II and the Ghana Shared Growth and Development Agenda (GSGDA) I that have been successively implemented and set for planning, monitoring and evaluation of the MDGs. Ghana also recorded the progress towards attainment of the MDGs in Annual Progress Reports (APR) on these

medium-term development frameworks. In addition, special MDG reports have been prepared on biennial basis since 2002 to examine the trends, the supporting environment and the resource needs for their achieving the MDGs (Republic of Ghana and United Nations Development Programme, 2015)

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According to the 2015 report, Ghana has largely achieved Goal 1 (eradication of extreme poverty and hunger), Goal 2 (achieve universal primary education), Goal 4 (reduce child mortality) and Goal 8 (develop a global partnership for development). The country has also made significant progress towards achieving Goal 6 (combat HIV/AIDS, malaria and other diseases) but has not achieved Goal 5 (improve maternal health) and Goal 7 (ensure environmental sustainability) and Goal 3 (promote gender equality and empower women).

Goal 4: Reduce Child Mortality by two thirds

The under-five mortality rate declined from the 1990 level of 122 per 1,000 live births to 82 per 1,000 live births in 2012, while infant mortality dropped marginally from 57 per 1,000 live births in 1994 to 53 per 1,000 live births during the same period and declined but fell short of the MDG target. The indicators show that still a large percentage (14 percent in 2013) of children have not had vaccination against measles by their first birthday, and poverty accounts for high child mortality rates in Ghana. For example, in 2012, households in the lowest wealth quintile reported an estimated under-five mortality ratio of 106 deaths per 1,000 live births compared to 52 deaths per 1,000 live births recorded for those in the highest wealth quintile. Likewise, households in the lowest wealth quintile reported a far higher infant mortality rate (61 deaths per 1,000 live births) than those in the highest wealth quintile (38 deaths per 1,000 live births) (Republic of Ghana and United Nations Development Programme, 2015: 40- 41). Poverty is associated with malaria risk and other infectious diseases that are major causes of death among children in Ghana.

Some of the main factors that contribute to the achievements in Goal 4 are implementation of a Child Health Policy and Health Strategy, sustaining of the Expanded Programme on Immunization (EPI), increased use on insecticide-treated nets (ITN) and improved malaria case management in health facilities, increased access to health services under the National Health Insurance Scheme (NHIS) and increased number of

Community Health Planning Services (CHPS). The key challenges that hinder improving child health are indicated in the report as lack of adequate resources to support the EPI and a limited number of well-motivated health personnel with appropriate skills. Such factors account for low quality of service. Others include lack of adequate national data that can provide complete and reliable information on children. Socioeconomic and socio-cultural factors such as low female literacy rates and empowerment contribute to sub-optimal outcomes regarding access to health services and health-seeking behaviour. These challenges also account for the inability of Ghana to reduce by two-thirds the under-five mortality rate between 1990 and 2015.

Goal 5: Reduce Maternal Mortality by Three Quarters

Ghana could not achieve MDG5 by reducing by three quarters the maternal mortality ratio between 1990 and 2015. The maternal mortality ratio (MMR) has always been estimated from institutional and non-institutional sources, with the latter source providing higher estimates. According to the 2015 report on the MDGs, the institutional ratio fell from 216 maternal deaths per 100,000 live births in 1990 to 144 per 100,000 live births in 2014 short of the global target of 54 per 100,000 live births in 2015 (Republic of Ghana and United Nations Development Programme, 2015: 10).

A number of interventions implemented to reduce maternal deaths in Ghana include free maternal health services, including delivery, and a comprehensive antenatal clinic programme linked to Child Welfare Clinics. Under these initiatives, midwives have been given training in safe motherhood skills, lactation management, abortion care, among others. In addition, an initiative known as MDG Accelerated Framework has been implemented purposely to boost the steps taken to reduce maternal death in the country towards achievement of MDG5. The implementation of Emergency Obstetric and Neonatal Care (EmONC) in all the ten regions of Ghana also aimed at reducing preventable maternal death risks in the country.

Notwithstanding these initiatives and programmes, MMR remains high in Ghana despite the efforts made, especially during the MDGs era, to tackle maternal deaths from various angles. According to the 2015 MDG report, the major causes on maternal death are preventable: haemorrhage, hypertensive diseases, sepsis infections and unsafe abortions;

and they account for 65 percent of maternal deaths. The report also indicates that supervised delivery that involves skilled birth attendants (SBA) can reduce complications and sepsis and thereby reduce risk of maternal death. But deliveries attended by skilled birth attendants are low among rural women especially who constitute the highest proportion of women in their reproductive years. Thus inadequate deployment of skilled health workers and other resources such as ambulance services remain key obstacles to reducing maternal death in Ghana. In addition to these, an ineffective referral system nationwide is compounded by a poor transportation system.

Like many other developing countries, Ghana faces the unfinished task of achieving the MDGs as it enters the Sustainable Development Goals (SDGs) era. The findings in this 2015 MDG report suggest that the impediments to improving maternal and child health are multi-dimensional and so must be any programmes and efforts that seek to address them in the SDGs era.

1.3 Purpose of the Report

The findings of the present research are expected to be used to enhance engagement among a number of actors in the health and related sectors and to serve as an alternative, credible evidence-based civil society organization (CSO) report on SRH trends and gaps in Ghana. Particularly, this research contributes insights into the lack of system response to issues raised over the past years. Eventually, the findings are expected to facilitate more responsive maternal and child health programming for the post-2015 development agenda.

1.4 Methodology

1.4.1 The Study Areas

Two districts each out of the 17 and 13 districts in the Central and Upper East regions respectively were selected for the study. The districts were the Agona East and Komenda-Edina-Eguafo-Abirem (KEEA) districts in the Central Region, and Bongo and Bui1sa districts in the Upper East Region. The selected communities from the districts include Mansofo, Naman wura and Otablikwa (Agona East District), Abina, Bando and Dompoase (Komenda-Edina-Eguafo-Abirem District), Kukuan, Ayobia, Daliga (Bongo District) and Balansa, Takunsa and Farinsa (Builsa District). The regions and districts are

some of the poorest in the country with low levels of income and limited access to health facilities. They were, therefore, purposively selected for the 2011 and 2014 monitoring studies and for tracking MDGs 4 and 5.

1.4.2 The Research Technique: The Score Card Approach

The main research technique used for the study was the score card approach. It is basically a research technique for investigating the quality of service from the viewpoint of clients so that informed decisions on the service and the outcome(s) can be based on input from communities that use the service. The score card is a tool for achieving grassroots participation in assessing service quality and monitoring of services through participatory rural appraisal (PRA) methods such as focus group discussion (FGD), with scoring and probing of scores and reasons behind the perceptions, and experiences with the service (Department of Planning, Ministry of Health, 2004). The score card approach was chosen instead of relying on focus group discussions alone because the approach provides opportunity for clients to score satisfaction and experience with services quantitatively and agree on levels through consensus building by means of FGD. To a very large extent, the score card approach makes it possible for both participants and researchers to reduce subjectivity as the scores are supported by reasons. These quantitative and objectivity elements of the score card cannot be achieved by means of the FGD approach alone. Further, monitoring and evaluation of satisfaction and experience with services or the service quality can be done over time based on the scores, and objectively too.

The answers of the clients were validated with service providers at validation workshops that were attended by selected participants from all the districts. Validation is the interface stage of the score card approach. The service providers at the workshop either confirmed the scores or contested them, and gave reasons. The validation workshop also served as a platform or forum for meaningful interaction between the clients and the service providers to discuss concerns and expectations from both sides.

1.4.3 Implementation of the Score Card Survey in the Communities

The survey was conducted in twelve (12) communities in the four selected districts in July 2014. Two groups were designated for the score card survey - mothers and adolescents (boys and girls). Different sets of questionnaires were administered to each

group, even though some of the areas of enquiry were similar (See Appendix 2). In every community one focus group for mothers and two separate adolescent groups (boys and girls) were set up to ensure participation of each group of respondents. Each focus group was made up of five to eight members to ensure adequate participation of all group members. For the adolescents, representatives from each of the two FGDs were selected to form a consolidated group (boys and girls mixed) that provided consolidated scores for the communities. In all, twelve (12) focus groups of mothers, twelve (12) focus groups of boys, twelve (12) girls focus groups and twelve (12) consolidated (boys and girls) focus groups (totaling 48 focus groups) were surveyed. The facilitator ensured that no group member(s) dominated the discussions and participants who seemed passive were encouraged to be actively involved. Pseudonyms are used to ensure confidentiality.

1.4.4 Method of Analysis

By the score card approach, data analysis begins right from the focus group discussion sessions. The group members were asked to give a score for the quality of the service or facility based on their experiences and satisfaction with them or their perception or opinion about them. A common score is reached through discussion or consensus building by all the group members with moderation by the interviewers. Reasons are given for each score and the final score is arrived at by a collective agreement or consensus among the group members. Scores must be consistent with the reasons or explanations provided. The whole exercise is about rating satisfaction or experiences with services and service providers.

The literacy status of participants guided the method used for the scoring. In this study, the scoring was done among illiterate women by showing visuals or objects that represented different levels of satisfaction or quality, or nature of services or conditions of particular indicators investigated. (See Appendix 1 for various ways of scoring.). Different types of faces as depicted in Appendix 1 were shown to participants for rating their level of satisfaction with the different types of services under investigation. Different sizes of stones representing different levels of quality or satisfaction were also shown to the mothers who had very low literacy status for the same purpose**.** The different types of faces and sizes of stones were equated to values on a Likert scale and translated into percentage points (0-100) for uniformity of analysis as well as easy

understanding for the reader**.** The adolescents, on the other hand, did the scoring by percentage points as their literacy levels were higher and because they were familiar with the percentage concept. Where scores were 100 percent, it meant the service or situation in question was found to be excellent and did not require any improvement or they were entirely satisfied with it. As the report indicates, these were rare cases.

