Ghana Civil Society Monitoring Campaign

HEALTH MONITORING REPORT, 2010

Alliance for Reproductive Health Rights (ARHR)

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Acronyms and Abbreviations

ANC	Ante-Natal Care/ Clinic
ARH	Adolescent Reproductive Health
ARHR	Alliance for Reproductive Health Rights
CSC	Community Score Card
DHMT	District Health Management Team
DHOC	District Health Oversight Committee
FGD	Focus Group Discussion
GH¢	Ghana cedi
HIV	Human Immune-deficiency Virus
HRH	Human Resources for Health
KEEA	Komenda Eguafo Edina Abrem
MDG	Millennium Development Goal
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
PNC	Post-Natal Care
PRA	Rural Appraisal
WIFA	Women in Fertile Age

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Executive Summary

Introduction
This report is the third in the participatory monitoring series initiated by the Alliance for Reproductive Health Rights (ARHR). Twelve communities from Agona East, Bongo, Builsa and Komenda Edina Eguafo Abrem (KEEA) were involved in this round of the exercise. The main tool employed in this monitoring round is the Community Score Card (CSC).

Perceptions of health services
For many of the more remote communities, transport and the road conditions present challenges in accessing formal healthcare. These notwithstanding, in each of the study districts, out-patient attendance rates are rising steadily both in absolute and relative terms.

Experiences vary regarding how patients are received at the facilities they attend. Overall, midwives and older nurses were assessed to be more patient and sensitive than their younger counterparts, and poor, non-literate women perceive themselves to be treated less humanely.

Long waiting times are common at some health facilities, especially in KEEA. Notwithstanding the lengthy queues, patients appear to be quite discerning and fully appreciate it when nurses are doing their best to facilitate prompt service or to assuage the pain of waiting.

Both service users and providers generally reckon staff numbers to be inadequate. Yet, data from the respective DHMTs contradict the perception of routine under-staffing of health facilities. It would appear that the larger issues may have to do, first, with imbalances in the distribution and mix of health workers and, second, with abuse of work hours.

Participants were generally very satisfied with the effectiveness of facility-based treatment, observing that the treatments offered usually result in a speedier and more complete recovery -- particularly when prescribed by the "*older doctors*".

Maternal and child health
Overall, maternal health markers appear to be improving across the monitoring districts. In comparison with previous years, the statistical indicators suggest improvements in ANC completion and, even more markedly, supervised delivery rates.

Family planning clinics were generally perceived to be well run, with confidential counselling and affordable supplies of contraceptive commodities.

Health insurance
There is broad agreement that point-of-use costs are significantly lower for those who have taken out NHIS policies. That notwithstanding, even those who have paid their premiums in full often have to shell out a range of supplementary sums. Participants routinely bemoaned that cash-paying patients are given preferential

treatment by facility staff. Neither do subscribers receive refunds for prescriptions which facilities cannot supply.

Subscription costs vary widely, even within the same cohort. Several factors account for the variability in charges reported, with different amounts charged depending on locality, whether it is a first-time subscription or a renewal, whether one is paying at an office or to an itinerant agent and whether a penalty is applied for late payment. Across the communities visited, children are ineligible to receive free treatment if they have not individually been registered as subscribers. Equally worrying is the fact that some service providers in the health insurance industry penalise subscribers heavily for late payment.

Facilities and insurance service providers interpret the provisions of the health insurance framework differently and, in many cases, contrary to the free maternal care policy. This ambiguity is unhelpful.

As a response to these inequitable experiences and insensitivities, many poor households avoid the NHIS, with significant numbers opting for alternative and often dubious treatments when they fall ill.

Adolescent reproductive health

Adolescent sexuality and reproductive health are generally taboo topics in homes across the communities visited. As a result, adolescents secretly acquire information on reproductive health primarily from their peers, older siblings, leaflets and the broadcast media. Overall, the quality of reproductive health information actually available to adolescents is low and, in many cases, plain dangerous.

Notwithstanding the fact that most of the preferred contraceptives are both affordable and available at local drugstores, there nevertheless remains a string of barriers hindering adolescent access and utilisation. Owing to the diverse barriers and misconceptions, adolescents frequently choose questionable methods of contraception.

Children are making their sexual debuts early, often before they attain adolescence and many adolescents -- both males and females -- have multiple sexual partners. Unsurprisingly, the incidence of under-age pregnancy was perceived to be rising in each of the communities visited, spawned by increasingly sensual dress codes, the sexualisation of the female body, electronic porn and the constraining impact of stigma on access to counselling services. Many poor households have access to only one room, meaning that adolescents in such homes routinely observe their parents making love. Sheer poverty coupled with persistent pressures from men promising all manner of gifts were also noted as pushing many adolescent girls into acquiescing to sexual advances from older men.

A number of key recommendations are presented at the end of the report.

1. Introduction

1.1 Background

Since 2007, the Alliance for Reproductive Health Rights (ARHR) has collaborated with communities in various parts of Ghana to monitor progress towards the achievement of the health MDGs.[1] These global development goals were jointly agreed by world leaders at the turn of the millennium as part of a comprehensive set of actions to accelerate the effort towards global equity and development. Locally, the goals represent a golden opportunity for civil society to support poor and vulnerable rights holders in their quest to demand improvements in the allocation of health resources as well as in the way in which health services are delivered and managed.

Earlier rounds of this participatory monitoring exercise conducted in 2007 and 2009 have given priority to:

* maternal and child health;
* sanitation;
* potable water;
* communicable diseases; and
* the role of non-medical factors in promoting healthier outcomes for the poor.

Following feedback from the earlier rounds, an appraisal of partners' evolving priorities and a reassessment of the Alliance's strengths vis-à-vis other health actors, the current monitoring round attempts to address a revised set of priorities which had not been captured effectively in the previous rounds. These include:

* reflections on service satisfaction;
* access to the National Health Insurance Scheme (NHIS);
* experiences of adolescent reproductive health (ARH); and
* human resources for health (HRH).

1.2 Purpose of the report

This report captures the findings from a participatory health monitoring study undertaken in 12 communities between November 2010 and March 2011. More specifically, the report aims to document the perceptions and healthcare experiences of poor and vulnerable rights holders in the participating districts (see Section 1.3). The findings documented in the report are expected to contribute to the broader civil society effort to track sector progress and to foster improved accountability among health service providers.

1.3 Methodology

The study was conducted by a core team of facilitators pooled from among ARHR's partner organisations and the secretariat. Four districts were covered in this round -- Agona East, Bongo, Builsa and Komenda Edina Eguafo Abrem (KEEA). All four had participated in previous rounds of the exercise. In all, 12 localities were visited, distributed equally between the Central and Upper East Regions.

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[1] Millennium Development Goals, specifically Goals 4, 5 and 6.

A participative approach was employed at all stages -- in brainstorming and selecting the core monitoring indicators, in generating the field data and in the preliminary (on-site) analysis of the data. Health rights holders were facilitated to share their perceptions and experiences using basic scoring techniques within a focus-group setting. To complement the perceptions elicited from service users, duty bearers were also engaged to share their assessments of healthcare delivery in their respective facilities and/or districts.

Three focus group discussions were held in each community, one each with:

* women who had recently had a child (and could share reasonably recent experiences of their engagements with health service providers);
* adolescent males; and
* their female counterparts.

Additional appointments were sought with representatives of the National Health Insurance Scheme (NHIS). However, not all of the staff contacted were willing to answer questions or to cooperate with the monitoring team.

The main tool employed in this monitoring round is the Community Score Card (CSC). It builds on more specific qualitative methods such as scoring, semi-structured interviewing and probing, all of which are common to participatory rural appraisal (PRA) studies. This makes the scorecard approach particularly suitable for research with communities in which literacy levels are low.

A further justification for the qualitative approach is that, in many cases, the health statistics available at district level are highly questionable. The following statistics [initially] presented to the monitoring team by the respective DHMTs[2] are illustrative. Delivery and pregnancy data from the Agona East and Builsa directorates, for example, suggested incredibly high miscarriage rates of the order of 50%.[3] The equivalent miscarriage rate computed from the KEEA data for 2010 was a whopping 84%. In two sets of data received simultaneously from the same desk at Bongo, the DHMT reported very different midwife numbers for 2010 -- while one said there were 12 midwives, the other reported 20. Builsa District claimed that live births rose sharply from 663 in 2009 to 2215 in 2010. Again, Agona East reported an infant population equivalent to 40% of the district's entire population. And in Builsa, a district with a reported population of some 84,000 people, the average daily out-patient attendance was given as 1.5. Clearly, the quality of health sector data emerging from the district directorates will need careful cleaning and serious verification if it is to have any relevance for policy and planning purposes.

