GHANA / SAPRI

IMPACT OF SAP ON AVAILABILITY OF AND ACCESS TO HEALTH CARE

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INTRODUCTION

The Ghana Medium-Term Health Strategies and Five-year Programme of Work focus on promoting good health for all in Ghana and enhancing geographical and financial access to services. The Ministry of Health (MOH) continues to be concerned about the inter-regional and intra-regional inequalities in access to health care and in health outcomes. The findings and recommendations of the 1998 Annual Health Sector Review have highlighted these concerns. The report stresses the need for special studies in the following areas:

- Implementation of the Internal Generated Funds (IGF) and the exemptions policies.
- Identification of barriers to access and use of services by the poor and the disadvantaged/vulnerable groups and methods of tackling them.

This health sector research report is one such study and has been commissioned by the Structural Adjustment Programme Review Initiative (SAPRI). This initiative is made up of representatives of governments, the World Bank and civil society organisations. Its main objective is to review periodically the impact of adjustment policies on civil society.

This study specifically reviews various policies meant to increase the access of communities to health services, identifies and describes, in a historical context, community perceptions of these policies, including mechanisms for exempting selected, vulnerable groups from paying for health services, and explores ways by which the community can meet the financial demands of the exemption policy in the context of limited government support. The goal is to evaluate the effects of the exemption policy on the vulnerable groups and to collate views on the feasibility of community-based insurance schemes.

This Health Sector Research Report consists of two parts, a desk study and a field study. The desk study involved a review of the available literature and studies on access to health services at various levels in Ghana. It identified a number of factors limiting access to health services, especially to people disadvantaged by reason of age, gender or residence, and largely formed the basis of the field study.

The report also presents the findings of the field study and consists of the following sections: background to the study, objectives, methods, key findings of the quantitative and qualitative surveys, discussion, and policy conclusion.

Background to the Study

In the late 1950s and early 1960s, Ghana had one of the highest levels of income and some of the best social and economic infrastructure in sub-Saharan Africa. Until 1983, Ghana's health system was financed mainly out of the national budget (Widstrand 1969, Sowa 1993, Bonsi 1996.)

The world economic recession of the early-to-mid 1980s, however, led to a decline in Ghana's economy. One indirect result was the fall in government expenditure on health care from 6.45% of the budget and 0.95% of gross domestic product (GDP) in 1980, to 4.38% and 0.35% respectively in 1983.

In order to arrest the situation, the government adopted a set of economic policies in a structural adjustment programme (SAP) that aimed to create a liberal socio-economic and political environment. The policies also sought to reduce government spending, notably on social services, and encouraged a change in the central government's role as the main provider and financier of health services in Ghana.

The introduction of user fees and charges for health services has meant that some people are excluded by reason of poverty or unwillingness to pay. Whilst the extent of this is unknown, it can be assumed that many people have difficulty in paying,bearing in mind the recent World Bank estimate that 35% of Ghanaians live below the poverty line.

To mitigate this problem therefore, the government introduced an Exemption Policy covering certain categories of people. These include:

- Refugees
- The poor
- Children under 5 years old
- Pregnant women
- Disabled people
- Elderly people aged 70 and above.

Problem Statement

Despite the increases in the levels of government expenditure to the health sector in Ghana, current spending is inadequate for the provision of equitable and good quality health services to the population (Republic of Ghana Medium-Term Health Strategy, 1995).

The rapid growth and youthful structure of Ghana's population pose special challenges to the health service. The population doubled between 1970 and 1994, growing at rate of 3% per annum. The proportion of the population above 60 years is on the increase. Women in the reproductive age bracket (15-49 years) and children constitute a high proportion of the population.

Preventable diseases like malaria, diarrhoea, respiratory tract

infections, measles and typhoid still persist, and are leading causes of morbidity and mortality. Epidemics like cholera, cerebro-spinal meningitis (CSM) and yellow fever still occur. Above all, there are new diseases such as HIV/AIDS and a resurgence of tuberculosis. Most of these largely afflict the vulnerable groups -- the poor, the aged, women and children.

It has been observed that utilisation of health services in Ghana, as measured by outpatient attendance, has been low, although fairly stable at around 0.35 per capita per what unit? Month, year?, (Cassels et al, 1991), though this may be explained by the fact that statistics for most private facilities are not included.

In general, the health delivery system and the distribution of existing social infrastructure are grossly inadequate and discriminatory. For example, in 1990, government health facilities, which accounted for 70% of the entire health service delivery system in the country, catered for an estimated 30-40% of Ghana's population (UNICEF, 1991).

Funding the implementation of the exemption policy constitutes about 5% of the total budget. The implementation of this policy has had many problems, the main one being that of determining who is poor enough to be exempted.

The government is committed to the objective of health for all. The strategy for achieving this objective is the primary health care (PHC) programme, which constitutes a vital component of the national health delivery system. To ensure that the PHC programme operates efficiently, health services have been decentralised to district level where staff have been retrained in PHC programme planning, implementation and management.

A major policy priority in the health sector is to address the

differences in health outcomes that are both avoidable and unjust (WHO, date?). In order to address this issue, additional information is required with respect to barriers to access to health services, especially for the poor and the vulnerable groups. The Task Force set up by the Ministry of Health (MOH) has adopted a number of approaches to obtain relevant information from communities on their perception of health and health services, including exemptions and waivers. The exemption policy is one of the health sector reforms designed to improve the performance of the sector and the health of the population.

The study just completed by MOH on the exemption policy has identified a number of factors, mainly administrative and managerial, that have bedeviled its implementation. However, the methodology of the study used is oriented to the perceptions of policy makers, health managers and health providers.

The beneficiary population covered in the study comprised only those people who visited the selected health facilities at the time of the study. Preliminary results show that many of the clients are not aware of the exemption policy, let alone motivated to utilise available services when ill. (Ministry of Health Preliminary Reports on Exemptions Study, January 2000)

There is the need to address the issues of exemptions from the perspective of the general community and, in particular, the vulnerable groups (pregnant women, children under 5, the aged and the poor), whether or not they have visited the health facility. The MOH study also gave little information on the effect on the general population of bottlenecks in implementing the policy.

As far as the SAPRI research methodology is concerned, only the participatory method was used. Completely absent is the political economy approach that would have given us a picture of trends in availability, access and use of public health facilities, including

infrastructure and service staff ratios.

Health sector policies in place since 1985 have encouraged private participation in the health sector and granted exemptions to certain categories of persons including the aged, pregnant women and children under-5. Financing this scheme is currently the sole responsibility of the government. The extent to which this can be sustained is yet to be determined. Meanwhile, alternative sources of funding are being explored. One such a possibility is a health insurance scheme that can embrace the majority of Ghanaians. Obtaining the views of communities and other stakeholders regarding their role in such a scheme would help in policy formulation.

Terms of Reference

In order to address the issue of health care inequalities, the Ministry of Health formed a sub-committee to conduct research into exemptions policy. The main objective was "to determine factors that affect effective implementation of exemptions and waiver mechanism of the poor and vulnerable groups at different levels of health delivery system so as to contribute to the improvement of equity of access to health service". The study, which was conducted early 2000, attempted to evaluate the extent to which the exemption and waiver protect the poor and the factors associated with effective implementation.

A critical review of the methodology and the results indicate that the study did not address the impact of the policy on vulnerable groups. There was no information about the role the beneficiary population play in the formulation of the policy. In August 1999, SAPRI had initiated studies to assess the impact of government policies on certain sectors such as agriculture, mining, education and health. Following the literature review on access to health and education, a number of issues were identified. The terms of reference (TOR) of this current study are based on the results of

the MOH study. They focus on the following:

- Design a broad framework showing how SAPRI methodology of political economy, participatory research appraisal and gender would be applied in the study (i.e. in the collection and analysis of data and interpretation).

- Review both public and private proposals for health insurance, commenting on their potential for reducing vulnerability among the poor and other groups.

- Identify alternatives to "exemptions" and "health insurance," specifying the survival strategies adopted by vulnerable groups to meet their health needs outside the formal sector.

- Assess trends in availability and access to public health care facilities before, during and after the introduction of health reforms.

- Appraise the experience of inter-agency co-operation in aid of implementing the scheme.

- Evaluate trends in availability and accessibility of infrastructure and services including staff and specialist/patient/x-ray/laboratory ratios following the liberalisation and privatisation of health services, including laboratory services.

- Collate community perceptions and views on health and health policy issues that affect them.

Objectives

General Objectives

1. To assess community awareness of health reform policies

relating to access of health services before, during and after SAP, especially exemptions.

2. To ascertain community views on developing a workable, community-based insurance scheme that enables vulnerable groups to have access to health care.

Specific objectives

1. To review trends in availability of and access to public health facility.
2. To review trends in availability of and access to infrastructure and services by/for vulnerable groups
3. To identify factors leading to the development and adoption of the exemptions policy.
4. To assess community awareness of public health facilities available to them.
5. To assess community awareness and perception of selected health policies (including exemption policy) relating to access to services.
6. To determine/identify factors inhibiting awareness of exemption policy and thus affecting utilization of public health facilities at community level.
7. To identify community mechanisms for assisting vulnerable groups to access health care services
8. To ascertain community views and perceptions of a community-based health insurance scheme.

METHODOLOGY

Study Setting

Profile of Ghana

Ghana achieved political independence in 1957. Since then various governments have made efforts to improve the material and social conditions of Ghanaians with varying degrees of success. The PNDC/NDC began two major tasks: reversing the economic decline of the 1970s and early 1980s, and laying the foundations for a lasting political order. A constitutional government began in January 1993. The Republic is based on a parliamentary system of government with an elected president and a national parliament.