The adolescents filled out a questionnaire on their sexual and reproductive health (SRH) behavior before each focus group discussion started. (See Appendix 2 for the questionnaire).

At the end of the survey when further data analysis was completed, a validation workshop was organized in all the four districts to ascertain the validity of the scores and findings. The District Health Management Team, local leaders, chiefs, teachers, among others, were invited to the validation workshops.

1.5 Structure of the report

The report is organized under six sections. Section one provides a brief background to the study and also outlines the methodology adopted for the study. The second and third sections are respectively on NHIS and maternal healthcare services. The fourth section covers access to family planning and abortion services. Adolescent reproductive health care is in section five. Section six provides the conclusion and key policy recommendations.

2.0 Functionality of NHIS

2.1 Introduction

The National Health Insurance Scheme is a pro-poor policy that seeks to improve financial access to health delivery in Ghana. When introduced in 2003, it formed part of Ghana's Poverty Reduction Strategy (GPRS). The present study investigated the provision of health services under NHIS with respect to registration of clients, issuing of NHIS cards, renewal of cards, and health care delivery at health facilities.

2.2 Satisfaction with the Functioning of NHIS

The level of satisfaction with the implementation of the NHIS (obtaining ID cards and accessing services) varied considerably within and among the districts. Nine (9) out of the twelve (12) communities' reported their experiences with NHIS as good, very good and excellent (70 percent and above), while two reported experiences as average (50 percent) and one indicated the functioning of the scheme as below average (40 percent). The scores ranged from 40 percent in Namanwura in Agona East District to 90 percent in Dompoase in KEEA District, both in the Central Region, and from 50 percent in Kunkuan to 90 percent in Ayopia, both in Bongo District in the Upper East Region, as can be seen from Table 2.1.

Table 2.1: Functionality of the NHIS, Community Consolidated Scores

	CENTRAL REGION						UPPER EAST REGION					
District	**KEEA**			**AGONA EAST**			**BONGO**			**BUILSA**		
Community / **INDICATOR**	Abina	Bando	Dompoase	Mansofo	Namanwura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Functionality of the NHIS	50	70	90	80	40	80	90	70	50	70	85	80

Source: Field work, July 2014

2.3 Satisfaction with NHIS

The various scores or rating of the services delivered under NHIS indicated that levels of satisfaction with the services were high, moderate and low. The reasons given by mothers for high levels of satisfaction in the communities include relatively affordable premiums,

access to health facilities for services even when one has no money (but holds the NHIS card) and provision of some medicines.

2.4 Challenges Affecting Functionality of NHIS

Feedback from the respondents suggest that the effective utilization and satisfaction with NHIS resources is inhibited when clients are required to make expenditures at health facilities apart from the NHIS premium. Mothers felt such payments defeated the purpose of NHIS and were illegal because receipts were not given in some cases. The poor attitude of some health care workers and delays in registration and renewal of NHIS cards (due to breakdown of biometric registration machines or for other reasons) were also major challenges that were reported.

In both regions, most mothers also complained about long periods of time spent at the health facilities to receive health services. They had to join long queues at the out-patient department (OPD). The average time spent waiting to see a doctor at the Bongo District Hospital, for example, was estimated at 60 minutes. On the average, another 60 minutes was required to collect medicines and 45 minutes to receive laboratory services. However, the average waiting time spent to receive services at clinics, health centres and Community-based Health Planning and Services (CHPS) compounds was shorter, ranging from five (5) to twenty (20) minutes.

The unavailability of drugs at the health facilities was one of the major concerns associated with the rating of the functionality of NHIS**.** Peculiar situations in various districts were also reported. For example, mothers in the Upper East Region observed that services offered under NHIS should not have excluded drugs for snake and dog bites because they were more common in the region.

Compared to KEEA where facilities are closer to the communities and the conditions of the roads are quite good (mothers walk for 10 to 45 minutes to nearest health facility), Agona East and Builsa districts have very poor road networks and vehicles are unavailable on the roads most of the time. These are major obstacles to accessing of health facilities. A mother in Mansofo (Agona East) observed:

"The distance from the community to the health center (Duakwa) is far and we spend huge transport fares getting to the facility. Sometimes cars are not easily available so we have to walk to Mensakrom before we can get a car to Duakwa and this gives us a lot of inconvenience." Regina, Mansofo

Mothers in Kukuan (Builsa District) walked 10 kilometres to the nearest CHPS compound, 20 kilometres to a health centre and 30 kilometres to Bongo District Hospital (when referred). In addition to the poor road network, high fares and poor conditions of the roads in the rainy season altogether made it difficult for patients to access health facilities. Unfortunately, mothers were unable to use a nearby private hospital because the facility did not accept NHIS cards and they found the charges unaffordable. All these obstacles have had adverse effects on the quality of the services accessed under NHIS**.** Various challenges noted at the focus group discussions are presented in Box 2.1.

Box 2.1: Accessing Services under the NHIS: Some Negative Experiences

"The distance to the health facility is too long and the road to the facility is bad. We can't walk to the facility when we are in labour". Matura, Tankunsa

"We have to walk to the clinic when we are in labour or for ANC. It is difficult to walk to the clinic. There are not enough nurses and midwives to attend to us. Sometimes, however, the nurses give us their phone numbers to call when labour starts".
Abiba, Farinsa

"Although we do not spend money when we go to the clinic, my major concern is with the road to the clinic. It is muddy, and since we walk to the clinic, it is a major worry". Mamaa, Balansa

*"Sometimes you go early in the morning and have to stay there up to 6pm before you are registered."*Abena, Agona East

*"Even though you have the NHIS card you are still made to pay for some expenses or drugs. At Elmina urban clinic, they first ask whether you brought money or not ...."*Akosua, 23 years, Abina

2.5 Proportion with a Valid NHIS Card

Concerns shared by women regarding the seemingly long long period of time it takes to register for an NHIS card determined their registration status and whether they had valid

cards to access services or not. A large proportion of both mothers and adolescents did not have valid NHIS cards (Table 2.2). Overall, the highest proportions of both mothers and adolescents with valid NHIS card are recorded in the Upper East Region. Among the mothers, half or more of those surveyed in the Upper East Region had valid cards compared to only two communities in the Central Region (Abina in the KEEA District and Otablikwa in Agona East District).

Table 2.2 Proportion of Respondents with Valid NHIS Cards

Region	District	Community	Group					
			Adolescents			Mothers		
			No. of participants in FGD	No. in FGD with a valid NHIS card	Proportion in FGD with a valid NHIS card (%)	No. of participants in FGD	No. in FGD with a valid NHIS card	Proportion in FGD with a valid NHIS card (%)
Central	**KEEA**	Bando	8	2	**25.0**	8	3	**37.5**
		Abina	8	5	**62.5**	8	6	**75.0**
		Dompoase	8	1	**12.5**	8	1	**12.5**
	Agona East	Otablikwa	8	3	**37.5**	8	4	**50.0**
		Mansofo	8	3	**37.5**	8	2	**25.0**
		Namanwura	8	3	**37.5**	8	3	**37.5**
Upper East	**Bongo**	Ayopia	8	3	**37.5**	8	7	**87.5**
		Kunkuan	7	5	**71.4**	8	4	**50.0**
		Daliga	8	4	**50.0**	8	6	**75.0**
	Builsa	Balansa	8	3	**37.5**	7	5	**71.4**
		Farinsa	7	5	**71.4**	8	7	**87.5**
		Takunsa	8	7	**87.5**	8	5	**62.5**

Source: Field work, July 2014

Among the adolescents, however, Ayopia (Bongo District) and Balansa (Builsa District), both in the Upper East Region and all three communities in the Agona East district, reported low percentages (37.5 percent) with valid cards. Adolescents in Bando (25 percent) and Dompoase (12.5 percent) in the Central Region recorded even lower percentages. The low proportions with valid NHIS cards may be explained by difficulty

in accessing the registration offices. Means of transportation is also limited in most of the deprived communities. It may be necessary for the NHIS officials to have set times for NHIS registration in consultation with the community members.

Generally, the NHIS was found to be affordable in the communities and better than the cash-and-carry health system, even though delays in the issuing and renewing of cards as well as long waiting periods at health facilities are major setbacks associated with NHIS services. Its functionality is rated higher in both Upper East Region than in the Central Region.

2.6 Coping with the Challenges associated with the NHIS

Since the respondents said they found NHIS useful, the survey attempted to establish how respondents coped with the challenges associated with the scheme. The mothers tried to arrive at the health facilities early to avoid joining long queues. When a visit or follow-up was planned, mothers in Kukuan, for example, set off by 5am on foot. The health care workers also took some measures to manage the long waiting time at the health facilities. At the Bongo District Hospital, priority was given to mothers with infants and pregnant women.