Regarding the limitations of the study, **the information elicited is qualitative and largely perceptional, reflecting the experiences and intuitions of poor citizens in the districts studied**. To that extent, it is acknowledged that perceptions are subjective and, now and again, can even be distorted by participants' exceptional experiences. Nevertheless, they are helpful for drawing the attention of service providers and policy makers to the voices of rights holders. It is also important to acknowledge the relatively small sample of four districts, itself a reflection of the

[2] District Health Management Teams

[3] The delivery data in question are gross values -- births facilitated by skilled attendants as well as those that were not attended by skilled personnel.

Alliance's limited resources. However, sticking with communities and districts with which the Alliance partners were already well known did encourage participants to share their experiences more freely. This was especially useful in the discussions around sensitive themes such as sexual behaviour, abortion and the coping strategies employed in the face of challenges with accessing healthcare.

The final stage of the methodology comprises feedback to service providers and an interface meeting between clients and service providers. The aim is to generate a commitment to reform. The agreements reached at the interface meeting will also be included in future monitoring rounds and will inform the conduct of subsequent interface meetings.

Ultimately, it is the hope of the Alliance that the voices of the Ghanaian poor that have been captured in the subsequent pages **will assist** not only **in drawing attention to the realities of poor people's healthcare situations, but also in holding health service providers to account** for the services they have contracted to deliver to their clients.

1.4 Structure of report

The report is in five parts. Following this introduction, Section 2 reports on respondents' experiences of healthcare facilities. Considerable attention is devoted to describing participants' assessments of the facility-based services they receive. Also discussed is how the poor respond to the challenges of accessing facility-based healthcare. In the third section, attention turns to examining citizens' experiences of the health insurance scheme, why so many remain off the register in spite of its acknowledged advantages, and a potpourri of discrepancies and inequities associated with its implementation. Section 4 then explores the subject of adolescent reproductive health. It pinpoints the hindrances to access and utilisation and describes adolescents' choices and behaviours regarding sex and contraceptive use. The hazards and unsafe coping strategies employed are documented in detail. The concluding section, 5, collates the key recommendations for civil society advocacy.

2. Experiences of Healthcare

For many of the more remote communities, transport and the road conditions present challenges in accessing formal healthcare. In several of the communities sampled, it takes approximately forty-minutes to an hour's walk in each direction -- typically along a pitted road -- to access the nearest formal healthcare facility. Commercial vehicles are often unwilling to provide services where the road conditions are particularly bad. During labour and emergencies, this can make a big difference to a patient's outcome. **These challenges notwithstanding, in each of the study districts, out-patient attendance rates are rising steadily both in absolute and relative terms** (Tables 2.5-2.8).

2.1 Human resources

Perceptions of shirking were reported for Agona Health Centre in KEEA (Section 2.2.2) and the Elmina Urban Health Centre. In respect of the latter, not even the personal secretary could say where the Municipal Director of Health Services was or when he would be back when the monitoring team visited on the morning of 02 December 2010. This kind of suboptimal communication is not uncommon in the sector and is altogether unhelpful.

2.2 Perceptions of health facilities

At each of the communities visited, participants were asked about the health facilities they attended. This was done separately for the different cohorts of adolescents/ young adults (separated by gender) and mothers with young children.

The following themes were then employed as the key indicators for a score card:

* whether staff treated patients politely and with dignity;
* whether the facility appeared to have adequate numbers of staff;
* whether services were delivered promptly;
* how affordable patients found the services to be;
* the quality of education/ information received; and
* how efficacious the treatment provided appeared to be.

The responses were quite revealing and are discussed in turn below.

2.2.1 Courteousness

Experiences vary regarding how patients are received at the facilities they attend (Tables 2.1-2.4). Some facilities do well on this criterion while others do not. Even within a facility, conditions are not always uniform. Often, the respect a patient is accorded varies depending on the ages of both the health worker and the patient. Adolescents were least likely to be satisfied with the attitudes of health personnel. In a discussion at Farinsa (Builsa District), an adolescent girl described how "*when you visit the hospital to complain that your illness has not gone, the nurse will insult you and tell you that you are abusing the scheme because it is free*." Her peer corroborated the account of inappropriate attitudes saying, "*I went there with a skin disease but was told to go home and use donkey droppings for treatment; that was unfair*."

In general, midwives and older nurses were assessed to be more patient and sensitive than their younger counterparts, some of whom were accused of veiled extortion when women report with labour. In frank discussions with nurses at the

district capitals, three[4] out of the four groups of nurses interviewed conceded the persistence of rude behaviours, particularly among the younger cohort. Health workers at Bongo Hospital confirmed that patients often "*bypass the younger nurses in search of the older ones*." In the words of a woman at Bando (KEEA), "*we are told to come back if we don't get well; but they also complain that we come too frequently and that we bring too many children because of the NHIS*."[5] A mother at Daliga (Bongo District) similarly observed that healthcare facilities "*sometimes refuse to treat two children of the same mother [on a single visit, on the pretext that] they both can't be sick at the same time*." By contrast, the midwife at the Soe clinic (Bongo District) was scored full marks by a focus group of women at Ayopia. Patients said they are even served a free portion of "*zunkum*" whenever they attend this midwife's clinic.[6] In assessing the nurses at that health centre, a group of women at Ayopia noted that "*the older nurses speak to us politely, … care for us [and] don't easily get angry*" whereas "*the student nurses … shout at us [and] are impatient*." Similarly, women at Farinsa and Takunsa reported that the nurses at the Wiaga and Sandema health facilities (in Builsa District) routinely offer them a drink of water, in acknowledgment of the long distances many of them will have walked.

At Abina (KEEA District), **mothers complained that they were often subjected to abusive language** by nurses at Cape Coast Metro Hospital (a.k.a. "*Central*"). It is bad enough that care workers should behave in such inappropriate ways towards patients. Even more worrying is the fact that this negative account has persisted since the situation was brought to the notice of the local authorities after the 2009 monitoring round. Participants in the women's focus group at Abina cited instances of extortion by nurses at that hospital. One informant specifically charged that "*they [the nurses] make demands for us to give 'a little something from our hearts'*."[7]

Overall, poor, non-literate women perceive themselves to be treated less humanely. Referring to their experience with Agona Health Centre (KEEA), the Bando women's group reported that "*as for those of us who have not been to school, we are not shown any respect at all*." Participants felt, by contrast, that genteel patients were treated graciously. From verifications carried out by the monitoring team, it appears that illiterate women do indeed wait longer hours but that this is partly because of problems with their records. While this may be justifiable in part, it is altogether unacceptable that they can be insulted for as much as daring to ask for updates. "*Sometimes, they throw our cards onto the floor in anger*," remarked one mother. Another observed, "*They yell at us if we're scared of the needle and make hurtful comments like 'If you don't want to have the injection, you can leave with your sickness.' Some of them are bad; and others are* ***really*** *bad!*" When asked whether they had reported such violations of their rights, a group of women at Bando responded that they never did. "*We don't want to deprive anyone of their daily bread*."

By comparison, citizens of Mansofo and Namanwura (both in Agona East District) as well as Dompoase (KEEA) had plenty of praise for the nurses at the Mensakrom,

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[4] The three facilities are the Elmina Urban Heath Centre, Bongo Hospital and Sandema Hospital.
[5] Similar allegations were made at Dompoase and some other sites.
[6] *Zunkum* is an indigenous drink made from millet flour and an assortment of aromatic spices.
[7] Nurses questioned often denied the allegations of extortion. However, this practice is widespread across the Ghanaian public system and is not unique to the health service.

Duakwa and Kissi health facilities respectively, describing them as patient. Most nurses at these facilities were noted as using gracious and compassionate expressions like "*please*", "*thanks*" and "*God keep you*" when speaking with patients, especially with the non-literate and noticeably vulnerable ones. Others said of the nurses at Duakwa, "*they don't play with people's lives*". However, even at these facilities, participants observed that the younger nurses (especially NYEP and student nurses) tended to treat patients disrespectfully.

In respect of Duakwa, the generally positive assessment is a marked improvement from years earlier when staff attitudes were so bad as to make patients opt for other facilities. The change is reported to have taken place after a piece of action research which pinpointed the attitudinal problem as the main cause of low patronage. That the same facility should now be scoring full points on the criterion of courteousness demonstrates that monitoring can indeed be productive if the findings are acted on in a sincere way.

Table 2.1: Summary of Score Card Results, Agona East District

Community	Assessment Theme						Mean Score[8]
	Staff are Polite	Service is Prompt	No. of Staff is Adequate	Service is Affordable	Info is of High Qual.	Treatment is Effective	
Mansofo	9/10	10/10	10/10		10/10		9.8
Namanwura	8/10*	10/10	7/10	0-5/10		8/10	7.1
Otabilkwa	10/10**	7/10	5/10		7/10	6/10	7.0

Source: Interviews with focus groups of recent mothers
* Participants scored older and younger nurses 9/10 and 2/10 respectively
** Older and younger nurses were scored 10/10 and 2/10 respectively at Otabilkwa

Table 2.2: Summary of Score Card Results, Bongo District

Community	Assessment Theme						Mean Score
	Staff are Polite	Service is Prompt	No. of Staff is Adequate	Service is Affordable	Info is of High Qual.	Treatment is Effective	
Ayopia	5/10	5/10	6/10	10/10	9/10	10/10	7.5
Daliga	8/10	6/10	9/10	6/10	7/10	6/10	7.0
Kunkuan	4/10	5/10	6/10	8/10	7/10		6.2

Source: Interviews with focus groups of recent mothers

[8] The mean for an ordinal variable is not statistically valid. Thus, the means indicated here are only intended to present a crude impression of how communities feel about their health facilities.

