SEXUAL AND REPRODUCTIVE HEALTHCARE

Report on 2019 Scorecard

(South Dayi and Akyemansa Districts)

Alliance for Reproductive Health Rights (ARHR)

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Acronyms and abbreviations

ARHR	Alliance for Reproductive Health Rights
CHN	Community Health Nurse
COVID	Coronavirus Disease
CSC	Community Scorecard
DA	District Assembly
DDHS	District Director of Health Services
DHMT	District Health Management Team
FBC	Full Blood Count
FBS	Fasting Blood Sugar
FDA	Food and Drugs Authority
FGD	Focus Group Discussion
GH¢	Ghana Cedi
GHS	Ghana Health Service
IDRC	International Development Research Centre
MEL	Monitoring, Evaluation and Learning
MoMo	Mobile Money
MP	Member of Parliament
NCA	National Communications Authority
NHIA	National Health Authority
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
PRA	Participatory Rural Appraisal
RCH	Reproductive and Child Health
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health[care]
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UHC	Universal Healthcare
UTI	Urinary Tract Infection
VEReF	Volta Educational Renaissance Foundation

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1. Introduction

1.1 Background

As global health goals relating to improved quality of care migrate into country level health policies and strategies, states must find ways to prioritise patient satisfaction and service quality as the evidentiary basis for improved patient outcomes. Furthermore, with the 2030 Sustainable Development Goals (SDGs) in focus – specifically, SDG 3.7: *Ensuring universal access to sexual and reproductive health-care services* and SDG 3.8: *Achieving universal health coverage* – there is need to pursue patient-oriented research to unpack the unique causes of poor reproductive health outcomes.

The community scorecard (CSC) approach has been employed in this study as a community-led monitoring, evaluation and learning (MEL) tool that enables citizens to assess the quality of reproductive health services. The approach provides an opportunity for decision makers at subnational and national levels to leverage the views of the women and adolescent girls within the health system, to enhance its responsiveness to their needs. Using qualitative methods such as interviews and focus group discussions, the CSC gives voice to these often-overlooked vulnerable community groups.

The present study recognises the significance of patient-centred care within a universal healthcare (UHC)-focused system and will contribute to improved quality sexual and reproductive health care, for at-risk women and adolescent girl groups in Ghana.

1.2 Purpose of report

The report documents the experiences and perceptions of citizens in seven communities regarding the state of healthcare service delivery with particular reference to sexual and reproductive health (SRH). Future rounds of the study will explore whether and how these perceptions are changing, assess the contribution of the research, and draw lessons for effective citizen-led advocacy. Ultimately, it is expected that these efforts will increase the health sector's appreciation of clients' views and needs, strengthen citizens' capacity to hold duty bearers to account for the quality of service delivery and rouse healthcare workers to deliver services more responsively and effectively.

1.3 Methodology

The assessment was conducted using the community scorecard as the main rubric. Previous work suggests that service providers do not appreciate clients' views and that clients lack the empowerment to demand credible improvements in services. Based on the study's objective of influencing change in service delivery, the scorecard was identified as a suitable action research tool.

The scorecard builds on techniques common to the participatory rural appraisal (PRA) research tradition such as scoring, semi-structured interviewing and probing. The conversational approach makes the scorecard particularly attractive for assessments with participants in poor and largely illiterate communities. In the spirit of action research, the scorecard goes beyond mere report production to actively facilitating citizen-provider engagement as a deliberate strategy for strengthening citizen voice and fostering downward accountability.

The fieldwork took place in October 2019 in eight communities across two districts – Akyemansa and South Dayi and was conducted by a team of six fieldworkers.

The assessment was conducted mainly with female focus groups distinguished by age. For each community, two focus groups were constituted – one comprising adolescent girls between the ages of 15 and 19, and the other made up of distinctly older women of child-bearing age (35-49). These demand-side focus group discussions (FGDs) were complemented with supply-side interviews with staff of the respective local health facilities. The composition of the groups interviewed is summarised in Table 1.1, below. In each community, the facilitation team worked to elicit participants' satisfaction on three sets of UHC indicators of accessibility, affordability and quality of service.

The discussions were facilitated, using a five-point satisfaction scale, to indicate clients' assessments of their local service providers on each of the pre-determined indicators. They were also asked to explain their scores and describe their experiences. After they had described their individual experiences for a single indicator, the facilitator would sum up and ask the group to score the facility as a whole on that particular indicator.

The final step in this round comprised a series of interface meetings between citizens and duty bearers, at which specific and actionable commitments were elicited from the latter to address the identified gaps in service delivery. To that end, multi-stakeholder engagements were held in Akyemansa and South Dayi Districts at which feedback from the research was shared with healthcare providers and other district-level policy actors. The meetings sought to foster consensus on the study's conclusions and, based on that, jointly agree on actions to resolve the bottlenecks in delivering quality healthcare to women and adolescent girls in the participant districts. The meetings were held in March 2020, just before the Government of Ghana imposed a range of lockdown restrictions as part of its measures to control the spread of the COVID pandemic. Among the key stakeholders involved in these engagements were the respective District Directors of Health Services (DDHSs), heads of selected health facilities, officials from the two district assemblies, community representatives, civil society actors, traditional and religious leaders, and the print and broadcast media.

TABLE 1.1: COMPOSITION OF FOCUS GROUPS

COMMUNITY	COHORT 1		COHORT 2		COHORT 3
	AGE	NO. OF ♀	AGE	NO. OF ♀	NO. OF STAFF
SOUTH DAYI DIST					
Tsate	15-19	9	35-49	7	2
Peki-Adzokoe	15-20	9	35-49	8	5
Abui Tsita	15-19	7	35-48	7	1
Wegbe Kpalime	15-19	7	35-48	7	5
SOUTH DAYI DIST					
Ayirebi	15-19	9	35-49	8	4
Brenase	15-20	6	35-49	7	2
Kotokuom	15-19	6	35-49	7	1

1.4 STRUCTURE OF REPORT

The report has nine sections. Following this introduction, Sections 2-8 present the findings for each study site in turn. The final section presents a set of key recommendations distilled from the analysis of the study findings for the attention of the pivotal state institutions – especially Ghana Health Service (GHS), the District Health Management Teams (DHMTs), National Health Insurance Authority (NHIA) and Food and Drugs Authority (FDA).

2. Experiences of clients at Tsate

2.1 SCORECARD RESULTS, TSATE

Clients and service providers alike were very satisfied with the indicators on quality of service and on most of the affordability indicators for their CHPS facility (Table 2.1). However, clients were clearly dissatisfied with the availability of medicines and related medical supplies – a situation that drives some to explore less credible healthcare options such as sharing medicines and self-medicating through drugstores.

TABLE 2.1: SUMMARY OF SCORECARD RESULTS, TSATE

Indicator	Age 15-19	Age 35-49	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	5	5	4
Availability of medicines	1	2	3
Availability of equipment	1	0*	3
Affordability indicators			
Cost of consultations	5	4	5
Cost of medicines and services	4	1	4
Health insurance	4	5	5
Quality of service indicators			
Respect for clients	5	5	5
Promptness of service	5	3	5
Confidentiality and privacy of care	5	5	5

** The group insisted on scoring 0 (below the bottom score of 1) to emphasise their dissatisfaction.*

The scores and experiences on the disparate indicators are discussed in more detail below.

ACCESSIBILITY OF SERVICES

All of the three cohorts interviewed assessed the accessibility to health services to be good, with a minimum score of 4. Indeed, both citizen groups (adolescent girls and middle-aged women) scored the facility a full 5.

The high level of satisfaction is interesting, considering that the facility has some of the lowest staffing levels – just two professional staff (a midwife and a community health nurse (CHN)) – and is isolated from other facilities higher up the healthcare delivery chain. By comparison, the health centres at Wegbe Kpalime and Peki Adzokoe (in the same district) each have nine professional workers – nearly five times as high as Tsate's.[1] That both of Tsate's health workers are resident at the facility appears to be a significant factor in the community's positive assessment of accessibility to healthcare. Further, the two caregivers try not to travel at the same time – even on weekends – to ensure that a skeletal level of service is still available in the event of an emergency. The older women noted that the staff are supportive and provide referrals even when they are on leave. Clients further appreciated the fact that the health workers also visit them in the community to enquire about and discuss their health issues and general wellbeing.

The main services patronised by clients include family planning, antenatal care, attended deliveries, basic postpartum care, treatment for intimate infections, HIV

[1] Ayirebi Health Centre (in Akyemansa District) has 13 professional caregivers.

testing, basic breast examination and counselling on SRH issues such as menstrual complications, vaginal infections and menstrual hygiene challenges. Adolescents valued the counselling they received on breast self-examination and how to manage "*white*" (candidiasis) infections, particularly the advice they receive on sun-drying their underwear as a way of minimising vaginal infections. They also appreciated the facility's practice of supplementing its SRH education efforts with outreach campaigns in the churches.

Records suggest that the facility serves approximately 170 to 180 a month (up to 40 clients per week). They also attend between three and five deliveries each month. Relative to the staff strength, these statistics are significant when compared with those for better-resourced facilities in the study.

Participants were generally comfortable with the 40-minute to one-hour walking distance to the CHPS facility. During labour, however, it is common to travel to the facility on a commercial motorbike (locally known as an "*okada*"), in which case the travel time is reduced to around five minutes. Clients further noted that when they are referred (typically because their issues are beyond the capacity of the CHPS facility), it is a huge challenge travelling to the district capital (Kpeve) or to Gemeni. This is because passenger transport services only operate to and from Tsate infrequently (on Tuesdays, Thursdays and Fridays) mainly because of its isolation and the rutted nature of the road surface.

Curiously, the adolescent girls perceived family planning as a service "*for older women*," contending that it predisposes them to a promiscuous lifestyle and related sexually transmitted infections (STIs). Quite clearly, more needs to be done to assist Tsate's adolescents to appreciate the benefits of modern family planning services. However, this ought to be done in a way that respects their desire to delay sex.

The research team also observed that the facility lacks running water, which raises questions concerning the state of hygiene surrounding deliveries and maternal care. Under the circumstances, water sometimes has to be carried over long distances from individual homes for women accessing delivery services at the facility. Often too, water has to be paid for at the high cost of GH¢1 for a mere 25-litre measure.

AVAILABILITY OF MEDICINES

Clients were very dissatisfied on this indicator, with the adolescent girls and middle-aged women scoring the facility just 1 and 2 respectively. Participants observed that drugs prescribed by the staff are often unavailable at the facility. The main medicines that are most readily available are the most basic ones – such as paracetamol, antimalarials, multivitamins, B complex pills. Staff confirmed that medicines were often in short supply, scoring the facility a modest 3, but felt that they tended to be blamed unfairly for a situation that is entirely beyond their control.

The lack of drugs at the facility is not merely inconvenient; it increases treatment costs and compels citizens to explore unconventional options. The community has no drugstore, so clients of the facility are required to travel to Gemeni at a cost of

GH¢8 to procure the medicines prescribed for them. The seriously rutted roads were cited as a further hindrance. Because of these problems, some participants said they circumvent the formal healthcare system by resorting to a range of local herbal preparations. Another coping strategy employed by the women is to rely on local pastors for spiritual answers to their healthcare questions. The adolescents recognised some of the risks involved, conceding that "*these herbs can affect one's health if a person is carrying a pregnancy*." This is because these options tend to be untested and thus lack the approval of the Food and Drugs Authority (FDA). By contrast, the older cohort failed to appreciate the dangers which these unorthodox remedies expose them to, probably because they were less literate than the adolescents.