For administrative purposes, the country is divided into 10 regions and 110 administrative districts. Each district is presided over by an elected district assembly with responsibility for policy development and planning to harness local resources for social and economic development.

The district assembly is the basic unit of government administration and is constituted as the planning authority for the district. There are various sub-district administrative structures and subordinate bodies of the district assemblies – the sub-metropolitan district councils, urban/town/zonal area councils and unit committees. The latter form the base structures of the new local government system, with units comprising settlements or groups of settlements with a population of 500–1,000 in rural areas and at least 1,500 in urban areas.

There are 10 regional co-ordinating councils that are administrative rather than political policy making bodies. Their functions include the co-ordination of the plans and programmes of district assemblies in the region, and monitoring and evaluation of programmes and projects.

With a very high rate of population growth (3%), Ghana's population almost doubled between 1970 and 1994 and was estimated at 19.5 million by 2000 (MOH, 1999). The high level of fertility (a total fertility rate of 4.5) has resulted in a youthful age structure and a high dependency ratio of almost one to one; children under 15 years account for 46.7% of the total population and the elderly (over 65 years) account for 3.7%. The urban population constituted 32% of the total population in 1984 but is growing at an estimated annual rate of 4.1%, with major concentrations in Accra-Tema, Kumasi, Sekondi-Takoradi and Tamale.

High population growth and rapid urbanisation pose a special challenge to health services. Maternal and child health services need to improve to cope with the problem of high fertility, which exposes women and children to numerous health risks during the course of pregnancy, labour, childbirth and after.

To meet these challenges, Ghana has revised its population policy with the ultimate goal of improving the quality of life through a number of relevant demographic objectives aimed at controlling population growth and leveling the fertility, mortality and morbidity rates.

Ghana has a mixed economy comprising traditional agriculture of small-scale farming, employing about 60% of the total adult labour force. There is also a small, capital-intensive, modern sector dominated by mining, and a rapidly expanding informal sector (petty trading, artisans, technicians, small-scale businessmen).

The past two decades have witnessed drastic changes in the economy. After relative prosperity in the 1960s, the economy experienced deterioration in the 1970s and early 1980s. Gross national product (GNP) fell from $100 per head in 1974 to less than $200 in 1981. Real gross domestic product (GDP) fell by 30% between 1975 and 1982. Exports fell by an annual average of 5.4% and the value of imports dropped by 8.0% annually from 1973 to 1983. The rate of inflation remained high, peaking at 123% in 1983.

Declining foreign earnings, shrinking output, acute shortages of consumer goods, dislocation of transport and communications, health and educational infrastructure were common features of the economy.

In order to cure the economic malaise, the government adopted in 1983 the Economic Recovery Programme (ERP) and structural adjustment policies that have led to positive changes in macro-economic indicators. Real GDP has increased from an average of 2% to 5% and the rate of inflation has been reduced to an average of 26% per annum.

In the educational sector, the main challenge is the high level of child and adult illiteracy. Although primary enrolment is relatively high (72%), there is an equally high drop out rate (40%) by the end of primary school, especially for females. Across the country, the higher the level of education, the lower the rate of female enrolment. In Senior Secondary School, for example, girls constitute about a third of total enrolment.

Funding education and health has become a problem for the government. Per capita real expenditure in these areas (at 1975 prices) declined by more than 70% between 1975 and 1982 and

capital investment became negligible. There were shortages of trained teachers, of essential supplies and of equipment. Educational reforms were begun in 1987 with the emphasis on improving quality and coverage by reducing pre-university education from 17 to 12 years and lengthening the academic year from 33 weeks to 40 weeks.

The health profile of the country is characterised by a prevalence of communicable diseases, under-nutrition and poor reproductive health, along with the emergence of non-communicable diseases including diabetes and cardiovascular diseases. Most of the diseases are preventable and easily treatable, notably the malaria, diarrhoea and respiratory infections that predominate among the ailments reported at outpatient departments.

Some of the communicable diseases occur in epidemic cycles, notably yellow fever and cerebro-spianl meningitis. Also, there has been a re-emergence of communicable diseases previously under controlsuch as tuberculosis. This has been associated with unplanned urbanisation with its attendant spread of unsanitary and overcrowded living conditions and with HIV/AIDS.

Health care delivery systems in Ghana can be classified into four categories – public, private for profit, private non-profit and traditional system. The government provides health services through the MOH. The latter has a hierarchical organisational structure from its central headquarters in Accra to the regions, districts and sub-districts.

Services are delivered through a network of facilities: health centres and district hospitals provide primary health care (PHC) services, regional hospitals provide secondary health care while two teaching hospitals at the apex provide tertiary services.

The MOH endorses decentralisation and recognises the district as the focus for planning and implemention of community-based services for which the DHMT?? is responsible.

Health care is structured in a three-tier system. “Level A” comprises health systems at community level, including trained birth attendants (TBA) and community health workers (CHWs). “Level B” comprises health posts and health centres at sub-district level. “Level C” comprises hospitals that function as district referral units. Regional and teaching hospitals may be considered as level D, as they provide tertiary services.

The private health sector includes religious missions, PPAG??, most of which provide about 40% of rural health care, and account for about 30% of hospital beds and 35% of out-patient care. The profit-making, private health system includes doctors, midwives, pharmacists and laboratory technicians.

The traditional systems consisting of spiritualists, psychic healers or herbalists, also provide a wide range of services including clinics, maternity and (other) preventive services.

Field Study Areas

The field study was limited to and conducted in two areas: one urban district and one rural district, namely the Accra Metropolitan Area in the Greater Accra Region (GAR), and Asuogyaman District in the Eastern Region (Fig. 1).

The Accra Metropolitan Assembly (AMA) area is one of the five districts within the Greater Accra Region (GAR), and one of the three metropolitan areas in Ghana. It is the national capital as well as the district capital. It occupies a land area of approximately 144 sq. km (MOH, 1999)

The AMA shares boundaries with two districts, namely the Ga

district to the north and west, and Tema Municipal Area to the east. To the south is the Gulf of Guinea, which stretches from Nungua through Teshie, La, and Osu to the Chemu Lagoon near Chorkor (Fig. 2).

Demographically, the AMA is the largest of the 10 leading urban centres of Ghana (Stephens et al, 1994). It contains nearly 70% of the total population of GAR, and accounts for 30% of Ghana's urban population, and 10% of the country's total population (MLG, 1992). Based on a growth rate of 3% annually, the population of AMA is 1,608,570 (MOH, 1999).

The AMA is divided into six sub-metro areas, the equivalent of sub-districts in the decentralised structure of local administration in Ghana. The six sub-metro areas, with their population, are: Ablekuma, - 455,865; Ashiedu -Keteke – 111,265; Osu Clottey – 188,619; Kpeshie – 304,439, Ayawso – 240,509, and Okaikoi – 307,875. Each contains between 4 and 14 residential areas or communities.

The AMA has a large concentration of government health facilities, which include Korle Bu Teaching Hospital, Ridge Hospital, PML Hospital and La Polyclinic. The distribution of government health facilities is as follows:

Urban health centres	-	2
Teaching hospitals	-	1
Hospitals	-	3
Maternity homes	-	2
Polyclinics	-	5
Clinics	-	16

There are quasi-government, private and mission facilities as well as pharmacies in the metropolis. Traditional healers are relatively numerous in low-income, high-density areas such as La, Old Teshie, James Town and Chorkor.

The diseases most frequently recorded in the metropolis in 1999 were malaria, urinary tract infection (URTI), diarrhoea, skin rashes, road and domestic accidents, oral cavity, hypertension, pregnancy-related complications, rheumatism and joint pains, acute eye infections.

The Asuogyaman District is one of the newly created districts in the Eastern Region with Atimpoku as its capital. The district covers an area of 580 square miles (1,507 sq.km).

It is bordered on the north by Kwahu North and Kpandu Districts, on the west by Manya District, on the east by Ho District and on the south-east by North Tongu District. The district has a projected population of 81,261. It is divided into four sub-districts:

Sub-districts	Population	Capital
Atimpoku/Senchi	13, 494	New Senchi.
Akwamufie/Apeguso	16, 080	Akwamufie
Anum-Boso	23,660	Boso
Gyakiti/Adjena/Akosombo	28,027	Adjena

The district is made up of three traditional areas: Akwamu, Anum, and Boso. These have scattered settlements of Ewes and Krobos, making the district cross-cultural.

The main economic activities include farming and fishing and formal employment with the majority of people working in the public service at the Volta River Authority (VRA), Akosombo Textiles Limited and Volta River Estates. There are 60 primary schools, 28 Junior Secondary Schools (JSS) and seven Senior Secondary School (SSS). The main mode of transport is road. Some communities living near or along the Volta Lake also use boats. There are good communication links between the district capital and other districts, as well as the Volta Region.

The presence of the VRA Hospital in the district enhances health delivery by augmenting the efforts of the District Health Management Team (DHMT). The VRA hospital concentrates its efforts in Akosombo, leaving the DHMT to concentrate on other parts of the district. Although private, the hospital serves as the district referral hospital. Its public health unit provides primary health service using the riverboat "ONIPA NUA" on the Volta Lake and the Oti River as far as the Dambai, which is outside the district.

Within the sub-districts (level B health stations) are maternal and child health and family planning (MCH/FP) units.

Health facilities in the district include two health centres, one community clinic, seven MCH/FP clinics, one private maternity home, one private clinic and one mission clinic (Salvation Army).

