The Limitations Of Ghana’s Rural Health Care Access:

Case Study: GA East, Greater Accra

Maria Polychronis
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For information on Global Futures, please contact us at: GF@Rutgers.edu

Maria Polychronis is a recent graduate of Rutgers University with a Master’s degree in United Nations and Global Policy Studies. As an international development professional, Maria has managed health, governance and human rights programs in the United States, United Kingdom and West Africa. Prior to development, she worked as a policy researcher in the House of Commons in London, and as a program coordinator in New York for the World Federation of the United Nations Association and the Permanent Mission of Iraq to the United Nations. Maria is currently living in New York City and preparing for her next project in East Africa.

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LIST OF ABBREVIATIONS
AFAWI – Alliance for African Women Initiative
ANC – Antenatal Care
CHO – Community Health Officer
CHPS – Community Health Participation Scheme
GDHS – Ghana Demographic and Health Survey
GHS – Ghana Health Services
MDGs – Millennium Development Goals
MMR – Maternal Mortality Ratio
NGO – Non Governmental Organization
NHIS – National Health Insurance Scheme
OOP – Out of Pocket Payments
PNC – Postnatal Care
SSNIT – Social Security and National Insurance Trust
UN – United Nations
UNICEF – United Nations Children’s Fund
WHO – World Health Organization
I. Introduction

Health care in Ghana has improved significantly throughout the years, especially since the introduction of the National Health Insurance Service (NHIS) in 2003. However, the issue has since become a matter of equity, leading many to question if the scheme is a pro-poor solution as was originally envisaged. There is no doubt that universal health coverage can increase access to health services, but in the case of Ghana, a foremost concern is that the NHIS is regressive, meaning that on average the richer segments of the population are paying less as a proportion of their income for health care than the poorer segments. This paper seeks to highlight the inequalities in the distribution of health care benefits particularly as poor rural access has perpetuated sub-standard maternal delivery services, which have caused an increase in maternal mortality rates.

Implementing the NHIS is remarkable accomplishment for the government of Ghana, not only within a sub-Saharan context but globally as well, particularly given that some of the most developed nations, such as the United States, have yet to implement universal health coverage for their citizens. However, by using external research and primary research conducted by me for the Alliance of African Women Initiative (AFAWI), I have concluded that while access to health services has increased, it has increased inequitably, servicing urban populations over rural ones, and richer populations over poorer ones. Providing adequate health care solutions to the most vulnerable citizens, particularly in light of the women's health crisis, should be a top priority for Ghana Health Services (GHS) and the NHIS as a matter of urgency. This paper will seek to examine why access to health care is difficult in rural Ghana and what can be done to expedite health coverage in these alienated parts of the country. Additionally, this paper will specifically look at maternal mortality as one of the most common health care issue as reported by locals and corroborated by external research. Lastly, recommendations will be provided based on my field work in rural Ga East with a view to make the NHIS an even more effective and powerful means of bringing access to health care to all segments of the Ghanaian population.
II. Ghana Health Services And The NHIS

Ghana has been applauded as being one of a small group of developing nations to pass legislation for universal health insurance coverage for its citizens. (Schieber, 88) The Government of Ghana passed the National Health Insurance Law in 2003 and the National Health Insurance Regulations in 2004 in an attempt to remove out of pocket payments (OOP) and significantly lessen financial barriers to health care access. (Gobah, 91) The NHIS that has resulted has earned global recognition and in 2010 the UN honored the managers of the scheme with a Global Award for Excellence. Nigeria, Ethiopia, Bangladesh, Mali, Senegal, Liberia, and the Democratic Republic of Congo are among the countries that have visited Ghana to learn from their health-financing model. (Mensah)

By the end of 2009, about 62% of the population was registered with 50% fully covered with valid identity cards. The NHIS is linked to Ghana’s poverty reduction strategy and is intended to be a pro-poor initiative. As part of the social protection aspect of the initiative, around 65% of NHIS membership does not pay annual premiums, receiving health care for free. (Gobah, 91) Children under 18 years, adults over 70 years, and indigents are exempted from paying annual premiums. In July 2008, a free maternal care policy was announced that exempts all pregnant women from paying premium and processing fees. The package was intended to improve skilled birthing access and processes to help reduce maternal and child mortality rates to achieve MDGs 4 and 5. Under this initiative, mothers have access to the full package of antenatal, deliveries and postnatal care at accredited health facilities free of charge. (Gobah, 92)

International evaluations of the NHIS have been mixed, with some experts praising it as a “good practice” approach to financing health insurance in lower-income settings while others criticized it for being less effective than it could be and for not being equitable for all segments of the population. The World Bank’s analysis of the efficacy of Ghana’s health system, based on the World Health Organization’s (WHO) criteria for effective service delivery, has both commended the progress that Ghana has made while pointing out stark inefficiencies and areas that urgently need to be improved. (Schieber, 89) In their report on health financing in Ghana, the World Bank states:

Ghana has a well-developed, highly decentralized, and evolving health system. The government is committed to health and has developed an integrated three-level (national, regional, and district) health system that incorporates a community-level health delivery system. Its governance, management, and organization reflect this structure. (Schieber, 92)

More specifically, the World Bank has praised Ghana for increasing public access to healthcare overall, citing that 64% of the ill sought medical care in 2005 as opposed to 44% in 1999. According to the NHIS, active membership had increased to 8.16 million users by 2010. Overall hospital occupancy has gradually increased to 60% currently, full immunization coverage has increased, HIV/AIDS prevalence is low, and Ghana is likely to meet the MDG target for child nutrition. According to the World Bank, Ghana produces more doctors than many other countries in the region and hospitals have a good availability of drugs. (Schieber, 109)

While the NHIS is progressive given the sub-Saharan context, if the Ghanaian health insurance model is to be emulated in other developing countries major structural reform is needed to make it a more efficient, equitable and pro-poor service. Among the criticisms of the health initiative are some crosscutting and wide-reaching structural issues that need to be addressed. The World Bank echoed other expert bodies’ criticism of the inefficiencies and ineffectiveness of the NHIS, stating:

...
"Ghana’s integrated health system faces challenges at every level in terms of workforce ratios; infrastructure, equipment, and transport deficits; the collection, analysis, and use of health data; drug procurement and the disappointing performance of the central medical stores; financing; quality assurance; and logistics management. To achieve its health reform goals, Ghana must deal with the inefficiencies and inequities in its service delivery system and do a much better job of providing primary care.” (Schieber, 110)