The most common means of transportation to health facilities in communities with poor physical access was by foot, bicycles and motorbikes. In the Upper East Region, motorbikes were preferred to bicycles for transporting women in labour, especially at night. Mothers in Agona East sometimes "chartered" taxis when faced with emergencies although this was considered expensive. A form of transport, popularly known as the "motor-king" (the trio-cycle) has become more common, especially in northern Ghana. This mode of transport has advantages such as being able to carry four or more people in its cabin; however, it was not available in all communities, and not at all times. It was reported in the Bongo District that the Ghana Health Service (GHS) has motor-kings designated in each sub-district for referral cases. Some local government authorities are also providing some support to communities. The contribution of an assembly man in this regard was noted by a resident:

"… he always carries the expectant mothers (with their husbands sitting behind) from the communities to the District Hospital late in the night across rivers in the rainy season. When they get to the river, the two men will get down whiles the

woman remains seated on the motor and they will push it across before they continue with the ride, Sometimes he could go twice in a day". (James, Ayopia)

In Namanwura and Otablikwa (Agona East), the men occasionally filled the potholes on the roads leading to the health facility at Duakwa to reduce the stress and delays mothers faced when travelling there.

Mothers with expired NHIS cards made every effort to have them renewed by going to the NHIS office on several occasions until they had their cards renewed. One mother reported that when she was pregnant, she spent three days and three nights at the Bongo NHIS office to ensure that her card is renewed, knowing that she was going to need it for delivery services. Others who had to wait for their cards avoided going for services unless their situation became critical. Some rely on provisional cards from the NHIS office to access health care. Still others depended on drug stores and herbalists and other local means of treatment such as the "nim" tree, bark of trees, pawpaw leaves and pineapple skin peelings to treat malaria. They used these local means of treatment as alternative medication or supplement to the prescribed medicine from health facilities and drug stores.

Some mothers, particularly in the most deprived communities such as Otablikwa and Namanwura in Agona East, relied on the services of community health nurses (CHNs) who visited the communities from time to time. Some mothers also relied on traditional birth attendants (TBAs); but in some cases, pregnant women had to pay for services at the health facilities when referred by a TBA., mothers Mothers with expired NHIS cards indicated that they relied on community health nurses who visited their communities. Others noted that they were familiar with the diseases they often suffered from and were able to treat them so they just avoided health facilities altogether.

2.7 Tracking the Functionality of NHIS

2.7.1 Availability of Drugs

In the 2011 survey round, a major concern raised by respondents in some communities in the Agona East district was their inability to obtain prescribed drugs from health facilities. As such, many patients relied on other sources outside the health facilities for drugs. This had consequences for additional expenditure and led to the use of traditional

medicine by some persons. Similar concerns are raised in this 2014 study. In addition, mothers in the Upper East Region noted that while snake bites are common in the region, drugs required for its treatment are mostly unavailable at the health facilities. Availability of drugs is a major factor affecting functionality of the NHIS in both regions.

The poor attitude of nurses and charging of fees at the health facilities on top of the NHIS has also persisted from the 2011 study to the present one. Even though the premium is considered affordable in the majority of the communities, additional charges at the facilities and the need to purchase some medication outside the health facility make the subscription to the NHIS costly to the communities.

2.7.2 Financial Transparency

The 2011 study raised concerns of financial transparency in health facilities. In Kissi, Duotu, and Seth Okai, for example, NHIS subscribers indicated that they were not provided with adequate information about payments and charges. Some subscribers felt they were charged for certain services they should have received free of charge. In Besease, subscribers reported that "weighing cards" were illegally sold to nursing mothers. In addition, there were complaints of extortion of monies from patients.

Matters relating to financial transparency are not as prominent in the 2014 study as they were in the 2011 study. But there were some other concerns. In Bando and Agona East districts, it was reported that persons classified as "rich" do not go through any difficulty during registration since they pay bribes to NHIS personnel. Some participants reported that they incurred additional expenditure from accessing health services. This is expected since the scheme does not cover all diseases in Ghana.

2.7.3 Service delivery

While service delivery was a challenge in some communities, it was an area in which other communities reported excellent performance inboth 2011 and 2014 studies. In the 2011 study the major concerns about service delivery included long periods of waiting at health facilities for service; poor attitude of nurses (young ones); inequities in the serving of clients because itwas not on a "first-come first-served" basis; as well as delays experienced in registration and renewal of NHIS cards. All these concerns were reported again in the 2014 study.

2.7.4 Coping Strategies

As indicated in the 2011 study, the present study also points out that community members purchase medicines at "drug stores" and use local herbs as the major alternatives to dealing with challenges in the provision of NHIS services. Some mothers depended on community health nurses in place of services provided at health facilities.

3.0 Access of Mothers to ANC, Supervised Delivery and PNC

3.1 Introduction

Generally, mothers were closer to the health workers when they receive maternity services -- ANC, supervised delivery and PNC services. Their expectations about these services and the reality determined how they scored the services.

3.2 Access to Antenatal Care Services

Differences in the mothers' experiences with ANC can be observed in Table 3.1. Overall, the selected communities in the Upper East Region reported better quality of service delivery than those in the Central Region as depicted by the scores. Moreover, the level of satisfaction with ANC in the Upper East Region communities varies less within the region than in the Central Region (Table 3.1). Five out of the six participating communities in Upper East rated ANC services as excellent: All three participating communities in Bongo District, for example, considered the ANC in their district as excellent and needs no improvement, rating them as 100 percent. Two communities in Builsa also found ANC services excellent, with scores of 90 percent and 85 percent. In the Central Region, on the other hand, only one community in Agona East District rated their ANC as excellent, with 100 percent, which was followed by a score of 60 percent in that district.

Table 3.1: Access to Antenatal Care Services

	CENTRAL REGION						UPPER EAST REGION					
District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to antenatal care services	70	60	50	100	60	40	100	100	100	90	30	85

Source: Field work: July 2014

Experiences with accessing ANC in the communities are mixed (See Box 3.1). While some mothers reported good behaviour on the part of the nurses, others have experiences to the contrary. The conditions at the facilities are great concern to the mothers.

Box 3.1: Experiences with Accessing ANC

Health workers sometimes rain insults on us; they complain that we are giving birth too much." Mama, Agona East District

The rude attitude of the midwife prevented some of us from taking maternal health care services at the Nsaba Health Center. Now that she had been transferred, we are happy and we shall be visiting the Nsaba Health Center for maternal care services." Akua, Agona East District

"The nurses treat us well, advise us on malaria prevention and other aspects of pregnancy. They tell us to eat meat, milk, and eggs if our blood level is low. We don't pay money for ANC. But the nurses advise us to save money for baby dresses and soap before and after delivery". Mara, Farinsa, Builsa District

"The washrooms are very dirty, and I am afraid I will come to the facility and take home a disease. The chairs there too do not make a pregnant woman comfortable. [The pregnant women like benches on which they can lie down and rest while waiting for ANC services.]" Radiya, Balansa, Builsa District

"There are problems with the facility. The maternity ward has an odour and that is not good. We prefer benches to chairs that are presently provided. [The pregnant women like benches on which they can lie down and rest while waiting for ANC services.] *There aren't enough health workers as compared to other places. Some of the nurses are too harsh".* Asana, Tankunsa, Builsa District

Furthermore, those who access ANC services at Bando (KEEA) CHPS zone noted that the health workers are always demanding money from the pregnant women. The attitude of the health workers at the CHPS compounds was also described as inhumane. However, the midwives in both KEEA and Agona East districts were singled out for what was described as their relentless efforts in ensuring that pregnant womens received antenatal care services. Respondents in the Central Region also faced challenges including poor sanitation of the waiting area at the clinics (especially at Dompoase), inadequate signage to direct patients to health facilities, exposure to mosquitoes at the Elmina Urban Clinic, poorly resourced CHPS zones, compelling mothers to spend long travel times to other facilities outside the communities.

In Bongo and Builsa districts, where higher scores were recorded for ANC services, indicating excellent antenatal care, respondents described health care workers as caring and they give prompt attention to mothers. Such good attitude of health workers contribute to high satisfaction with the services and account for the high scores. The

score for Tankunsa is exceptionally low – 30 percent. The main challenges there include very poor road network from the community to the health facilities and inadequate resources at the health centers, including dirty environs, poor sitting provisions, and poor sanitation in the washrooms. The conditions affecting ANC in Tankunsa exist in other communities as can be seen from Box 3.1, but the degree to which they affect the community is higher and account for the very low level of satisfaction with ANC there.

3.3 Access to Supervised Delivery

The scores and reported experiences and opinions of mothers in all the four selected districts in both regions indicate that the quality of delivery care is the worst of all the maternal services. Conditions and challenges related to physical and financial access (transport fare) to the health facilities and attitude of the nurses were also ranked high. In Bongo, the mothers indicated that optimal antenatal and postnatal care is provided by the health care workers as they give prompt attention to patients, and respondents rated them at 100 percent. They, however, gave a score of 80 percent for delivery care.

There were vast differences in the experiences and opinions about the quality of access to supervised delivery between the regions and among the communities, as can be seen in Table 3.2. Two communities in the Central Region – Dompoase (KEEA) and Mansofo (Agona East) rated access to supervised delivery services as excellent. In three other communities in the Central Region and one in the Upper East Region, supervised delivery was rated as very good (80 percent). In the Upper East region, delivery services were rated far lower than in the Central Region and varied greatly among the communities. Ayopia in Bongo District reported the highest quality of delivery service, rated as 80 percent, and Kukuan (also in Bongo District) reported the lowest quality delivery service, rated as 10 percent. Further discussion with participants revealed that the difference in transportation and road network linking communities to health facilities was the major factor associated with the disparities in the rating of service quality among the communities in Bongo.