The pattern of diseases as obtained from the January-March 2000 report from Akosombo Hospital is as follows: malaria, URTI, acute eye infection, oral cavity diseases, gynaecological disorders, pregnancy-related complications, rheumatism and joint pains, skin diseases and ulcers, accidents and hypertension.

For the district as a whole in the first two quarters of the year, the top 10 diseases were malaria, diarrhoea, yaws, measles, schistosomiasis, AIDS, chicken pox, urinal hepatitis, and tuberculosis. . Schistosomiasis is said to be endemic.

Study design

The two sites for the field study were chosen according to distance and cost criteria. Asuogyaman, a rural district, represents a forest zone while AMA is an urban area and coastal location. Two sub-districts were randomly selected from each district. Atimpoku/Senchi and Apeguso sub-districts were selected out of four in the Asuogyaman district, whilst Kpeshie and Ayawaso sub-

metro areas were selected out of the six sub-metropolitan areas in the AMA. Five clusters were selected from each sub-district using a modified, 30-cluster sampling procedure (Appendix I).

In all, 10 clusters were selected from each district (Fig. 3 and 4). Twenty households were interviewed per cluster. A total of 200 households were thus covered in each district (ie 100 per sub-district) for the quantitative component of the field study.

For the qualitative study, three communities were chosen from the selected sub-districts in each sample district: Atimpoku, Old Akrade and Abomayaw in Asuogyaman; Accra New Town, Old Teshie, and "Dar es Salaam", within Teshie-Nungua Estate in the Kpeshie sub-metro area.. Sites for both the quantitative and qualitative data are shown in figures 3a and 3b.

Data collection instruments and tools

Both quantitative and qualitative data collection instruments were used.

The qualitative method applied is subsumed in the SAPRI research methodology comprising three perspectives, namely (a) political economy, (b) participatory rapid appraisal (PRA), and (c) gender.

These were applied as follows:

Political economy – the questionnaire and question-guide for data collection include questions on three categories of health policies at different points from which to address issues on utilisation/access before, during, and after the SAP in general, and the exemption policy in particular. These include:

- PHC/Health For All by 2000 (1980s)
- User Fees/Cash and Carry System (1985)
- Exemption Policy (1995)

- ♦ Health Insurance Scheme (current policy issue) on health financing.

Participatory Approach - Selected community members were involved in the research process of problem identification and analysis, using the semi-structured interview guide (SSI) for focus group discussion (FGD) in-depth/key informant interview, guided walk, seasonal analysis mapping and institutional analysis.

Gender perspective - Both interviewing teams and community participants were made up of males and females, young and old and varied ethnic and occupational backgrounds. (See Team composition in Appendix 3)

Both the structured questionnaire (SI) which contains approximately 70 questions (Appendix 2a) and the semi-structured interview guide (Appendix 2b) were designed to cover the following issues:

- Awareness of health facilities in the locality, prevalent diseases in the community/locality, knowledge/awareness of selected health policies (eg. exemption, cash and carry system and PHC).
- How community members perceive the policies
- How vulnerable groups (the aged, pregnant women, mothers with children under 5 years) perceive these policies

Training of field staff

A one-week training course for the field staff was organised at Abokobi Guest Villa on 1-6 May 2000.

The training took the form of lectures, discussion, role-playing and field practice. Techniques of community entry or approach, of interviewing rural communities, and of holding group discussions and key informant interviews were particularly emphasised. Since the PRA methodology has elements of flexibility and informality,

the learning process continued in the field throughout the research process. Some members of the National Technical Committee provided input during the training. Field practice (pre-test) was done in three communities: Akpormam, Boi, and Abokobi township. Results of analysis provided the basis for modifications of the research tools.

Field Work (Data Collection)

The structured interview begun on 11th May 2000 in both study areas simultaneously. A team of five interviewers, including one supervisor, was assigned to each district. Each team consists of three males and two females (Appendix 4). The team covered 10 clusters in each district and interviewed 20 households from each cluster (i.e. 200 households per district).

The semi-structured interviews began on May 22nd and ended around 6th June 2000 in the three communities from each district. The qualitative data collection was preceded by and continued with several visits to the relevant governmental and local authorities, including chiefs and Assemblymen, as well as to the selected communities. Selected health personnel were also interviewed using the informal questions guide at two public health facilities (La Polyclinic in Accra and the community clinic in Asuogyaman) and two private health facilities (Manna Mission Hospitals) at New Senchi.

Data Analysis and Quality Control

Apart from first-hand field editing of both quantitative and qualitative data, residential analysis (transcription, triangulation and synthesis) was organized between 1st and 15th July 2000. Data entry for the quantitative data did not begin until mid-July 2000 after coding of open-ended questions. Two of the interviewers were employed to assist in the coding.

Double data entry was done by two clerks under the supervision of

the research assistant, who is also a computer programmer. This was a quality control mechanism to ensure accuracy.

Both EPI-INFO and SPSS package were used (one for data entry, and the other for tabulation and frequencies).

RESULTS/FINDINGS

The data was analyzed in such a way as to reflect the SAPRI methodology: political economy (trends in access/awareness of health reforms), gender (groups of both sexes, age by urban/rural location) and participatory (group analysis of key issues, selected reform policies – exemption, insurance etc.)

Health services – an overview

For a little over a decade after independence in 1957, Ghana enjoyed free medical care. In 1969, however, the government of the Second Republic abolished all privileges enjoyed by public servants, including free medical care. This was largely because the government could not sustain the cost of these privileges. Consequently, medical fees were re-introduced with the enactment of the Hospital Fee Decree, 1969, which was later amended as the Hospital Fees Act, 1971. (Nyonator, F. 1999). The Hospital Fees Act did not last long because the military government installed after the 1972 coup d'etat restored free medical care.

In its effort to improve health services, Ghana adopted the primary

health care (PHC) concept. It is a global health policy framework published by the World Health Organisation (WHO) in the Alma Ata declaration of 1978. PHC addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services.

The underlying objectives of PHC are to integrate two main streams of activities and processes: the growth and extension of basic health services and the development of local communities in terms of infrastructure, education, initiatives and resources. These objectives are incorporated in the definition of PHC as "essential health care universally accessible to individuals and families in the community by means accessible to them, through their full participation and at a cost that the community and country can afford. It forms the integral part of the country's health system, of which it is the nucleus and the overall social and economic development in the community" (WHO, 1978).

PHC involves education with regard to prevailing health problems and the methods of preventing and controlling them; promotion of improved food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

Until 1983, Ghana's health system was financed mainly by the national budget. Economic decline had made it increasingly difficult to sustain those levels of funding By 1983, real per capita income had fallen by 75% of its 1970 level; the index of real minimum wages had declined from 183.4 in 1970 to 38.0 in 1982 [what is the base year?] and the government deficit had risen from 0.4 to 14.6% of GDP, representing 65% of total government spending. (Ghana/UNICEF, 1990; Sowah 1993)

Health expenditure as a share of GDP declined from 0.95% in 1980 to 0.35% in 1983, and from 6.46% of the national budget in 1980 to 4.38% in 1983 (Ghana/UNICEF, 1990; Sowa, 1993).

As a result of the economic situation and government spending priorities, there was a serious deterioration in public health services, with adverse consequences for the health of the population. The shortage of drugs in government health facilities compelled some patients to buy prescribed drugs from private pharmacies. In addition to the lack of essential equipment and materials, transport facilities were inadequate for the supervision of peripheral health services, maintenance of vehicles and essential equipment was poor and health staff lacked motivation (Goodman & Waddington, 1993; Abel-Smith, 1993).

In order to stabilise the overall economic situation, the government adopted a new set of policies set in the framework of a World Bank and International Monetary Fund-approvedstructural adjustment programme (SAP). The policy changes began with the Economic Recovery Programme (ERP) of 1983–86), which initiated the removal of subsidies and, in the health sector in particual, an intensification of fee collection for health services and enforcement of the Hospital Fees Act.

The SAP was implemented in three phases:
Structural Adjustment Programme I (1987 – 1988)
Structural Adjustment Programme II (1989 – 1990)
Structural Adjustment Programme III (1991 – 1992)

SAP I reinforced the ERP and aimed to maintain an incentive framework for stimulating growth, encourage savings and investment, strengthen the balance of payments and improve the efficiency of resource use.

SAP II was designed to strengthen earlier macro-economic

reforms, promote infrastructure development and institutional support in order to encourage private investment and boost production. It also aimed to enhance poverty reduction efforts through the achievement of growth and employment objectives.

SAP III sought to consolidate and intensify the programmes and actions undertaken since 1983. It focused on private sector investment, state enterprise and tax policy reforms, alleviation of poverty and cocoa policy reforms.

In the health sector, SAP policies included the charging of "user fees" and full cost recovery of drugs, staff redeployment and rehabilitation of facilities. The goal was to ensure increased access to health services and increase their utilisation of (Avle SK & Ekey FV, 1999). The aim of implementing in 1985 a full cost-recovery system for drugs in public health institutions – known as "cash-and-carry" -- was to establish a user-financed, revolving drug fund to improve and sustain the availability of essential drugs and provide all public health facilities with adequate and safe drugs at affordable prices.

The period after 1983 saw an upward trend in health spending, reaching 1.07% of GDP and an 8.74% share of the national budget. Further increases were noted in 1988, five years after the introduction of user fees.

At the same time, however, the government sharply raised fees for hospital beds and consultations in 1985. This formed part of the drive to charge user fees for major social services including health. The measure was in advance of the World Bank Health?? and Education Rehabilitation project agreed to later that same year. One of the provisions was that the MOH should meet some 15% of its recurrent spending from cost-recovery measures (Alan Roe & Hartmult Sehneider, 1992). There is some evidence, albeit inconclusive, that the higher user charges have discouraged the use

of health facilities.