Table 2.3: Summary of Score Card Results, Builsa District

Community	Assessment Theme						Mean Score
	Staff are Polite	Service is Prompt	No. of Staff is Adequate	Service is Affordable	Info is of High Qual.	Treatment is Effective	
Balansa	10/10	10/10	10/10	9/10		10/10	9.8
Farinsa	8/10	10/10	7/10	10/10	10/10	10/10	9.2
Takunsa	8/10	10/10	10/10	9/10	10/10	10/10	9.5

Source: Interviews with focus groups of recent mothers

Table 2.4: Summary of Score Card Results, KEEA District

Community	Assessment Theme						Mean Score
	Staff are Polite	Service is Prompt	No. of Staff is Adequate	Service is Affordable	Info is of High Qual.	Treatment is Effective	
Abina	3/10	5/10	7/10	6/10		10/10	6.2
Bando	3-5/10	1/10	2-4/10	2-3/10	6/10	6/10	3.8
Dompoase	8/10	6-7/10	7-8/10	0/10*		0/10	4.4

Source: Interviews with focus groups of recent mothers
* Score by younger mothers; older mothers scored 6/10

2.2.2 *Promptness of service delivery*

Long waiting times are common at some health facilities, especially in KEEA. Patients frequently said they had to wait for two to three hours in a queue before being attended to. Not uncommonly, a visit to the health facility takes up the better part of a patient's (or carer's) day. Again, Mensakrom Polyclinic stood out in respect of the promptness of service and nurses' dedication to duty. Members of the mothers' focus group at Mansofo said of them: "*[These] nurses are just fantastic; … they attend to us briskly. Even when they have to take a phone call, they are quick about it and ask if we can excuse them for just a minute to take the call*." Similar comments were made of nurses at Nsabah (Agona East).

Notwithstanding the lengthy queues, patients appear to be quite discerning and fully appreciate it when nurses are doing their best to facilitate prompt service or to assuage the pain of waiting. Thus, the women's focus group at Namanwura scored the Duakwa health facility full points for prompt service even though they acknowledged that there are not enough nurses and that the queue can be quite lengthy, especially during emergencies. Both the laboratory technician and the nurses at that facility were very well spoken of for being businesslike and sensitive to their patients.

Owing to unusually long waits at Agona Health Centre -- coupled with other unpleasant experiences at that facility -- patients in that catchment area are opting for facilities farther afield (e.g. at Bronyibima and Elmina). While their patients agonise in long queues, nurses were often reported to spend lengthy periods on social phone

calls and in chats with their colleagues.[9] All of this is further aggravated by allegations of queue-jumping by well-connected patients who come by the backdoor.

On their part, nurses interviewed at the facility level debunked the allegation of slow service. In their assessment, because midwives often operate away from public view (e.g. monitoring labour cases and attending deliveries), it is easy for out-patients to assume that they are simply malingering. Proactive communication, coupled with greater sensitivity on the part of facility authorities, could go a long way to improving patient-care worker relations. That, of course, does not negate the need to accelerate the training of healthcare staff.

Once again, patients were dissatisfied with the working hours of the "*doctor*"[10] at Agona Health Centre (KEEA). He was said to spend very little time at the facility. Bemoaning their experiences, a focus group of mothers at Bando recounted: "*we're always being told that he has taken his child to school … or gone to pick his child up from school*." Others reported that "*they are always saying we should appreciate that they want their children to become doctors too*."

2.2.3 Staff adequacy and distribution

Both service users and providers generally reckon that staff numbers are inadequate. At the Soe clinic, for example, there is often just one nurse available to retrieve patients' records, take their histories and prescribe treatments. Participants perceived that, in such situations of *de facto* under-staffing, nurses tend to rush their patients and exhibit other signs of impatience. Often, nurses who have worked long hours can be heard venting their frustrations and complaining of tiredness towards the end of their shift. Other participants reported being scolded if nurses assessed their illness to be "*minor*".

Yet, analysis of data supplied by the respective DHMTs appears to contradict the perception of routine under-staffing of health facilities (Tables 2.5-2.8). Data derived from the respective DHMT records show daily patient/skilled worker ratios for Year 2010 ranging between an incredibly low 2.1 in Agona East District and 5.2 in KEEA, statistics which would be the envy of many other countries. It would appear, thus, that the larger issues may have to do, first, with imbalances in the distribution and mix of health workers and, second, with abuse of work hours (see, for example, § 2.1 and 2.2.2) rather than with the official patient/skilled worker ratios. In KEEA, for example, nurses at the central facility (Elmina Urban Health Centre) were concerned that while their routinely overwhelmed facility only has five midwives, the psychiatric facility at Ankaful (where deliveries are altogether infrequent) has what they perceive to be an excess, with two midwives.

[9] This was especially true of health extension workers (a.k.a. "*Kufuor nurses*").
[10] Presumably meaning Medical Assistant.

Table 2.5: Human Resource Profile, Agona East District

Indicator	Year		
	2008	2009	2010
Number of qualified doctors	0	0	0
Number of qualified medical assistants	2	2	2
Number of qualified midwives	11	11	11
Number of other qualified nurses	N/A	36	41
Total skilled health-workers*	N/A	49	54
Annual OPD attendance	27,231	34,139	30,046
Average daily OPD attendance**	104	131	115
Daily out-patient count per skilled health-worker*	N/A	2.7	2.1
District Population	75,890	77,484	79,111

Source: DHMT
* Computed from DHMT records
** Computation assumes a five-day week

Table 2.6: Human Resource Profile, Bongo District

Indicator	Year		
	2008	2008	2008
Number of qualified doctors	1	1	1
Number of qualified medical assistants	N/A	5	5
Number of qualified midwives	N/A	N/A	20
Number of other qualified nurses	N/A	N/A	76
Total skilled health-workers*	N/A	N/A	102
Annual OPD attendance	58,104	70,824	82,404
Average daily OPD attendance**	223	272	316
Daily out-patient count per skilled health-worker*	N/A	N/A	3.1
District Population	85,009	85,944	86,889

Source: DHMT
* Computed from DHMT records
** Computation assumes a five-day week

Table 2.7: Human Resource Profile, Builsa District

Indicator	Year		
	2008	2008	2008
Number of qualified doctors	1	1	1
Number of qualified medical assistants	2	4	4
Number of qualified midwives	18	19	23
Number of other qualified nurses	58	62	80
Total skilled health-workers*	79	86	108
Annual OPD attendance	88,620	102,915	126,728
Average daily OPD attendance**	340	395	486
Daily out-patient count per skilled health-worker*	4.3	4.6	4.5
District Population	83, 209	83, 165	84,089

Source: DHMT

*   Computed from DHMT records
** Computation assumes a five-day week

Table 2.8: Human Resource Profile, KEEA District

Indicator	Year		
	2008	2008	2008
Number of qualified doctors	1	2	1
Number of qualified medical assistants	5	5	5
Number of qualified midwives	8	9	12
Number of other qualified nurses	53	54	59
Total skilled health-workers*	67	70	77
Annual OPD attendance	82,627	95,195	104,679
Average daily OPD attendance**	317	365	402
Daily out-patient count per skilled health-worker*	4.7	5.2	5.2
District Population	132,774	135,562	138,409

Source: DHMT
*   Computed from DHMT records
** Computation assumes a five-day week

2.2.4 *Affordability of services received*

There is broad agreement that **point-of-use costs are significantly lower for those who have taken out NHIS policies**. For individuals who are not insured, healthcare costs are a real challenge. Access to the NHIS can itself be burdensome, and even those who have paid their premiums in full often have to shell out a range of supplementary sums, as described in Sections 3.2 and 3.3. Further, while the NHIS does indeed make formal healthcare more accessible, the differentials in the mean satisfaction scores (Tables 2.1-2.4) are rather less sharp than one may have expected, given that participation rates are several times higher in the northern sites (Table 3.1).

Some health facilities appear to be more proactive in dealing with poor patients. Thus, residents of Nananwura and Otabilkwa (Agona East District) observed that medications were generally less expensive at the Nsabah facility than at the Swedru Municipal Hospital and that Nsabah was also less likely to turn away non-NHIS patients unable to afford treatment.