AVAILABILITY OF EQUIPMENT

Participants were scathing in their assessment of the availability of equipment at the facility. The younger cohort settled on the bottom score of 1, saying they had only observed a manual sphygmomanometer, a thermometer and a weighing scale at the facility. They did not understand why a facility that provides delivery services should lack a laboratory or the ability to scan for foetal heartbeats. On this, it is clear that they do not appreciate the CHPS policy and the hierarchy of facilities within Ghana's healthcare delivery system. As the staff explained, they are limited in the range of services they can render, along with the associated equipment they are entitled to, being a "*Level A*" facility. They noted that while the equipment situation could do with some improving, they make do with a boiler (for sterilisation) and a set of artery forceps and dissection forceps (for maternal care and delivery services).

The older women reported that they "*have to travel all the way to Peki … to access laboratory services or to do a scan*." The transport charge for each such visit is GH¢15, an amount the women consider to be prohibitive. This further contributes to their reliance on herbs and spiritual healthcare options, regardless of the efficacy. They also complained that family planning methods are chosen for them without any evidence of an assessment to determine which methods may be best for them. Describing the facility as "*undeserving of a score*" in respect of this indicator, they assigned a score of zero to emphasise their displeasure. In response to the women's adverse assertion regarding how family planning options are assigned, the health workers indicated that they have and do use a wheel chart. The confusion can probably be resolved by opting for a deliberately transparent and participatory approach when selecting family planning methods, so that clients can feel involved and see how the decision was arrived at – even if they cannot fully understand the finer mechanics.

COST OF CONSULTATIONS

All groups interviewed considered consultation costs to be affordable. The older cohort of women scored the facility 4 on this indicator, while the adolescent girls scored the facility the maximum 5 points. Participants reported that they experience no charges for consultations. As one adolescent observed, "*we do not have to pay upfront when consulting …*.". An older woman confirmed thus: "*it is free; we do not pay anything*." The only reason the older women declined to give a perfect score was because consultations had not always been free in the past.

COST OF MEDICINES AND SERVICES

While the adolescents considered the cost of accessing the facility's services to be affordable (with a corresponding score of 4), the older women were much less positive, scoring a low 1. On their part, the adolescents noted that, on several occasions when they did not have money to pay upfront for services, the health workers went ahead to provide services based on assurances that the girls would return with the payments. The girls said they had been faithful in honouring their part of the bargain and that they did not leave these bills unpaid.

There were significant divergences in the claims of clients and health workers regarding the costs of family planning commodities. Clients said they were charged GH¢2 for short-term (three-month) options and GH¢10 for longer-term options. By contrast, the staff said that short-term options only cost clients 50 pesewas. The reason for the disparity is unclear and may need following up on.

Participants also alleged that receipts were not always issued for payments made and that they were sometimes confronted with unexpected charges. They observed that women in labour were required to bring along a range of items (such as bleach, toilet soap and antiseptics for disinfecting the utensils and linens used in delivering the babies). They said they were also required to pay between GH¢70 and GH¢90 after delivery. The differential in the delivery charge is reportedly based on the baby's sex, with baby boys ostensibly being more challenging to manage. Participants said such payments were not covered by official receipts. Women said they start saving up toward this expenditure once they discover they are pregnant. It appears, however, that the older women's score of 1 was also influenced by the poor drug supply situation, which some could not resist factoring into the discussion on costs.

On their part, the caregivers noted that services such as antenatal care, HIV testing, checking a client's weight and blood pressure, and counselling are all done free of charge for clients with NHIS subscriptions. They contended, however, that some women ignore the advice they are given during their antenatal sessions and show up for delivery "*empty-handed – without delivery items such as delivery pads, toilet rolls, delivery mats and clothing for their babies*." Under such circumstances, the midwife noted that she is compelled to use her own resources to provide these personal items, for which she has to recover her money. This may explain the circumstances under which no receipts are issued for payments made. Still, it ought to be followed up on by the CSO and health authorities.

HEALTH INSURANCE

With a minimum score of 4, the focus groups were united in their satisfaction with the operation of the National Health Insurance Scheme (NHIS) at Tsate. They also noted that it was easy to renew expired/ expiring cards at the CHPS compound. Somewhat surprisingly, however, while five of the nine adolescents had valid subscriptions, only one of the seven older women did. This may be attributed, in part, to the considerably lower cost which adolescents have to pay for subscriptions, with annual renewal costs of GH¢7 for those below 18 years, compared with GH¢25 for adults.

According to the discussion groups, a non-subscriber may be billed as much as GH¢50 on a single visit to the facility, depending on the specific issues she presents with. This can be a huge burden in this largely agrarian community where most households subsist on low incomes with low resilience, worsened by increasingly capricious rainfall patterns. Such households easily turn to alternative healthcare options – such as seeking spiritual resolutions or relying on local herbs of disputable efficacy. Others may self-medicate based on what may have been prescribed for a friend with a similar condition. However, participants also observed that, for similar health issues, paying clients appeared to receive more drugs than non-paying clients. That notwithstanding, they agreed that it was much better to have a subscription.

Participants observed that the fact that subscriptions can no longer be initiated at the community level posed a significant deterrent for first-time subscribers. They complained about the challenges associated with of having to travel to the district capital, Kpeve, for that initial service. These challenges have arisen since the introduction of a somewhat centralised biometric registration process designed to curb abuses of the scheme. Some clients spoke of "*very long queues*" or of officials "*demanding bribes before processing [their] subscription applications*" when they travel to Kpeve. A participant related her experience thus: "*those of us who are not able to bribe [have to] sit there from morning to evening*." It is unclear, however, whether the issue of long queues and extortion persist, with recent improvements nationwide in the situation regarding the biometric equipment.[2]

RESPECT FOR CLIENTS

Both citizen cohorts were completely satisfied with their health workers' sensitivity and courteousness, scoring them 5 on this indicator. The younger participants used expressions such as "*good*" and "*God-fearing*" in describing the health workers and their relationships with them. A young girl described being welcomed pleasantly to the facility, with staff asking about her wellbeing. The girls attributed the amiable relationship to the fact that the staff live on the premises and hence "*see the community members as part of their wider family*."

Some spoke of the sacrifices the personnel make because of the familial relationships with community members. They told of how staff make some time to attend to pressing cases before going to church on Sundays. A participant spoke of a nurse "*[staying] back one Sunday morning to administer a couple of infusions before leaving for church*." Another confirmed the warm and familial disposition of the staff, noting how "*the midwife [goes the extra mile] to advise us to use Peki while she is away on leave*." Another mother depicted her experience of childbirth as "*easy*," attributing this to

[2] When the biometric registration process was introduced several years ago, internet connectivity challenges, power outages (with associated rationing) and frequent system crashes caused routine disruptions, facilitating widespread rent-seeking behaviour in NHIS offices nationwide. The incentives facilitating such extortionist behaviours no longer exist in many parts of the country.

the quality of delivery care she received at the facility. Clients also appreciated the fact that staff visit them in their homes "*to see how our sick children are faring*."

PROMPTNESS OF SERVICE

While the adolescents scored the facility the full 5 points for promptness, the older women scored a more modest 3. However, the lower score by the older cohort was explained by the fact that the caregivers sometimes have to leave the facility to provide child welfare services outside the health facility, resulting in delays in attending to clients who are waiting at the facility. They appreciated that this arose because the facility had only two serving professionals. To compensate, "*they are available on weekends, when necessary*" to attend to clients. That said, some women said they occasionally sensed a little irritation when they visited the facility over weekends with non-urgent issues. They added, however, that pregnant women always received priority attention, even on weekends.

Participants estimated that it typically takes about half an hour to be attended to, if the client already has a hospital identification card. They acknowledged, however, that waiting times were longer on days when many clients visit the facility. Service delivery may also be slower on weekends when staff have competing household chores to attend to.

CONFIDENTIALITY AND PRIVACY OF CARE

All groups interviewed scored the facility 5 on this indicator too. An adolescent depicted the staff as "*keepers of secrets*" and remarked that staff were at pains to keep clients' confidentiality. Another added: "*one can speak freely because the consultation [for SRH services] is not done at the OPD, but at the weighing room*." The older cohort were likewise confident that information they gave out was not divulged.

3. Experiences of clients at Peki-Adzokoe

3.1 SCORECARD RESULTS, PEKI-ADZOKOE

The summary scores from the Peki-Adzokoe focus groups in respect of their local health centre are presented below, in Table 3.1. Somewhat similar to the situation at Tsate, clients at Peki-Adzokoe scored their facility poorly on the accessibility of medicines and equipment. Owing to persistent deficits in the availability of medicines, some clients either resort to using herbal remedies or refuse to renew their insurance subscriptions when they expire. The adolescents expressed misgivings about unsavoury attitudes among some health workers.

TABLE 3.1: SUMMARY OF SCORECARD RESULTS, PEKI ADZOKOE

Indicator	Age 15-20	Age 35-49	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	3	5	5
Availability of medicines	2	1	2
Availability of equipment	1	1	1
Affordability indicators			
Cost of consultations	5	5	5
Cost of medicines and services	3	1	5
Health insurance	4	2	4
Quality of service indicators			
Respect for clients	2	5	5
Promptness of service	4	5	4
Confidentiality and privacy of care	5	3	2

ACCESSIBILITY OF SERVICES

Participants had mixed responses on this indicator, some quite unflattering. It only takes community members some 10-20 minutes or so to walk to the facility, owing to its central location, so they do not need to pay for transport. However, the adolescents were entirely unimpressed about the *de facto* availability of staff, even though the facility has as many as nine professional care givers. They said that apart from the staff often reporting to work late, their attention was also divided while they were at post. It irked them to sometimes "*observe the nurses using their phones or browsing*" but added, "*we go there because it is [geographically] accessible … even though we are not benefiting from the centre*." They further contended that they were sometimes turned away by the health workers when they returned to the facility with unresolved issues. The fact that the facility does not open on weekends was another factor detracting from participants' assessment of how accessible services are. Arguably, **their score of 3 masks the depth of negative sentiment on the indicator**. The older women and facility staff both awarded a score of 5, presumably focusing mainly on the geographical dimensions of access.

AVAILABILITY OF MEDICINES

Scores on this indicator were poor, with a poor 2 at the highest – even in the view of the facility's staff. Participants asserted that a single drug was prescribed for all manner of conditions they presented at the health centre with. They asserted that they were typically told that they could only be supplied with other drugs if they were prepared to pay upfront – even with NHIS subscriptions. They alleged that the health workers defended this position by claiming that these other drugs (besides basic ones like paracetamol and iron supplements, along with those for regulating high blood pressure) were not received from the Regional Medical Store but had been procured from private sources. Yet, state regulations expressly require facilities to source all their drug supplies from their respective regional stores, and explicitly forbid them from purchasing drugs from the open market even in the event of stockouts.

As a coping strategy, and to circumvent the high costs of formal medicines, participants said they resort to the use of traditional herbal remedies such as "*pepree*" and "*liliti*". Others said they practise self-medication, facilitated by the fact that there is a pharmacy within the settlement.

AVAILABILITY OF EQUIPMENT

All three cohorts assigned the lowest score (1) in their discussions of this indicator. Clients claimed that they were only aware of a weighing scale, a blood pressure monitor and some thermometers. These they considered to be grossly inadequate for delivering effective SRH services. The older cohort of women were especially concerned that a health centre would lack a scanner, compelling them to be referred either to Peki Government Hospital or to Ho Municipal Hospital for assessments. They asserted that they were inclined to ignore the health centre and seek services elsewhere because of this. One woman described how she was referred to Ho each time she made her antenatal visits. However, a combination of the recurrent transportation cost and the bumpy ride persuaded her to stay at home instead. Health workers confirmed that expectant mothers often complained of aches after referrals to Kpeve in particular.