During the period 1988-1993, overall government expenditure and government health expenditure had seen steady increases in nominal terms, though not by the same proportion. (WHO, 1994). The average increase of the total government expenditure over the period was 10.8% while that of the health sector expenditure was 7.8%. A yearly assessment shows that the health sector suffered worse in the year between 1990 and 1992. Total government expenditure rose by 18.6% during the fiscal year 1990/91 while the expenditure for health sector rose only by 1.4%. Then between fiscal year 1992/93 while total government expenditure sharply rose by 23.3%, the health sector lost proportionately to only 14%.

Of the various components of health expenditure, salaries and wages were the most important item, averaging 39.8% between 1988 and 1992, followed by drugs, which averaged 32.8%. In early 1992, the government was forced to give sharp salary increases to health workers, following industrial strike action. This resulted in severe disruption in the balance hitherto maintained between salaries and drug allocations. Salaries rose to 61.6% of health expenditure in 1994 while the share of drugsplummeted by more than half to 16.4% in 1994 from 33.5% in 1992.

The annual share of the Ministry of Health in government spending averaged about 9% and 1.2% of GDP from 1985 to 1988 (Ghana/UNICEF, 1990). However, in real terms the allocation to MOH has remained the same since 1987. The pattern of government spending on the health sector remained the same up to 1995 (Republic of Ghana, Medium Term Health Strategy, 1995, 1999).

User fees and exemptions

Historical perspective

Paying for health services in Ghana is not a recent phenomenon. At Ghana's independence in 1957, user charges in government health facilities were abolished. The practice was reintroduced in 1969 with the enactment of the Hospital Fee Decree, which was later amended to the Hospital Fees Act of 1971. From a token fee for consultation, the user charge regime developed to the 1985 system of fixed fees for consultation, examination and circumscript interventions??, laboratory and related diagnostic procedures, as well as charges for drugs at full cost (K. Elliot, 1996; F. Nyonator 1999).

The government increased user fees in all government facilities with the objective of raising revenue to offset recurrent costs and to deter frivolous use of equipment and other resources.

There were separate charges for outpatients, for medical and surgical treatment, hospital accommodation and catering. The price schedule moved from lower charges at lower levels (clinics and health centres) to higher charges at the teaching hospitals. There were also differential charges for adults and children.

The schedule provided exemptions for three categories of people:

1. Paupers, on the basis of inability to pay
2. Patients with specified communicable diseases such as leprosy and tuberculosis, and
3. Health workers and trainees in health training institutions.

Among the components of the Economic Recovery Programme was the removal of subsidies and the intensification of fee collection for health services under the Hospitals Fee Act. Realising the potentially adverse impact of this programme at the

household and community level and on the very success of the ERP itself, the government initiated the Programme of Actions to Migitigate the Social Costs of Adjustment (PAMSCAD).

The health component of PAMSCAD involved the provision of essential drugs within the PHC framework. In 1988, modifications were made to the Hospital Fee Act that included the supply of drugs at full cost to patients. Provisions were also made for health facilities to retain increasing proportions of their revenue.

The MOH then adopted a list of essential drugs for use within the public sector. Problems of procurement of drugs and the inequitable allocation of drugs to health facilities prompted the introduction and implementation in 1992 of the "cash and carry" scheme, formally known as the Revolving Drug Fund.

Concurrently, The government defined entitlements to full or partial exemption from paying under L.I. 1313 that set up the Hospital Fees Regulation of 1985. Psychiatric patients were now added to those categorieseople qualifying for full exemptions. Some services were also made free of charge, including immunisation, antenatal and post-natal services and treatment at child welfare clinics.

Hospital accommodation and catering services were excluded. L.I. 1313 also provided for exemptions from all charges except those for drugs prescribed for a wide range of mostly communicable diseases.

The objectives of these regulations were to ensure that people with communicable diseases could get medical care and to encourage the use of preventive services.

One of the objectives of our study was to determine the extent to which people at community leve are aware of the exemption

policy. Another objective was to ascertain any differences in views from within households to within a district.

Exemption Policy
Historical Perspective of those exempted

1983 – 1985	**1989**	**1995**
Pauper s	Psychiatric Patients	Refugees
Patients with Leprosy	Immunisation Poor	
Patients with TB	Treatment at Child Welfare Clinic	Children under 5 years
Health Workers	Antenatal/Postnatal Service	Pregnant Women
		Disabled Persons
		Elderly of 70 + years
		Emergency cases
		Government Officials
		Malnourished children

The introduction of user charges for health services means many people will be excluded by reason of poverty and geographical location. With the World Bank estimate of 31% to 35% of the population living below the poverty line, it can be assumed that many people have difficulty in paying.

Quantitative study

1. Demographic and socio-economic characteristics of the study population.

In both study areas, a total of 2,213 persons were covered in the 400 households surveyed. In the Accra Metropolitan Area sample, the total household population of 1,162 is made up of 570 (49%)

males and 592 (51%) females. The Asuogyaman District household population of 1,050 consists of 443 (42%) males and 607 (58%) females. (Table 1). Females form 51% of the urban sample population compared with 58% for the rural sample.

Table 1 (a) Sex Distribution of Sample Population by Sub-district: AMA

Sub-district	Population			Percentage			Sex Ratio
	M	F	Both Sexes	M	F	Both Sexes	
Ayawaso	296	293	586	50.0	50.0	100	100
Kpeshie	277	299	576	48.0	52.0	100	92.6
Total	570	592	1162	49.0	51.0	100	96.3

Table 1 (b) Sex Distribution of Sample Population by Sub-district - Asuogyaman

Sub-district	Population			Percentage			Sex Ratio
	M	F	Both Sexes	M	F	Both Sexes	
Atimpoku	219	297	516	42.0	58.0	100.0	73.7
Apeguso	224	310	534	42.0	58.0	100.0	72.3
Total	443	607	1050	42.0	58.0	100.0	73.0

Age Distribution

In the two urban locations (Ayawaso and Kpeshie), children under 5 years form 9% and 12% respectively of the population. In the rural sample, the proportions of children under 5 years are 10% for Atimpoku and 12% for Apeguso. The elderly in the sub-metro area form 5% compared with approximately 6% for the rural sample population.

Household size and structure

The average household size for the metro study area is 5.8 people, compared to rural samples with average household size of 5.3.

With regard to household structure, both urban and rural households have a high proportion of couples and their children. However, the proportion is higher in the urban sample than in the rural one.

In the urban sample, over 70% of household members are Christian, with Muslims constituting 17% on average (for example, Muslims form 27% of Ayawaso compared with 6% for the Kpeshie). In the rural sample, Christians constitute over 90%, with Moslems forming a negligible proportion (3%). A relatively high proportion of people have no religious affiliation. Approximately 4% in Kpeshie (Accra) and 4% in the Apeguso (Asuogyaman) claimed they have no religion. We suspect these might be people with traditional religious beliefs since these sub-districts have typically indigenous communities.

In the Accra study population, 60% have had primary level (primary + middle/JSS) education compared to 70% for those in the Asuogyaman district. Accra had a higher proportion of those with secondary or higher education (24%) than Asuogyaman (4%). Those with no education are 15% in Accra and 23% in Asuogyaman.

In the urban sample, 43% of the eligible persons were married compared with 48% in the rural sample. Those never married constituted 48% and 31% for AMA and Asuogyaman respectively.

With respect to occupation, farmers constitute less than one percent (0.8%) in the urban/coastal sample compared with 28% in the rural/forest sample. Petty traders were approximately 18% and 15% in the two areas respectively. There was a higher proportion

(12%) of salaried workers in AMA than in the Asuogyaman district (4%). In each district, approximately 12 % of people are unemployed.

Exemption category

Interviewers were asked to identify those in the households who were pregnant, children under 5 and the aged people who are to be exempted from paying for services from public health facilities.

In the AMA sample, children under 5 (i.e. women with children under 5 years) were 7.4%, pregnant women constituted 4.6% and those aged 70 years and above made up 4%. In the Asuogyaman sample, children under 5 years were 11.5%, pregnant women only 1% and the aged 2.7%.

Awareness of health facility

As shown in the table below, households in the urban/coastal area (AMA) are aware of the existence of health facilities in the following order: private health facility (36%) including mission facility (5.0%), pharmacy/chemist's shop (32%), and public health facility (27%).

In the rural/forest area, the order is as follows: private health facility (34%), public health facility (19%) and pharmacy shop (20%). A higher proportion of people in the rural district are aware of the community clinic (17%) than in the urban sample (4%). About 6% of households did not know of any health facility in the rural sample

Table 2: **Awareness of Health Facility in Area by Household (Distribution in %)**

Facility	AMA (Urban)	Asuogyaman (Rural)
Public facility (Hospital)	26.3%	18.7
Private hospital/clinic	30.7	27.7
Mission facility	4.9	6.2
Pharmacy shop/chemical seller	32.0	20.7
Community clinic	3.8	16.7
Others	20	4.3
Don't.Know (DK)	-	5.7
Total	100.0	100.0

Nearest health facility

Concerning which health facility was nearest, households responded in the following ways. More than half of the households interviewed (57%) in the metro sample, said a pharmacy/chemical shop was the nearest facility. Another 27% said the nearest is the private health facility. Only 5% of households said that a mission health facility was nearest to them.

In the Asuogyaman district sample, the public health facility is the nearest to approximately 25% of households; next is community clinic (19%), followed bythe pharmacy (18%) and the private health facility (15%).