2.2.5 *Quality of education/ information*

Mothers were generally impressed with the quality of education they receive at the specialist maternal and child care clinics (ANC[11]/ PNC[12]). There was particular appreciation for the quality of counselling they receive on personal hygiene, nutrition, family planning, breastfeeding, HIV and preparations towards delivery. Most informants also said the dosages of the medications they received were explained to them. A focus group of mothers at Farinsa recounted how "*the nurse at the dispensary never tires of explaining how to take the drugs correctly*." However, in the

[11] Ante-natal clinic
[12] Post-natal clinic

view of the authors, the haste with which medications are sometimes dispensed does present a risk that many illiterate patients will not get the instructions right.

2.2.6 *Efficacy of service*

Participants were generally very satisfied with the effectiveness of facility-based treatment, observing that the treatments offered usually result in a speedier and more complete recovery -- particularly when prescribed by the "*older doctors*". Women at Bando observed that "*the medicines we are given are effective when we take them*." Their counterparts at Otabilkwa concluded likewise, that "*most of the time, we recover after taking the medications*." The response at Ayopia was equally consistent: "*those who do not get [well] are those who do not follow the instructions correctly*."

Facility-based laboratory tests were similarly perceived to be effective in aiding diagnosis. These largely positive sentiments were echoed across most sites, as demonstrated in the relatively high scores in Tables 2.1-2.4. It appears then that the *capability* of service providers is not really at issue. The larger problem has to do with the persistence of negative attitudes among some health workers. Such attitudes dent patients' esteem, restrict *de facto* access to health services and, ultimately, threaten the achievement of the health MDGs.

That notwithstanding, there were also instances where patients did not see the treatments they are given to be efficacious. In one example, a focus group of women at Dompoase scored their health facility zero on this variable. When asked to explain, one woman remarked, "*At Kissi, they only ever give us 'Para',*[13] *no matter the ailment*." Another endorsed her colleague's assessment, saying "*the drugs we are given when we go to Elmina have more 'weight'*." The situation is apparently influenced by the fact that the facility is largely run by nurses rather than a doctor. A mother captured this concern rather aptly when she observed that "*you never see the doctor; only the nurses*." Indeed, a whopping nine out of the ten women interviewed at Dompoase said they were treated by a nurse on their last visit to that facility. Thus, even though healthcare workers are considerably more polite and patient at Kissi than they are at Elmina -- and even though Kissi is easier to reach than is Elmina -- residents of Dompoase nevertheless attend the Elmina facility as the norm, restricting their use of the Kissi Health Centre mainly to emergencies, deliveries and well-person clinics.

2.3 Maternal and child health

Overall, maternal health markers appear to be improving across the monitoring districts. In comparison with previous years, the statistical indicators suggest improvements in ANC completion and, even more markedly, supervised delivery rates (Tables 2.9-2.12). Women attending also seem much more satisfied than in previous years with the level of access as well as the quality of services at these clinics. The attitudes of health-workers at these clinics also appear to be better than across the wider health service. In community after community, mothers reported receiving personalised counselling on a range of relevant areas -- e.g. family planning, breastfeeding, maternal and child nutrition and domestic hygiene -- and indicated that these services were generally delivered by caring midwives. The main criticisms had to do with lengthy queues and disrespectful behaviours by the

[13] I.e. Paracetamol, a popular analgesic.

younger midwives/ attendants. However, even these complaints diminished markedly with PNCs held at the community level.

Table 2.9: Maternal Health Indicators, Agona East District

Indicator	Year		
	2008	2009	2010
No. of pregnant women	4,031	3,574	2,699
No. of pregnant women who made 4 ANC visits	1,901	2,555	1,867
No. who made 4 ANC visits as % of total pregnancies	47%	71%	69%
Prop. of deliveries with a skilled attendant at birth	41%*	49%*	59%*
District Population	75,890	77,484	79,111

Source: DHMT
* Many of those with difficult pregnancies opt to have their babies at the Agona West Municipal Hospital

Table 2.10: Maternal Health Indicators, Bongo District

Indicator	Year		
	2008	2009	2010
No. of pregnant women	3,512	2,732	2,860
No. of pregnant women who made 4 ANC visits	2,805	2,508	2,554
No. who made 4 ANC visits as % of total pregnancies	80%	92%	89%
Prop. of deliveries with a skilled attendant at birth	52%	67%	83%
District Population	85,009	85,944	86,889

Source: DHMT

Table 2.11: Maternal Health Indicators, Builsa District

Indicator	Year		
	2008	2009	2010
No. of pregnant women	3,226	3,104	2,905
No. of pregnant women who made 4 ANC visits	2,462	3,208	2,179
No. who made 4 ANC visits as % of total pregnancies	76%	103%*	75%
Prop. of deliveries with a skilled attendant at birth	34%	43%	53%
District Population	83, 209	83, 165	84,089

Source: DHMT
* DHMT staff attributed this to women crossing over from neighbouring West Mamprusi District for ante-natal clinics

Table 2.12: Maternal Health Indicators, KEEA District

Indicator	Year		
	2008	2009	2010
No. of pregnant women	5,061	4,928	4,779
No. of pregnant women who made 4 ANC visits	3,853	4,262	4,842
No. who made 4 ANC visits as % of total pregnancies	76%	86%	101%
Prop. of deliveries with a skilled attendant at birth	35%	39%	43%
District Population	132,774	135,562	138,409

Source: DHMT
* Some -- esp. those with difficult pregnancies and complications -- opt to have their babies at the better-equipped hospitals in neighbouring Cape Coast

2.3.1 Family planning

In general, family planning clinics were perceived to be well run, with confidential counselling and affordable supplies of contraceptive commodities. Most of the women interviewed were aware of multiple options for delaying pregnancy and said the nurses take their time to present the options and allow clients to make their own choices. As indicated in Section 4.2, the most basic contraceptives are generally available at local chemical shops. However, in the northern sites, women complained that owing to men's aversion to family planning, they had to be particularly discreet about the subject and could only access contraceptives at distant facilities, often during PNC sessions. This was corroborated by nurses at Sandema Hospital.

Table 2.13: Family Planning Indicators, Agona East District

Indicator	Year		
	2008	2009	2010
No. of women in fertile age (WIFA)	18,214	18,596	18,987
No. using modern contraception	4,295	7,624	4,921
No. using modern contraception as % of WIFA	24%	41%	26%
District Population	75,890	77,484	79,111

Source: DHMT

Table 2.14: Family Planning Indicators, Bongo District

Indicator	Year		
	2008	2009	2010
No. of women in fertile age (WIFA)	N/A	N/A	N/A
No. using modern contraception	2,476	2,053	1,932
No. using modern contraception as % of WIFA	N/A	N/A	N/A
District Population	85,009	85,944	86,889

Source: DHMT

Table 2.15: Family Planning Indicators, Builsa District

Indicator	Year		
	2008	2009	2010
No. of women in fertile age (WIFA)	19,745	19,902	20,180
No. using modern contraception	5,676	8,794	7,508
No. using modern contraception as % of WIFA	29%	44%	37%
District Population	83, 209	83, 165	84,089

Source: DHMT

Table 2.16: Family Planning Indicators, KEEA District

Indicator	Year		
	2008	2009	2010
No. of women in fertile age (WIFA)	30,538	31,179	33,210
No. using modern contraception	N/A	N/A	N/A
No. using modern contraception as % of WIFA	88%	60%	39%
District Population	132,774	135,562	138,409

Source: DHMT

Overall, the most common contraceptive options available were the male condom, the pill (a.k.a. *Secure*) and injectables. Interestingly, injectables -- and to a lesser extent, implants -- are relatively more popular in the north, where women have much less control over decision-making and thus opt for methods that are more easily concealed from their husbands.[14] Tubal ties were less commonly mentioned, and tend to be dreaded among the category of women interviewed.

At GH¢1 for a course, mothers everywhere were satisfied that the pill is reasonably priced. They also appreciated the confidentiality of the family planning services which they receive. The combined outcome of these positive assessments -- especially the availability and affordability of contraceptive options and confidential services -- is that the women interviewed tended to stick with the formal methods and to avoid the herbal alternatives on offer. However, in each of the monitoring districts, utilisation rates have declined from 2009 levels (Tables 2.13-2.16) -- a situation which nurses attributed to shortages of some specific commodities, particularly Jaddel. In a small number of cases, stories of side effects experienced by some women who had used various ostensibly safe methods had deterred other women from exploring formal family planning for themselves.

[14] According to our informants, many northern husbands frown on their wives using contraception as it ostensibly makes it easier for them to cheat in the relationship.