According to the health workers, **pregnant women were not attending regularly for antenatal care owing to the dearth of diagnostic equipment. In their assessment, this predisposed them to avoidable complications during delivery**. Recently, however, facilities in the sub-district have begun to network and share resources. Thus, occasionally, one of the facility's two midwives assembles all of the pregnant women needing assessment and travels with them to the Wegbe-Kpalime facility to use their mobile ultrasound scanner. Alternatively, they sometimes request the scan attendant to visit Peki-Adzokoe with the scanner when they have assembled five or six pregnant women. While the health workers acknowledge this arrangement as having enhanced their access to vital equipment, they nevertheless point out that it remains a more restrictive and less convenient service than if they had such facilities on site.

Participants perceived that no equipment was used to assess them prior to the facility prescribing family planning methods for them. Several clients shared experiences of how they had to have the initial family planning methods replaced owing to adverse side effects. A woman in the cohort of older women narrated how she started losing weight and feeling sick after she had been put on a five-year plan. Because of this, the device had to be removed after just a year, resulting in her promptly getting pregnant.

COST OF CONSULTATIONS

Clients and staff alike had no reservations regarding consultation costs. All scored the facility 5 on this indicator. Each group affirmed that the facility does not charge for SRH consultations, even for clients who do not have valid NHIS subscriptions. The adolescents said there is a charge of GH¢2 which first-time clients must pay for a personal folder but agreed that the cost was not an issue.

COST OF MEDICINES AND SERVICES

While clients generally thought the cost of medicines and services were prohibitive, staff of the facility considered these costs to be entirely reasonable. Clients asserted that there were so many services which their insurance premiums did not entitle them to access for free. In the words of an adolescent, "*we still have to pay for services*." Another contended that she paid no less than GH¢20 for an injection and that staff often claimed, "*it is not hospital medicine, so we have to pay ….*" An older woman told of having developed chest pains during her pregnancy. She said she was put off by the GH¢100 cost quoted for a chest scan upon referral, so she opted to "*explore home remedies instead*." She still lives with the pain. Various colleagues in her cohort cited birth control costs in the region of GH¢15 for five years' protection, GH¢10 for three years, GH¢3 for three months and GH¢2 for a single month.

With scores of 3 and 1, the client cohorts said they opt for traditional medicine (mainly herbs) as a coping strategy. Those who are better off simply choose to utilise other facilities farther afield where they are assured of a wider range of services. Others said they got pregnant while waiting to access the family planning services.

On their part, **the healthcare workers stated that several SRH services are excluded from the NHIS package at their facility**. However, they considered these to be highly affordable, scoring 5 on this indicator. The considerably lower charges they cited for family planning services – GH¢0.50 for a month's protection, and GH¢2 for all of the other protection methods lasting from three months to five years – buttressed their point. According to them, they also provide free condoms to those who request it. They added that the key logistics which a woman must come along with when she reports in labour include sanitary towels, a mackintosh for the bed, a delivery mat, antiseptic, bleach and baby clothing.

HEALTH INSURANCE

There were mixed feelings regarding the efficacy of the health insurance scheme, but the adolescents and facility staff were quite satisfied on the whole. The older cohort of citizens scored 2 on this indicator, with the other groups scoring 4. Six out of the nine adolescents said they had active NHIS cards, asserting that this enhanced their access to formal healthcare services. However, they were daunted by the long queues they have to endure at Kpeve as first-time NHIS registrants. Some narrated stories about how they had to make return journeys because "*the machine had broken down*." They also observed that Kpeve market days were particularly notorious for long queues at the NHIS office, presumably because it was easier for citizens from all over to access transport services. Despite this challenge, they felt it was useful to have the card because "*disease does not inform you before striking*."

Many of the older women refuse to renew their NHIS subscription upon expiry because they perceive that "*most of the medicines prescribed when [they] report with SRH issues are not covered by the insurance*." They observed that they are "*always made to go and buy [these medicines] elsewhere*." Others felt that medicines covered by the NHIS are merely intended to "*relieve symptoms*" – compared to the "*potent*" ones which treat the root causes but which they are compelled to pay for.

Under the circumstances, a participant opined that "*there is no need to subscribe for health insurance*." She shared an experience from one visit to the health centre when she was told that the medicine which she needed had run out but was approached by a health worker soon after, offering to sell her the same medicine, which she bought. Because of this experience, she no longer attends the health facility, opting instead to go directly to the pharmacy for treatment. Another participant narrated how, on one visit to the facility during her pregnancy, she was told diagnosed as being anaemic but was told that the medicine she required was not covered by the insurance. As a result, she was made to pay GH¢20 for it.

RESPECT FOR CLIENTS

While the adolescents felt that they were not treated courteously, the older women were full of praise for the gracious countenance of the facility's staff. The two groups scored the facility 2 and 5 respectively on this indicator. The adverse observations voiced by the adolescents included nurses spending too much time chatting among themselves or on their phones. The contended that it would appear more respectful if nurses cut their private discussions short once a client walked into the facility. Some said that well-educated clients appeared to receive priority attention while illiterate clients were discriminated against. One narrated how her pregnant sister had delayed going to Peki for an ultrasound scan she had been referred for because she was broke at the time. Unfortunately, while she was waiting to mobilise funds for the journey to Peki, she went into labour. This allegedly so upset the midwife that the family had to plead extensively before she agreed to attend to the lady.

Staff conceded occasionally raising their voices when they perceived it to be "*in the interest of the client*." A nurse shared an example of how she once yelled at a mother who had brought her child to the facility for treatment. According to her, she had instructed the mother to prepare a suspension by stirring a powdered medication into water before administering it to the child only to find the mother administering the dry powder to the child. Some adolescents likewise felt that clients sometimes deserved the unkind treatment they received because they report very late with serious conditions, often involving young children.

PROMPTNESS OF SERVICE

Participants agreed that services are quite prompt at the Peki-Adzokoe Health Centre. They observed that the facility was not a very busy place. However, they also noted that the out-patient department (OPD) did not always open on time. Staff admitted that they were wanting when it came to punctuality. Some explained that, on market days, they visited the market before making the journey to work. The citizen groups scored them 4 and 5 on this indicator.

CONFIDENTIALITY AND PRIVACY OF CARE

Overall, community members were confident that staff did not divulge their health secrets. However, women in the older focus group noted that the OPD was not spacious enough and, thus, clients were compelled to use the adjoining veranda as a waiting area. They mentioned further that the window of the consulting room opens out onto a section of that veranda, which had the potential of compromising

the confidentiality of conversations taking place in the consulting room, especially during the facility's peak periods. They asserted that this had kept some people from patronising the facility's SRH services. For these reasons, they scored the facility 3 on this indicator.

On their part, the adolescents scored the facility 5, acknowledging that the health workers speak in soft tones during consultations. The score is somewhat surprising considering the concerns raised by the staff and the older women, both of whom identified some significant threats to privacy stemming from the design of the facility. The health workers in particular described the layout of the health facility as "*not being privacy friendly*". One added that she wished she could shut the door to the consultation room but was unable to do so because the room was hot during the day. Indeed, the health workers believed strongly that some girls who would have wished to access the facility's adolescent corner services were shying away from doing so because the service shares a common space with family planning. Based on these experiences, the staff score the facility 2 on this indicator.

4. Experiences of clients at Abui Tsita

4.1 Scorecard results, Abui Tsita

The summary scores for Abui Tsita are presented below, in Table 4.1. Clients were very happy with the quality of service, but very dissatisfied with the accessibility and affordability indicators.

Table 4.1: Summary of scorecard results, Abui Tsita

Indicator	Age 15-19	Age 35-48	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	5	2	3
Availability of medicines	1	1	3
Availability of equipment	0*	1	3
Affordability indicators			
Cost of consultations	--	5	4
Cost of medicines and services	2	1	3
Health insurance	1	1	3
Quality of service indicators			
Respect for clients	5	5	5
Promptness of service	5	5	5
Confidentiality and privacy of care	5	5	5

** The group insisted on scoring 0 (below the bottom score of 1) to emphasise their dissatisfaction.*

Accessibility of services

The group of adolescent girls was very satisfied with the accessibility of SRH services at their local CHPS compound. On average, the facility attends to about 90 clients per month. For the average resident, it takes just about five minutes to reach the facility. However, those from better endowed households prefer to access

services at the larger facilities at Peki and Gemeni (partly because of occasional flooding and other challenges cited in the next few sections). Despite these, the adolescents gave a score of 5.

Citing cyclic flooding problems, the older women were much less satisfied and scored the facility 2 on this indicator. Being older, they appear to be disproportionately impacted by the annual floods that hit parts of their settlement. At the height of the rainy season, the floodwaters are reportedly knee-deep, posing very real constraints to pregnant women and new mums wishing to visit the facility. According to the health workers, this barrier encourages residents to "*resort to medications from drug peddlers who visit the community – a situation that often led to … complications especially for pregnant women*." Citizens however appreciated the fact that the nurses are resident at the health facility and thus "*always available to render health services*" to them.

AVAILABILITY OF MEDICINES

Clients said they experienced serious challenges with accessing medicines when they visit their CHPS facility with SRH complaints. For this reason, both citizen groups scored the facility a mere 1 on this indicator. The health worker interviewed confirmed routine stockouts. Further, supplies are often mismatched with the needs of the facility. As a result, clients are typically expected to buy their medicines from elsewhere based on "*prescription notes*" written for them by the nurses. The adolescents perceived that in as many as eight in every ten visits, they were made "*to go and buy medicines elsewhere*." This they find expensive. The older women said they are made to show such medicines procured from outside to the health workers "*for approval*" before using them.

Both client groups reported falling back on traditional herbs, owing to the challenges with the availability of medicines at their CHPS facility. They found this option to be convenient and much less expensive too. That said, commodities for family planning services were reportedly almost invariably available.

AVAILABILITY OF EQUIPMENT

Clients were altogether disappointed that what they considered to be basic equipment for maintaining a healthy pregnancy – such as equipment for monitoring foetal heartbeats and ultrasound scanners – were not available at the facility.[3] Staff affirmed that the facility does not even have a sphygmomanometer for checking clients' blood pressure. Both citizen groups also perceived that there were no tools for matching an individual with the ideal family planning method for that person. A woman in the older cohort said she became pregnant when she unilaterally abandoned the family planning method she was placed on because it caused her waist pains. Underscoring her frustration with the equipment situation,

[3] Contrary to clients' perceptions, ultrasound services fall outside the range of basic-level services for CHPS (Level A) facilities.

one adolescent said, "*all they have at the facility are beds and something that looks like a measuring tape*." To emphasise the depth of their dissatisfaction, the adolescents scored the facility 0 (below the bottom score of 1), while the older women scored 1.

Participants described serious consequences of not having an ultrasound scanner at their CHPS compound. For a start, they often skip the ultrasound referrals to Peki Hospital or Jayjay Health Centre "*due to financial constraints*." The older women perceived a resulting chain reaction in which they tend to encounter avoidable challenges when their babies are due, owing to their having disregarded the ultrasound referrals. They perceived that the resulting challenges they run into during labour compel them to be referred to Peki Hospital for specialist attention. Some of them shared accounts of instances when they were so referred but ended up giving birth on the way to Peki because of the long distance (c. 45 km; or 1hr 30 min), compounded by the time lost in labour and undergoing initial assessments at Abui Tsita. One said she lost her baby on one such journey. The women perceived that they would not have lost their babies or delivered on the road had there been an ultrasound machine at the Abui Tsita CHPS compound.