Major weaknesses in the system include current health care provider densities that are far below the levels recommended by WHO, meaning that there are too few health workers overall with most of them located in urban areas. Therefore rural areas, which tend to have the highest levels of poverty, are underserved despite their greater need for access to subsidized health services. (Schieber, 109) Many people lack physical access to primary health care and maternal and neonatal mortality and nutrition remain somber issues. The health staff that is available often lack adequate capacity and have few financial and infrastructural resources to work with. Financing, is indeed another pressing issue, with the World Bank predicting that the NHIS would go bankrupt by 2013 due to the overwhelming burden carried by the government to cover the cost of 95% of the communicable diseases afflicting Ghanaians and the 65% of the population that fall within the exemption categories. (Schieber, 111)

The most disappointing findings of the study are that Ghana is unlikely to meet the MDG targets for child and maternal mortality. When benchmarking health outcomes with neighboring countries in Sub-Saharan Africa, Ghana’s performance has been much less impressive, despite many researchers asserting that Ghana started from more progressive levels. Specifically, among countries with similar levels of income and health spending, Ghana performs worse than average with respect to child and maternal health and mortality. (Schieber, 109) This may be a result of Ghana having fewer health workers per capita than other countries with comparable levels of income and health spending, with a shortage of specialists. (Schieber, 104) Dr. Linda Van Otoo, the director of health services for the Greater Accra region, told Al Jazeera news in their coverage of the health situation in Ghana, that the country’s doctor-patient ratio is approximately one doctor to 15,259 patients in a year. “Physician assistants also see about 38,000 patients in a year while midwives and nurses attend to about 6,000 and 1,400 patients respectively annually,” she said. “This is very serious because the World Health Organisation’s revised standard for doctor-patient ratio is 1:600.” (Mensah)

Despite the operational and financial limitations of the NHIS, it appears that consumer satisfaction levels are high. According to the 2008 Citizens Assessment Survey by the National Development Planning Commission, 92% of insured members are either “very satisfied” or “satisfied” with the health services they have received through the NHIS. (Schieber, 110) An independent study collected through interviews with 320 individuals and three service providers in the Volta Region of Ghana also found that most customers of the NHIS are satisfied with the services received, although not by such high margins as the Citizens Assessment Survey indicated. Findings of the survey suggest that respondents are generally satisfied with the performance of the service in the district polled; with 71.6% of the insured indicating they are either satisfied or very satisfied. 19.3% reported either being dissatisfied or very dissatisfied with performance of the scheme. (Gobah, 96)

Some of the dissatisfaction reported by respondents revolved around obtaining coverage in the first place. Of the insured respondents, 53.5% reported having faced difficulties when enrolling in the scheme. The responses suggest that the difficulties were largely institutional and operational with 41.7% of respondents facing delays in the issuance of identity cards, 26.8% facing delays in the registration process, 11.9% said the registration centers were too far away and 8.3% stated that education on the scheme was not enough. (Gobah, 97)
III. Rural Access To Health Care, A Pro-Poor Solution?

The biggest criticism of the NHIS stems from concerns that it is not a pro-poor solution to health service issues, and in fact disenfranchises large proportions of its rural dwellers. Since most Ghanaians live in rural settings (Gobah, 95), this places huge risks for the uninsured. Despite the fact that such a large percentage of members are exempt from paying for the scheme, neither the benefits elicited by the scheme nor the enrollment process for the scheme is pro-poor. A major study on the progressivity of health care financing in Ghana concluded, "the distribution of total benefits from using health care in Ghana is pro-rich. The richest quintile gained almost double (24%) the benefits gained by the poorest (13%). The two richest quintiles accounted for almost half of total health care benefits, whilst the two poorest quintiles gained less than 30% of total public and private health care benefits. The distribution of benefits is pro-rich in both the public and private sectors, but particularly in the private sector (Akazili, Garshong, 116)

One of the main reasons for this is that concerted efforts to target the poorest quintiles of the country have been substandard. (Akazili, 2) The scheme has very rigorous definitions for which members will qualify as being "poor", meaning that some poor and near poor do not qualify and are required to pay premiums. This substantially affects the number of people that will seek out enrollment. (Schieber, 112) The difficulty in identifying poor people causes flat rate premium payments instead of graduated premium payments based on socio-economic status, which very much defeats the purpose of attempting to provide a safety net for vulnerable women, children and the elderly. (Akazili, 3)

These issues are echoed in a report by Aljazeera that came out this year titled, “Ghana’s Successful but Unpopular Healthcare” that asserts the poor still struggle to get medical care. The article cites that registration sites are overcrowded with hundreds of people sometimes waiting as long as over twelve hours in a queue to register themselves and their children. Once insured, interviewed respondents still claimed to continue to wait for several hours before they can see their physicians. Issues such as those depicted in the Volta Region survey and the Aljazeera report prove that registering and gaining access to medical attention is difficult, particularly for the most vulnerable in society who may not be as physically capable to withstand such discomfort in order to register and receive treatment. It seems that despite the NHIS providing free health care for 65% of the registered customers, experts agree that the scheme does not benefit the poor as much as it benefits the more affluent members of society. (Schieber, Gobah, Mensah.)

Additionally, medicines are often too expensive for the poorest quintiles to afford even when they have coverage. The World Bank states that Ghana’s medical supply chain system is weak and inefficient leading to excessive costs for medicines on the NHIS medicines list. The average price of medicines, for example, is two to three times the median international reference price. (Schieber, 114)

In a study covering 2,986 households, or approximately 14,050 individuals, in six districts of Ghana, the distribution of benefits and financial burden was investigated. The results echo these same concerns that “the distribution of total health benefits is pro-rich (rather than pro-poor), meaning that poorer groups receive a lesser share of benefits from using health services (measured in monetary terms) than richer segments, and benefits are not distributed according to need for care”. (Machu, 146) Specifically, the study finds that while there are parts of the scheme that are progressive, out-of-pocket payments and health insurance for the informal sector are regressive making the distribution of health care benefits is generally pro-rich. (Machu, 147)
The health insurance scheme is intended to allow poorer households to pay lesser premiums than wealthier households, but this study revealed little variation between higher and lower income households. Given the nature of informal sector work, difficulties exist in assessing household income levels in order to assign socio-economic based premiums, which often results in the charging of a flat premium payment. (Machu, 150) The study went on to find that:

Flat-rate contributions contributed to the regressivity of informal sector voluntary schemes due to difficulties in identifying household income levels. The regressivity of out-of-pocket payments is due to the incomplete enforcement of exemption and waiver policies, partial or no insurance cover among poorer segments of the population and limited understanding of entitlements among these groups. Generally, the pro-rich distribution of benefits is due to limited access to higher-level facilities among poor and rural populations, who rely on public primary care facilities and private pharmacies. Barriers to accessing health care include medical and transport costs, exacerbated by the lack of comprehensive insurance coverage among poorer groups. Service availability problems, including frequent stock-outs, limited or no diagnostic equipment, unpredictable opening hours and insufficient skilled staff also limit service access. Poor staff attitudes and lack of confidence in the skills of health workers were found to be important barriers to access. (Machu, 146)

OOP payments are highest in Ghana, accounting for about 40% of total health care expenditure, (compared with Tanzania at nearly 26% and South Africa at about 18%, two other countries where this study was held). (Machu, 151) About 35% of NHIS members surveyed in Ghana thought that the premiums they were paying were too high and nearly half wanted them reduced. (Machu, 150) Additionally, a staggering 25% of those insured had no knowledge that the NHIS exemption mechanisms existed so those who may have been eligible for an exemption from the premium would therefore not have benefited from this incentive. (Machu, 151)

This proves that the poor still have difficulties affording health care even when they are insured, but what about the 15 million people in Ghana that are not insured? (Mensah) According to the Volta Region study, affordability of premiums was mentioned as the major barrier to enrolment for 41.9% of the uninsured polled. The proportion was higher among rural dwellers (33.8%) than urban dwellers (8.1%). An additional 10.8% of the rural respondents reported not trusting the organizers of the scheme. To more comprehensively target the poor, rural access must be increased. The poorest Ghanaians live in rural areas; however, research indicates that rural areas are grossly under covered by the health scheme. (Gobah, 95)

A survey of data collected in seven districts in northern Ghana from 5,469 women aged 15 to 49 in 2011 provides further compelling evidence that the Ghana national health insurance scheme, rather than being pro-poor as was originally formulated, tends instead to differentially benefit the relatively prosperous respondents. In this survey conducted in the Upper East Region, Ghana’s most impoverished region, urban residents were more likely to be insured than rural counterparts. 65.3% of urban residents were insured while only 38.1% of rural residents were insured, indicating that the majority of respondents living in rural areas where poverty is often widespread remain uninsured. (Akazili, 5)

Compared to urban residents, rural respondents were 30% less likely to be insured by the NHIS (Akazili, 2). Given that the Upper East Region of Ghana is the poorest and most remote region, it would be expected to have high health coverage in such areas. However, not only is the insured coverage rate of 40% n the region unacceptably low, variations in coverage by socioeconomic status are also evident. The insurance coverage rate for women in the lowest socioeconomic quintile is only 33.9% compared to 58.3% among households in the highest quintile. This finding supports results obtained elsewhere in Ghana and sub-Saharan Africa showing that the relatively prosperous are more likely to join the national health insurance schemes than the relatively poor. (Akazili, 5)
IV. Cultural And Demographic Considerations For The Distribution Disparity

Given that the insurance premiums are based on household income and socio-economic status, it would be beneficial to assess how income is distributed within Ghana, and whether cultural, ethnic, political or regional variables affect the proportion of the population that bears the majority of the burden in financing a national health insurance scheme. While income distribution data on Ghana exists a lot of it is dated, and given the difficulty in identifying the income of the informal sector, many have questioned how accurate this data is. A study on the regional income differences in Ghana presented to Umea University in Sweden stated that, "Literature on income inequality in Ghana had mainly centered on the differences between the southern and northern regions. Therefore, there are relatively fewer studies on likable socio-economic and demographic factors that affect income differences/inequality in these regions. On the other hand, exploration of income inequality at the regional level is relatively unattended to in research literature and a novelty." (Adjei, 103) The most recent information available can be found in the 2008 Demographic and Health Survey, commissioned jointly by the Ghana Statistical Service and Ghana Health Service. For a break down of the wealth quintile, religious and ethnic makeup of a sample size of 4,916 females and 4,568 representing the general Ghanaian population, please see Annex 1.

The results of this study identified that ethnicity and religion have different impacts on regional income, citing that Christians have a positive effect on regional income levels. Regions with a high share of a population over 60 years of age, the ethnic group of the Akans, and Muslims have low regional income compared with regions with high share of Christians and low share of Akans. (Adjei, 103) (1) Additionally, income differences between the northern and southern regions of Ghana still vary significantly. Income differences between urban and rural regions are persistently high but are more noticeable in the rural areas in the northern regions. This may be due to the less urbanized environment, which may additionally account for the major differences in education and job prospects. (Adjei, 109)

Unfortunately, official reports from the NHIS or Ghana Health Services do not appear to categorize membership based along these cultural or ethnic lines. In the 2012 NHIS Annual Report, the most recent annual report found on the NHIS website, broader membership categories are provided. According to this report, children under 18 years constitute more than half of active NHIS membership. The premium paying members that work in the informal sector constitute approximately 35.5% of the active members. (NHIS Annual Report, 20) See chart below for details: (2)

Figure 1: Active NHIS Subscribers by Category.

![Active NHIS Subscribers by Category](http://www.nhis.gov.gh/files/2012%20NHIA%20ANNUAL%20REPORT.pdf)
While official nationwide statistics based on more detailed representation of the population do not exist, independent studies have been able to assess a more detailed makeup of NHIS membership. One of the most comprehensive data samples taken in Ghana, polling 3,468 individuals (1,422 male, 2046 female) found that wealth quintile, education, and religious affiliation played a role in NHIS membership levels. Specifically, the study found that the two wealthiest quintiles accounted for almost half the membership enrollment, with 53.6% of membership for males and 48.7% for females. Those with secondary or higher education accounted for a staggering 77% of enrollment for men and 62.7% for women. Christians accounted for almost two thirds of the membership enrolment and the northern/southern divide was palpable with over two thirds of the NHIS customers coming from Southern Ghana. (Dixon, 4) For more details refer to Figure 2 below.