3. Health Insurance

3.1 Proportion enrolled

Active NHIS subscription rates are low at several of the monitoring sites. Significant proportions of respondents, particularly in the southern districts, lacked serviceable health insurance subscriptions. Of 15 women interviewed at Bando, for example, five had never enrolled, a full half (seven) said their subscriptions had expired; and only three had valid subscriptions. At Namanwura, all ten male youths interviewed and 16 out of 18 women respondents had never registered for the NHIS, let alone consider renewing their subscriptions. Among adolescent girls in that community, only two out of the eight interviewed were current with their subscriptions. Similar accounts were echoed in the other southern localities (Table 3.1). In some cases, the few that had enrolled had been assisted to do so by some benefactor such as the Member of Parliament (MP) for their constituency, presumably from their share of the District Assemblies Common Fund.[15] Too often, illiterate subscribers were completely unaware that their subscriptions had lapsed till they were turned away at the facility level. This was commonest in the northern districts, where literacy rates can be particularly low, especially among the womenfolk.

It seems somewhat curious that NHIS participation rates are higher -- and significantly so -- at the northern sites, where citizens are generally poorer (Table 3.1). Bongo District, for example, is especially rocky and infertile. Coupled with the savannah's single rainy season, its livelihoods are particularly unstable and its malnutrition statistics are among the worst nationwide. Yet, NHIS subscription levels are several times higher than they are in the Central Region (Tables 3.1, 3.2). Evidently, there are other important variables beyond mere affordability that explain this north/south divide and the decision to participate in the NHIS (see Section 3.2-3.4).

Compared to the cash-and-carry regime, the NHIS is considered to be advantageous. Nevertheless, affordability remains a challenge for many poor households. This conundrum is aptly captured in the words of a group of adolescent females at Dompoase who noted that "*the NHIS is good, but because we don't have the money to register, we have not been able to access the scheme*." For such groups with low and unstable incomes, forking out a lump-sum payment of GH¢12-20 to an NHIS agent can be quite burdensome. It can be even more challenging where households are compelled to register (or renew their subscriptions) as a family unit. At several of the southern sites, the younger adults felt that they generally didn't fall ill frequently enough to warrant taking out an insurance policy.

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[15] The grant disbursed to parliamentarians is intended to be used by them for developmental purposes in their electoral constituencies.

Table 3.1: Proportion of interviewees with valid NHIS cards

District	Community	Mothers	Adolescent ♂	Adolescent ♀
Agona East	Mansofo	2/7	1/8	1/7
	Namanwura	1/18	0/10	1/14
	Otabilkwa	1/15	0/8	0/9
Bongo	Ayopia	4/12	4/7	4/7
	Daliga	4/8	3/9	5/11
	Kunkuan	6/13	3/11	6/12
Builsa	Balansa	13/15	4/9	9/10
	Farinsa	16/20	5/5	6/11
	Takunsa	8/8	8/9	5/10
KEEA	Abina	5/16	0/3	0/4
	Bando	3/15	2/7	2/8
	Dompoase	5/10		2/5

3.2 Satisfaction with NHIS

Among those who have had some experience of the NHIS (including those whose subscriptions have not been renewed), adolescents and the southern communities were typically less satisfied than the others in the sample. Considering that ANC and PNC services came out as the most accessible and hospitable, it is not difficult to see why mothers would be generally more satisfied than adolescents. In the overwhelming majority of southern communities visited, the various focus groups complained about the limitations of the NHIS. One of the most frequent complaints was that medicines prescribed (particularly the more expensive ones) could often not be supplied by the facility, compelling subscribers to pay for such treatments from their pockets. A group of youthful males at Abina observed that "*the medicine is merely written on a piece of paper for you to go and buy from the drugstore.*" This experience was retold in many other monitoring communities and was cited by those who had failed to maintain their subscriptions as a major deterrent.

Almost everywhere, participants bemoaned that cash-paying patients are given preferential treatment by facility staff. In community after community, informants reported that those who paid cash received attention more promptly and that health facilities were also more likely to dispense the prescribed medicines to such clients.[16] In a minority of cases, patients with NHIS subscriptions have set their cards aside and paid for consultations in order to be treated promptly. The Swedru Hospital was cited as being particularly notorious for extorting money from subscribers desiring a speedier service. The quantum taken is reportedly between GH¢1 and GH¢2.

[16] Even at the Mensakrom Polyclinic, where the nurses were very well spoken of, patients nevertheless noted that those who pay cash get superior attention.

Time after time, participants gave examples of how two people from the same community would attend a facility with the same complaint, receive the same prescriptions but, thereafter, only the person paying cash at the facility would be offered medication by the dispensary, while their colleague with an NHIS card would be told to take their prescription sheet to a drugstore. Sometimes, those on the NHIS would be told that the facility had run out of the medication. Commenting on this situation, adolescent girls at Bando opined that "*the nurses prefer cash to the [NHIS] card*." According to participants interviewed, this happens more frequently with the relatively more expensive prescriptions, which scheme-designated chemists are unable to supply. As a result, many respondents perceived that the scheme was not really worth enrolling in.

Subscribers do not receive refunds for prescriptions which facilities cannot supply. It is altogether surprising that none of the participants in the focus groups had ever been notified -- either by their NHIS offices or by their respective health facilities -- of their entitlement to be reimbursed for prescriptions they were compelled to purchase from private drugstores if these were for medicines on the NHIS *Medicines List*. Only at the KEEA validation workshop did one participant acknowledge having prior knowledge of his entitlement to such a refund. Even then, when he had tried claiming back his money, the sheer bureaucracy involved -- together with the associated cost of to-ing and fro-ing -- had compelled him to give up in frustration. At the end of the day, such additional charges make the real cost of NHIS participation considerably higher than the subscription charge *per se*. That insurance service providers seem to be interested only in the revenues they can rake in is completely unacceptable -- indeed quite dishonest -- and exacerbates the disadvantage which poor households endure.

3.3 Other challenges affecting access and utilisation

The cost of subscription varies widely even within the same cohort (Table 3.2). For example, it costs GH¢16 (including a GH¢1 "*processing fee*") to renew an adult subscription in Agona East, whereas it would cost GH¢9.50 in Builsa District. In Agona East, "*processing fees*" can be as high as GH¢6 when agents go out into the communities to sign up subscribers.[17] In a focus group discussion with recent mothers at Otabilkwa (Agona East), it came to light that people posing as NHIS agents sometimes visit the community presumably to register subscribers only to vanish with clients' payments.

Across the interviews held **in the Builsa District, NHIA officials were alleged to insist on all members of a household registering collectively, a situation which significantly increases the burden of scheme membership in that district**. It was further disclosed that where, at the time of renewal, a household member had out-migrated or died, it was all but impossible to persuade the officials to adjust the household's invoice downwards. Thus, households are sometimes compelled to pay the premium on behalf of deceased members just to ensure unbroken service. Adolescents at Balansa, one of the communities sampled in that district, were displeased with the abusive behaviours poor citizens endure from some staff of the scheme. Similar accusations were made at the KEEA validation workshop.

[17] Adults at Namanwura and Otabilkwa are charged GH¢18 and GH¢20 respectively when registering in their communities.

Curiously, however, subscription rates were higher in Builsa than in the other monitoring districts (Table 3.1) -- even exceeding the national statistics. Across the three communities studied in that district, the proportions of members dropping out of the scheme were also markedly lower than for the other monitoring districts, particularly the southern ones. Anecdotal evidence suggests that the exceptional enrolment rate for Builsa is accounted for, in large part, by the more proactive marketing of the scheme in that district.

*Table 3.2: Health insurance annual charges, non-SSNIT contributors (GH¢)**

District	First registration			Renewal		
	Adult	Child	Aged	Adult	Child	Aged
Agona East	16-20	0-4	Free	16	1	1
Bongo	12-15	3-4		12-15	3-4	
Builsa	12	4		9.50	1-3	
KEEA**	15-16	4-5; 15-16¤		12-13	1-2; 12-13¤	

* In some cases, the charges include so-called "*processing fees*"
** SSNIT contributors pay GH¢4-5 for first registration and GH¢1-2 for renewals
¤ Older children (approx age 15-17) are sometimes treated as adults

Source: NHIS offices in the participating districts; community-level focus groups

Several factors account for the variability in charges reported, with different amounts charged depending on:

* locality;
* whether it is a first-time subscription or a renewal;
* whether one is paying at an office or to an itinerant agent; and
* whether a penalty is applied for late payment.

One thing that is clear from this monitoring round is that NHIS costs are higher in the southern districts sampled than in their northern counterparts (Table 3.2). Precisely why so is, however, unclear.

Across the communities visited, children are ineligible to receive free treatment if they have not individually been registered as subscribers. In an interview, the scheme manager for KEEA insisted that children's subscriptions must be paid alongside their parents'. What this means is that children of parents who are unable to afford subscriptions for themselves (or who simply neglect their parenting responsibilities) cannot access the free child care policy and must pay for services at the point of delivery. Equally unthinkable, adolescents at Bando indicated that some agents of the NHIS insist on charging older children (from around age 15 up) the full adult rates (Table 3.2). Wider and clearer education on the policy's position on children would seem necessary.