COST OF CONSULTATIONS

The facility does not charge for family planning consultations but applies a flat GH¢5 charge for other SRH consultations. For clients with valid NHIS subscriptions, all consultation costs are borne by the scheme. The older women scored the facility 5 for this indicator while the sole nurse interviewed scored the facility 4. The scoring by the adolescents is expunged because it wrongly included considerations outside this indicator.

COST OF MEDICINES AND SERVICES

Participants were very unhappy with the broader array of expenditures they are required to bear when they visit the health facility with SRH issues and scored the facility 1 accordingly. They noted that referrals can entail heavy financial outlays. A woman narrated how she ended up borrowing GH¢100 to finance a referral to JayJay Health Centre in Tsanakpe.

The health cost of the coping arrangements which clients employ can be dear. A participant in the women's focus group recounted how she had to switch to traditional medicines as a fallback because she could not afford the drugs prescribed for her by the facility. Participants told of an incident when a woman from the community lost her life after staying at home and relying on such traditional remedies. Others share their medicines with their friends/ neighbours who cannot afford the drugs prescribed for them.

To aid clients who are unable to finance their drug costs outright, the health workers sometimes pre-finance these medicines and resell them to clients on credit – this in clear breach of sector guidance on drug procurement by public facilities. Regardless of the motivation, this practice remains unregulated. Sadly too, many clients fail to honour their payment plans. Such clients often end up avoiding the facility for a long time, in a perverse attempt to assuage their discomfiture.

There are several disparities in the costs stated for family planning services. The women said they are charged GH¢5 for the tests required to ascertain that they are not pregnant before they can initiate a family planning method. They said they were charged GH¢2 for a three-month plan and GH¢20 for a three-year plan. By contrast, the facility cited family planning charges as GH¢1 for three months and GH¢5 for implants.

Even though facilities are forbidden from charging for removing family planning devices, Abui Tsita CHPS compound charges GH¢10 for the service. According to the nurse interviewed, the supplies required for the procedure are typically not included in the items the facility receives from the Regional Medical Store. As a result, the care workers said they feel compelled to procure these supplies from their pockets and pass the costs on to clients. Another reason for charging for the service is the belief by the caregivers that the family planning services are abused when they are inexpensive. The impression formed by the facility is that clients return home after going through a procedure and are then influenced by uninformed neighbours and friends to return to the facility for a different device. Staff therefore employ the unapproved removal charge as a way of deterring clients from thoughtlessly returning to request for alternative methods.

HEALTH INSURANCE

All three groups interviewed affirmed that medicines covered by the NHIS were often not available at the facility. Both client cohorts scored the facility 1 as a result, with the adolescents generally feeling that the scheme was "*not worth paying for*" as they were still obliged to "*pay for every medicine due to the unavailability of the medicines covered by NHIS*." For very similar reasons, just two of the seven participants in the focus group of older women had an active NHIS subscription. In the words of one such participant, "*it is better … to do cash-and-carry at the health facility [rather] than spend GH¢25 to renew your card and still [have to] pay for medicines when you visit the facility with SRH issues*." Some participants said this compels them to rely on herbs like "*etreku*" (the seed of the calabash gourd) for suppressing menstrual pains. The nurse confirmed that many of the medicines for addressing SRH issues such as candidiasis and urinary tract infections (UTIs) are not supplied to Abui Tsita, being a "Level A" facility. In order that clients "*do not have to go all the way to Gemini or Peki to buy their drugs,*" facility workers sometimes operate a parallel private market in such medicines, as observed above.

RESPECT FOR CLIENTS

Both client groups scored the facility 5 and observed that staff of the facility were always respectful toward them. The adolescents were particularly impressed that the health workers could spare time for basic courtesies even though there were just two of them at the facility. They described the nurses as "*family*" because of their warm and welcoming personalities. Participants noted how "*they start showing concern for us from the moment we step foot in the facility; … they converse with us*" and "*they take their time to take care of you even though they are under pressure*." The older women added that they had never heard of any instance of disrespect toward anyone from the community. Echoing these sentiments, the nurse described how much more challenging it makes their work when clients leave their hospital cards at

home. She confirmed that they always maintained their composure despite this being a common occurrence.

PROMPTNESS OF SERVICE

Participants also indicated that staff were punctual and delivered services in a brisk manner at Abui Tsita. They mentioned that the nurses are resident at the facility and so "*are always available except on Sunday afternoons because they have to go to church.*" The nurse noted that about the only times that they were not available to deliver services at the facility were when they were away on outreach missions around the locality. All groups scored the facility 5 on this indicator.

CONFIDENTIALITY AND PRIVACY OF CARE

The focus groups were emphatic that the facility staff act professionally, keeping their discussions confidential. The adolescents observed that when they were accompanied by an adult to the facility, "*the nurses would gently ask the adult to wait outside.*" On their part, the older women noted that consultations were always held "*behind closed doors,*" with the nurses reassuring them that their private issues were safe with them. They were not aware of any instance of a client complaining of her confidence being breached. On the contrary, one of them narrated an incident when the nurse "*advised me to tone down my voice while I was consulting on an SRH issue.*" All groups scored the facility 5.

5. Experiences of clients at Wegbe Kpalime

5.1 SCORECARD RESULTS, WEGBE KPALIME

The focus group discussions suggest that clients at Wegbe Kpalime were least satisfied with their access to medicines and equipment (Table 5.1.) They were generally satisfied with the quality of service delivered by the overwhelming majority of the facility's nine professional health workers. However, the older women's scoring of the "respect" indicator was rather less complimentary because of the attitude of a particular midwife.

TABLE 5.1: SUMMARY OF SCORECARD RESULTS, WEGBE KPALIME

Indicator	Age 15-19	Age 35-48	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	5	5	4
Availability of medicines	3	1	3
Availability of equipment	1	1	4
Affordability indicators			
Cost of consultations	5	5	2-4
Cost of medicines and services	4	2	2
Health insurance	3	5	4
Quality of service indicators			
Respect for clients	5	2	4
Promptness of service	5	5	4
Confidentiality and privacy of care	4	3	4

ACCESSIBILITY OF SERVICES

Explaining their score, the participant groups noted that the 15-minute journey to the facility was not burdensome and each gave a score of 5 to reflect this. They also felt that, with its nine professionals, the Wegbe Kpalime Health Centre was quite able to respond to the broad range of SRH issues that clients visited with. However, an older participant shared an experience when she had to be redirected to a different facility because the midwife was on leave and had travelled out of the settlement. Owing to the distance to that other facility, the woman ended up delivering her baby in a taxi. She nevertheless acknowledged that the facility had rendered the full range of antenatal services she expected to receive.

Unlike the practice at the CHPS level, staff of the Wegbe Kpalime Health Centre treat candidiasis, but refer unresponsive cases to Kpeve. Cases of rape and abortion are also referred upwards to a specialist at Kpeve.

AVAILABILITY OF MEDICINES

Both the adolescent and older women's groups complained about challenges with drug supply at the health facility. In the majority of cases, they said that the facility was only able to supply a small proportion of the drugs it prescribed for them when they visited with SRH issues. Participants told of how they sometimes responded to this situation by coping with whatever limited medicines the facility could supply or by supplementing what they received with herbal remedies, which they consider to be quite efficacious. According to the older women, a major consideration in arriving at such a decision is the GH¢8 transportation cost to Kpeve, which they find exorbitant. The adolescents and older women scored 3 and 1 respectively for this.

Box 1: Preferred Primary Care Provider Network

Some healthcare facilities in the South Dayi and North Tongu districts are reportedly exploring synergies through a pilot project funded by USAID. Under the project, primary healthcare facilities across a sub-district actively strategise to network their respective resources. Thus, where one facility has an ultrasound scanner, the

facilities in the network could develop a joint calendar that allows the scanner (along with its technician) to service other facilities in the network on specified days.

Other resources that have been networked in the trial include laboratory services, drugs and human resources. In the case of drugs, a facility that is experiencing a shortage of one drug may access stocks from a sister facility that has an excess of that drug. Similarly, where a slow-moving drug is nearing its expiry date in one facility, the information can be shared with other network members to enable those who have newer stocks to make some exchanges. Clearly, such an initiative has potential to benefit client populations experiencing access challenges of various sorts.

AVAILABILITY OF EQUIPMENT

Clients and staff had diametrically opposing perceptions on this indicator, with both client groups scoring the facility 1. Citizens complained that "*there is no equipment to assess pregnancies*" when they visit the facility. They were particularly concerned about the facility's inability to conduct ultrasounds and simple laboratory tests. As a result, they said they were routinely referred to hospitals in Sokode, Ho and Kpeve for laboratory tests and other SRH-related assessments. Owing to what they described as prohibitive transportation costs, the older women said they "*either resort to traditional medicines or just stay at home*" rather than endure the referrals. On their part, the health workers scored the facility a healthy 4, saying that the facility has recently received a mobile ultrasound scanner. That should significantly impact clients' views of the facility.

Curiously, the health workers said they have a laboratory with a technician, in sharp contrast to the perception of the client groups. Whether this discrepancy signals a suboptimal functioning of the laboratory is unclear. For now, it appears that a laboratory does exist but that its services are very basic and limited. Staff also conceded that even examination beds were lacking, "*hindering effective service delivery to pregnant women*."

Clients also lamented that "*there is no equipment to determine the ideal family planning method*" for them. They attributed the "*many side effects from family planning*" to this perceived lack of relevant equipment to facilitate effective matching. A young girl told of how she developed lower back pain and gained considerable weight after enrolling onto a family planning method at the facility. Some of the older women said the injectables caused them to bleed excessively during their periods. As a result of such stories about side effects, some of them have decided either not to enrol for family planning services or to suspend the plans they had been on. They simply "*depend on hope for protection …*" against pregnancy, an approach which they admitted had failed several among their cohort.

COST OF CONSULTATIONS

Clients appreciated the fact that consultations are "*now free*" and scored the facility 5. They observed, however, that they were previously asked to contribute GH¢2 "*to pay casual staff/ cleaners helping out at the health facility*." Facility staff too noted that new clients are required to pay GH¢7 (or GH¢10 if they do not have a valid NHIS subscription) to cover "*the cost of a folder and hospital identification card*."

COST OF MEDICINES AND SERVICES

The adolescent girls and older women scored 4 and 2 respectively on this indicator. They were concerned that several expenditures are not covered by the NHIS, so they always had to make some out-of-pocket payments at the facility. Several of the women raised concerns about the cost of injections, and an adolescent said she "*had to pay as much as GH¢12 for an injection because it was not covered under the NHIS*." Participants observed that the cost of services appeared to be linked to the severity of the SRH issues they consulted the facility on. Staff said, however, that there are no laboratory charges for pregnancy, haemoglobin level and blood group tests.

Clients cope with the charges in diverse ways. While some of those who were unable to afford the orthodox medicines and services relied on traditional remedies, others negotiate with the health personnel to receive the services on credit. An example was cited by the caregivers of a mother who absconded from the facility without settling her delivery bill. It is not uncommon too for health workers to dip into their own pockets to support poor pregnant women with one-off meals or to finance their emergency transport costs to referral hospitals.

The older cohort said women in labour were required to arrive at the facility with antiseptics and detergents, along with an amount of GH¢50 to cover incidental expenditures. Comparing this to the cost of using Traditional Birth Attendant (TBA) services – now outlawed – the women emphasised that the TBA's services had been less expensive. One health worker observed with bemusement how ostensibly poor women who perceive the cost of formal healthcare to be prohibitive are suddenly able to raise funds to purchase new fabrics whenever there is a funeral. This practice is actually quite widespread across poor communities and betrays an imbalance in priorities which mindfully delivered education may help address.