Table 3.2: Access to Supervised Delivery

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to supervised delivery	80	80	100	100	60	80	80	30	10	70	75	60

Source: Field Work: July 2014

In the Central Region, delivery service is accessed mostly from two facilities (Agona Clinic or Elmina Urban Clinic) and they are considered as the best in the districts. However, claims of extortion by the health workers, insults, impatience, and problems with mosquitoes at these facilities were also reported and supported by the following statements:

"They call us all kinds of names. Some even call us witches during labour when we are unable to push very well. Sometimes, I think it is better when you deliver at home because the TBAs pamper us during delivery. Kakra, Agona East District

"*We [expectant mothers] are asked to purchase items to be used during labour – Dettol* [disinfectant], *toilet soaps, toilet rolls, powder, pomade, etc., and when you forget any, you are forced to buy some at the clinic at exorbitant prices. This is not good at all."* Yaa, 28 years, Abina, KEEA District

"The facility has good infrastructure conducive for delivery, but there are lots of mosquitoes when you sleep overnight." Araba, 32 years, Bando, KEEA District

In Builsa, the mothers indicated that the majority of women in the district delivered in hospitals but some also depended on TBAs, because the number of nurses trained to assist in delivery was not enough. Negative attitudes of nurses and midwives were

uncommon in Builsa, but women in labour were left on their own by nurses, the mothers pointed out.

The mothers in Bongo reported that nurses mocked older pregnant women because nurses expected older women to have stopped bearing children. Respondents also complained about the large number of items required by the nurses to be brought by expectant mothers to the hospital when they came for delivery. Lack of beds at the CHPS compounds for pregnant women was also noted as a major concern in Bongo District. Another major concern was the lack of prompt action on the part of the nurses when pregnant women arrived at the health facility for delivery. The following statement is an example:

"Sometimes when you arrive at the health centres in labour, some of the nurses who are around don't pay prompt attention to you". Halia, Bongo.

3.4 Access to Postnatal Care

The scores given for PNC in all the communities ranged from 70 percent to 100 percent. The exceptions were in two communities, one each in Agona East District (Namaruwa) and Builsa District (Takunsa) whose scores were very low (Table 3.3). The low scores were explained mainly by poor service, limited physical access and poor relationships of the nurses with the mothers. In the Upper East Region also, the mothers indicated that the nurses were doing very well but the poor transport network and long distances to health facilities were constraints to accessing PNC.

Table 3.3 Access to Postnatal Care

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to post-natal care	100	90	100	100	60	100	100	90	100	95	10	70

Source: Field work: July 2014

3.5 Tracking Access of Mothers to ANC, Supervised Delivery and PNC

Uptake of antenatal care services appears to be improving in the monitoring districts as both the 2011 and 2014 reports indicates improvements in ANC completion.

On delivery care, findings from the 2014 study indicate that supervised delivery services in all selected communities in the Central Region (except Namanwura) and in one community in the Upper East Region (Ayopia) were rated excellent and very good just as in the 2011 round of tracking. Generally, delivery services compared to ANC and PNC have received the lowest rating at health facilities in all the four districts of both regions, however, the Upper East Region reported better services than the Central Region.

The results of the 2014 study indicated that, with the exception of two communities (Namanruwa and Takunsa), access to PNC was rated highly in the other selected communities. The substandard performance of these two communities was due to poor service delivery and limited and poor physical access to health facilities as well as unsatisfactory relationship of the nurses with the mothers. These conditions have persisted and was also documented in the 2011 study.

3.6 Tracking the Institutional Indicators for Maternity Care

The levels and trends of some key institutional indicators that contribute to the quality of services delivered in the study districts and the outcomes are discussed in this section.

3.6.1 Human Resource

Only one or two doctors were at post in three of the four districts between 2011 and 2014 (Table 3.4). KEEA had two doctors, while Bongo and Builsa had one each. There was no doctor in Agona East District between 2011 and 2014. The doctor-patient ratios in the districts in 2013 were 1:79,292, 1:87,625 and 1:60,057 in KEEA, Bongo and Builsa, respectively. The number of qualified midwives in the districts was also very low, considering the population sizes in the districts, ranging from 8 (eight) in Agona East to 29 in Bongo.. Even though there were other qualified nurses and community nurses in all the districts, access of mothers to maternal healthcare services can be negatively affected by the low number of midwives delivering services at the health facilities.

Overall, the human resource profile of the four districts has not changed. The number of qualified doctors in a district since 2008 (as indicated by the 2011 study) has been one or two. The number of midwives increased by only two to seven since the beginning of the

tracking studies in 2007 while that of other qualified nurses and community nurses remained steady (as in KEEA), increased (in Agona East and Bongo) or fluctuated (in Builsa).

Table 3.4: Human Resource Profile

Human Resource Profile: Agona East District

Indicator	Year		
	2011	2012	2013
Number of qualified doctors	-	-	-
Number of qualified midwives	9	9	8
Number of other qualified nurses	4	75	83
Number of community health nurses	36	43	44
Average daily OPD attendance			
District Population		91,330	94,161

Source: Agona East District Health Head Office, 2014

Human Resource Profile: KEEA District

Indicator	Year		
	2011	2012	2013
Number of qualified doctors		2	2
Number of qualified midwives		14	16
Number of other qualified nurses		88	88
Number of community health workers		16	16
Average daily OPD attendance		322	352
District Population		153,816	158,584

Source: KEEA District Health Head Office, 2014

Human Resource Profile: Bongo District

Indicator	Year			
	2011	2012	2013	2014
Number of qualified doctors		1	1	****
Number of qualified midwives		22	22	29
Number of other qualified nurses		69	71	115
Average daily OPD attendance		1.5	1.6	1.0
District Population		86,586	87,625	88,677

Source: Bongo District Health Head Office, 2014

Human Resource Profile: Builsa District

Indicator	Year		
	2011	2012	2013
Number of qualified doctors	1	1	1
Number of qualified medical assistants	4	4	3
Number of qualified midwives	7	9	10
Number of other qualified nurses	4	4	8
Number of community health nurses	39	42	24
District Population	58, 641	59,345	60,057

Source: Builsa District Health Head Office, 2014

3.6.2 Maternal Health Indicators

The number of pregnant women in 2011 and 2012 (and 2014 for Bongo only) was about the same in Agona East but declined in the rest of the districts (see Table 3.5). The proportion of women who made at least four (4) ANC visits increased in Agona East (49.7 percent in 2012 to 55.7 percent in 2013) but declined considerably in the three other districts (Table 3.5). Builsa recorded the greatest decline, from 95.0 percent in 2011 to 71.1 percent in 2013. The 2011 tracking report indicated fluctuations in the proportion of women who made at least four (4) ANC visits in three of the four districts from 2008 to 2010; in KEEA the increase in the proportion was sustained.

The percentage of deliveries with supervised care increased slightly in KEEA from 73.1 percent in 2012 to 76.7 percent in 2013, and at a higher rate in Builsa, from 75.4 percent to 81.6 percent within the same period. These changes indicate worsening trends in this indicator in the districts because the 2011 tracking results showed steady (KEEA and Builsa) and rapid (Agona and Bongo) increase in the proportion of deliveries with skilled attendant from 2008 to 2010. For example, the percentage increased from 52 percent in 2008 to 83 percent in 2010 in the Bongo district. In the Central Region, the ratio of midwife to the number of delivery with skill attendance at birth ratio worsened in Agona East (1:234 to 1:256) but improved in KEEA (1:172 to 1:132). There was both improvement in Builsa (1:183 to 1:143) and worsening in Bongo (1:114 to 1:167) in this indicator between 2011 and 2013 in the Upper East Region too.

Table 3.5: Maternal Health Indicators

Maternal Health Indicators: Agona East District

Indicator	Year		
	2011	2012	2013
No. of pregnant women		3,743	3,744
Number of pregnant women who made 4 ANC visits		1,863	2,086
Number who made 4 ANC visits as % of total pregnancies		49.7	55.7
Number of deliveries (whether attended or not)		-	-
Number of deliveries with a skilled attendant at birth		2,110	2,051
% of deliveries with a skilled attendant at birth		-	-
Midwife to the number of delivery with skill attendance at birth ratio		1:234	1:256
Number of women attending PNC		2,047	2,197
District Population		91,330	94,161

Source: Agona East District Health Head Office, 2014

Maternal Health Indicators: KEEA District

Indicator	Year		
	011	2012	2013
No. of pregnant women		4,850	4,572
Number of pregnant women who made 4 ANC visits		4,643	4,111
Number who made 4 ANC visits as % of total pregnancies		95.7	89.9
Number of deliveries (whether attended or not)		3,292	2,767
Number of deliveries with a skilled attendant at birth		2,406	2,121
% of deliveries with a skilled attendant at birth		73.1	76.7
Midwife to the number of delivery with skill attendance at birth ratio		1:172	1:132
Number of women attending PNC			
District Population		153,816	158,584

Source: KEEA District Health Head Office, 2014

Maternal Health Indicators: Bongo District

Indicator	Year			
	2011	2012	2013	2014
No. of pregnant women		2643	2697	1935
Number of pregnant women who made at least 4 ANC visits	-	2052	2015	1540
Number who made at least 4 ANC visits as % of total pregnancies	-			
Number of all deliveries (whether attended or not)	-	2538	2463	1953
Number of all deliveries with a skilled attendant at birth		-	-	-
% of deliveries with a skilled attendant at birth		-	-	-
Midwife to the number of delivery with skill attendance at birth ratio		1:114	1:111	1:167
District Population		86,586	87,625	88,677

Source: Bongo District Health Head Office, 2014

Maternal Health Indicators: Builsa District

Indicator	Year		
	2011	2012	2013
No. of pregnant women	1,547	1,524	1,465
Number of pregnant women who made 4 ANC visits	1,470	1,115	1,042
Number who made 4 ANC visits as % of total pregnancies	95.0	73.2	71.1
Number of deliveries with a skilled attendant at birth	1,282	1,322	1,422
% of deliveries with a skilled attendant at birth	75.4	76.8	81.6
Midwife to the number of delivery with skill attendance at birth ratio	1:183	1:147	1:142
District Population	58, 641	59,345	60,057

Source: Builsa District Health Head Office, 2014

3.6.3 Family Planning Indicators

The number of women using contraception and as a percentage of women in fertile age declined from 25.9 percent in 2012 to 20.4 percent in 2013 in Agona East but increased slightly in KEEA, from 37.4 percent to 38.2 percent during the same period. An improvement in this indicator in Bongo from 2012 (27.6 percent) to 2013 (34.8) was followed but a decline in 2014 (27.6 percent). Lack of improvement in this indicator signals worsening reproductive health status of the mothers.