Even when a subscription has been paid in full, a subscriber may still be compelled to forfeit several months of service. This is because it often takes several months for the subscriber's card to arrive. In communities across KEEA, a six-month

lag is reportedly common.[18] Only in one interview did participants report receiving their cards in less than three months. Until their cards arrive, subscribers cannot access the service for which they have paid. In the process, many poor households have to pay additional costs at the facility level and the *real annualised cost* for the first year of subscription works out as GH¢24-32 -- i.e. twice the notional amount -- for participants in the majority of communities sampled. Quite predictably, the delay in the issuance of cards constitutes a serious disincentive to poor households, for whom each cedi has a more significant impact on wellbeing.

Equally worrying is the fact that some service providers in the health insurance industry penalise subscribers heavily for late payment. Subscribers at Balansa (Builsa District) complained about being surcharged if they fell behind in renewing their subscriptions. At Bando, various categories of participants reported that, for each month for which their subscription had expired, they were made to pay GH¢1 by the management of the mutual health scheme at Teterkissim. An informant whose subscription had lapsed in December 2009 reported how, when she finally found the GH¢13 to restart her subscription in September 2010, she was made to pay an additional GH¢9 in penalties for the nine months for which her subscription had been dormant. Such accumulated arrears make renewals particularly challenging and partly explains why so many participants appear to be dropping out in the localities sampled. Of four adolescent females who were interviewed at Bando, all three who had previously had a subscription were emphatic that they had no intentions to renew their lapsed subscriptions. In addition to the deterrent effect of this illegal levy for late payment, the girls also felt that there was little point when cash-paying clients receive a superior service when they report at the facility.

It seems curious too that the receipts issued to subscribers do not reflect the penalty payments. That poor communities should be made to endure such huge and unaccountable charges for wholly unusable subscriptions is not only insensitive but also plain unethical. The fact that receipts are not issued for certain payments further contributes to the myriad of misconceptions around the scheme. In KEEA District, some clients insisted that they had been charged amounts in the region of GH¢5 to be migrated from a mutual to the NHIS. Yet, officials insisted that no charges are made for migrating from one scheme to another. The simple act of issuing a receipt would have been quite adequate to clear the air on an issue like this.

In several cases -- particularly in the south -- paid-up subscribers reported that facilities charge for certain basic supplies. Only in respect of Mensakrom Polyclinic did subscribers report that they have never had to pay additional charges at the point of service.[19] Respondents in KEEA, by contrast, asserted that they still have to pay for injections at the Elmina Urban Health Centre (EUHC), even with valid insurance policies.[20] Mothers also alleged that some facilities demand between GH¢2.50 and

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[18] Participants at a validation workshop held on 10 June 2011 reported that some applicants had still not received their cards after two years. According to them, computer breakdowns are the typical reason cited for these delays.

[19] The same group said they are made to pay a mandatory GH¢1 at the dispensary when they attend Swedru Municipal Hospital and that they pay a further GH¢1 for lab tests at that facility.

[20] Anecdotal evidence suggests that some of these charges may simply reflect extortionary behaviours by some nursing staff.

GH¢3 for ante-natal laboratory tests and that they routinely pay for gauze, cotton wool and several other consumables when they report with labour, in spite of the free maternal care policy and regardless of whether or not they have valid NHIS subscriptions.[21] Others said they pay between GH¢1 and GH¢3 for a hospital card. A participant reported that her husband had been compelled to pay GH¢20 for a blood transfusion at Swedru Municipal Hospital even after her son had been made to donate blood. Because of the abusive treatment they are often subjected to, patients are reluctant to question service providers.

Facilities and insurance service providers interpret the provisions of the health insurance framework differently and, in many cases, contrary to the free maternal care policy. This ambiguity is unhelpful. For example, some facilities in the south demand advance payments for caesarean sections whereas others perform the procedure without any charge whatsoever. Even with regular deliveries, patients are often made to supply various items such as gauze, sanitising spirit and other disinfectants, sanitary towels and water-proof bed covers -- some of which are sold by nurses who operate micro-businesses at their respective facilities. In several cases, mothers in the southern communities also reported having to pay for various drugs during labour.[22] And, except at Kissi, pregnancy test expenditures of GH¢3 are deemed ineligible under the free maternal care policy in KEEA.[23] While it is understandable to exclude negative tests, positive tests ought to qualify under the policy as they affirm a positive maternal status. If health authorities generally acknowledge maternal health to cover the period of pregnancy through childbirth and several months into the postpartum phase, then excluding such women from the *free maternal care* policy appears illogical and questionable. Indeed, the fact that women are required to pay for the pregnancy test (regardless of whether they have valid NHIS subscriptions) was noted as a reason why some women delay ANC in KEEA District. Greater transparency is needed in the interpretation of, and public education on, the "*free maternal care*" policy to make it clearer nationwide whether pregnant and postpartum mothers have to pay any costs and if so, which those are.

An NHIS subscriber using the Agona Health Centre (KEEA) said he was required to pay GH¢20 for a minor operation to remove a lump from his arm. Other subscribers said they had to pay for medications to alleviate sight and breathing difficulties.[24] Consistently, mothers who had been made to supply various items during labour expressed suspicions that the nurses kept the leftovers and resold them to other patients attending for delivery.

3.4 Coping strategies

As a response to these inequitable experiences and insensitivities, poor households tend to avoid the NHIS, with many opting for alternative treatments

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[21] The Kissi Urban Health Centre was singled out by Dompoase residents as an exception. Staff of the Elmina Urban Health Centre however disputed these assertions, insisting that women do not pay for these services if they have active insurance policies or if they have registered their maternity status with the relevant NHIS office.

[22] The Duakwa Health Centre is one of the few which the monitoring team found to be implementing the free maternal care policy quite faithfully.

[23] Indeed, all maternal cases -- regardless of NHIS status -- are seen for free at the Kissi Urban Health Centre.

[24] This was corroborated by adolescent males at Bando, who reported that they were made to pay for eye drops and to have boils treated.

when they fall ill. These alternatives include a string of untested herbal brews,[25] other forms of self-medication and enema applications[26] (especially for children, particularly in the Central Region). The range of unorthodox "*treatments*" used includes salt solutions and ash potions for constipations and stomach aches while infusions are prepared from the leaves and barks of acacia, avocado, baobab, bamboo, cocoa, mahogany, mango, moringa, neem, papaya, plantain and teak trees are used -- either individually or in various permutations -- as ostensible remedies for malaria, other fevers and pains.[27] To treat diarrhoeas, mothers at Mansofo grind variable proportions of cotton, neem and other leaves for enema applications.[28] Others rely on leftover medications -- including antibiotics -- from their friends (or from previous prescriptions) or utilise the services of unlicensed health practitioners and spiritualists. Prayer camps are, for some, the preferred destination for illnesses that are not easily explained (e.g. sudden rapid weight loss) or which are perceived to have spiritual origins (e.g. swollen limbs).[29] At Kunkuan (Bongo District), cow dung is sometimes applied to the forehead or to other parts of the body as an analgesic balm.

A small minority said they borrow to finance treatment at formal healthcare facilities. Generally, those unable to afford the NHIS premiums were said to delay visiting the health facilities when ill. Healthcare workers interviewed observed that such patients tended to present with relatively more advanced stages of illness.

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[25] Some herbal treatments are purchased while others are foraged from the local fields based on indigenous knowledge gleaned from the "*old lady*" of the village. Curiously, some respondents indicated that herbal remedies are often effective in the short term but that the problems often recur after a while. While there is not enough evidence to go on, a plausible hypothesis would be that such remedies address the symptoms rather than the root causes.

[26] Enemas are often shared, reflecting inadequacies/ deficiencies in public education.

[27] The menu of herbs used for medicinal purposes appears much more varied and nuanced in the southern communities.

[28] In some northern communities -- such as Daliga -- ash is mixed into water and drank as a remedy for unstable stomach conditions.

[29] There are also significant numbers who are averse to prayer camps.

4. Adolescent Reproductive Health

4.1 Access to relevant information

Adolescent sexuality and reproductive health are generally taboo topics in homes across the communities visited. As a result, adolescents secretly acquire information on reproductive health primarily from their peers, older siblings, various leaflets (such as the "*Life Guide*") published by NGOs, as well as from radio and television. School-based education on reproductive health does not appear to be regular or adequate. Facility staff also confirmed that very few adolescents patronise the reproductive health corners where these are provided. The few who do visit are mainly females suspected to be pregnant, often accompanied by a parent.

Overall, the quality of reproductive health information actually available to the adolescents interviewed is low and, in many cases, plain dangerous too (ref. Section 4.2). Adolescents interviewed noted that the facility environment is not sufficiently youth-friendly as they must share the waiting area with adults seeking family planning assistance.[30] They further reported that they were often insulted by the nurses when they visit the Adolescent Health Corners without an accompanying adult. In KEEA, NYEP counsellors at Agona were assessed to be particularly off-putting in their demeanours, making it unattractive for local youths to avail themselves of the potentially valuable service. At Bando, all eight girls interviewed had absolutely no knowledge of the existence of formal reproductive health services. Only one of the eight would mention it to her mum if she was approached for sex by a man; two would tell a peer. Only with two of these girls had a parent ever discussed sex.