HEALTH INSURANCE

Clients appreciated the potential of the NHIS to cut their formal healthcare costs but had negative feelings about its operation in practice. The older women were concerned about the transportation cost to Kpeve and the time spent on the process of registering for a card as a first-time subscriber. Of the seven older women, five had previously registered for the NHIS but only three of them still had active subscriptions. However, they appreciated the fact that they can renew their subscriptions locally – at the health centre – for just GH¢7 for persons below 18 and GH¢25 for those aged 18 and above. They eventually agreed on a score of 5, concluding that apart from the challenges with queues and delays when first registering, the NHIS was beneficial on balance as it enhances access to facilities and cuts the expenditures on services received.

The adolescent girls were unhappy that the scheme "*does not cover most of the medications for treatment of SRH issues*" and scored the service 3. They complained that they "*only get paracetamol when [they] visit the facility with such issues*" while their remaining drug needs are merely "*written out as prescriptions for [them] to go and buy elsewhere*." This, they said, eroded their faith in the NHIS, undermining their zeal to

renew their subscription when their cards expire. However, one of their number described being delayed at the facility and spending much more money on drugs because she did not have her NHIS card with her, contending that being insured has benefits in terms of time and finances.

The health workers noted that illiterate clients are often unaware when their cards have expired. When such clients report at the facility, the health workers ask them to return with the relevant renewal fee, after which they are served. The staff observed that assisting clients to renew their subscriptions is even more seamless if they have Mobile Money (MoMo) credits on their phones.

RESPECT FOR CLIENTS

Overall, clients appeared to be very happy with how they are treated by the majority of the caregivers at the facility. Sometimes, health workers even bought food for clients and paid their transport fares with their own money. The adolescents scored the facility the full 5 points. However, the women felt that a score of 2 was more deserving to register their utter displeasure at how they are treated by one particular midwife. They acknowledged that while the nurses are very respectful and kind to them, even following up on them at home, "*one bad nut spoils the pack*." They were clearly put off by the midwife "*repeatedly shouting at us*." While conceding this unprofessional behaviour, one of the adolescents however empathised with the midwife, noting thus: "*sometimes we, the clients, also contribute to the health worker raising her voice or being disrespectful to us because we don't stick to the advice we are given during our consultations … so we keep returning with the same condition. In that case, she has the right to shout at us*."

On her part, the offending midwife was completely defensive and unrepentant. She felt that the facility's priority is to save life, so they "*have to be tough with certain clients, particularly pregnant women; sometimes, shouting is good … to save the baby*." Another caregiver shared an experience of a client arriving at the facility to deliver "*without basic items such as sanitary pads*" and noted that others are also slow to report when they are in labour, "*preferring to wait till the baby is almost out before rushing to the facility*."

PROMPTNESS OF SERVICE

The clients interviewed were all impressed with how promptly they were attended to and scored the facility 5. In the average case, it takes some 30-40 minutes to be attended to by a caregiver. However, staff noted that clients who visit without their OPD cards tend to spend more time because it takes some time to locate their folders. Also, where folders cannot be found after a long search, the client is given a new folder. They lamented that this undermines continuity of care as the previous history recorded in the old folder cannot be accessed. The older women asserted that even at night, the nurses "*respond promptly when called upon even though most of them don't live that close to the facility*."

CONFIDENTIALITY AND PRIVACY OF CARE

Clients' perceptions around the confidentiality of their healthcare issues were mixed. The adolescents felt confident about confidentiality assurances they had been given by staff. Further, they had never heard anyone raising confidentiality concerns

in the community. While scoring the facility 4 on this indicator, they nevertheless suggested that "*most of the health workers are not fluent in the local (Ewe) language and so sometimes have to ask other clients to assist with interpretation*." One participant had an experience of once serving as an interpreter when she visited the health facility with menstrual pains. As a result, one of the girls said, "*most (sic)*[4] *of us do not visit the facility but rather resort to traditional medicines or go to other facilities where we do not encounter any language barrier*."

Scoring a more reserved 3, the older women – with their longer history of association with the facility – had more nuanced perceptions. According to them, in the past, all of the staff had been native to the Volta Region and so easily made friends on arrival and gossiped about clients' health status. Through such unprofessional behaviours, clients' secrets – including very sensitive cases of HIV – became public across the community. By contrast, "*many of the current nurses cannot speak the Ewe language and do not actively divulge clients' private issues*." However, they are compelled to rely on bilingual clients for interpretation services. As with the adolescents, they too acknowledged this to be a major deterrent to clients with sensitive SRH issues. While staff do seek a client's consent before involving anyone else – whether staff or client – this remains an area that deserves serious attention.

6. Experiences of clients at Ayirebi

6.1 Scorecard results, Ayirebi

The summary scores from the Ayirebi focus groups are presented below, in Table 6.1. On virtually every indicator, the adolescents were more satisfied with the facility than their mothers were. Access to medicines emerged as the indicator with lowest satisfaction, including by the care workers. Here too, clients did not always feel treated with dignity.

[4] Note that it is common for the word "*most*" to be used interchangeably with "*many*" in Ghanaian English. Thus, it is unclear whether it is really the majority that is intended here.

TABLE 6.1: SUMMARY OF SCORECARD RESULTS, AYIREBI

Indicator	Age 15-19	Age 35-49	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	3	2	3
Availability of medicines	3	2	2
Availability of equipment	4	3	3
Affordability indicators			
Cost of consultations	4	2	4
Cost of medicines and services	4	3	4
Health insurance	3	3	3
Quality of service indicators			
Respect for clients	4	2	4
Promptness of service	4	2	4
Confidentiality and privacy of care	5	3	5

ACCESSIBILITY OF SERVICES

Citizens are not particularly happy with the level of access to services. The main SRH issues which clients visit the Ayirebi Health Centre with are antenatal and postnatal care, family planning, breast care, menstrual problems, UTIs and STIs.[5] Even though the facility has as many as 13 professional health workers and sees only about 20 clients daily, it only managed scores of 3 and 2 by the adolescents and older women respectively.[6] Both citizen cohorts assessed that staff numbers were too low, with the older group observing that the OPD was covered by a single nurse. On their part, staff explained that the overwhelming majority of the facility's staff are community health nurses and are thus routinely away on community outreaches during regular hours. One woman questioned the efficacy of services, observing that she had battled an itchy vaginal discharge for over six months, with the facility unable to resolve it, leading to her switching to herbs to assuage her discomfort. Yet another from that group complained about the facility closing before 4:00 o'clock in the afternoon. It appears that the staffing issue may be one of human resource management rather than mere numbers.

The 20-30-minute commute on foot was not too long in itself, but many clients (particularly mothers) said they made the journey on commercial motorbikes at a cost of GH¢2 because of the very pitted road surface.

[5] The adolescents self-identified unprotected sex and the abuse of local douche preparations (from ginger and cloves) as major contributors to the high incidence of infections among their cohort.
[6] The facility also does about 10 deliveries a month.

Somewhat surprisingly too, awareness about the range of services available at the health centre appears to be limited among the adolescents. For example, some in the adolescent focus group were not aware that the facility could assist with addressing menstrual challenges. A 15-year-old in the discussion group had been completely oblivious to the existence of a Reproductive and Child Health (RCH) unit at the centre. Others simply found it embarrassing to take their SRH issues there and so either suffered quietly or opted for indigenous remedies. Another girl described the endless itching and pain she endures because she is too shy to visit the facility with her candidiasis infection.

AVAILABILITY OF MEDICINES

Participants were also unhappy about the unavailability of medicines and supplies, again scoring the facility a mere 3 and 2. In the words of one woman from the older group, "*most drugs aren't available – and even paracetamol is prescribed to be bought from outside*" at higher costs than when they are available at the facility. Some of the clients said the situation was so bad that they were tempted to believe that "*the health workers pilfer the medicines to sell to non-NHIS clients*." Because the medicines are more expensive in the drugstores, clients said they often "*take the prescriptions home and hope for natural relief*." Others seek respite through indigenous herbal concoctions for conditions as varied as lower abdominal pain, embarrassing itches, vaginal discharges and urinary tract infections or even to dilate the cervix during labour. The oldest of the women interviewed opined thus: "*when the health facility does not have the medicines, I take it as a sign from God to visit the prayer camp instead*." An adolescent mother narrated how "*whenever I take my baby to the facility with chills, headaches or high temperatures, I am only given paracetamol*." She said her friends who visited the facility with their babies "*always received the very same medication – be it for vomiting, diarrhoea or a runny nose*."

According to the head midwife, it can take several months from the date of requisitioning medicines till they arrive. The focus group of staff added that the facility often receives little more than iron supplements to support adolescents and adults with their menstrual cycles. They agreed that "*it is somewhat the norm for the facility to prescribe medicines for clients to buy from the drugstore and licensed chemical sellers*" in the locality. Staff felt helpless that clients have to settle for indigenous herbs because they are unable to afford the medicines prescribed for them. In the words of the head midwife, "*we can't do anything about it; … we can't give what we don't have*."

AVAILABILITY OF EQUIPMENT

Perceptions were modestly better on this indicator, with scores of 4 and 3 by the adolescents and the older women respectively. They found it helpful that an ultrasound machine was brought to the facility from Oda Hospital on antenatal days. The older women perceived that the maternity unit "*had everything with the exception of a scan machine*." Staff contested this, explaining that the facility does have a scanner, but that it can only be operated when the sole trained staff is at the facility. They added that a request has been made to the regional directorate to train

an additional staff on the use of the scanner to minimise breaks in providing this important service; however, they have not received any response to this request. The facility is yet to receive a response to the request. The older women also complained about the lack of oxygen, the condition of the beds and inadequate drip stands at the facility. On their part, staff were concerned that the different units of the facility had to share basic items like a weighing scale and a sphygmomanometer; they also missed not having a nebuliser for asthmatic mothers.

The single most emphasised criticism, however, had to do with what clients perceived – probably inaccurately – to be an overly slow and obsolete laboratory. Both the adolescents and older women tended to interpret the approximately hour-long waits for their lab results to mean that the lab equipment was either faulty or obsolete. The older women opined that "*the equipment … in the lab is slow and not good at all*." That clients have such a warped appreciation of how laboratories work is quite troubling as it could promote exit behaviour. The issue could benefit from a more deliberate policy toward openness when prescribing treatments and services for clients.

COST OF CONSULTATIONS

Paid-up subscribers of the NHIS were satisfied with consultation costs while non-subscribers found the charges prohibitive. For the former, consultations are provided free of charge, while others said they have to pay GH¢10 on each visit. Folder were reported to cost an additional one-off charge of GH¢15 for non-insured clients. With seven of the nine adolescents being active subscribers, their group scored the facility 4 while the older women scored 2 mainly because most of those in that focus group lacked NHIS subscriptions and so could not benefit from the free service.

In order to access the free consultation service, one needs to show both their active NHIS card and their health facility card. Where clients had misplaced their facility cards, they were required to pay for replacements. The charge for this service is ambiguous, with the older women claiming to pay GH¢7 while the staff insisted it was GH¢5. However, for minor ailments (described by the nurses to include headaches, malaria, colds and diarrhoea), the nurses sometimes provided consultation services to non-NHIS adolescents without charge.