![Figure 2: NHIS SAMPLE DEMOGRAPHIC](http://www.biomedcentral.com/content/pdf/1472-698X-13-35.pdf)

These findings echo previous literature that regard NHIS coverage as being a pro-rich health care scheme, despite intentions to make payments progressive for the most vulnerable in the country. It can be deduced from the figures given above that the citizens most likely to enroll and benefit from the scheme are Christians in the wealthiest quintiles that have received a higher education and reside in Southern Ghana, or in other words, the most affluent members of Ghanaian society. (Dixon, 5)
V. Implications Of Poor Rural Access To Health Care - Child And Maternal Health Crisis

The urban-rural distribution disparity remains a point of concern for many academics that have evaluated health care in Ghana. (Mensah, Akazali, Garshong) Given that the poorest Ghanaians live in rural areas, they form a significant portion of the population that is underserved, and this is particularly evident in the lack of skilled birthing and delivery services for mothers. (Gohab, 95) In Ghana, between 1,400 and 3,900 women and girls die each year due to pregnancy related complications. (Sakeah, 9) Maternal mortality, which accounts for 14% of all female deaths, is the second largest cause of female deaths in Ghana (Ganle, 15), after cardiovascular diseases (WHO). These persistently growing maternal mortality ratio (MMR) prompted the Ghanaian Minister of Health to declare maternal mortality a national emergency in 2008. (Johnson, 2)

In 2013 alone, approximately 3,100 women in Ghana died from pregnancy-related complications. Recent statistics point to an MMR of 380 deaths per 100,000 live births. A recent qualitative study on health system barriers states that because medical records are often ill kept, a more accurate statistic would be estimated to range from a low of 200 to a high of 1,300 per 100,000 live births. (Ganle, 16) The 2010, WHO estimates suggest 350 maternal deaths per 100,000 live births in Ghana. This MMR is high when compared with other sub-Saharan countries such as Namibia, which has a MMR of 130 deaths per 100,000 live births but is lower than the sub-Saharan African regional estimated average of 510 maternal deaths per 100,000 live births. (Sakeah, 10) Between 2003 and 2009, the MMR in Ghana increased on a daily basis, despite the relative availability of maternal health services. (Yakong, 2433)

As mentioned earlier, the World Bank study suggested that Ghana is off track to achieving the MDG 4 and 5 targets despite implementing the free maternity care policy. The same study further highlighted the fact that among countries with similar levels of income and health expenditure, Ghana performed worse than average with respect to neonatal, infant, under-five, and maternal mortality. (Schieber, 111) In rural Ghana, MMRs have been more prevalent and have raised alarms leading many to question why rural women are underutilizing maternal health services. It is clear that the gap between rural and urban women’s general and reproductive health continues to widen.

Experts agree that access to skilled doctors, nurses or midwives at birth is essential to decrease maternal deaths, and such access should be available to women in rural areas as well as urban areas. (Sakeah, 5) In sub-Saharan Africa, only half of women delivered with the assistance of skilled attendants. In Ghana, skilled delivery rate is slightly higher at 68% but there are rural–urban disparities. In 2011, only 54% of rural women delivered with the help of skilled attendants, compared to 88% of urban women. Globally, about 63% of women receive support and care during birth from a skilled health worker. In the case of Ghana, there has been steady improvement in the coverage of skilled birth attendance - from 40% in 1988 to 55% in 2010. Despite this improvement, 45% of births are still delivered at home without any form of skilled care, although there are significant regional variations. (Sakeah, 12)

Interestingly enough, the staggeringly high MMRs could ostensibly point to a lack of gender parity in the healthcare system but this does not appear to be the case. Gender does in fact appear to be a determinant of utilization of the NHIS, but on the contrary there are more females covered than males. A recent study shows that a higher percentage of users are women (60%) and males were less likely to use formal healthcare services. A possible explanation could be that men who could not afford to pay the premiums for all household members would prefer for the women and children in the households to be insured. (Fenny)
VI. The Practical Solution With Limitations – Community Based Health Care

The fact that such high maternal mortality rates still persist and rural access to health care is still lacking is disappointing given the serious steps the Government of Ghana has taken to address both these interlinked issues. Since maternal mortality was declared a national emergency in 2008, successive governments have committed their efforts to address this problem. Current President John Dramani Mahama promised to continue action to reduce the high rate of maternal mortality in the country as part of his presidential campaign in 2012. (Johnson, 2)

One of the initiatives championed by his administration is the expansion of the Community-based Health Planning and Services (CHPS) scheme to bring healthcare closer to rural women. President Mahama’s National Democratic Congress Party identified in their election manifesto that CHPS is a priority health initiative to improve access to health care for all. (Johnson, 2) This initiative would build upon and enhance the scheme that had been functioning, if somewhat dormant, for years. Since its inception in 2000, the programme has been an innovative way to expand health care coverage in rural communities, however it was underutilized and underfunded. In 2005, the Ghana Health Service piloted a revamp program that involved training Community Health Officers (CHOs) as midwives to address the gap in skilled attendance. These persistently growing MMRs prompted the Ghanaian Minister of Health to declare maternal mortality a national emergency in 2008. An inspiring component of the initiative was that if it was successful it could be replicated across the country, particularly in rural communities with modest resources. (Sakeah, 10) Newly reformed, CHPS has become a major national programme focused on promoting primary health care in marginalized communities. Following a slow start, the number of functional CHPS compounds doubled from 868 to 1675 between 2009 and 2011.

The CHPS programme is a grassroots initiative at heart and relies heavily on community resources for leadership, clinic construction, health workers and service delivery and programme oversight. Each of the CHPS zones, or delineated geographic areas assigned to each CHPS site, are staffed by a resident CHO and are supported by community volunteers, community health committees and traditional health care providers including local doctors, traditional birthing attendants and herbalists. CHPS is also an educational resource aimed at raising awareness of the prevention and care of prevailing health problems affecting the community. Maternal and child health care is a primary focus as well as family planning and immunization. (Sakeah, 9)

The government and leading health service officials were perceptive in assuming the importance of community engagement in the health care management process as it can substantially reduce childhood mortality as well as increase ownership and accountability of health outcomes. Community participation is a significant part of health service delivery in developing countries and a practical way to involve males in the family planning process. Community health volunteers have been used elsewhere to encourage community involvement and to compensate for severe shortages of health professionals. (Sakeah, 11) Results of previous studies on the impact of CHPS showed that participants in the CHPS areas were four times more likely to receive maternal care when compared with their counterparts in the non-CHPS areas. (Naariyong, 1710) Women in the CHPS areas were more likely to receive better technical process quality of antenatal care services in the rural districts policed than their non- CHPS counterparts. They concluded that therefore increasing the CHPS intervention coverage in non-CHPS areas might serve as a basis for improving the quality of antenatal care in other rural districts of Ghana as well. (Naariyong, 1716)