4.2 Contraception behaviour

The adolescents and young adults interviewed employ a wide range of contraception measures in their sex lives, some extremely risky. Virtually all youth groups interviewed observed that the main contraceptives of choice were generally available at their local drugstores and affordable too. However, in several of the northern communities, a condom sold for more than double the price charged in the southern communities.[31] The most affordable orthodox options are the condom, the female pill (which boys often recommend to their female partners) and various spermicidal creams which boys smear around the head of the penis immediately preceding penetration. At Bando, however, the girls did not appear to know about other options beyond the condom.

Notwithstanding the fact that most of the preferred contraceptives are both affordable and available at local drugstores, there nevertheless remains a string of barriers hindering adolescent access and utilisation. Sexual stigma -- conditioned by society's norms of propriety -- is one major factor. Youthful males at Bando said their local (Abreshia) "*drugstore keeper's probing questions tend to put us off buying and using condoms*." He was noted to often ask questions like "*who sent you*" or "*what are you using it for?*" Adolescent girls also expressed a fear that "*the local drugstore keeper*

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[30] By contrast, the Red Cross and other NGOs were said to organise their services along age lines, rendering them more adolescent-friendly.

[31] The modal price in the southern sites was GH¢0.20, whereas the same product sells for around GH¢0.50 in the northern communities sampled.

might leak the information to our parents". Because of the stigma associated with sex, adolescents tend to shy away from seeking support at the health facilities. "*Even the nurses tag you as a bad boy*," according to a participant in a focus group of adolescent males at Abina. In the view of another, "*the nurses may tell on us to our parents*." *De facto* choice is also influenced by various misperceptions and poor/ ineffective sex education. As a result, it is not uncommon for adolescent girls to lack an effective appreciation of their menstrual cycles or to know when during that cycle they are most prone to becoming pregnant. The viral nature of sexual legend leaves adolescents highly vulnerable to some quite dangerous myths and misinformation around what constitutes safe and effective contraception. Indeed, only at Balansa did any of the groups interviewed insinuate that contraception was not stigmatised.

Owing to these diverse barriers and misconceptions, adolescents frequently choose questionable methods of contraception. Even aphrodisiacs (which adolescent males at Mansofo referred to as "*sexy medicines*") are mistaken for contraceptives. The outcome is anyone's guess -- especially when withdrawal remains popular among males. In the not uncommon event of pregnancy, it is common for boys to pressure their partners to take *Cytotec* tablets (*misoprostol*; *prostaglandin* E_1). Widely available at local drugstores over the counter and relatively inexpensive too, this controversial solution works by ripening the cervix and contracting the uterus, thereby inducing abortion. However, birth defects are a risk in failed *misoprostol* abortions.[32] Equally worrying is another dimension of abuse discovered at Abina, where the young men recounted how their female partners, so impressed by *Cytotec*'s apparent efficacy, now take the drug as a prophylactic, *ahead* of sexual intercourse. *Postinor-2* (a.k.a. the morning-after pill) is another drug that is being abused. Repeated abuse of this drug -- like most other drugs -- can threaten its efficacy. At Namanwura, adolescent girls said that they mix between ten and 20 tablets of paracetamol (*acetaminophen*) in a bottle of Guinness stout as a prophylactic measure.

Other ostensibly abortifacient "*remedies*" which desperate girls employ in their bid to get rid of unwanted pregnancies include dissolving large doses of sugar[33] in dark carbonated drinks (typically a malt or cola drink or Guinness stout). Other home-based abortion methods mentioned in the Agona East interviews include drinking *satadua* leaf brews or saltpetre brine,[34] or applying suppositories made from various leaves, ginger and other roots. Abortion enemas are also made from concentrated salt solutions or by blending various leaves with saltpetre and *akpeteshie* (a locally-distilled gin). Girls at Namanwura also described "*quack doctors*" administering repeated vigorous sex -- with resultant bleeding -- as yet another option for aborting pregnancies. In general, it appears that it is the youngest adolescents who employ the most questionable methods -- likely because they have the least adequate appreciation of the subject of sexuality.

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[32] See http://en.wikipedia.org/wiki/misoprostol

[33] Three cups was mentioned as the norm.

[34] Saltpetre (potassium nitrate, locally known as *kawu*) is a key component in the manufacture of gunpowder and other explosives, due to its oxidising properties. Across Ghana, it is more popular as an effective but low-cost tenderiser during food preparation, especially with beans. The precise mechanism by which it stimulates abortion (and the level of success) is unclear, however.

Among boys, the unorthodox options employed include taking four to six tablets of paracetamol dissolved in two "*tots*" (approx. 200 ml) of *akpeteshie* shortly before commencing intercourse.[35] Not only is this method patently ineffective; the high alcohol content combined with the practice of gulping this potent gin down (rather than sipping it) further exposes young users to severe intoxication, with attendant risks. Further, repeated use of such a high-alcohol "*antidote*" greatly increases the probability of addiction in one's adult years. Those lacking the boldness and/or appetite for *akpeteshie* may try dissolving minty sweets in a cola drink. Other boys interviewed believe that drinking copious amounts of water ahead of unprotected intercourse is able to render the sperm impotent, presumably by effectively diluting the semen.[36] In some communities, taking between one and three tablets of paracetamol is presumed to be an alternative to the water-only prophylactic. Boys also rely on herbal concoctions, though rather less commonly than their girls do.

There are even more horrifying methods. In their desperation to terminate unwanted pregnancies, misguided girls will sometimes shove sticks up their vaginas or gulp down a bottle of Guinness with ground glass stirred into it. Another chilling way in which adolescent girls attempt to terminate unplanned pregnancies is to insert the ground glass deep into the vaginal cavity, in the hope of shredding the foetus. Girls seemed completely oblivious to the fact that the foetus is implanted well beyond the reach of their fingers. The profuse bleeding that typically results from this dangerous practice is, unfortunately, misperceived to represent a successful mincing of the foetus. Some of the respondents knew of deaths that had resulted from such unsafe methods. Also common in Agona East, pregnant girls insert ash, household bleach or laundry blue (smalt; Prussian blue)[37] into the vagina. Informants cited serious bleeding, barrenness arising from complications, birth deformities and even deaths as known consequences of such unsafe abortion techniques. Clearly, the level of sexual misinformation among adolescents is high and the consequences are too grave for the subject of ARH to be left to chance.

4.3 Teen pregnancy

The incidence of pregnancy was perceived to be rising in each of the communities visited, spawned by increasingly sensual dress codes, the sexualisation of the female body, electronic porn[38] and the constraining impact of stigma on access to counselling services and "safe contraception". But even at Balansa -- where girls indicated that contraception is not stigmatised and where reproductive health education seems much better than the norm -- there are over ten cases of teen pregnancy each year.

Many poor households have access to only one room, meaning that adolescents in such homes routinely observe their parents making love. This leads them to want to experiment themselves. The study also revealed that some girls are simply ignorant about their safe and unsafe periods. Others lack a functional appreciation of contraception options or how to use them effectively, with abuse as a predictable

[35] http://en.wikipedia.org/wiki/akpeteshie reports that *akpeteshie* contains as much as 40-50% alcohol by volume.

[36] Girls at Otabilkwa have a similar practice.

[37] http://en.wikipedia.org/wiki/prussian_blue

[38] In the context of this report, electronic porn includes sexually explicit music, movies and internet clips.

outcome (Section 4.2). Thus, it is not uncommon for the pill to be taken recklessly or for condoms to be rejected after the first course of intercourse.

Sheer poverty coupled with persistent pressures from men promising all manner of gifts were also noted as pushing many adolescent girls into acquiescing to sexual advances from older men (including some of their own teachers). In some of the poorest communities, hunger can drive a girl into occasional transactional sex. The urge among adolescent girls to conform and be seen in trendy, body-hugging clothes was also identified as a contributory factor to their increasing vulnerability to sexual predators. On the one hand, poor girls find that they succumb more easily to monetary "*favours*" which enable them to acquire these clothes. On the other hand, their male counterparts become more easily aroused when they see local girls dress in such revealing clothing. According to some adolescent males, they go as far as to steal from their own parents when they find themselves overcome with such lust. Adolescents of both sexes insinuated that a significant proportion of young girls were involved in soft forms of transactional sex, mostly with men in proximate communities. In some cases, girls from poor homes choose to get pregnant as a form of insurance if they perceive their partner's family to be relatively well off by local standards. This is sometimes done with the blessing of the poor girl's parents. Adolescent girls at Otabilkwa cited instances where a girl's parents would nudge her into an affair with comments like, "*can't you see your friends?*"

Risky sexual behaviours persist in all communities visited. Frequently, girls said their boyfriends insisted on unprotected sex on the pretext that intercourse was less fulfilling when performed with a condom. Boys routinely confirmed this, noting that "*it doesn't taste as good when one is wearing a condom*." At Bando, male youths described their female counterparts as timid, adding that "*they don't even demand that we use condoms*." Others observed that "*our local girls don't insist on our wearing condoms because they fear they might displease us … or even lose us to other girls*." In various interviews, boys were also noted to employ emotional blackmail, threatening to end relationships if girls insisted on their wearing condoms.