COST OF MEDICINES AND SERVICES

The adolescents were pleased that when medicines were in stock, paid-up NHIS subscribers received these for free, and so scored the facility 4 on this indicator. These medicines were said to include calcium and iron tablets, multivitamins, paracetamol and anti-malaria tablets. Pregnant women also receive tetanus injections for free during their second and third trimesters. Without an active NHIS policy, however, pregnant adolescents said they paid GH¢5 for a urine test and GH¢20 for an ultrasound pregnancy scan. The older women scored the facility 3, asserting that medicines were too often not available, so they were directed to buy whatever was prescribed for them from the drugstores in town.

With the exception of the haemoglobin test which costs GH¢5, lab tests are free for adolescents. Pregnant women too were exempted from paying for their lab

tests – including those for HIV, fasting blood sugar (FBS), syphilis, sickling and UTI. However, older women said they were charged GH¢5 if they were not pregnant, irrespective of whether they had NHIS policies or not. The tourniquet used during blood extraction was reported to cost GH¢5 which, once again, clients paid for regardless of whether they were insured. When clients were unable to afford the full range of lab tests prescribed for them, the lab technicians exercised their discretion in prioritising which tests to conduct.

The main family planning commodities sold to SRH clients include Jadelle (at GH¢7, with a 12-month lifespan), Depo Provera injections (at GH¢3, with a three-month lifespan) and one-month injections (at GH¢3). Pregnancy tests are a prerequisite to being assigned any of these commodities.

HEALTH INSURANCE

NHIS subsidises some lab tests. For example, a full blood count (FBC) is subsidised by 50% for those with active policies. Without insurance, it costs GH¢10. Illustrating the value of the NHIS, an adolescent described how her scans and medicines cost her just GH¢5 when she visited the facility with menstrual problems as a fully paid-up NHIS client but how "*on a different day, I visited the health centre with the same problem and I had to pay GH¢50 because my NHIS had expired*." The group confirmed that they were not charged for drugs supplied to them under the NHIS. However, they observed that these were usually out of stock. While agreeing that the NHIS has facilitated access to healthcare by making it less expensive overall, they nevertheless scored the facility 3 on this indicator because of the routine shortages in the range of medicines for which insured clients are eligible.

Overall, the older women too found the NHIS policy to be supportive. However, they had similar criticisms about the policy, also scoring the facility 3. Some even suspect that "*some people at the facility exploit us, telling us the drugs aren't available so that they can pocket the money when we pay*." Such is the depth of suspicion aroused by the poor supply of medicines and supplies at public healthcare facilities.

The women also perceived that uninsured clients – who paid for services at the facility – typically "*received better drugs than NHIS clients did*." A member of the group declared angrily, "*we are tired of being handed paracetamol each time we go there*." Amoxicillin and ethambutol were cited as examples of such perceivably superior medications that were sold to paying clients by the facility's pharmacy.

The facility does not reimburse or otherwise compensate NHIS clients for medications it is unable to supply. However, where a client is insured but cannot pay the subsidised lab fees, the fees may be waived depending on the severity of their condition. Registration and renewal fees cited for over-18s were in the range of GH¢25-27. On top of that, some of the older women had been compelled to travel to Oda Hospital at a cost of another GH¢25 to access subscription renewal services. However, others said they were able to renew their subscriptions locally, at Ayirebi.

Staff described reimbursements to them by the NHIA (for expenditures incurred by the facility on their behalf) to be "*very slow*." According to the group of health

workers interviewed, "*reimbursements by NHIA are sometimes 50% less than the [expected] amount*," further eroding the facility's capital.

RESPECT FOR CLIENTS

The girls interviewed had mixed responses about how they were received by staff but scored the facility 4. Staff of the maternity unit were singled out for praise. One girl recounted that even if they were "*simply visiting friends on the maternity ward, [they] were still received warmly*." They described how swift and patient the midwives and attendants were with women in labour and how "*when lactating adolescent mothers fail to show up at the Child Welfare Clinic, the nurses come to their homes*." Curiously, however, they felt that the shouting at women during labour was "*normal and [that it] helped them deliver quickly and ensured the babies' safety*." They also noted that confrontations occasionally arose "*when patients were rude to the nurses or when guidelines given to patients were not adhered to*." An example was cited of a family that had brought a member to the facility expecting their case to be treated as an emergency. The nurse had calmly asked them to sit and wait their turn, but this provoked the family into starting an argument which in turn caused the nurse to rudely ask them to leave if they felt they could not wait. In another incident, a participant described being shouted at simply because she had not responded when her name was called out. In a different example, a participant observed that "*they usually shout at us when we don't have money to pay for our medicines that are not covered by NHIS*."

The older women were much less generous with their score, agreeing to award just 2 points. A participant recounted a story from visiting the facility with her two sick children. Before her child was called forward, she had to take the younger child to use the washroom. On her return, she realised that her child's name had been called while she was away, and the nurse angrily ordered her to join the queue from behind, embarrassing her. Others complained of the pharmacist spending too much time on phone calls while clients were waiting their turn. Another participant perceived that the nurses treated their friends preferentially. However, five of the eight women were happy with the staff of the maternity unit.

The community health nurse acknowledged "*shouting at some teenagers when they misbehave*" – or "*when they behave immaturely*," as another phrased it. She contended that her actions were squarely in response to rudeness on the part of adolescents especially. Other health workers said they try not to retaliate when clients behave disrespectfully towards them. Whatever the cause, the kind of intolerance behaviours narrated above are quite unacceptable in a care-giving environment.

PROMPTNESS OF SERVICE

Health workers were reported to arrive late for work, especially after the weekend, when many of them travel out of Ayirebi. They then have to set up before they can attend to clients. Unlike most of the facilities in the Volta Region sample, clients reported waiting times of an hour to two hours on a good day, and considerably longer if they had to do labs. The Physician Assistant attributed the long waiting times to unavoidable laboratory processes and the tedium associated

with the facility's records system. According to him, a new system is being developed to ease the process of identifying clients' folders. Occasionally too, the midwives have to attend emergency deliveries before catering for clients waiting for pre-natal services at the Reproductive and Child Health Unit. On their part, some clients perceived that referrals from nearby CHPS facilities at Odumase and Nyamebekyere contributed to the long waits at this facility. These explanations notwithstanding, it is difficult to reconcile the facts for a facility with 13 professional staff seeing an average of just 20 clients a day and performing some 10 deliveries a month. The adolescents and older women scored 4 and 2 respectively on this indicator.

CONFIDENTIALITY AND PRIVACY OF CARE

Client satisfaction was greatest on this indicator, with the adolescents scoring 5 and the older women scoring 3. They adolescents observed that whenever individualised counselling was required, it took place in the privacy of the family planning room. Even though they can be seen entering the family planning room, not all of them were bothered by it because they were sure their conversations could not be overheard. Further, the nurses usually sought their consent before discussing their cases with other staff. One described how "*when I went there with candidiasis, they just listened to me and gave me my medications without judging me or telling their colleagues*." On their part, the older women – who are relatively more likely to visit with pregnancies or labour – were critical of the fact that the male and female wards are only separated by a thin plywood panel. They were also more concerned than the adolescents that they could be seen entering the family planning unit. However, they too were comforted by the confidential nature of counselling and family planning services. Clients who test positive for HIV are counselled, then referred to the Akyemansa Health Directorate for antiretrovirals (ARVs). Somewhat curiously, the health workers opined that the plywood partitioning was not an issue and that no-one could see or hear across the panel. Fortunately, citizens of Ayirebi have commenced work to expand their health facility, with support from their Member of Parliament (MP) and their traditional authorities. The project includes staff accommodation and separate wards for males and females, and is expected to resolve current problems of privacy, confidentiality – as well as with staff routinely arriving late for work.

7. Experiences of clients at Brenase

7.1 SCORECARD RESULTS, BRENASE

The summary scores from the Brenase focus groups in respect of their local health facility are presented below, in Table 7.1. Overall, clients' scores appear to reflect both higher levels of satisfaction and consensus here. Teen pregnancy is particularly common across the locality, with three girls in the six-person adolescent focus group nursing babies and the other three carrying pregnancies at the time of the study. Poverty and poor parenting were identified as factors influencing this unusual condition. Staff observed that clients tend to avoid the facility when medicine stocks run low, while the latter acknowledged adopting unorthodox practices such as

relying on traditional herbs and short dosing when they are unable to afford the medicines prescribed for them.

TABLE 7.1: SUMMARY OF SCORECARD RESULTS, BRENASE

Indicator	Age 15-19	Age 35-49	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	4	2	4
Availability of medicines	4	3	3
Availability of equipment	1	2	3
Affordability indicators			
Cost of consultations	5	4	4
Cost of medicines and services	4	3	3
Health insurance	4	4	4
Quality of service indicators			
Respect for clients	5	4	4
Promptness of service	5	4	5
Confidentiality and privacy of care	5	5	5

ACCESSIBILITY OF SERVICES

Clients assessed that the Brenase Health Centre was quite convenient to reach geographically. Those for whom it is too far to walk have to pay between GH¢1 and GH¢2 depending on whether they opt to travel by "*trotro*" (shared minibus) or by "*okada*" (commercial motorbike). However, the laboratory is not accessible after 2 o'clock when the morning shift ends. This can be a challenge because residents of this farming community often visit the facility after returning from the farms.[7] The older women especially were concerned about the facility closing at noon on Saturdays and not opening at all on Sundays. Clients and staff alike also felt that staff numbers did not match demand, especially where midwifery services were concerned. The adolescents scored the facility 4 while the older women, with a wider range of concerns, scored it 2.

The facility has nine professional health workers and performs an average of 13 deliveries each month. The main SRH issues which clients visit the health centre with include family planning, pregnancy, menstrual hygiene, STIs (typically vaginal infections, gonorrhoea, syphilis), HIV testing, breast care and counselling.

Many opt for alternative options beside the Brenase health facility. The local drugstores and St. John's Hospital at Ofoase are popular choices. Others continue to use the services of a local TBA, popularly known as "*Auntie Esther*." Drawing a distinction between what they perceive to be "*physical sicknesses*" and "*spiritual sicknesses*," the older women said they always take the latter to the prayer camps.

[7] In Ghana's hot climate, it is common for farmers to start work early in the morning, to minimise their exposure to the afternoon sun.

Even with "*physical sicknesses*," they still turn to herbal medicine or the prayer camps when they are either unable to afford the medicines from the health centre or when cure appears to be delayed. In pregnancy too, they "*use herbs to strengthen the foetuses*." These misconceptions and practices are fuelled by unregulated advertising of alternative therapies by a local unlicensed "*Information Centre*" in Brenase (but also common elsewhere in Ghana) and is a major concern for staff of the facility.

AVAILABILITY OF MEDICINES

Both the adolescents and older women were unimpressed with the level of access to medicines at the facility but still scored the facility 4 and 3 respectively. Participants felt that antenatal supplements and family planning supplies were widely available. However, both of the client focus groups asserted that other medicines prescribed for them were often not available at the facility dispensary, compelling them to buy these from the drugstores. The older women said they received little more than paracetamol whenever they visited the facility, regardless of the issues they presented with. Echoing this concern, another participant said, "*you only get about two out of every five medicines prescribed for you*."

The younger cohort contended that the high cost of medications at the drugstores pushed them into skimping on the prescribed drugs and exploring herbal alternatives from the forests while the older women identified prayer camps as a further fallback. An adolescent mother told of how she was invoiced GH¢22 by a drugstore for drugs that had been prescribed for her baby. As she could not afford the expenditure, she ended up giving her baby only the medicines that the facility had been able to supply. A caregiver noted, "*if they come and aren't able to get drugs from the facility, they resort to taking herbal concoctions like 'awomre' which they apply during the third trimester of the pregnancy and 'abeduro' (turkey berries) which they use during the first trimester*." She narrated a recent incident in which a pre-term baby died after her adolescent mother had administered herbal concoctions.