Utilization of health facility

Among the urban households studied, 35% of them claim they "always" visit the nearest health facility in times of sickness. Nearly 40% occasionally do so, and one in four (25%) "never" visit the closest facility to them. Similarly, 35% of the rural households would always go to the nearest health facility

whenever anyone in the household is sick. A little over 50% of households only "sometimes or occasionally" visit the nearest health facility to seek treatment. In all, only two households (2%) on average never visit any health facility whenever ill in the rural area.

In the city sample, 34% (43 out of 126) of the households claim that they only sometimes go or not at all, because they have no money or that the cost of service is rather high. For 16% of them, it is because of the bad attitude of staff. For nearly 7% of households, it is due to the location of the facility. For 4%, it was the promptness with which they areattended to.

In the villages and/or rural communities, the high cost of services and lack of money was the reason why 71% of the households visit or attend the health facility only "occasionally" or never at all. For 3% of the households, the bad condition of roads causes them to occasionally or "sometimes" visit the facility nearby.

Table 3: Reasons For "Sometimes/Occasionally/Never" Attending Nearby Health Facility

Reason	Ayawaso	Kpeshie	Total	Atimpoku	Apegusso	Total
Location of facility	3	5	8 (6.5)	3	7	10 (9.3)
No money to pay/cost too high	25	18	43 (34.7)	37	39	76 (71.0)
Promptness of services	6	4	10 (8.1)	2	-	2 (1.9)
Bad attitude of staff	1	3	4 (3.2)	5	-	5 (4.7)
Health care not good enough	17	6	23 (18.5)	-	3	3 (2.8)

Non-availability of drugs	-	1	1 (0.8)			
Other	12	23	35 (28.2)	7	1	8 (7.5)
Bad condition of roads	-	-	-	2	1	3 (2.8)
Total	64	60	124 (100)	56	51	107 (100)

Free treatment (exemption)

Respondents were asked whether they or any member of their household had ever been treated free at any government health facility. In the urban study area, approximately 85% replied that they had never been treated free. In the rural study area, over 90% said that they had never been treated free when they or any member of their household visited government health facility (90% in Atimpoku and 95% in Apeguso).

Of the 30 households in the urban sample who claimed they had been treated free, 24 (80%) said that someone had paid on their behalf for the service received. Ten of the 24 households said that the employer of their spouses paid for them. Another 10 said their own employers paid for them. Thus out of the 200 households studied in the AMA, only six had someone who had been ill and had actually been treated free.

In the rural district, out of 10 of the 200 households who claimed free treatment was given to someone who had been ill, four (40%) said that the employers of their spouse had paid on their behalf, while seven said that the employer of the sick person had paid for the treatment supposed to have been free. In this case, therefore, only three households out of the 200 studied in the rural (forest) district had ever received free treatment.

For 14 out of the 28 households in the AMA (50%), this “free” treatment was received less than five years ago: two had it 10 years

ago and another four had it 15 years ago.

Those who claimed they had received the free treatment less than five years ago were asked to indicate the kind of services that were given free (see Table 4).

Table 4: The kind of services that were given free.

Services	AMA	ASUOGYAMAN
Consultation		1
Antenatal / post natal	4	1
Treatment (drug injection)	-	2
Medication (drugs only)	-	4
Admission	1	2
Everything	9	2
Total	14	12

In the AMA sample, 4 of the 14 people (29%) that received free treatment less than five years ago said that it was "antenatal/postnatal" service that was free; nine (64%) stated that "everything" was free.

In the Asuogyaman sample, 4 out of 12 (33%) households state that "medication" was free, whilst two in each œase claimed that "treatment", "admission" and everything were free.

Pregnancy within the past 5 years

Household heads were asked whether any female member had been pregnant within the last five years. The objective of this question and related questions is to determine the expenditure pattern of households on pregnancy, delivery and child welfare since the exemption policy was introduced in 1995.

Of the 200 households surveyed in the Accra metropolitan area, 90 (45%) reported that there had been pregnant women in households within the past five years. In the Asuogyaman district, 86 out of the 200 (43%) households reported that there had been pregnant women in them.

The age distribution of pregnant women in the two sub-districts of each study district is as follows:

Table 5: Age Distribution of Pregnant Women by District (%)

Age group	AMA			ASUOGYAMAN		
	Ayawaso	Kpeshie	Total	Atimpoku	Apegusso	Total
<20 yrs	19.4	1.9	10.7	11.9	-	6.0
20-24	16.7	14.8	15.8	19.0	25.0	22.0
25-29	27.8	31.5	29.7	35.7	25.0	30.4
30-34	22.2	18.5	20.4	21.4	20.5	21.7
35-39	11.1	18.5	14.8	7.1	18.2	12.7
40-44	2.8	9.3	6.1	4.8	9.1	7.0
45-49	-	5.6	2.8	-	2.3	1.2
All ages	100 (36)	100 (54)	100 (54)	100 (42)	100 (44)	100 (86)

In both districts, most of the pregnant women (30%) are found in the age range 25-29 years, with Kpeshie in the AMA and Atimpoku in Asuogyaman contributing substantial proportions, namely 32% and 36% respectively. There is a relatively high proportion of pregnant women under age of 20 years in each of the sub-districts that are identical in population characteristics: Ayawaso (19%) and Atimpoku (12%). These are more complex or heterogeneous households, containing people of different ethnic

backgrounds, in contrast to Kpeshie sub-metro that is made up of mainly homogeneous ethnic Gas, and then Apeguso that has communities with little migrant characteristics.

The latter sub-districts also have relatively larger proportions of pregnant women in the age group 45-49 years, namely 6% for Kpeshie and 2% for Apeguso.

On whether the pregnant women were attending or had attended antenatal services, almost all (98%) of those in the AMA sample had done so; and 93% (80/86) had done so in the Asuogyaman sample. (Table 6)

Table 6: Is she attending OR has she ever attended antenatal service?

	AMA			ASUOGYAMAN		
	Ayawaso	Kpeshie	Total	Atimpoku	Apeguso	Total
Yes	35	54	89	38	42	80
No	1	1	2	4	2	6
Total	36	55	91	42	44	86

In both study areas, almost all the most recently pregnant women had paid for the antenatal services received. It was only in four cases in the AMA study area that no money was paid; in Asuogyaman, it was only in one case that no payment was made for antenatal services.

With respect to the amount of money paid for antenatal services by the women with a recent pregnancy, 35% of those in AMA paid between ¢5,000 and ¢15,000 per visit. In the case of Asuogyaman, 37% of them paid between ¢15,000 and ¢25,000. Thirty-four per cent (34%) paid between ¢5,00 and ¢15,000.

Table 7a: Payment for services by women during most recent pregnancy

Amount	AMA			ASUOGYAMAN		
	Ayawaso	Kpeshie	Total	Atimpoku	Apegus o	Total
Less than ₵5,000	4	1	5 (5.9%)	1	3	4 (5.1%)
₵ 5,000 - ₵14,999	12	18	30 (35.3%)	8	19	27 (34.2%)
₵15,000 - ₵24,999	5	11	16 (18.8%)	17	12	29 (36.7%)
₵25,000 - ₵34,999	4	7	11 (12.9%)	7	1	8 (10.1%)
₵35,000 - ₵44,000	2	1	3 (3.5%)	1	4	5 (6.3%)
₵45,000 - ₵54,999	-	1	1 (1.2%)	2	1	3 (3.8%)
₵55,000 - ₵64,999	-	2	2 (2.4%)	1	-	1 (1.3%)
₵65,000 - ₵74,999	3	1	4 (4.7%)	-	-	-
₵75,000 +	-	1	1 (1.2%)	-	-	-
DK/Can't Tell	1	11	12 (14.1%)	-	2	2 (2.5%)
Total	31	54	85	37	42	79

Table 7b: Average amount of money spent daily

Amount	Ayawaso	Kpeshie	Total	Atimpoku	Apeguso	Total
¢ 1,000 - ¢ 3,999	1	-	0.5	2	4	3.0
¢ 4,000 - ¢ 6,999	10	13	11.5	29	32	30.5
¢ 7,000 - ¢ 8,999	7	5	6.0	15	20	17.5
¢ 9,000 - ¢ 9,999	3	1	2.0	3	3	3.0
¢10,000 - ¢12,999	18	21	19.5	33	27	30.0
¢13,000 - ¢15,999	8	14	11.0	8	8	8.0
¢16,000 and above	51	43	47.0	9	5	7.0
NR	2	3	2.5	1	1	1.0
Total	100	100	100	100	100	100

With regard to average daily expenditure by households, Table 7b shows that in the urban sample, nearly 50% spend a daily average of ¢16,000. About 20% spend between ¢10,000 to ¢13,000. Approximately 12% spend between ¢4,000 to ¢7,000.

In the rural district, about one-third of households spend less than ¢7,000 daily; approximately 18% spend between ¢7,000 to ¢9,000, and a little over 45% spend between ¢10,000 to ¢16,000 a day.

Self-reported sickness in the previous two weeks

Heads of household or their representatives were asked whether any member of the household had been sick in the two weeks prior to the date of interview. In the AMA district, 43% of the sample population had reported sickness, and in the forest (Asuogyaman)

district approximately 40% had reported sickness. In the AMA sub-metro, 41% reported in the Ayawaso area and 44% did so in the Kpeshie area. In the rural sub-districts, sickness in the previous two weeks was reported in 34% of the cases in the Atimpoku area, and in 45% of the cases in the Apeguso area.

The age distribution of those reporting sickness is shown in the table below.