It is not only boys who demand unprotected sex, however. In many instances, boys indicated during the monitoring visits that their female sexual partners preferred unprotected sex either as a way of demonstrating the depth of their affection or on the basis of a groundless fear that the condom could dislodge into the vagina, leading to death. Some younger mothers at Dompoase opined jovially that sex with a condom "*lacks taste*"[39] and that it is more difficult for them to achieve orgasm. Adolescent girls at the same community had typically used condoms on their sexual debuts, but had promptly abandoned their use when mocked by their peers. Others feared that the "*rubber*" (presumably the latex) used for making condoms rendered them more susceptible to malignancies of the reproductive tract. Indeed, out of the ten mothers in that focus group, not even one was happy with using condoms. In some cases, girls were said to avoid contraceptive usage for fear that it might affect their future fertility. Anecdotal evidence suggests that stories of women who have experienced adverse side effects after using certain contraceptives may be a contributing factor to this phobia.

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[39] Meaning it is not gratifying.

According to both male and female respondents, only the most focused girls with clear life goals are uncompromising about condom use. This minority of girls were said to practise a "*no condom, no sex*" policy. The average girl, however, is greatly constrained in her ability to negotiate sex -- whether in saying no or in insisting on condom use.

Clearly, there is much more that remains to be done by way of adolescent education in order to separate sexual fact from myth/ superstition. In seeking to foster safer and more responsible outcomes for children and adolescents, it would be particularly useful to encourage greater parental openness on the subject of sexuality. If approached in caring and responsible ways within the trusted and more secure environment of the home, it would better enable adolescents and children to appreciate and manage their sexuality more responsibly.

The most common effects of teen pregnancy in the communities visited were girls dropping out of school because of pregnancy, disgrace and the inability to raise their babies properly owing to deficits in their parenting skills as well as challenges on the financial side.

4.4 Average age at first sexual intercourse

Children are making their sexual debuts early, often before they attain adolescence (Table 4.3). The start age in the monitoring sites is also often lower for girls (mean of 12) than for boys (mean of 13 years).[40] Indeed, in nine out of the twelve communities sampled, girls generally experience sex before they attain adolescence. In some communities, this even occurs before puberty.[41]

Table 4.3: Typical age at sexual debut (yrs)

District	Community	♂	♀
Agona East	Mansofo	18	13
	Namanwura	10-12	10-11
	Otabilkwa	12	12
Bongo	Ayopia	10-11	12
	Daliga	12	12
	Kunkuan	12	10-12
Builsa	Balansa	12	13
	Farinsa	12	11-12
	Takunsa	15	13
KEEA	Abina	9-10	10-12
	Bando	15	9
	Dompoase		12-13

[40] These means should be interpreted with caution as the sample size is relatively small and the methodology qualitative.
[41] Here, adolescence is equated with the teen years.

4.5 Average number of simultaneous sexual partners

Many adolescents -- both males and females -- have multiple sexual partners. Reasons cited for such behaviour include insecurity, lack of self-control, sheer unfaithfulness and, in the case of girls, poverty. The last factor (poverty) explains why girls tend to have more partners than boys at the sites visited (Table 4.4). The combined product of this behaviour, the young age at which children are starting sex and the reckless abandon with which unprotected sex is practised is indeed a horrifying prospect.

Table 4.4: Typical number of simultaneous sexual partners

District	Community	♂	♀
Agona East	Mansofo	2	2
	Namanwura	2	3
	Otabilkwa	2	1
Bongo	Ayopia	4	3
	Daliga	2	2
	Kunkuan	2	3
Builsa	Balansa	2	2
	Farinsa	2	2
	Takunsa	2	2
KEEA	Abina	3	3-6
	Bando	3	3-4
	Dompoase		3

4.6 Abortion care

Abortion is highly stigmatised and girls who are perceived to have undergone abortions are shunned by their peers. However, stigma has only succeeded in driving abortions underground, not deterring them. Affordability was cited as a key barrier to facility-based abortions. At around GH¢150-450 in Agona East[42], GH¢150 in KEEA, GH¢80-120 in Bongo and GH¢100 in Builsa District, few girls living in poor communities can afford the cost of a facility-based abortion.[43] Thus, girls seeking to abort a pregnancy often look for alternative means -- e.g. self-medicating on drugs prescribed by their peers, consulting the local druggist confidentially or choosing other questionable methods described in Section 4.2.

[42] Facility-based abortions available to women in Agona East are at Swedru and Winneba, and thus technically outside their district.

[43] The charge rises with the age of the pregnancy.

5. Key Recommendations

This section collates the key evidence-based recommendations emerging from the study.

For health sector statistics to be more relevant for policy and planning purposes, urgent steps will need to be taken to check the veracity of data emerging from the district directorates (Section 1.3).

To improve relationships between patients and care workers, health practitioners and facilities need to be more proactive in communicating with their clients (Section 2.2.1).

In order to ensure a more equitable access to relevant human resources, redistribution will be vital. This, of course, does not negate the urgent need for more staff at some facilities (Section 2.2.3).

The study found that the capability of service providers is not really at issue (Section 2.2.6). However, there is a larger issue regarding the persistence of negative health worker attitudes (Section 2.2.1). Improvements are required both in the education of service providers and in monitoring in order to ensure unfettered access to health services and to reverse discrimination and extortion in the implementation of health insurance. The wider public also deserve more effective education on the NHIS. Appropriate sanctions ought to be instituted and applied to deter unjust behaviours. The Justice Committees and the District Health Oversight Committees (DHOCs) need to be more proactive in checking abuse and protecting the rights of poor and marginalised populations.

Insurance subscriptions should only be sold to subscribers after they have been properly educated on their rights, privileges and remedies under the scheme (Sections 3.2, 3.3).

Greater transparency is needed in the interpretation of, and public education on, the "*free maternal care*" policy to make it clearer nationwide whether pregnant and postpartum mothers have to pay any costs and if so, which those are (Section 3.3).

The level of sexual misinformation among adolescents is high and the consequences are too grave for the subject of ARH to be left to chance (Section 4). Much remains to be done by way of adolescent education in order to separate sexual fact from myth/ superstition. In seeking to foster safer and more responsible outcomes for children and adolescents, it would be particularly useful to encourage greater parental openness on the subject of sexuality. If approached in caring and responsible ways within the trusted and more secure environment of the home, it would better enable adolescents and children to appreciate and manage their sexuality more responsibly and safely.

Annex 1: Facilitating a Community Score Card

* Lead-in question(s) for teasing out group's criteria (a.k.a. indicators) for assessing service quality:
  - "Are you happy with your health facility?"
  - "Why/ why not?"
* Make up a max of 8 performance criteria by adding from list below:
  - Politeness/ respect
  - Punctuality of staff
  - Adequacy of staff (numbers)
  - Promptness of service
  - Affordability of service
  - Quality of information/ guidance received
  - Effectiveness of treatment

  Note: Criteria should all be "positive" -- i.e. a higher score should mean higher satisfaction
* Get the group to score each criterion, taking note of the discussions that take place during the scoring negotiation
* ***Continually probe*** *for* ***(a)*** *explanations/ reasons,* ***(b)*** *outliers,* ***(c)*** *outcomes,* ***(d)*** *citizens' reactions and* ***(e)*** *anecdotes*
* Ask group to propose "simple, doable recommendations"

Annex 2: Community-Level Field Guide (Adolescent Groups)

District:
Community:

Adolescent Focus Groups

- Separate ♀ from ♂
- Group description: number, approx age band
- Service providers should be separated from other community members
- Remember to "interview the visual"

* Investigate functionality of **NHIS** -- e.g.:
  – Proportion of adolescents who have access
  – Overall satisfaction with NHIS
  – Challenges relating to NHIS
  – Coping strategies employed when they cannot access formal care

* Access to contraceptives
  – Ease of access
  – Specific types available
  – Types **not** available
  – Hindrances to access

* Access to relevant information on reproductive health

* Access to adolescent counselling services

* Are services youth-friendly?

* Level of stigma and discrimination around contraception and abortion

* Teen pregnancy
  – Trend
  – Causal factors
  – Effects

* Ability to negotiate safe sex

* Average age at first sexual intercourse

* Average number of simultaneous sexual partners

* Suggestions for improving health outcomes for adolescents

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