Staff observed that patronage was often dependent on the availability of drugs. Elaborating on this, the community health nurse described how "*whenever clients visit the facility and notice that there are no medicines … they inform the other community members who then wait till they hear that medicines are available; … there was a time when for about two weeks, we didn't even have paracetamol!*" According to the health workers interviewed, drugs that usually run out of stock include cetirizine, cefuroxime, metronidazole, benzathine, penicillin and oxytocin. Often too, paracetamol tablet/ syrup stocks get depleted before new supplies arrive. Another concern raised by the health workers is the fact that the facility is not permitted to stock or administer anti-snake serums despite being surrounded by farming settlements.

AVAILABILITY OF EQUIPMENT

The facility had the worst scores for this indicator. Clients were concerned that the facility lacked certain specific items like an ultrasound scanner and an incubator and so only awarded scores of just 1 and 2. One teenager told of how she resorted to prayer camps during her pregnancy as a way of circumventing the GH¢20 ultrasound fee she would have had to pay at another health facility in the district capital. She added that her two children were both delivered by "*Auntie Esther*" – the local TBA. The older women complained of "*beds [that] squeak and have worn-out*

mattresses." One of their number noted how "*there's only one delivery bed available so whenever there is more than one woman in labour, the others have to deliver on mats laid out on the floor*." Staff said they lacked items such as manual vacuum aspirators, doppler machines, sterilisers, nebulisers, suction pumps and oxygen equipment. Further, they have to rely on flashlights whenever there is a power outage. The ceiling fans were also faulty, beams were broken, and the roof leaked.

COST OF CONSULTATIONS

On consultation costs, clients were pleased that no such charges were demanded of them. The younger and older cohorts scored the facility 5 and 4 respectively for this. The health workers indicated, however, that an all-inclusive charge of GH¢15 is taken for a folder, consultation and labs for a first-time client who is uninsured. A fee of GH¢10 is also taken when clients misplace their cards. The older cohort felt that this was done to punish careless clients. A member of that focus group told of how she once misplaced her hospital card but was able to recall her unique identifier because her son had written it down for her. She was offended that she was still made to pay the full GH¢10 for a new card before she was attended to.

COST OF MEDICINES AND SERVICES

Clients found the cost of medicines to be high but said services like the lab and family planning were affordable. They paid between GH¢5 and GH¢10 for lab tests (with the bottom figure for urine/ pregnancy confirmation tests). Each round of antenatal supplies cost them GH¢1.

Clients also have to pay supplementary fees when they are on admission at the wards. Presumably, the cleaner – who is also responsible for doing the laundry – is not on the public payroll and so each admitted patient is required to contribute GH¢5 towards the cleaner's compensation.

HEALTH INSURANCE

Clients were generally pleased that the NHIS provided an opportunity to access healthcare at a reduced cost. Illustrating the point, a teenager whose subscription had lapsed for years described how she had to fork out GH¢70 for her labs and medications when she was rushed to the facility during an asthma attack. Clients particularly appreciated the fact that registration and renewal charges are waived for all pregnant women. For pregnant women to qualify for such fee-free subscriptions, however, they must first present their pregnancy cards as evidence to the NHIS provider. Other adults reportedly paid GH¢25 for registration and GH¢24-25 for renewal while children paid GH¢6 for either service. Both client cohorts awarded a score of 4 on this indicator. However, there were some significant concerns which end up curtailing the scheme's expected benefits.

Some of the older women were baffled by the fact that some NHIS-eligible drugs were not available to NHIS subscribers but could be accessed with cash. One woman described initially being declined a drug as an NHIS client but eventually getting the same drug from a nurse for cash. On their part, staff explained that they proactively arrange with drugstores to supply drugs that have run out and that these drugs have to be sold for cash because they are not part of those supplied by the state. However, clients noted that such drugs tend to be cheaper at the local

drugstores, suggesting that they are either marked up by staff or that the versions available at the local drugstores might be fake. Either way, this issue deserves further interrogation by the District Health Management Team (DHMT).

RESPECT FOR CLIENTS

Both of the citizen focus groups generally appreciated the health workers and described them as friendly, scoring them 5 and 4 on the indicator. The adolescents also appreciated the home visits which the current midwife makes to pregnant girls. This was echoed by the older women. The younger cohort observed that "*sometimes, the midwife hugs us … demonstrating that she has our wellbeing at heart*." Further, "*she makes sure we are fine before we leave the facility*."

By contrast, clients indicted a particular health worker[8] responsible for the records and one lab technician, labelling them as "*rude, ... often treating us condescendingly*." In scoring the facility 5 on this indicator, the adolescents made it plain that they did not include the two "*deviant*" staff members in that reflection and that the two deserved "*a score below zero*!" The older women described how the nurse handling the records "*usually throws folders at people if they are slow in coming up when they have been called*" and one said she no longer uses the facility when that particular official is on duty. However, an adolescent felt that clients were equally to blame for their mistreatment since "*some patients were sometimes difficult*."

PROMPTNESS OF SERVICE

Clients were satisfied on this indicator as well, scoring 5 and 4. The adolescents said the midwife came across as someone who was always eager to receive them. Clients observed that the facility workers routinely report to work by 8 o'clock and that clients typically spent under an hour at the facility. Where lab tests are required, however, they said they could spend up to three hours at the facility. However, the older cohort observed that staff availability was constrained over weekends as some of them travel out of the community to visit their spouses. They added further that "*a couple of them usually report late because they have chosen to live outside the community; they live at Ofoase because they can get better food and better apartments*" than they would at Brenase.

CONFIDENTIALITY AND PRIVACY OF CARE

Both client groups scored the facility 5 on this. The adolescents explained that "*information we give to the facility staff never goes out; they keep everything a secret*." According to them, they are fully at ease discussing their family planning and other reproductive health issues with staff. "*We also visit the facility with our [STIs] because we know we will receive the needed care and attention … without any outsider becoming privy to what we have shared*."

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[8] The culprit was identified as a cleaner who sometimes doubles as a records keeper when there are staff shortages at the facility.

8. Experiences of clients at Kotokuom

8.1 Scorecard results, Kotokuom

The summary scores from the Kotokuom focus groups in respect of their local health facility are presented below, in Table 8.1. The scores suggest significant client discontent around the majority of indicators.

Table 8.1: Summary of scorecard results, Kotokuom

Indicator	Age 15-19	Age 35-49	Service Providers
Accessibility indicators			
Accessibility of services (facilities and skillset)	4	4	2
Availability of medicines	1	3	3
Availability of equipment	2	2	1
Affordability indicators			
Cost of consultations	5	5	4
Cost of medicines and services	1	1	4
Health insurance	2	1	5
Quality of service indicators			
Respect for clients	5	5	5
Promptness of service	5	2	4
Confidentiality and privacy of care	1	5	5

Accessibility of services

The focus group participants were pleased that it only took them some 15-20 minutes to walk to their CHPS facility. However, they were unhappy that the facility has only one health worker – a senior community health nurse. "*Sometimes, the [only] nurse has to leave the facility to travel to Brenase to supplement her stocks; Brenase is not far but she doesn't come back early because she [also] has to submit reports. That means the clinic is closed on that day*," an adolescent girl observed with undisguised irritation. Even so, the adolescent group opined that even though the nurse was the only worker at the facility, she was always accessible and did her best to address clients' healthcare issues. Both client groups scored the facility 4 on this indicator.

The facility does not deliver babies because of the lack of a midwife. Owing to this and other staffing limitations, clients are regularly referred to Brenase Health Centre and St. John's Catholic Hospital in Ofoase, the district capital. Most deliveries are referred to Holy Hornell Maternity Home, also in Ofoase.

Availability of medicines

Participants complained about the inability of the facility to dispense most of the drugs that are prescribed for them. The adolescents and the older women scored the facility 1 and 3 respectively. The adolescents referred to the facility derisively as "*Para asa*" – to wit, "*paracetamol has run out*" – which they said was a common refrain when they present with menstrual cramps and other issues. One observed: "*for almost everything we present at the facility with, we are given prescriptions to go and buy*

the medicines from the local drugstores." Another participant reinforced the message, adding: "*I went there with [candidiasis] and she (the nurse) said she didn't have the medicine I needed, so I should go to the drugstore and buy it*." On her part, the nurse confirmed prescribing antibiotics such as metronidazole and ciprofloxacin for clients presenting with STIs.

The older women said drug supplies consistently ran out in under a month. For the next two months, while awaiting the next tranche of supplies from the Regional Medical Store, they are routinely given prescriptions to take to the local drugstores. A participant said she opts for the facilities at Brenase or Abirem instead, because of this situation. Three of the seven women in the older cohort said they either use herbal preparations when they cannot afford the prescriptions or simply resort to prayers at "*Canaan*" – a local prayer camp.

AVAILABILITY OF EQUIPMENT

Both client groups were outraged by the level and state of equipment and scored the facility 2 on this indicator. Their concerns revolved mainly around the absence of ultrasound scans and laboratory facilities, compelling them to travel to Abirem Hospital at a cost of GH¢7. In the discussion with the older cohort, a member was irritated that "*everything concerning pregnancy has to be referred to the bigger facilities*" outside Kotokuom. They perceived, rather scathingly, that the facility existed "*merely to weigh our new-borns, dress wounds and dispense vitamins and iron supplements to females in the community*." Another described "*squeaky beds with worn, bedbug-infested mattresses which no-one wanted to lie on*." The nurse corroborated the stories of her clients, admitting that the facility only had a weighing scale and a sphygmomanometer, and that the refrigerator, light bulbs and ceiling fans were all out of order.

Others were concerned about the structural fittings. Describing a visit to the facility one night, one participant reported that the facility "*didn't even have basic light bulbs*." She was horrified that the nurse had to work with a flashlight and felt that the facility had been abandoned by the state. Yet another raised issues with the fact that "*the fans have all broken down, making it unbearable whenever there is a queue; … we are always wiping away sweat from our brows when we visit the facility*." Together, these problems contribute to pushing the older women to opt for traditional medicine.

COST OF CONSULTATIONS

The waiving of consultation fees for active NHIS subscribers was something both client groups were happy about, scoring 5 for this indicator. Both groups perceived that uninsured clients had to pay for folders but could not tell how much the costs were.

COST OF MEDICINES AND SERVICES

Adolescents and the older women were united on how expensive the facility turned out to be in terms of medicines and services. They felt that the facility charged too much for the pregnancy tests[9] and the facility card (at GH¢10), for example. It irked some of them that the "*card*" was "*not even proper card but mere paper with the facility's name, one's name and the registration date written on it*." They felt ripped off by the fact that they were "*required to pay another GH¢10 whenever we misplace this 'paper hospital card'*." The fact that the facility lacked medicines meant that clients had to incur additional expenditures on medicines even if they were NHIS policyholders. Relevant family planning commodity costs were cited as GH¢7 for Jadelle (lasting for a year), GH¢3 for a Depo Provera injection (which lasts for three months) and GH¢3 for a one-month injection.

HEALTH INSURANCE

All six adolescents and seven older women had active NHIS subscriptions. This situation is greatly facilitated by the fact that renewals can now be done using a smartphone. The older folk, many of whom were illiterate, said they typically asked the young men in the settlement to assist them with the service. They were pleased that, overall, the NHIS facilitated access to healthcare. The older women said that, because of this, they even borrowed to renew their subscriptions if they didn't have money when their subscriptions expired. The adolescents said that first-time registrations cost them GH¢8.