Table 8 (a): Age distribution of people reported sick in previous two weeks - AMA

Age	AMA		
	Ayawaso	Kpeshie	Total
0 – 4	11 (26.8%)	5 (11.4%)	16 (18.8%)
5 – 9	5 (12.0%)	2 (5.0%)	7 (8.2%)
10 – 19	2 (5.0%)	4 (9.0%)	6 (7.1%)
20 – 29	5 (12.0%)	11 (25.0%)	16 (18.8%)
30 – 39	7 (17.0%)	8 (18.0%)	15 (17.6%)
40 – 49	3 (7.0%)	9 (20.0%)	12 (14.1%)
50 – 59	5 (12.0%)	2 (5.0%)	7 (8.2%)
60 – 69	2 (5.0%)	1 (2.0%)	3 (3.5%)
70+	1 (2.4%)	2 (5.0%)	3 (3.5%)
All Ages	41 (100)	44 (100)	85 (100)

Table 8 (b): Age distribution of persons reported sick in past two weeks - ASUOGYAMAN

Age	ASUOGYAMAN		
	Atimpoku	Apeguso	Total
0 – 4	9 (26.5%)	11 (25.8%)	20 (28.6%)
5 – 9	1 (2.9%)	2 (4.5%)	3 (3.8%)
10 – 19	2 (5.9%)	3 (6.8%)	5 (6.0%)
20 – 29	3 (8.8%)	4 (9.1%)	7 (9.0%)
30 – 39	6 (17.6%)	3 (6.8%)	9 (11.5%)
40 – 49	9 (11.8%)	4 (9.1%)	8 (10.3%)

50 – 59	7 (20.6%)	4 (9.1%)	11 (14.1%)
60 – 69	1 (2.9%)	10 (22.7%)	11 (14.1%)
70+	1 (2.9%)	3 (6.8%)	4 (5.1%)
All ages	34 (100)	44 (100)	78 (100)

In the AMA, those reporting sick in the previous two weeks were mostly in the age groups 0 – 4 years (19%), 20 – 29 years (19%), 30 – 39 years (18%), and 40 – 49 years (14%).

In the Asuogyaman district, those reporting sick are mainly in the age group 0-4 years (29%); about one in 10 are found in the age groups 30 – 39 years and 40 – 49 years. A substantial proportion (14%) is found in the middle and old age groups, 50 – 59 years and 60 – 69 years. Thpse aged 70+ years form 5%.

In both districts, more females (62% for AMA and 65% for Asuogyaman) than males (39% and 35% respectively) have reported sick.

The diseases that household members suffered from during the previous two weeks as reported by the household heads are varied. They are grouped as in the table below. Fever and headache, symptoms of malaria, are the predominant conditions in both the Accra area (27%) and the Asuogyaman district (28%). Pains of the various parts of the body (17 – 24%) are the next in both areas, although stomach problems constituted about 20% of cases reported in Accra. Many different conditions were mentioned by respondents and these could only be grouped as “others” (25% and 36% for Accra and Asuogyaman districts respectively).

Table 9a: Diseases reported by household members who were sick in the past two weeks

Disease	AMA		
	Ayawaso	Kpeshie	Total
Fever + headache	12	11	23 (27.1%)
Bodily pains	5	9	14 (16.5%)
Cough (inc. TB)	-	2	2 (2.4%)
Stomach problems	9	8	17 (20.0%)
Heart problems	1	-	1 (1.2%)
Blood pressure	1	4	5 (5.9%)
Others	12	9	21 (24.7%)
DK/Cannot tell	1	1	2 (24.0%)
Total	41	44	85 (100)

Table 9b: Diseases reported by household members who were sick in the previous two weeks

Disease	ASUOGYAMAN		
	Atimpoku	Apeguso	Total
Fever + Headache	12	10	22 (28.2%)
Bodily Pains	13	6	19 (24.4%)
Cough (inc. TB)	3	-	3 (3.8%)
Stomach Problems	1	2	3 (3.8%)
Heart Problems	-	1	1 (1.3%)
Blood Pressure	-	2	2 (2.6%)
Others	15	13	28 (35.9%)
DK/Cannot Tell	-	-	-
Total	44	34	78 (100)

Respondents were asked to list among persons reporting sick, those that were children under 5 years, pregnant women and the aged.

In the Accra sample, a total of 21 children under 5 years (10 in Ayawaso and 11 in Kpeshie) were identified. This forms 25% of those reporting sick. There was only one pregnant woman and one

aged among those reporting sick (both from the Kpeshie area).

In the Asuogyaman district, the sick include 38 (45.7%) children under 5 years, 14 in Atimpoku and 24 in Apeguso, 2 pregnant women and two (2) aged.

When asked what those who were sick did first or where they visited first, the responses are as shown in the table below.

Table 10a: What the Sick Person Did First

Action first taken	AMA		
	Ayawaso	Kpeshie	Total
Visited public hospital/clinic	10	10	20 (23.5%)
Visited public health centre/clinic	9	4	13 (15.3%)
Visited Community Clinic	-	-	-
Visited private hospital/clinic	5	5	10 (11.8%)
Visited Mission Hospital/Clinic	1	-	1 (1.2%)
Bought drug from Pharmacy/Chemical Shop	11	17	28 (32.9%)
Brought drug from Peddler/Vendor	-	-	-
Visited Traditional Healer/Herbalist	-	-	-
Treated Self/Used herbs	4	2	6 (7.1%)
Other	-	1	1 (1.2%)
Nothing	1	5	6 (7.1%)
Total	41	44	85 (100)

Table 10b: What the Sick Person Did First

Action first taken	ASUOGYAMAN		
	Atimpoku	Apeguso	Total
Visited public hospital/clinic	5	2	7 (7.0%)
Visited public health centre/clinic	2	4	6 (7.7%)
Visited Community Clinic	4	7	11 (14.1%)
Visited private hospital/clinic	7	7	14 (17.9%)
Visited Mission Hospital/Clinic	1	-	1 (1.3%)
Bought drug from Pharmacy/Chemical Shop	10	9	19 (24.4%)
Brought drug from Peddler/Vendor	-	6	6 (7.7%)
Visited Traditional Healer/Herbalist	1	-	1 (1.3%)
Treated Self/Used herbs	2	5	7 (9.0%)
Other	-	-	-
Nothing	2	4	6 (7.7%)
Total	34	44	78 (100)

In the Accra area, 39% of those who reported sick in the previous two weeks visited a public health facility; approximately 13% visited a private health facility including a mission hospital; a third (33%) first went to a pharmacy.

In the Asuogyaman district, 17% first went to a public health facility; and 19% visited the private health facility. Again, a greater proportion (24%) resorted first to the pharmacy. Fourteen per cent (14%) first visited a community clinic.

In both the urban and rural sample areas, between 7 and 8 % did

nothing; whilst 7 and 9% treated themselves or used herbs. In the Asuogyaman district, especially in the Apeguso subdistrict, as many as 8% bought drugs from drug peddlers.

Each of the respondents (households) who took some action or visited a health facility when a member fell sick was asked to state the amount spent in all.

In Ayawaso, 20 respondents mentioned various amounts of money spent. Four (20%) spent less than ₵5,000; another four spent between ₵5,000 and ₵15,000; two spent between ₵15,000 and ₵25,000; another two paid between ₵35,000 and ₵45,000 and two more paid between ₵105,000 and ₵115,000. Each of the remaining six paid sums ranging from ₵55,000 to ₵155,000 and above.

In the Kpeshie area where 26 respondents stated they had paid some money, 10 (39%) spent less than ₵5,000; nine (35%) spent between ₵5,000 and ₵15,000. Two each of the remaining six respondents paid between ₵15,000 and ₵25,000, between ₵25,000 and ₵35,000 and between ₵35,000 and ₵45,000.

In the Apeguso area, five (22.5%) of the 22 (23%) respondents who took some action during sickness of a member paid less than ₵5,000. Another five spent between ₵5,000 and ₵15,000. Two (9%) paid between ₵15,000 and ₵25,000 for healthcare; whilst four (18.2%) claimed to have spent between ₵25,000 and ₵35,000. In two other cases, more than ₵155,000 was spent.

Regarding the amount spent on specific activity undertaken for a sick member of the household, the table below shows the pattern.

A total of six spent less than ₵5,000 in Ayawaso when they visited a public health facility.

Knowledge of the exemption policy

Those who visited a public health facility when sick or when a member of the household was sick in the previous two weeks were asked whether they knew they were not expected to pay.

Out of the (33) in the urban study area, (19 in Ayawaso, 14 in Kpeshie) only two (6%) from the Kpeshie areas knew that they were not expected to pay for the service received. In the Asuogyaman sample, out of a total of 43 from the two sub-districts 38 (88%), including all the 24 from Apeguso, did not know that they were not expected to pay for services received from the public health facility.

Reasons for not visiting any health facility

In the AMA, 41 respondents (25 in Ayawaso and 16 in Kpeshie) did not visit any health facility besides a harmacy chemical store. For eight of these (20%), the reason was that the cost was too high; for four (10%) the waiting time was the reason.

In Asuogyaman, 22 out of 37 people (59.5%) from both sub-districts did not visit any health facility during their most recent reported sickness because the cost of service was perceived to be too high. For two others, lack of drugs was the reason. Three had problems with the cost of transport.

Knowledge of Exemption at Household Level

Every household was asked what they knew about the exemption policy in general in order to determine the proportion of members that are aware of the exemption policy. The responses are shown below for both AMA and Asuogyaman.