Table 3.6: Family Planning Indicators

Family Planning Indicators: Agona East District

Indicator	Year		
	2011	2012	2013
Number of women in fertile age (WIFA)		22,924	23,634
Number using modern contraception		5,943	4,817
Number using contraceptives as % of WIFA		25.9	20.4
District Population		91,330	94,161

Source: Agona East District Health Head Office, 2014

Family Planning Indicators: KEEA District

Indicator	Year		
	2011	2012	2013
Number of women in fertile age (WIFA)		36,916	39,338
Number using modern contraception		13,794	15,038
Number using contraceptives as % of WIFA		37.4	38.2
District Population		153,816	158,584

Source: KEEA District Health Head Office, 2014

Family Planning Indicators: Bongo District

Indicator	Year			
	2011	2012	2013	2014
Number of women in fertile age (WIFA)		20175	20417	20662
Number using modern contraception		5563	7095	5732
Number using contraceptives as % of WIFA		27.6	34.8	27.7
District Population		86,586	87,625	88,677

Source: Bongo District Health Head Office, 2014

Family Planning Indicators: Builsa District

Indicator	Year		
	2011	2012	2013
Number of women in fertile age (WIFA)	13,663	13,827	13,993
Number using modern contraception	-	-	-
Number using contraceptives as % of WIFA	-	-	-
District Population	58, 641	59,345	60,057

Source: Builsa District Health Head Office, 2014

4.0 Access of Mothers to Family Planning and Abortion Care Services

4.1 Introduction

In Ghana, access to family planning services has been determined by several factors regarding the supply of and demand for the service. The major factors include how the service is delivered, physical and financial access to the service and contraceptive methods, as well as attitudes to and misconceptions and fears about contraceptives. Among sexually active females, husband/partner opposition has been a major barrier to contraception. Induced abortion has also been a sensitive issue in Ghanaian society and is highly stigmatized. In this study, the mothers scored access to family planning with respect to availability and the quality of the service.

4.2 Access of Mothers to Family Planning Services

It can be seen from Table 4.1 that access to the services varied in both regions, but generally, higher scores were recorded in the Upper East Region as compared to the Central Region. Lack of free choice of family planning methods and negative attitudes of relatives and the wider community were reported in all the communities as major barriers to accessing contraception. Mothers in Bongo District (Upper East Region) noted that some families (extended) still would not allow them to practice family planning. The extent to which these conditions existed in the selected communities and districts varied and may account for the differences in the scores as depicted in Table 4.1 below. It is instructive to note that no community rated the services as excellent or a total score of 100 percent.

Table 4.1: Access to Family Planning Services

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to family planning services	30	95	50	80	80	40	90	80	50	75	95	95

Source: Field work, July 2014

In the Upper East Region, apart from Kukuan (Bongo District), the scores were high, ranging from 75 percent to 95 percent in two communities (Takunsa and Farinsa in Builsa District). In Kukuan, access to the service was rated as average (50 percent)

The scores varied greatly in the Central Region. In KEEA district, women in Bando scored their access to and quality of family planning services very high (95 percent), while those in Abina and Otablikwa scored theirs as below average. The reasons given for the low level of satisfaction included the unfriendly nature of the facility, specifically the attitude of service providers, and the cost of the services that they explained were not affordable to them. In Agona East, on the other hand, the mothers explained that the health workers occasionally came to the communities to educate them, which ensured that a number of them were on one method or another. The different experiences with the family planning service in the Central Region are presented in Box 4.1.

Box 4.1: Experiences with Access to Family Planning in the Central Region

*"We have to walk to the next village (Mensakrom) before we can have access to some of the family planning commodities. There is no pharmacy in the community where we can buy even condoms."*Akosua, Mansofo,Agona East District

"The service is readily available for us when we call the nurse (CHO in charge), she is ready to come and provide us with the service. Usually, there is an announcement that, there will be a family planning service for free and the CHO is ready to remove it [insert clarification of what is removed] for them whenever they want to." Naana, Namanwura, Agona East District

"Every woman should be on the service [family planning]*, "but for the service some of us would have given birth to a thousand children".* Gloria, Namanwura

"*My mother did it* [family planning] *and she nearly died".* Nana Yaa, Abina, KEEA District

4.3 Abortion care

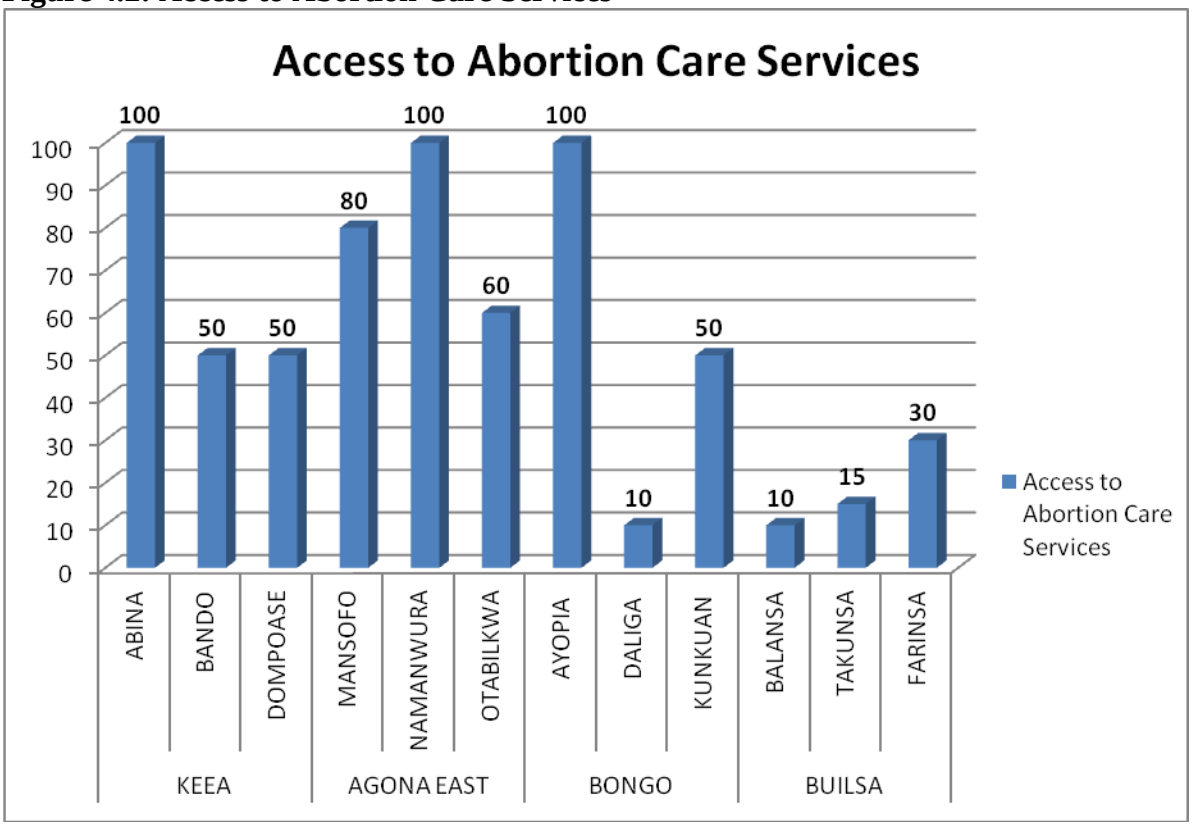
Vast differences in access to abortion care were observed among the communities, as can be seen from Table 4.2. The scores ranged from 10 percent in two communities in the Upper East Region (Daliga in Bongo District, and Balansa in Builsa District) to 100 percent in one community each in KEEA (Abina), Agona East (Namanwura) and Bongo

(Ayopia). By scoring access to abortion care as 100 percent in the communities, the women meant there were no hindrances to receiving abortion care at health facilities even though the family and wider society frowned upon the practice. Opposition to abortion care was demonstrated among the mothers at the FGDs too. A viewpoint of a mother in Agona East District is illustrative:

"We wish that if anyone commits [induced] abortion, the client should be left to die or the health staff should kill the client by giving her injection. This is because we are religious people and we don't want to have anything to do with abortion."

Victoria, Otablikwa,

Figure 4.2: Access to Abortion Care Services



Source: Field work, July 2014

Levels of access to abortion care in the Upper East Region were lower than in the Central Region. Mothers in the Upper East Region considered high levels of stigma and discrimination towards induced abortion as responsible for limited access to abortion care. The women explained that sometimes the health workers accepted and treated women seeking abortion care but the community did not accept the practice. The respondents noted that women who had induced abortion were disrespected and shunned

in the communities while those who had spontaneous abortions faced none of these problems.