However, despite the high maternal coverage in CHPS areas, the MMR is still very high in Ghana. (Naariyong, 1710) Ultimately, the impact of the CHPS initiative in rural areas is lacking given the limitations in funding, geographical scope and access, and staffing. (Ganle, 13) Research conducted on 185 expectant and lactating mothers and 20 healthcare providers in six communities in Ghana revealed that CHPS coverage was very limited in rural Ghana. Only 9.9% of all the births were in communities within 8 km of CHPS. The majority of births either occurred in communities with access to a health facility (42.9%) or those with no access to any sort of health facility (47.2%). Overall, only 35.5% of all rural births were attended by skilled health personnel.
Skilled delivery care is free, but community members who reside far from the CHPS compounds cited transportation as a major reason for not accessing maternity services. Long distance to the health facilities, the absence of public transportation in remote communities or the cost of transportation are all major obstacles to the use of professional delivery services. (Sakeah, 10)

Even having access to health facilities doesn’t always equate to attendance by women, as there are limitations to the CHPS compounds even when they do exist. Some communities mentioned inadequate medicine, logistics and poor infrastructure in health facilities as further obstacles for the provision of efficient and effective services. Research also shows that the attitude of some nurses towards their patients is abysmal, which prevents some pregnant women from seeking skilled delivery services. The attitude of nurses has proven to be a major barrier for women accessing skilled delivery services. (Sakeah, 10)

The Volta Region study discovered that most people do not make use of the health centres and CHPS compounds located in their communities. Various reasons given for this include lack of trust of these facilities and their staff, lack of skilled personnel, and inadequate basic equipment and supplies. (Gobah, 96) Women specifically experienced major challenges in accessing reproductive health care, and distance was not always the inhibiting factor. In fact, women’s relationships with healthcare providers more often than not influenced their attendance of health facilities. Although there were some positive interactions with nurses recorded, negative experiences appeared to be more common. A study on women’s experiences receiving health care in rural Ghana reveals that women’s accounts of these negative experiences are discussed in relation to four themes: experiences of intimidation and being scolded, experiences of limited choices, experiences of receiving silent treatment, and experiences of a lack of privacy. (Yakong, 2435)

Nurses were observed to spend very little time with women and disregarded their questions while providing care. Many women recalled experiences in which they were scolded for not seeking care earlier, for not practicing birth control, or for asking too many questions. They were also threatened that treatment would be withheld if they did not comply with instructions from nurses, and were treated ‘like children’, ignored, and disrespected. Sometimes they reported that their relationships with some nurses were so off-putting that they did not want to seek care for themselves or for their children from particular clinics and nurses, regardless of the seriousness of the condition. Poor relationships between nurses and women often led to women’s inability to seek health care. (Yakong, 2435)

To provide further insight into the everyday workings of health services in rural Ghana and to highlight the challenges that health practitioners and citizens face to deliver and access adequate care, I refer to my fieldwork in Ga East, Greater Accra as an empirical example.
VII. Case Study: Ga East, Greater Accra

During my three month field assignment in Accra, I served as principle Health Researcher and Monitoring and Evaluation Officer for the Participatory Monitoring and Evaluation Programme, commissioned by Ghana Health Services (GHS) and jointly executed by SEND Ghana and the Alliance for African Women Initiative (AFAWI), two Ghanaian owned and operated NGO’s who commissioned my research. My duties were far reaching and varied in scope and capacity, allowing me to work closely with GHS staff, CHO’s and the community itself. This afforded me a greater understanding of some of the issues conveyed up to this point in this paper, which I will attempt to communicate in real life examples drawn from my fieldwork in the rural health sector in Greater Accra, Ghana.

1. OBJECTIVE

My objective was to gather first hand accounts from citizens to shed light on critical areas of improvement for health care access in the Abokobi district of rural Ga East, Greater Accra, particularly as it relates to infant and maternal mortality rates, which are staggeringly high for a nation that uses a national insurance scheme:

Specific Objectives:

1. **Abokobi Hospital**: To uncover why the citizens of Kpongpo and Boi in the Abokobi district are not seeking health care at Abokobi Hospital.

2. **Boi/Kpongpo CHPS Compound**: To uncover exact needs of CHOs and to formulate a pricing and fundraising strategy to more effectively achieve program aims.

3. **UNICEF/WHO National Polio Vaccination Campaign**: Participate in the national polio vaccination campaign to assess the obstacles of citizen outreach in rural Ga East and to provide recommendations for improvement.

1.1 ABOKOBI HOSPITAL

1.1.1 STATEMENT OF THE PROBLEM

Ghana Health Services has commissioned me, through AFAWI, to assess the efficacy of the Abokobi Hospital, the state hospital in Ga East, and the CHPS compounds in Ga East, and assess their standing within the community. GHS is concerned that not enough citizens are accessing health services at the Abokobi Hospital and are instead vising only the CHPS compound that services two CHPS zones, Kpongpo and Boi. This is particularly worrisome for GHS because the CHPS is very sparse in provisions and staffing compared to the hospital, even more so than average since it services two zones or twice the population it was intended to serve.

1.1.2 METHODOLOGY

For the assessment of citizen access to Abokobi Hospital, the study was based on both qualitative and quantitative data from a primary data pool of 50 Boi and Kpongpo residents. The primary source was solicited via a questionnaire and semi structured interview questions administered with the help of the resident CHO of the district as a translator. Raw data was entered into a spreadsheet and interviews were transcribed. Refer to Annex 2 for survey structure and contents.