TABLE 11: Knowledge of the Exemption Policy

Category	AMA			Asuogyaman		
	Ayawaso	Kpeshie	Total	Atimpoku	Apeguso	Total

Aged (70+ yrs)	19	21	40	15	7	22
Children < 5 yrs	3	9	12		5	5
Pregnant women	3	6	9	6	2	4
Others	6	12	18		1	1
Total	**31**	**48**	**79**	**21**	**15**	**46**

In the urban sample, 40% (79 out of 200) of the households interviewed knew that government health facilities were giving free treatment to some people (13 for the Ayawaso and 48 for the Kpeshie sub-metro samples). This contrasts with the rural sample where 22% (44 out of 200) know of the exemption granted by government health facilities.

Concerning categories of persons to be exempted

In the urban area, 51% (40 out of 79) mentioned the aged as those exempted, compared with 50% (22 out of 44) in the rural area who mentioned the aged.

Similarly 15% (12 out of 79) in the urban sample cited children under 5 as the next category of people government facilities treat free; this category is the next mentioned in the rural sample. Both areas mentioned pregnant women as those exempted in the proportion of 11% (9 out of 79) and 18% (8 out of 44) respectively.

On the kind of services those mentioned are to be exempted from, most respondents were of the view that "all types of services" should be provided free. This was mentioned in 48% (35 out of 73) of the cases in the urban sub-areas and 53% (23 out of 43) of the cases in the rural subdistricts.

Table 12: Knowledge of Categories of Services to be Exempted

	AMA			Asuogyaman		
Category	Ayawaso	Kpeshie	Total	Atimpoku	Apegusso	Total
Registration Card	5	6	11	3	1	4
Antenatal/Post natal	-	1	1	1	-	1
OPD Consultation	-	3	3	-	-	-
OPD Injection	-	1	1	-	-	-
Drug Supply	2	9	11	1	3	4
Laboratory Service	2	3	5	2	3	5
All Types	13	22	35	18	5	23
Other	1	3	4	-	-	-
DK/NR	2	-	2	4	2	6
Total	25	48	73	29	14	48

The households were further asked about their awareness of certain diseases that are to be treated free in government health facilities.

In the AMA between 14% and 21% mentioned tuberculosis. The next disease mentioned is mental illness (6% in Ayawaso and 12% in Kpeshie). In Ayawaso, HIV/AIDS was mentioned in 6% of the cases. In both sub-metro areas approximately 50% of the households do not know of the diseases that are to be treated free at government facility.

Ignorance of the listed diseases that are to be treated free at government facilities is more pronounced in the Asuogyaman district where over 70% of the households in each sub-district sample indicated that they were not aware of these diseases.

In Atimpoku sub-district, the diseases that are somewhat known are tuberculosis (10%) and leprosy (5%). In Apeguso, those frequently mentioned are tuberculosis (8%), snakebite (4%) among others (6%).

The categories of people that those in the AMA think should be exempted are shown below.

Opinion of household on exemptions

Households were also asked to indicate

i. the diseases in their own opinion that should be treated free at government health facility
ii. whether or not some people should be exempted
iii. the type of people that should exempted
iv. the kind of services that should be offered free by the government health facility.

Among the diseases/illnesses spontaneously mentioned, some of which fall into the exemption category are as listed in the following table.

Table 13: Diseases respondents think should be treated free (%)

DISEASE	**AYAWASO KPESHIE**	**ATIMPOKU APEGUSO**
TB.	11.0 12.0	16.0 15.1
HIV / AIDS	12.0 11.0	9.0 4.0
Mental illness	6.0 2.0	3.0 1.0
Leprosy	3.0 3.4	9.0 6.0
Snakebite	- -	4.0 9.0

Dogbite	- -	0.5	0.4
Yellowfever	3.0 5.4	8.8	17.3
Cholera	5.0 7.4	10.0	14.0
None	3.0 2.0	-	0.9
Others	48.0 32.0	27.0	29.3
D. K./N.R.	9.0 5.4	12.0	4.0
TOTAL	**100 (146)** **100 (144)**	**100.0 (112)** **(238)**	**100**

In the AMA, 95% of the respondents (households) think that some people should be exempted from paying for treatment received. In the Asuogyaman sample, 74% of the households are of the opinion that some people should be treated free.

These are mainly the aged (34%), the poor (18%), orphans (20%), children under 5 years (10%) and to a lesser extent, the disabled (7%), and pregnant women (6%).

In the opinion of the rural households as shown below, those to be exempted should include the aged (33%), children under 5 years (20%), orphans (14%) and the disabled (5%).

Table 14 (a): Categories of people respondents think should be exempted - AMA

Exemption Category	Ayawaso (%)	Kpeshie (%)
The aged (70+ yrs)	33	34
The poor	24	11

Orphans	19	20
Children under 5yrs	9	11
Disabled people	4	9
Pregnant women	3	9
Leprosy patients	-	-
Everybody	1	1
Nobody	-	-
Unemployed	2	2
Youth	2	1
DK.	2	2
Total	100	100

Table 14 (b) Categories of people respondents think should be exempted – Asuogyaman

Exemption Category	Atimpoku (%)	Apeguso (%)
The aged	33	33
Children under 5 years	21	19
Pregnant women	19	17
Orphans	12	15
Disabled people	4	5
The poor	2	4
Everybody	4	3
Leprosy patients	2	1
Mental patients	1	1
Unemployed people	1	1
DK	1	2
	100	**100**

The main reasons people advanced for advocating exemptions for those they think should be exempted in both study areas include:

- They cannot work; they are too weak to work (the aged, the disabled, pregnant women).
- They are not working (children under 5 years, orphans, the unemployed).
- They have no money/they cannot afford health services (the poor, the youth)

The implications are that since these people are not in a position to work, they will be unable to pay for health services when they are ill. The respondents gave similar reasons for suggesting exemptions in respect of specific services.

Support for financing for those who cannot afford health services.
On how or who should finance those who cannot afford to pay for their own health, most of the households (over 60%) maintain that the central government should support them (see table below)

Table 15 "Who should pay for those who cannot afford health services?" (Distribution in %)

	Ayawaso Kpeshie	Atimpoku Apegsu
Central government	55.5 63.4	65.4 64.5
District Assembly	1.6 2.4	 1.6
Community members	6.3 -	13.1 5.6
Household members	13.3 13.8	16.9 22.6
Commmunity- based financial	3.9 1.6	- -

scheme		
DK/Can't tell	8.8 17.1	4.6 5.6
Other	18.0 17.1	4.6 5.6
Total	100(128) 100 (123)	100(130) 100 (124)

In the sub-metro areas especially Ayawaso, a list of varied sources of assistance were advocated and grouped as "other" (48%). Household support was mentioned in 13% of the cases. Support from community members or community-based financing was mentioned in about 6% of the cases.

The pattern is similar in the rural sub-districts where 65% of the household thinks that the central government should pay for those who cannot afford health services. Twenty per cent think that household members should support such people, while another 10% think community members should provide support. Only 2-3 % think that such people should be supported through community-based financial schemes.

Health policies in the 1980s

Health For All by the Year 2000

A series of questions sought to determine the knowledge or awareness in households of health polices in the 1980s that relate to accessibility of health care services to communities.

The questions bore on the extent of knowledge, then the source of that knowledge and finally, the meaning of the primary health care concept of "Health for All by the Year 2000".

As shown in the table below, approximately 44% in the urban sample and 36% in the rural sample know of the slogan. More than

two-thirds of the households who know of the slogan first heard it from the radio, while 48% of the rural household sample heard it from the same source. Those who heard from health workers constitute between 8% and 9%. District Assembly were a source of this information for approximately 20% of rural households compared to just 2% of urban household …

Table 16: Household awareness of the slogan: "Health for All by 2000" (Distribution in %)

	AMA	Asuogyaman
Response. Category	Ayawaso Kpeshie	Atimpoku Apeguso
Yes	44 43	37 34
No	56 57	62 64
NR	- -	1 2
Total	100 100	100 100

Table 17: Source of information on slogan "Health for All by 2000.

Source	Ayawaso Kpeshie Tots	Atimpoku Apeguso Tots
Health worker	9.1 (4) 7.1 (3) 8.1	10.8(4) 5.9 (2) 8.5
Dist. Assembly	2.3(1) 2.4 (1) 2.4	13.5 (5) 26.5(9) 19.7
Radio	75.0(33) 66.7(28) 70.9	51.4 (19) 44.1(15) 47.9

TV.	4.5(2)	4.8(2)	47	-	
Others	9.1 (4)	19.0(8)	13.8	24.3 (9)	20.6 22.5
NR	-	-	-	-	2.9 -
TOTAL	100(44)	100 (43)	100(87)	100(37)	100(34) 100(71)

(Absolute numbers in parenthesis)

Concerning the meaning of the slogan, the following are the responses of urban households, in order of frequency.

Table 18 (a): The meaning of "Health for All by 2000" – Urban Households

Response Category	Ayawaso	Kpeshie	Total
▪ Everyone will enjoy free Medical /health care	29.5(13)	42.9(18)	36.0 (31)
▪ Hospital service/treatment will be available to all	15.9(7)	21.4(9)	18.6 (16)
▪ Health services will be made affordable for all	9.1(4)	9.5(4)	9.3 (8)
▪ Everybody will be healthy by 2000	15.9(7)	24(1)	9.3 (8)
▪ There will be health facility in every community	6.8(3)	4.8(2)	5.8 (5)
▪ Do not understand	9.1(4)	16.7(7)	12.8 (11)

▪ Sufficient drug supplies to all health facilities	2.3(1)	-	1.2 (1)
▪ Others	11.4(5)	2.4(1)	7.0 (6)
• Total	100(44)	100(42)	100.0 (86)

(Absolute numbers in parenthesis)

To a little over a third (36%) of those who are aware of the slogan in the urban area, it means that "everyone will enjoy free medical/health care". To between 16 and 20% of the households, it means "hospital service or treatment will be available for all". To 9% of households in the urban area, the expression means "health service will be made affordable for everyone". In the Ayawaso submetro, seven households (16%) stated that the expression means "everybody will be healthy by 2000". The slogan is not understood by about 13% (9% in Ayawaso and 17% in Kpeshie) of the respondents.