The role of health workers in preventing mothers from abortion care was also acknowledged by the mothers: *"The doctors charge a huge amount of money to discourage people from committing abortion and only those who can afford it do it."* Yaa, Bando, KEEA

It was, however, reported at the FGDs that some nurses and doctors in the health facilities do assist mothers to terminate their pregnancies. As disclosed by a mother:

"I was charged GH¢300.00 [in 2010] for an abortion. The baby didn't die and the doctor refused to return my money" Marian, Abina, KEEA District

An experience reported by a young girl is probably an indication that adolescents probably attempted to receive abortion care in times past:

"I tried going for abortion when I was in school but the doctor told me to come along with one of my parents to sign some documents before it can be performed. Since I never wanted my parents to know about it, the abortion could not be done." Ama Bando, KEEA District

Family planning and abortion care are met with negative attitudes in the various communities. The health workers are reported to have different attitudes from those of the communities. Family opposition is a barrier to contraceptive use. Stigmatization of abortion also prevents mothers from accessing abortion care.

4.4 Tracking Access of Mothers to Family Planning and Abortion Care

Findings from the 2014 study indicated that lack of knowledge about the range of services available to women and their inability to make decisions about choices represent the major factors that hindered the patronage of family planning services just as was found among women in the 2011 study. But the high cost of family planning services, which was not reported in the 2011 study, was noted in the 2014 round.

Reasons given for the poor uptake of family planning included the unfriendly nature of the facility and the cost of services. Abortion care was highly stigmatized in all study communities and access to abortion services was also the lowest rated service in the communities. Although abortion care was stigmatized, the mothers recounted that health workers were sometimes willing to provide abortion care.

5.0 Adolescent Reproductive Health Care

5.1 Introduction

Ghanaian society frowns upon reproductive health care for adolescents. Against this background, this study examined the availability, delivery and accessibility of adolescent reproductive health care in the communities. Factors included access to contraceptives, abortion care, relevant information on reproductive health and counseling as well as friendliness of adolescent reproductive health services.

5.2 Access of Adolescents to Contraceptives

The aspects of access to contraceptives examined included ease of access, availability of specific types and the hindrances to accessing them. Higher scores indicated better access to contraceptives. Overall, adolescents in the selected communities in the Upper East Region reported better access to contraceptives than those in the Central Region (Table 5.1). Moreover, disparities in contraceptive access are lower in the Upper East Region compared to the Central Region. At the district level, adolescents in Agona East reported lower scores on access to contraceptives than any other district. But Bando community in KEEA District reported the least access (indicated by the lowest score of 10 percent).

Table 5.1 Access to Contraceptives among Adolescents

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to contraceptives	50	10	70	40	20	15	40	85	80	75	65	60

Source: Field work July 2014

The adolescents gave a number of reasons that limited their access to contraceptives including:

- Unfriendly nature of facility services to the youth, particularly poor attitude of service providers;

- Unavailability of drug or chemist stores in the communities where contraceptives can be purchased.
- Gender issues (boys compared to girls are "expected" by society to buy contraceptives and are also more capable of doing so) and
- General negative perceptions of wider society on contraception among adolescents.

The major challenges facing the youth regarding their access to contraceptives that were captured at the FGDs were mostly poor service provider behaviour and poor attitude on the part of community members (Box 5.1).

Box 5.1: Attitude of Service Providers and Community Members to Adolescents' Access to Contraceptives

"Some health workers refuse to give us condoms because they say we are young. But, we can get condoms from a "drug" store in Wiaga [another community]*."* Eric, Farinsa

"The workers in the hospital do a lot of gossiping when we try to get condoms." Adam, Tankunsa

"As for the health workers, they will receive you and give you treatment. But they will regard you as a "spoilt girl" and point at you in public to others. They will say, 'Look at the small girl who uses contraceptives'. They shout at you and make it difficult for you to go to them the next time." Peace, Farinsa

"Some health workers go to the extent of bringing information from the hospital about people's medical history when they get access to it or they work there, and they talk about them in the community." Eva, Dompoase

"The health workers do not give better care to any one they know may have ever aborted a pregnancy." Albert, Balansa

"When we [the boys] are seen buying the cds [condoms], we are perceived as womanizers. So we have to make arrangements to get them without being noticed. I call the 'drug' store attendant before going there, so when I get there, he gives it to me secretly." Ebow, Dompoase

"Contraceptives, such as condoms, are not easy to come by. You can become barren if something goes wrong with the use of the contraceptive. Even when you put on weight people think you are using contraceptives." Fatima, Balansa

"People in the community see you as "bad" if you go in for contraceptives." George, Farinsa

5.3 Stigma Related to Abortion Care and Contraception Among Adolescents

The adolescents in all the communities reported that stigmatization of abortion care from health facilities and contraception was very high. The scores recorded for the levels of stigma associated with them in nine (9) out of the twelve (12) communities were at least 80 percent. Fifty percent was recorded in two others (Table 5.2). It was only in Bando (KEEA) that the adolescents reported a low level of stigma (23 percent).

Issues of abortion and use of contraceptives are considered as immoral and those who access them are also regarded as antisocial in the communities, according to the adolescents. The adolescents further accused people who sell contraceptives (drug store keepers) or offer abortion care in their community (health care workers) as sources of gossip and finger-pointing to adolescents who access contraception or seek abortion care. They also pointed out that a health care worker who cares for a girl seeking post-abortion care after an unsuccessful abortion will give information to the community members about it and the girl will eventually be stigmatized.

Table 5.2: Level of Stigma Related to Contraceptive Use Among Adolescent and Abortion Care

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Level of stigma	90	25	50	80	80	100	85	50	100	90	95	80

Source: Field work, July 2014

As a result of the stigma associated with abortion care from health facilities and contraception among adolescents, they used crude methods to abort unwanted or unintended pregnancy. These included the use of all kinds of herbs and other types of substances. In Dompoase, for instance, the adolescents indicated that they performed induced abortion by drinking fermented palm wine mixed with sugar, a mixture of

paracetamol, *akpeteshie* (a local drink with very high alcohol content), and grounded glass bottles.

According to the adolescents, stigma regarding abortion is a little higher in the communities than that associated with contraceptive use by young people. This is because people who had abortions were frequently seen as murderers and shunned in society. All kinds of people, including the adolescents themselves, stigmatized young people who used contraceptives or sought abortions. The adolescents noted that the elderly humiliated them when they accessed contraceptives and abortions.

The adolescents in Farinsa noted that parents were insulted when their daughters were known to have performed abortions. The adolescents were in turn caned by their parents. Comments from the FGDs in Takunsa aptly described the experiences of the adolescents:

"Those who abort pregnancy are regarded as murderers. People may even avoid you if you are known to have committed abortion." Abiba, Tankunsa

"Girls who commit abortion are given names like murderers and prostitutes. Adolescents who talk about contraceptives are seen as "spoilt". Health workers scold those who come for abortion. Children seen buying condoms are insulted. Some parents advice their wards to stay away from those who use or buy condoms. Our peers also mock at us when they hear that you have gone to abort pregnancy." Habib, Tankunsa

5.4 Teenage Pregnancy

It was observed in all the communities that teenage pregnancy is common and placed the pregnant girl in a difficult situation, including financial problems and stigma. The scores indicated the level of such difficulty and were very high in all communities, except Bando, Daliga and Dompoase

Table 5.3: Problem of Teenage Pregnancy in the Communities

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Level of stigma	90	25	50	80	80	100	85	50	100	90	95	80

Source: Fieldwork, July 2014

The fate of teenage pregnant girls was described as deplorable. It was also noted that young men or youth who impregnated adolescents were often insulted to the extent that they absconded from the community, leaving the teenage girls behind. Meanwhile, health care workers also made derogatory remarks about pregnant teenagers and spoke to them harshly at the health facilities. Teenage pregnant girls were humiliated in their community too as they and their partners were considered as irresponsible. Consequently, the girls had to go through a lot of difficulties.

On the contrary, some adolescents in Farinsa pointed out that, teenage pregnant girls faced mixed reactions from women in their community. One of them noted:

"Some women will praise you for being pregnant and say that is what makes you a woman. Besides, you are more than 15 years. Others will make fun of you and your mother and say that she "sold" you to men for money." Charity, Farinsa

The adolescents identified a number of reasons teenage pregnancy was prevalent in their communities. The most cited factor was poverty, which, they noted, forced girls to depend on boys or men for their needs, including the purchase of sanitary pads. Lack of parental care and influence was also cited as contributing factors to teenage pregnancy. Parents are therefore blamed if their teenage daughters get pregnant.

5.5 Access to Relevant Information on Reproductive Health

The adolescents in the Upper East Region, with the exception of those in Ayopia, had better access to relevant information on reproductive health than those in the Central

Region as the scores in Table 5.4 show. Most of them received information on puberty, sex, menstruation and the menstrual cycle, abstinence, condom use, sexually transmitted diseases (STDs), among others, in school under the School Health Programme (SHP). On the other hand, they received very little information on reproductive health from home, as commented by one of the boys: *"Community members think you are "spoilt" when you ask or talk about sex."* Willie, Farinsa.

According to the adolescents, young people who seek information on reproductive health were regarded as prostitutes and people pointed at them in the community because they were considered too young and immature for reproductive health matters. Meanwhile, poor attitude of nurses was also a barrier to provision of relevant information from health facilities to adolescents. Therefore, they had limited access to relevant information on reproductive health, as the scores on Table 5.4 indicate.