1.1.3 FINDINGS

Of the population poled in Kpongpo and Boi, 89.7% have accessed health services at Abokobi Hospital at least once, 80.8% of them being female. Of the reasons cited for visiting the health centre, pregnancy and child related issues were the main concern according to 50% of the respondents. Secondly, injuries and other illness were 26.9% and Malaria was the third most prevalent reason with 23.1%. A breakdown of the reasons given for seeking healthcare at Abokobi hospital can be found in figure 3 below.
Customer satisfaction responses received through these questionnaires and interviews in this rural part of Ga East vary significantly with the nationwide poles on health care satisfaction conducted by the World Bank and the Ghana Ministry of Health, as well as other studies cited in this paper. An overwhelming 50% of respondents claimed to be either unsatisfied or very unsatisfied with the health services they received. 42.3% were satisfied or very satisfied and 7.7% were neither satisfied nor unsatisfied. A breakdown of customer satisfaction responses can be found in figure 4 below.
Of the residents questioned, 65.4% of residents claim to not have returned to Abokobi health centre after their disappointing experience, choosing to either seek care in another institution (42%), go to natural native healers (23%), or pursue no form of health care at all (35%). Of the 10.3% of respondents that have never been to Abokobi Health Center, a staggering 1/3 claim this is due to the bad reputation and weak referral systems attributed to Abokobi Hospital. All citizens polled said that the hospital was within walking distance to them and even pregnant women said they could walk there alone easily. This proves fairly comprehensively that poor service is the reason why many citizens are foregoing treatment at the hospital, and not distance and lack of transportation as would be assumed and as stated by previous research.

The main reasons respondents gave for being unsatisfied with the health care provided at the hospital were that no treatment was received or they were referred to another hospital (37.5%), poor service of staff or negligence (33.3%), wrong or insufficient medicine was given (12.5%), lack of the required equipment (8.4%) and malpractice (8.3%). A breakdown of the reasons given for dissatisfaction with health care received can be found in figure 5 below.

The largest complaint from residents is receiving no treatment when they went to the hospital and were consequently referred elsewhere for treatment. One woman we spoke to was turned away from the hospital when she was in labour:

“No midwife was available at the time and we were referred to Madina hospital. There was no ambulance to take me so we took a tro tro (a shared bus, public transportation) and I ended up giving birth on the way.”

Another female resident, who was pregnant at the time of this interview, broke down in tears when asked about her experience at the hospital:

“My first child was ill, he had a terrible fever and we went to the hospital to see a doctor but all they gave him was first aid. They said there was no nurse available, and they didn’t have the equipment we needed. They referred us to Ridge Hospital but my child died before we could get there.”

The second biggest complaint from residents was the poor service they received. Many stories were recorded of nurses being rude, inattentive and even negligent. One woman recounts her experience of giving birth at Abokobi Hospital:

“During my childbirth the nurse was forceful and hitting me to push harder. The nurse was scolding me and unhappy with me and walks out midway, I had to finish the birth alone without anyone but the cleaner that was in the room and she had to hold my baby with no gloves on.”
One woman spoke of having to wait to be seen while in labour and the poor service she received from the nurse on duty at the time:

“I was in labour and went to the hospital but when I got there the nurse said her shift ended and would not help. Had to wait two hours for another nurse to come. Then the power went off and there was no generator.”

Another woman we interviewed had a similar story of long waiting times and negligent nurses:

“My son was very ill but the nurse’s shift ended and wouldn’t help him but she stayed and read a book in the corner. We hurried to private hospital. I heard that the facilities are better now but I don’t want to risk going back. I heard too many bad stories from neighbors.”

Many other residents had severe complaints about substantial mistakes that health workers made at the hospital, and many were unhappy with the quality of drugs they received. One woman said she was given the wrong medication for her illness and claims she almost died as a direct result. A man said that his son developed an abscess after a vaccination was administered wrongly and is left permanently crippled. Another woman claims to have received painkillers for malaria and no first aid for a head injury, and was referred to another hospital for both these emergencies.

1.1.4 LIMITATIONS

This study could not be extended to a larger sample size and to more districts in Ga East due to the time limitations of the CHO translator and coordination difficulties with Ghana Health Services. Of the respondents polled, 82.8% were female which may account for the large portion of the results stating that maternity was the major issue for seeking health care. This may be because the female translator felt more comfortable approaching women for interviews. Another possible reason is that since interviews took place during the day, most men were at work out of the home and the only citizens that remained were women in the homes or female shopkeepers in the more accessible parts of the village.

1.2 CHPS COMPOUND

Through informal discussions with local residents, I discovered that most preferred to go directly to the CHO for assistance and avoided going to the hospital. It was very evident that the CHO held good standing in the community and many people approached her in a very friendly manner throughout our research in the town over those several weeks. I was present for several occurrences when mothers would bring their children for check ups or general advice for their daughters. On one such occasion a mother brought her young pre-teen girl to speak and gain advice from the CHO in relation to sexual activity and prophylactics, as the mother entrusted her with this information and with the guidance of her child.

The Abokobi/Boi CHPS zones is the only one in Ga East with a compound. The community members themselves held a fundraiser to have the compound built as a mud structure, but the rent is past due, and at the moment they cannot afford electricity either. The compound is currently stocked with BP apertures and family planning education material and commodities. The remainder of the CHO’s in Ga East do home visits, as they do not have an office. For specific family planning days or vaccinations, CHO’s work out of the central hospital, in churches or mosques or at primary schools.

The Abokobi CHPS compound is a one-room mud structure that lacks toilet facilities, a sink and basic equipment. Interviewing the GHS lead nurse and the resident CHO provided me with an understanding of what provisions and equipment is needed, and on behalf of AFAWI I held an international fundraiser to raise money and awareness for this cause. The funds gathered were able to fund most of the following below, and more fundraising will be needed to fund the remainder:
The CHPS compound lacked the following necessities:

- Vaccination fridge
- Desk and chairs
- Supplies cabinet
- Examination bed
- Blood Pressure Apparatus
- Baby weighing scale
- First aid kit
- Bandages/plaster
- Thermometer
- Veronica bucket, anti-bacterials and soap

1.3 NATIONAL POLIO VACCINATION CAMPAIGN

As part of my work for AFAWI, I joined the UNICEF and GHS teams in completing an intensive three-day Polio Immunization Campaign between the 27th – 29th of October, 2014, in the Ga East district of Greater Accra. The goal of this campaign was to have every child under five years of age in the country visited, vaccinated against polio, and given a Vitamin A supplement.

During this assignment, I was able to witness first hand how challenging it can be to deliver health care to rural communities in Ghana. Most of the households in Ga East reside in inaccessible and remote rural villages, often separated from each other by dense forests and swamps. There is not always direct access to health centres and schools to conduct vaccinations en mass. For this reason, dedicated community volunteers went door to door on foot, starting early morning after sunrise, to ensure that all children in Ga East were accounted for and vaccinated. Volunteers know their community areas intimately and were able to map out hidden communities in the forests that no outsider would ever be able to find alone on foot.