They observed, however, that they often had to make supplementary payments for their medicines because "*NHIS drugs were always in short supply at the facility*." As a result, the adolescents scored 2 for this while the older cohort scored 1. The latter complained that despite being insured, they still had to pay for various services – with some injections, for example, costing them as much as GH¢10. Some of them felt that, "*in reality, the NHIS covers only minor ailments such as stomach upsets, headaches and coughs*" and that, "*even so, the relevant medicines for treating such ailments are often not available at the facility*," compelling them to buy these from their local drugstores. The facility acknowledged that injections it administered for malaria were not covered by the NHIS and attracted a charge of GH¢8.

RESPECT FOR CLIENTS

Both client groups gave the facility the full score for this. Clients applauded the courteousness of the senior community health nurse. She was variously described as "*a good listener*", "*not [being] judgmental*", "*offering good counsel*" and "*respecting clients' opinions*." One woman in the older group spoke of the nurse apologising whenever there was a long queue. The adolescents also noted how she would "*drop whatever she was doing to attend to us*" whenever they called at her home with their issues.

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[9] These were stated variously as GHS3 and GHS5.

PROMPTNESS OF SERVICE

The two client cohorts diverged in their perceptions on this indicator, scoring her 5 and 2 respectively. While the adolescents appreciated that the nurse "*attends to us as quickly as she can*," the older women were critical of how much time she spends with each client. On the one hand, the older women claimed to appreciate the burden of being the only professional at the facility; on the other hand, they insisted that she could speed up her consultations – which average around five clients daily. A member of the group said she now uses the health centre at Brenase "*because [she] is overwhelmed by the queue at Kotokuom*."

Both groups recognised that the nurse was a lactating mum who did not start work at the usual hour of 8 o'clock. However, the adolescents were more tolerant of this than the older women were.

CONFIDENTIALITY AND PRIVACY OF CARE

On this indicator too, the two client groups had very divergent perceptions. The younger ones scored the facility 1, while their older counterparts score it 5. The adolescents were clearly influenced in their scoring by unhappy memories from the past. They recalled how previous nurses spoke insensitively to them, sometimes describing them as unkempt and publicly rebuking them about their underwear being dirty. They also described the current counselling practice as "*open counselling*" and said they were unhappy about this. They observed that everyone could see their urine samples when they went for pregnancy tests. Some said that such passive breaches of their privacy caused them to go directly to the drugstores with their health issues. The older women felt, however, that counselling was confidential and that it took place in a private room. Further, they had never heard of any client's confidential information being divulged.

9. Key recommendations

On accessibility of services:

- Efforts should be made to make staff allocation more equitable. Facilities with just one or two professionals (e.g. Kotokuom, Tsate, Abui Tsita) are particularly at risk of becoming non-functional when a health worker is on some form of leave (e.g. annual/ maternity/ sick leave) or undertaking outreach assignments.

- Across the board, facilities should employ a more transparent and participatory approach when assisting clients to select family planning methods. The process should also include discussions around likely side effects.

- More needs to be done to enhance citizens' appreciation of the hierarchy of facilities and services within Ghana's healthcare delivery system. This will help moderate clients' expectations at the CHPS level especially.

- Greater investment should be made in educating adolescents to appreciate the benefits of modern family planning services (e.g. Tsate). However, this ought to be done in a way that respects individual girls' and parents' desire for their

daughters to delay sex. Weekend discussion fora with adolescent groups can be helpful for enhancing their Knowledge around sexuality and breaking down barriers around taboo topics like managing menstrual hygiene. Partnerships with credible non-state actors can be helpful in rolling out such a strategy.

- The lack of ultrasound scanners significantly undermines clients' confidence in the health system and discourages them from patronising the facilities' antenatal services. GHS may wish to prioritise these more highly when resourcing health centres. Measures to facilitate sharing by facilities (as in the example described in Box 1) would lighten the cost burden, while enhancing access and efficiency of resource utilisation.

- Similar creative ways should be explored to enhance access to other supplies and services. The research has consistently shown that when drug and other supplies are deficient, citizens adopt a range of perverse and risky behaviours – e.g. self-medication, sharing friends' medicines, avoiding their formal healthcare facilities, refusing to renew their health insurance subscriptions, leaning on friends for medical guidance, or turning to unproven and unlicensed spiritual and herbal remedies. The potential outcomes of such practices are anyone's guess.

  Building proactively on reflections from the *Preferred Primary Care Provider Network* experiment in South Dayi experiment, the participating districts should reflect on, hone and rapidly scale the networking concept to a larger number of healthcare facilities. In an environment characterised by routine shortages, the potential benefits of such a strategy are too important to ignore. These include a lower incidence of drug spoilage (and, thus, improved drug access), fewer temptations for staff to indulge in illicit commercial behaviours, improved matches between supply and need, and more optimal resource utilisation.

- The strong belief among low-literacy populations that certain diseases (like HIV) have spiritual origins and that several others do not respond effectively to orthodox medicine has detrimental health outcomes. Unfortunately, such beliefs are reinforced by the wave of unlicensed "*Information Centres*" springing up across provincial districts and urban enclaves populated by low-income groups. In Brenase and elsewhere, these "*Information Centres*" use loudspeakers to market all manner of unlicensed indigenous therapies, with absurd claims of one single medication simultaneously curing headaches, stomach aches, heart disease, diabetes, infertility, gonorrhoea, skin rashes, piles, constipation and dysentery. Transport terminals and buses serving inter-regional circuits are another avenue for such unethical marketing. The failure of the pivotal state institutions – especially the Food and Drugs Authority (FDA) and the National Communications Authority (NCA) – to act on this growing danger amounts to a serious dereliction of duty. Institutions such as the District Assemblies (DAs), NCA, FDA and Ghana Health Service (GHS) all need to sit up and act decisively and in coordination against this menace.

On affordability of services:

- NHIS should intensify its review and public engagement efforts to address the subscription-related issues raised by clients – e.g. allegations of extortion, client entitlements and other challenges surrounding the registration process.

- In particular, the lack of drugs at health facilities – a situation repeated ad nauseum across virtually all facilities visited – amounts to short-changing NHIS policyholders and ought to be remedied forthwith. Ultimately, it is the poorest citizens who are being hit hardest by this systemic failure and the state's neglect to honour its side of the NHIS contract.

- Complaints about facilities issuing receipts selectively (e.g. Tsate, Peki-Adokoe) need investigating and correcting. In some cases, particularly where drugstores were not easily accessible, the practice arises in part because health workers ostensibly feel obliged to set up parallel, unregulated medicine markets to spare clients the high transportation costs and inconvenience. It seems likely too that health workers also see this as an opportunity to enhance their personal incomes. Whatever the rationale, facilities are expressly forbidden from purchasing drugs from the open market even in the event of stockouts. Thus, the informal regime whereby facility staff are retailing medicines to patients clearly flouts sector regulations and must cease.

- The significant and widespread disparities between family planning charges cited by citizens and healthcare providers ought to be investigated and acted upon to enhance confidence in the formal healthcare delivery system. In some cases (e.g. Tsate, Peki-Adzokoe, Abui Tsita), expenditures quoted by clients were as much as three to six times higher than those given by facility staff. In some facilities too, the disparities centred around card replacement and other costs.

- Closely related is the disparity in charges by different public health facilities. For example, some facilities charge for pregnancy tests and haemoglobin tests (e.g. Ayirebi and most others) whereas others do not (e.g. Wegbe Kpalime). Coupled with the disparities mentioned in the preceding bullet, this makes it difficult for clients to know when they are being fleeced.

- The perverse and widespread practice of prioritising funeral expenditures above other dimensions of wellbeing is one that undermines poor households' access to formal healthcare. It may be helpful to address this issue by including it in the health service's public education portfolio. To be effective, however, this deep-seated issue will have to be approached in a sensitive and deliberately participatory (rather than a merely didactic) way.

On quality of services:

- The practice of health workers spending lengthy periods on their phones during work hours without due regard to clients (e.g. at Peki-Adzokoe) is discourteous and must be discouraged.

- Other hostile attitudes among care givers reported by clients (e.g. at Peki Adzokoe, Ayirebi, Brenase) ought to be similarly addressed. As care workers, facility staff, including cleaners and other non-professionals, should be continually retrained to show respect to clients at all times and in all situations to avoid driving clients into opting out of facility-based services.

- The loss of confidentiality which sometimes arises when there are non-ethnic staff (e.g. Wegbe Kpalime) needs reflecting on. In future, staff allocation ought to be matched more closely with language ability.

- At facilities like Ayirebi, a more deliberate effort should be made to separate males from females by building inexpensive block-wall partitions rather than using plywood, which is entirely unhelpful to client confidentiality.

- Where facility design significantly threatens the confidentiality of client consultations (as is the case at Peki-Adzokoe), it may be wise, in the short term, to hold adolescent corner and adult family planning services on alternate days. This will increase adolescent girls' confidence in the privacy of their consultations.

- In future, clients' privacy and confidentiality concerns should be addressed more proactively right from the design stage of facility development. A higher level of anonymity can be assured by providing a small but private "*customer sorting area*" – a kind of halfway space between the OPD's general waiting area and the consultation/ specialised service rooms (e.g. family planning or adolescent corner). Clients can then be called one at a time into that halfway area and be directed to the relevant service destinations from there.

- Where residential accommodation exists on site for health workers (e.g. Tsate, Abui Tsita), the evidence from the study suggests that it can contribute significantly to improving citizens' de facto access to healthcare. District Assemblies may wish to consider supporting their health facilities with such additions.

- When prescribing services for clients, greater openness would help in correcting clients' misperceptions about how laboratories work and why test results are typically not instantaneous (e.g. Ayirebi). Such a simple practice could help in reducing clients' tendencies to practise exit when they do not appreciate the services being rendered.

- Finally, stakeholders at the district-level interface meetings suggested a scaling of the scorecard process to other communities and districts as a means to collaboratively unearthing the challenges of the health delivery system and jointly generating relevant responses. Conducted as a routine activity, the scorecard has potential to impact accountability in service delivery.

Annex 1: Supplementary inputs and action points from district interface meetings and national-level dissemination workshop

- Stakeholders in the district-level interface meetings reproved the widespread practice of requiring women in labour to bring along basic non-drug consumables – such as gloves, gauze and cotton wool. Under Ghana's Free Maternal Health Care Policy, these consumables are supposed to be provided by the health facilities while the pregnant women provide other items like cot sheets and diapers. The policy further forbids charging women for attending their deliveries. Henceforth, pregnant women will be notified to report any incidents of unapproved charges to the District Health Management Team (DHMT) for redress.

- The NHIA office for South Dayi acknowledged challenges faced by new clients in not being able to register via the tele-payment platform. Staff of the authority indicated that a number of satellite offices have recently been set up in selected communities to mitigate this challenge. Such important information ought to be communicated more widely.

- As a measure in enhancing service quality, stakeholders recognised the need to dust off the Patients Charter and step up community education on its contents – for clients as well as service providers. To that end, civil society actors – such as Volta Educational Renaissance Foundation (VEReF) – who are currently engaged in such efforts need to review and hone their community mobilisation cum education skills, along with their functional appreciation of the charter.

- Participants in the national-level workshop suggested that the formal healthcare sector's community education approach could draw useful lessons from the more effective marketing approach employed by itinerant medicine peddlers and advertisers of traditional medicines. It appears that the informal sector has been more successful in marketing partly because it targets citizens where they congregate (e.g. in marketplaces and transport terminals) and tends to be more persistent in its marketing.