Table 5.4 Access of Adolescents to Relevant Information on Reproductive Health

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to relevant information on reproductive health	50	10	70	40	20	15	40	85	80	75	65	60

Source: Field work, July 2014

5.6 Access to Adolescent Counseling Services

Access of adolescents to counseling services at health facilities was very limited or non-existent at the health facilities of the two study districts in the Central Region as depicted by the scores shown on Table 5.5. In Otablikwa (Agona East), the adolescents reported that counseling services were non-existent in the community and the adolescents gave a score of zero (0) to indicate that. The adolescents in the Upper East Region generally recorded higher scores, indicating a fairly good access to adolescent counselling from the health facilities and school. Counseling on reproductive health issues is also part of the

SHP. But it was pointed out that there is no specific place at the health facility for adolescent counseling.

Table 5.5: Access of Adolescents to Reproductive Health Counselling

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa
Access to adolescent counselling	10	20	6	40	10	0	80	90	60	90	60	65

Source: Field work July 2014

5.7 Youth-friendliness of Reproductive Services at Health Facilities

Lack of youth friendliness of health facilities, particularly delivery procedures have been a major obstacle to access of adolescents to reproductive health services. The concept "friendliness" investigated in the score card survey refers to the attitude of the service providers, facility design, and delivery procedures, including privacy.

The adolescents in the two regions generally felt that services in the health facilities are not youth-friendly. But the adolescents in the Upper East Region recorded higher scores, indicating higher levels of friendliness of services to the youth in that region compared to those in the Central Region. In the Central Region, Bando, Namawura, and Otablikwa recorded comparatively very low scores, 30, 20 and 0 percent, respectively. The other communities rated the friendliness of youth services close to average, scoring at least 45 percent.

Poor attitude of health workers towards the youth, and a seeming lack of seriousness towards the health needs of the youth were the main reasons given by the adolescents for unfriendliness of the services. Other major concerns raised by the adolescents are the hours of operation that fall within school hours. As noted, *"The facility closes early; around 2 pm. If we go to school, we will not come and meet them [the health workers]".* The adolescents' desire that health facilities should provide services to them when they

close from school and in designated areas since they feel shy to share facilities with the adults. It was pointed out, *"They [the health workers] treat us as if we are adults".*

5.8 Adolescent Reproductive Behaviour

Sexual coercion and abuse are major factors associated with the sexual experience of young sexually active persons in Ghana. The score card survey examined the ability of the adolescents to negotiate safe sex, that is, the autonomy to decide when, how, where and whom to have sex with. Age at first sexual intercourse, a major determinant of sexual health and behaviour, was also examined.

5.8.1 Ability to Negotiate Safe Sex

Generally, the adolescents' ability to negotiate safe sex is rated low as indicated by the low scores assigned to them in most of the communities. Adolescents in as many as seven communities in both regions, but mostly in the Central Region and Builsa District, assigned very low scores (10 to 30 percent) for their ability to negotiate safe sex. Those in Bongo District and in Agona East (Otablikwa) considered their ability as average or a little more than that. It was only adolescents in Abina (80 percent) who said they have a very high ability to negotiate safe sex.

Table 5.6 Ability to Negotiate Safe Sex

District	KEEA			AGONA EAST			BONGO			BUILSA		
Community / INDICATOR	Abina	Bando	Dompoase	Mansofo	Namawura	Otablikwa	Ayopia	Daliga	Kunkuan	Balansa	Takunsa	Farinsa

Source: Field work July 2014

There were differences in the boys' and girls' ability to negotiate safe sex (indicated by the scores). The girls' FGDs recorded lower scores than the boys in all the communities. Traditional gender relations require that girls be submissive and succumb to their male partners' sexual demands. It must, however, be noted that some of the girls created the impression that they do not negotiate safe sex due to financial constraints or fear of losing their boyfriends in the process. The girls in Mansofo noted: S*ometimes we are afraid to*

lose our boyfriends. We love them and we are unable to negotiate safe sex most of the time.

An adolescent boy in Bando also explained financial transactions that shed light on unsafe sexual relations among the girls:

"Some of the girls don't like condoms. Even those who want you to use it, when you give them little money they will allow you have sex with them without protection."

But the girls are also constrained by unpredictable behaviour of their sexual partners that compels them to decide not to negotiate safe sex:

"Some of our boyfriends tell us they will withdraw [coitus interruptus] *so we shouldn't worry. The sad thing is that they don't go by their words, therefore what do you achieve with negotiations if it wouldn't work?"* Abigail, Namawura

The boys in Balansa and Farinsa noted that the girls explain to them why they should use condoms and even give then money to buy some. According to the girls in Takunsa, some boys, however, tell girls that they can take care of them so they could have unprotected sex, and further entice them with money to do so even when the girls initiate the negotiation or do not like condom themselves. Other boys, they noted, negotiate condom use, knowing that they cannot take care of a girl.

5.8.2 Sexual experiences and contraception

A total of 180 adolescents in the two regions (12 communities in four districts) filled out a questionnaire on sexual experiences and contraception. Ninety-six (53.3%) were girls and 84 (46.7%) were boys. Just over a fifth (21%) were younger than 15 years.

5.8.3 Age at First Sex

Less than two-thirds (60.6 percent), that is, 109 out of 180, indicated that they have never had sex. Among those who have ever had sex, 38 percent (27 out of 71) had their first sex before 15 years, and the rest (62 percent) did so between 15 and 19 years. A higher percentage of the girls (39.5 percent) than the boys (35.7 percent) had their first sex before 15 years.

Table 5.8 Age at Sexual Debut

District	Community	Male		Female	
		10 -14	15 - 19	10 -14	15 - 19
Agona East	Mansofo	1	-	1	-
	Namawura	0	5	2	4
	Otablikwa	-	1	-	1
KEEA	Abina	1	5	-	3
	Bando	2	1	-	2
	Dompoase	2	4	4	4
Bongo	Ayopia	2	-	-	1
	Daliga	-	1	1	3
	Kunkuan	-	-	1	-
Builsa	Balansa	1	-	2	1
	Farinsa	1	1	-	1
	Takunsa	-	-	6	6
All		**10**	**18**	**17**	**26**
		35.7%	**64.3**	**39.5%**	**60.5%**

Source: Field Work June 2014

5.8.4 Contraception

Twenty-two out of the 180 (12.5%) adolescents first used contraceptives when they were between ages 15 and 19 years, while a tenth (18) of them did so between 10 and 14 years. A little more than two out of five (44%; 71 out of 180) of the adolescents who had ever had sex never used any contraceptive. In all, 21 out of the 180 (11.7%) of them have at least one child.

5.8.5 Number of Simultaneous Sexual Partners

For their past sexual encounters, one had had five simultaneous partners, two have had four, three have had three, while 29 (16.5%) have had one sexual partner. Two of the respondents currently had three sexual partners, while three had two partners. Fifty-one out of the 180 (28.3 percent) had a sexual partner and 15 respondents (8.5%) at the time of research did not have a sexual partner.

Table 5.9: Number of Current Simultaneous Sexual Partners

District	Community	Male			Female		
		1	2	3	1	2	3
Agona East	Mansofo	-	-	-	-	-	-
	Namawura	2	-	-	6	-	-
	Otablikwa	-	1	-	1	-	-
KEEA	Abina	2	-	1	3	-	-
	Bando	3	-	-	2	-	-
	Dompoase	3	1	1	7	-	-
Bongo	Ayopia	1	-	-	-	-	-
	Daliga	2	-	-	4	-	-
	Kunkuan	-	-	-	5	-	-
Builsa	Balansa	1	-	-	1	-	-
	Farinsa	-	1	-	-	-	-
	Takunsa	1	-	-	8	-	-

Source: Field Work June 2014

6.0 Key Policy Recommendations

The purpose of the study has been to provide credible evidence that can be used to enhance engagement with actors in the health and related sectors and provide input into the post-2015 development agenda. Therefore, the major concern for policy intervention and advocacy should be on how the MDGs and related indicators have changed over time and what factors are associated with the changes.

The results show different levels of improvement in some indicators and no improvement in other indicators. For instance, problems such as limited physical access to health facilities and drugs, low institutional indicators and poor attitude of health care workers and community members to patients have persisted. As Ghana transitions to the post-MDGs era, the following should be at the centre of policies that seek to improve health of mothers and adolescents in poor and vulnerable communities in line with the post-2015-human rights paradigm/approach (Berer, 2013; Sadik, 2013) :

1. A new understanding of the right to service must go beyond provision of health facility to include reliable and efficient transportation systems and infrastructure connecting communities with health facility as well as adequate human resource for service delivery. This will ensure vulnerable communities' right to health services. Particular attention should be given to Agona East and Builsa districts.
2. Human capacity building for improved service delivery must include addressing unprofessional attitude of health care workers and establishing incentives for good performance for nurses who have regard for professional delivery of services.
3. Sensitization of patients, particularly adolescents, to demand service provision under good nurse-client relationship. This should be an initiative that should be placed at the centre of health delivery with strong support from civil society advocacy groups such as ARHR in line with the post-MDGs rights-approach paradigm.
4. A new perspective of adolescent reproductive care should be based on adolescents' views and definition of youth friendliness as noted by the adolescents in this study: separating adolescent service points from that of adults

and providing more favourable hours of operation that extend beyond school hours for adolescents.