Equipped with a small ice cooler, ice-packs, vaccines, temperature monitoring forms, marking sheets, a permanent marker, chalk, and targeted area maps, we went door to door to reach every household. The Polio vaccines were completed by placing two drops of the serum inside each child's mouth and then coloring in his or her left pinky finger with a marker to indicate which child has received the vaccination. Each home was marked with chalk to indicate where volunteers had been. A Z1 with a circle meant that all children under 5 were vaccinated, a Z1 without a circle meant that we were not able to access the children, and marks were made on the housing structure to return at another time.

This was a well-coordinated and committed team effort that found practical solutions to the complex issue of making vaccinations accessible to rural communities. Overall, the Greater Accra volunteer teams surpassed their vaccination targets of reaching 513,000 children under five years of age. Ga East surpassed their targets with the greatest margin, reaching the most number of children within our district. In Ghana alone, the first phase of this joint effort has vaccinated nearly 6 million children against the disease. (GHS)

2. DISCUSSIONS AND ANALYSIS

The examples given in my fieldwork in Abokobi further emphasize the issues raised previously in this paper. Specifically, this fieldwork has confirmed that even for the residents of Ghana who are able to afford health care or are provided free health care as part of the exemption social protection scheme, health care is often hard to come by with varying degrees of quality.

The first lesson learned is that delivering access to rural villages in Ghana is challenging. As exemplified in the structuring of the polio immunization campaign, certain districts are remote and almost invisible given the harsh terrain. In many parts of the district there are no roads and often times the roads that do exist are
in very poor condition and are dangerous to navigate. Dirt roads are often turned to flooded swamps in the rainy season and are therefore impossible to navigate. Automobiles that are purchased for fieldwork are mostly bought used and in poor condition and unfit to navigate the coarse roads, and often this leads to further costly issues with mechanical problems and maintenance. Additionally, there are no maps or navigation devices to enable easy location of the areas targeted, meaning locals are the only ones that can provide assistance in bringing health coverage to the doorsteps of their fellow citizens.

Even those who have direct geographical access to health facilities are not always guaranteed to receive proper care. Whether insured or uninsured, my research agrees with the previously cited literature that claims health service is below par and unacceptable at times, as in the example of the Abokobi Hospital. Severe understaffing, lack of empathy and interest by health workers, lack of appropriate equipment and medicines all make receiving proper care difficult.

Lastly, my research has proven that the addition of a CHPS compound and a CHO that serves the community diligently have helped the situation in the rural areas by providing a good supplementation to the state facility. Many people prefer to attend these facilities and are happy with the care they receive there. However, the research confirms that CHOs cannot replace hospital care as they are grossly underfunded and lack many basic necessities, including staff and equipment.
VIII. Recommendations

Ghana has come a long way in terms of developing a modern health care delivery system, improving the availability of effective drugs, and operating effective public health programs. However, based on my research I can make the following practical recommendations for more effective health service delivery, taking into consideration that GHS has limited funds to invest in advanced technology and modern innovations:

1. COMMUNITY ENGAGEMENT

Fieldwork in rural Ga East has reinforced the fact that communities in Ghana support each other and make communal sacrifices for the greater good of their district. It was the community in Kpongpo and Boi that joined efforts and their own resources to build the CHPS compound and this provided ownership and pride in its development. Additionally, during the Polio vaccination campaign, volunteers undertook the responsibility to go door to door to ensure all the children in their community received immunizations. Without local involvement the UNICEF team would have had a very difficult time locating many of the villages targeted.

A practical strategy given the lack of funding and staffing shortages would be to more efficiently organize volunteer programs to better meet the needs of the community. Outreach should be coordinated with the many nursing schools in Greater Accra to arrange for credit to be given to students who volunteer as health practitioners in their towns. In Ga East we noticed that many volunteers initially gave their time but were unable to sustain doing so without receiving payment. It would be worthwhile to ear mark some District Assembly funds to give small compensation to volunteers to incentivize them to continue working. These incentives could be as small as a transportation stipend or a lunch allowance. Even small rewards have the potential to increase volunteer interest in community health services.

2. LOGISTICS AND ORGANIZATIONAL IMPROVEMENTS

The Polio vaccination campaign and the field interviews conducted in Abokobi highlighted that fact that in the absence of maps or any form of central database system at the local level, reaching households is very difficult because we simply do not know where these homes are. The vaccination team relied heavily on locals to draft makeshift maps of the area to be assigned to each team so that overlapping of efforts could be avoided. However, the next time a vaccination campaign occurs this process will need to be repeated.

I, along with the AFAWI team, suggested that we undertake the creation of a central database in Abokobi to record where households are and the specific health needs of each home. This in turn would be given to the District Assembly and hopefully be replicated in other rural areas. The survey (see Annex 2), will be administered by volunteers who will go door to door to briefly survey the residents of each household and make note of any health ailments they may have and whether or not they have received treatment. This is also a great way to ensure promotion of health services and to answer any questions that residents may have about the health services provided, registration for the NHIS and the location and functionality of the CHPS compound.

If we are able to create a central database of the population, we could be more efficient in providing adequate health services. Health workers could have a stronger grasp of the health needs of their communities, which will allow them to provide more tailored service and to ensure that no one lags behind in receiving healthcare. There would be a greater understanding of the needs of the most vulnerable members of the community, especially the elderly, young children and severely ill, including those living with HIV/AIDS. When epidemics such as cholera routinely emerge throughout the district, a centralized database of citizens will allow for a faster assessment of the impact on the district as well as an added tool in tracking the epidemic. Additionally, community campaigns involving immunizations and vaccines will be easier to administer when a database exists of all community members and their locations.
3. TRAINING OF HOSPITAL STAFF AND HUMAN RESOURCES FOR HEALTH

The effects of health care provider and patient relationships have proven to play a big role in how residents seek out health care services. There has been an overwhelming response to the negative experiences with rude, incompetent and indifferent health staff when seeking treatment. It is clear that appropriate staffing norms do not exist and this affects the productivity and the attitude of health workers. Policies and regulations need to be implemented to address the behavior of nurses and health staff, and appropriate repercussions need to be dealt to those who have neglected and or provided hostile treatment to their patients.