5. Tackling poverty in deprived communities should be a major drive towards reducing adolescent girls' vulnerability to having sex for financial gain, including having unprotected sex, which they resort to in order to gain a higher financial reward from sexual partners to meet their material needs.

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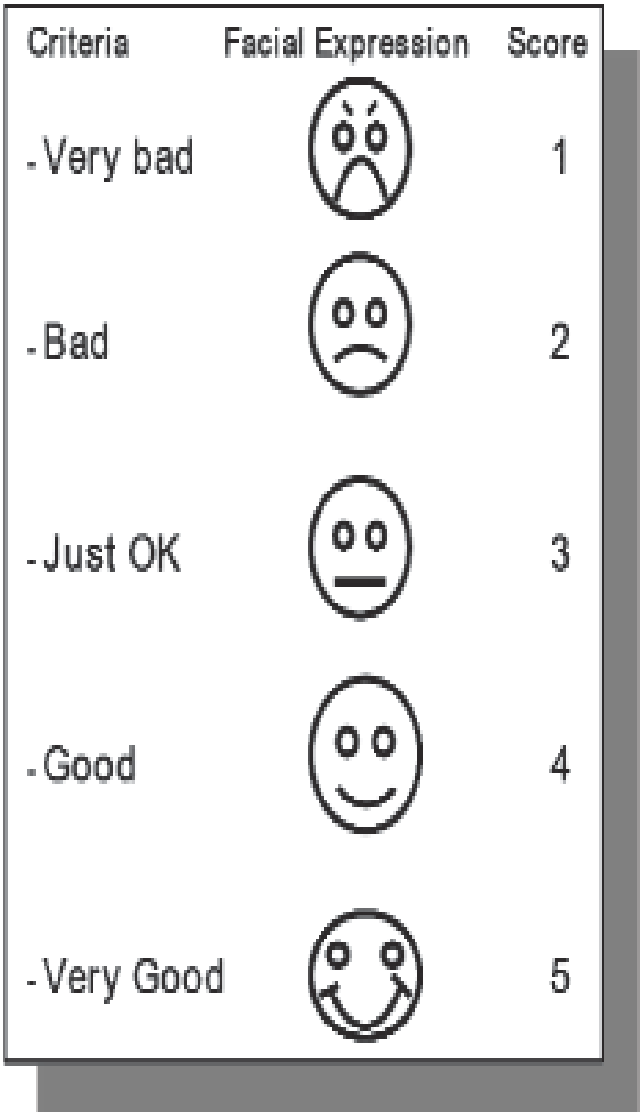
Appendix 1: The Score Card Survey Symbols

(Adapted from Social Development Notes, Participation and Civic Engagement (2004)

- **Using faces to show feelings**



Likert Scales

Examples - Scoring matrix:

Group name: …….. Date: ……... Village: ……..….. Catchment area: ……..

Indicator	Score					Reasons
	Very bad = 1	Bad = 2	Just okay = 3	Good = 4	Very good = 5	
Indicator 1 ……						
Indicator 2 ……						
Indicator 3 ……						

SCORING MATRIX (0 - 10)

Group name……..…….. Date…/…./20…. Village …… Catchment area……..

Indicator	*Score*					*Reasons*
	0 – 2 Very bad	*3 & 4 Bad*	*5 & 6 Just okay*	*7 & 8 Good*	*9 & 10 Very good*	
Indicator 1 ……						
Indicator 2 ……						
Indicator 3 ……						
Indicator 4 ……						
Indicator 5 ……						
Indicator 6 ……						

Appendix 2: Mother Focus Group - Guide Sheet

1. Investigate functionality of the NHIS

- Proportion enrolled
- Affordability of premiums
- Routine expenditures disallowed on NHIS
- Overall satisfaction with NHIS
- [other] challenges relating to NHIS
- Coping strategies employed when they cannot access formal care

2. Antenatal Care Services

- Service Access and Quality
    - Proximity
    - Money and related issues
    - Connecting infrastructure – e.g. roads and transportation issues
    - Hospital infrastructure and facilities – e.g. sitting area, washrooms, etc.
    - Attitude of health workers
    - Availability of health workers

3. Supervised Deliveries

- Service Access and Quality
    - Proximity
    - Money and related issues
    - Connecting infrastructure
    - Hospital infrastructure and facilities
    - Attitude of health workers
    - Availability of health workers

4. Post-natal Care

- Service Access and Quality
    - Proximity
    - Money and related issues
    - Connecting infrastructure
    - Hospital infrastructure and facilities
    - Attitude of health workers
    - Availability of health workers

5. Family Planning

- Service Access and Quality
    - User friendly facilities
    - Proximity
    - Money and related issues
    - Local perceptions
    - Facilities
    - Attitude of health workers
    - Availability of health workers

6. Abortion Care

- Service Access and Quality
    - User friendly services

- Proximity
- Money and related issues
- Local perceptions
- Facilities
- Attitude of health workers
- Availability of health workers

7. Alternative MHC Services

- Availability and use of TBAs
- Availability and use of Spiritual Healers

8. Male involvement in MHC

- Level of involvement of partners/husbands in MHC services
  - Family Planning
  - Contraceptive use
  - Abortion
  - Antenatal
  - Post-natal care
- Fertility and sex preferences

9. Immunization

- Coverage in community
- Immunization of own children

10. Suggestions related to the rights to services

- Knowledge on rights to services
- Exercising rights to services

11. Suggestions for improving health outcomes for mothers

Main health facility used by mothers ***Dist.*: ……km *Travel time*: …….min**

*** Continually probe for:

- Explanations/reasons
- Outcomes
- Anecdotes

*** Ask group to propose "simple, doable recommendations".

MATRIX FOR A CONSOLIDATED SCORECARD

You have the indicators already scored in each village or community and now have scoring to be done by representatives of the various communities. THE SCORES MUST BE JUSTIFIED BY THE REASONS.

YOU NEED TO PROBE THEM AND HELP ALL THE REPRESENTATIVES TO COME TO AGREEMENT.

ADOLESCENT FOCUS GROUP - GUIDE SHEET

- **SCORING MATRIX**

Objectivity on the part of the researcher (especially the moderator) is required here. Allow the community to assess the indicator, but remind them that the exercise is not about pointing fingers at the service providers. It is also not about settling scores. Let them know that the objective is to improve upon the services provided; with regards to maternal and child health.

DO NOT IMPOSE YOUR OWN IDEA, WHAT PREVAILS IN OTHER COMMUNITIES OR YOUR OWN SCORE ON THE COMMUNITY.

1. Investigate functionality of the NHIS

- Proportion enrolled
- Affordability of premiums
- Routine expenditures disallowed on NHIS
- Overall satisfaction with NHIS
- [other] challenges relating to NHIS
- Coping strategies employed when they cannot access formal care

2. Access to contraceptives

- Service Access and Quality
    - User friendly facilities
    - Proximity
    - Money and related issues
    - Local perceptions
    - Attitude of health workers

3. Access to relevant information on reproductive health

- Service Access and Quality
    - User friendly facilities
    - Proximity
    - Money and related issues
    - Local perceptions
    - Attitude of health workers
    - Availability of health workers

4. Access to adolescent counseling services

- Service Access and Quality
    - Proximity
    - Money and related issues
    - Connecting infrastructure
    - Hospital infrastructure and facilities
    - Attitude of health workers
    - Availability of health workers

5. Are services youth-friendly?

- Money and related issues
- Local perceptions
- Attitude of health workers
- Availability of health workers

6. Level of stigma and discrimination around contraception and abortion

- Local perceptions
- Attitude of health workers

7. Teen-age pregnancy

- Money and related issues
- Local perceptions
- Attitude of health workers
- Availability of health workers

8. Ability to negotiate safe sex

- Gender differences
- Money and related issues
- Local perceptions

9. Average age at first sexual intercourse

10. Average number of simultaneous sexual partners

11. Suggestions related to the rights to services

- Knowledge on rights to services
- Exercising rights to services

12. Suggestions for improving health outcomes for adolescents

Main health facility used by mothers ***Dist.*: ……km *Travel time*: …….min**

*** Continually probe for:

- Explanations/reasons
- Outcomes
- Anecdotes

*** Ask group to propose "simple, doable recommendations".

MATRIX FOR A CONSOLIDATED SCORECARD

You have the indicators already scored in each village or community and now have scoring to be done by representatives of the various communities.

THE SCORES MUST BE JUSTIFIED BY THE REASONS.

YOU NEED TO PROBE THEM AND HELP ALL THE REPRESENTATIVES TO COME TO AGREEMENT.

Appendix 3: Community level field guide

ALLIANCE FOR REPRODUCTIVE HEALTH RIGHTS –

TRACKING OF HEALTH MDGs 4 & 5 IN FOUR SELECTED DISTRICTS

Dear Sir/Madam,
You are invited to participate in a research on adolescent sexual and reproductive health experiences. Your contribution is crucially important in achieving the objectives of the study and your response will be kept highly confidential. Thank you in advance.

A: BACKGROUND

1. Sex of respondents Male [ ] Female [ ]

2. Age range < 15 [ ] > 15 [ ]

3. Educational Status
……

4. Ethnic group

Fanti	Other Akan	Ewe	Ga	Other Ghanaian	Non – Ghanaian

5. Religious affiliation:

Christian	Muslim	Traditional Religion	No religion	Other (specify)

B: SEXUAL BEHAVIOUR

6. Age at first sex .....

C: CONTRACEPTIVE BEHAVIOURS

Age at first contraceptive use .....

Current type of contraceptive use .....

Previous type of contraceptive usage .....