Training should also be provided on the importance of relationship building and maintenance in health care. Health workers need to be taught that their attitudes and behavior matter and that their work ethic and commitment to their duties must be proven or appropriate measures will be taken as a result. Additionally, more incentives should be in place to ensure and reward good performance by health workers.
IX. Suggestions For Further Research

For a more robust understanding of how income and wealth distribution affects enrollment in the NHIS, further research should be done. A stronger correlation between ethnic and religious groups and their income levels should be studied because it is clear that these causal relationships exist from the external research cited in this paper. Additionally from a qualitative perspective it would be worthwhile to look into how the different ethnic and religious groups perceive the NHIS and the modern type of health care it represents to gage if this affects their health seeking behavior.

Monitoring and evaluation is another important aspect that has not been covered in this paper and deserves further research. It would be beneficial to understand what groups, international, independent or of official capacity, are tasked with evaluating the NHIS and its progress, to ensure that progress in on track and targets are met. Specifically, it would be interesting to know what local grassroots initiatives are in place to independently evaluate health care quality and the needs of the communities they operate it, and to assess how they are managing this and with what difficulties. The Alliance for African Women Initiative is one such organization and my duties as Monitoring and Evaluation Officer fall within the scope of this undertaking. Perhaps a more detailed analysis of the monitoring and evaluation process as it relates to Ghana would be a great follow up article on this research.
X. Conclusion

In summary, the NHIS and its initiatives to promote universal access to healthcare have made significant improvements in the lives of many Ghanaians. Given the sub-Saharan context, the Government of Ghana has achieved significant results in a relatively short time span. However, before Ghana is used as a model health care provider for other developing nations, major reform is necessary to improve equity and quality of care.

A major restructuring of the health care scheme is warranted to redeploy staff in accordance to where they are needed most, specifically in rural and impoverished areas, especially to address the health care concerns of women and mothers. More funds need to be shifted to enhance the capacity of the CHPS scheme as it shows promise for raising future health outcomes in rural areas. Additionally, training and incentivizing of health workers and volunteers will bridge the gap between health services and reluctant customers, and raise the standard of care throughout the country. Above all, the Ghanaian health system must continue to leverage the power of community involvement and the great relationships and support systems found between neighbors, as this is the true Ghanaian spirit and approach to problem solving.
Works Cited:

Notes
(1) The authors also noted that Christians account for a greater portion of the population, around 60%, which could also account for some of the income variations per region. (Adjei, 107)
(2) SSNIT in figure 1 refers to the contributors and benefactors of the Social Security and National Insurance Trust.
# ANNEX 1: Demographic Makeup Of Ghana

<table>
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<tr>
<th>GDHS Sample Demographic</th>
<th>% of Male respondents</th>
<th>% of Female respondents</th>
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</thead>
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<tr>
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</tr>
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<td>Second</td>
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<td>Middle</td>
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</tr>
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</table>

ANNEX 2: Health Facilities Access Survey

Objective: To determine if the district’s health facility is accessible to the towns of Boi and Akporman.

Name of interviewer ____________________________________________________________

Date __________________________


(A rural community is a community with a population of less 5000)

Town __________________________ District __________________________

Region __________________________

Sex of respondent: Male □ Female □

Age of the respondent: 18-28 □ 29-39 □ 40-49 □ 50-59 □ 60+ □

1. Do you stay in this community? Yes □ No □

2. Are you from this district? Yes □ No □

3. Have you ever accessed the district’s health facilities? Yes □ No □

If you have accessed the health facility:

4. How many times did you attend?
   a. 1-2
   b. 3-4
   c. 4-5
   d. 5+

5. When did these visits take place?
   a. 2014
   b. 2013
   c. 2012
   d. 2011
   e. before 2011

6. What services did you request?
   a. X
   b. Y
   c. Z
7. Describe your experience and satisfaction with the services.
   a. Very satisfied
   b. Satisfied
   c. Neither satisfied nor unsatisfied
   d. Unsatisfied
   e. Very unsatisfied

8. If you have not accessed the health facility please state the reason:
   a. No need – no health problems  Yes □  No □
   b. Attitude of the staff  Yes □  No □
   c. Don’t know where the facility is located  Yes □  No □
   d. No access to transportation, not in walking distance  Yes □  No □
   e. Don’t believe the services will be beneficial  Yes □  No □

9. Do you know where the health facility is located?  Yes □  No □

10. Do you know the services provided at the health facility?  Yes □  No □

11. Do you have access to transportation or is the health facility within walking distance of your home?  Yes □  No □

12. Do you know anyone who has attended a health facility?  Yes □  No □

13. Have you ever had the need for health services in the past?  Yes □  No □
ANNEX 3: Community Monitoring Forms

CHPS COMMUNITY VOLUNTEER’S MONITORING FORM (DAILY)

NAME OF HOME VISITOR: …………………………………………………

CHPS COMPOUND: ………………………………………………………………………

DISTRICT: …………………………………………………………………………

SUPERVISOR/CHO: ……………………………………………………………………

DATE: …………………………………………………………………………………

<table>
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<tr>
<th>Community</th>
<th>House No.</th>
<th>Family Name</th>
<th>Patient Name(s)</th>
<th>Services Needed</th>
<th>Services Provided</th>
<th>Notes/Recommendations</th>
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</tbody>
</table>
CHPS COMMUNITY VOLUNTEER’S COMPILATION FORM (MONTHLY)

NAME OF HOME VISITOR: ………………………………………………………………………

CHPS COMPOUND:…………………………………………………………………………………………

DISTRICT: …………………………………… SUPERVISOR/CHO:………………………………………

MONTH:………………………………… YEAR:…………………………

TOTAL NUMBER OF HOMES VISITED …………………………

TOTAL NUMBER OF PATIENTS SEEN: ……………………………

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<thead>
<tr>
<th>No.</th>
<th>Name of Community</th>
<th>No. of homes visited</th>
<th>No. of patients visited</th>
<th>Record of Services Requested</th>
<th>Record of Services Provided (REFERALS)</th>
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<td></td>
<td></td>
<td>Referal</td>
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<td></td>
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<td>Y</td>
</tr>
</tbody>
</table>


NAME - CHPS COMMITTEE COMPILATION FORM (MONTHLY)

CHPS COMPOUND: .......................................................... DISTRICT: ........................................
MONTH: ....................................................... YEAR: ........................................ TOTAL NUMBER OF HOMES
VISITED: ........................................ TOTAL NUMBER OF PATIENTS SEEN: .................................

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<tr>
<th>No.</th>
<th>Name of Community Volunteer</th>
<th>Community</th>
<th>Name of Supervising CHO</th>
<th>No. of Homes Visited</th>
<th>No. of Patients Seen</th>
<th>Referral was Made</th>
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