Table 18 (b): The meaning of "Health for All 2000" - Rural Households

Response Category	Atimpoku	Apeguso	Total
▪ There will be a health facility in every community	24.3(9)	50.0(17)	36.6 (2.6)
▪ Everyone will enjoy free medical / health care	18.9(7)	-	9.9 (7)
▪ Everybody will be healthy by 2000	16.2(6)	26.5(9)	21.1 (15)
▪ Hospital services/treatment			

will be available for all	16.2(6)	8.8(3)	12.7 (9)
▪ Do not understand	10.8 (4)	5.9 (2)	8.5 (6)
• Sufficient drug supplies to all health facilities	2.7(1)	2.9(1)	2.8 (2)
▪ Health services will be made affordable to everyone	2.7(1)	2.9(1)	2.8 (2)
▪ Other	8.1(3)	2.9(1)	5.6 (4)
Total	100(37)	(34)	100 (71)

(Absolute numbers in parenthesis)

To over one-third of the rural households (37%) (Atimpoku - 24%, Apeguso - 50%), the slogan means “there will be a health facility in every community" in Ghana. To approximately 20%, the expression means "everybody will be healthy by the year 2000." In 9 out of the 71 households (13%) in both sub-districts that know of the slogan, it means “Hospital services/treatment will be availabe for all". The slogan is not understood by about 8% (11% in Atimpoku, 6% in the Apeguso) of the households.

For nearly 90% of the respondents in the sub-metro areas, the goal of the slogan "Health for All by the 2000" has not been achieved. The proportion of people in the rural sub-districts who think the goal has not been achived is even higher (94%).

In the urban area, some of the reasons for saying that the goal has not been achieved are that: -

- People still pay for health services (19%)
- Many places still do not have health facilities (17%)

- No improvement in health services has been noticed (17%)
- Government cannot afford/achieve the goal (14%)

The rural households think that the goal of "Health for All" has not been achieved largely because:

- Many places still do not have health facilities (46%)
- There has been no improvement in health services (11%).

In Apeguso in particular the proportion of those who maintain that many places still lack health facilities is close to 60%. According to 29% of the respondents, no improvement in health facilities has been observed.

User Fees

The next policy question addressed to the households is the "cash and carry" system.

Table 19: Awareness of the "Cash and Carry System"(Distribution in %)

Response Category	Ayawaso Kpeshie	Atimpoku Apeguso
Yes	90 68	53 82
No	9 32	47 17
NR/DK, not sure	1 -	- 1
Total	100 100	100 100

In both urban and rural areas, over 65% of households have heard of the “cash and carry”system. Comparatively more urban households (79%) than rural (68%) know of the concept.

Table 20: Sources of First Information on the "Cash and Carry" System.

Source of Information	Ayawaso Kpeshie	Atimpoku Apeguso
Health workers	40.0 47.6	67.9 62.2
District Assembly	- -	5.7 7.3
Church organization	1.1 -	- 3.7
Chiefs and Elders	1.6	3.8 2.4
Other	58.9 50.8	22.6 23.2
Cannot Remember	- -	- 1.2
Total	100(90) 100(63)	100(53) 100(82)

Health workers are the primary source of information or knowledge about the "cash and carry" concept for most households. This is the case for between 40% and 48% of the households in the sub-metro samples, and between 62% and 68% in Atimpoku and Apeguso.

The rest in the sub-metro areas (51-59%) heard it from different sources, including neighbours, friends and the media. Those who heard from "other" sources in the Asuogyaman district constitute 23%. The District Assembly and Chiefs and Elders were also source of awareness of the concept in 6.5% and 3% of the cases respectively.

Meaning of the "cash and carry" concept

Table 21 (A): Meaning of the Cash and Carry Concept - Submetro household (%)

Meaning	Ayawaso	Kpeshie	Total
▪ You have to pay before you are treated	68.9(62)	66.7(42)	68.0 (104)
▪ You pay before receiving drugs	15.6 (14)	11.1 (7)	13.7 (21)
▪ You pay for every single service	7.8(7)	14.3 (9)	10.5 (16)
▪ Others	-	6.3 (4)	2.6 (4)
▪ DK /Do not understand	7.8(7)	1.6 (1)	5.2 (8)
Total	100(90)	100(63)	100 (15.3)

In the sub-metro sample area, over two-thirds of the households (67-69%) stated that the concept means one has to pay before treatment. Approximately 14% (15.6% in Ayawaso and 11% in Kpeshie) stated that the concept means paying before receiving drugs. To 10% (7.8% and 14%) of the respondents, the concept means you pay for every single service. Seven households in the Ayawaso sub-metro do not understand the concept.

In the Asuogyaman district, approximately 67% similarly stated that the concept means one has to pay before treatment. Nearly 9% say the system means that you deposit money before admission. To another 9%, the concept means you pay for every

single service" Ten households do not understand the concept.

Table 21 (b) The meaning of the "Cash and Carry" concept - Asuogyaman households (%)

Meaning	Atimpoku	Apeguso	Total
▪ You have to pay before you are treated.	66.0 (55)	67.1 (55)	66.7 (90)
• You deposit money before admission	9.4 (5)	8.5 (7)	8.9 (12)
▪ You pay before receiving drugs	3.8 (2)	7.3 (6)	5.9 (8)
▪ You pay for every single service	7.5 (4)	9.8 (5)	8.9 (12)
▪ Others	5.7 (3)	-	
▪ DK / Do not understand	7.5 (4)	7.3 (6)	7.4 (10)
Total	100(53)	100(82)	100 (135)

To most of the households in both the urban (96%) and rural sample (80%) areas, the policy or the system is still operating. The reasons advanced by urban households for this assertion are:-

- They still pay before treatment (70% Ayawaso, 91% in Kpeshie)
- Drugs are being sold (9%)

Similar reasons are given by rural households as 74% in each of the two sub-district sample maintain that they still pay before treatment is given. Seven per cent of people in Apeguso and 4% in Atimpoku say that drugs are still being sold to patients.

Qualitative study

Introduction

The PRA procedure used for the qualitative study in the two sites comprised of 22 focus group discussions (FGDs) and 21 in-depth interviews/key informant interviews, involving chiefs, community leaders, church leaders, traditional healers and assemblymembers.

The FGD involved the following groups: one men's group, one women's group, six women with children under 5 years of age , four pregnant women , five elderly people and six young people. The in-depth interviews were held in the six communities.

Each group was made up of 4-9 participants on average. The age of the women participants, including mothers with children under-5 years and pregnant women, ranges from 18 to 38 years. The elderly were those between 70 and 85 years.

The age of individuals for the in-depth interview also ranges from 30 to 70 years.

Findings of the PRA in the selected communities in Asuogyaman district: Old Akrade, Atimpoku and Abomayaw.

Health facilities available

The main occupation of the people interviewed in the district is farming and fishing.

Out of the three communities studied, only Atimpoku has health facilities. In addition to its District Assembly clinic, Atimpoku also has a community clinic, a herbalist and a spiritualist. Community members have a wide variety of health facilities -- mainly outside the locality -- to choose from whenever they are sick. Old Akrade and Abomayaw do not have any health facilities.

All three communities, however, travel to neighbouring health centres and also sometimes go to the herbalists in order to meet their heath needs.

Table 22: Health facilities available to the three communities

Facility	Atimpoku	**Old Akrade**	**Abomaya w**
Council clinic	X		
Community clinic	X		
Juapong private clinic	X	X	X
Akosombo Hospital	X	X	X
Drug store	X		
Herbalist	X	X	X
Spiritualist	X		
Public health centre	X		
Atua Government Hospital		X	
Fodzoko		X	
Akuse		X	
Agomanya		X	
Battor		X	
Anum			X
Apeguso			X

In Atimpoku, the aged and women with children below 5 years old mentioned the health facilities they patronise as Merciful Clinic (a private clinic at Juapong), the Council clinic and spiritual churches.

The pregnant women listed the VRA hospital at Akosombo and Juapong clinic as the health facilities they use.

From the discussion held in Old Akrade, it was discovered that the youth resort to the cheaper alternatives of herbal treatment or go to the Juapong or Akosombo clinic when they have money. The pregnant women either attended Juapong or Akuse for treatment. Women with children below 5 years, the aged and the Chief go to the Atua Government Hospital. The elderly sometimes prefer the hospitals at Fodzoko and Agomanya. Women with children below 5 years sometimes go to Akuse. The Chief also mentioned Battor as one of the places he attends for health care.

Elderly men in Abomayaw go to the herbalist more than they travelto the hospitals. Elderly women attend the Akosombo, Juapong and Anum hospitals more, explaining that even after visiting the herbalist, the sickness still persisted at times.

Table 23: Prevalent Diseases in the three Communities

Disease	**Atimpoku**	**Old Akrade**	**Abomayaw**
Abdominal pains	X		
Anaemia		X	
Asthma		X	
Bilharzia	X	X	
Blood Pressure	X		
Bodily pains			X
Convulsions		X	
Cough	X		
Diarrhoea			X
Dizziness	X	X	
Fever	X	X	X
Heart attack	X		
Headache	X	X	X
Hernia	X	X	X

Hypertension	X		
Leprosy	X	X	
Malaria	X	X	
Measles	X	X	X
Onchocerciasis		X	
Skin diseases	X		X
Snakebite		X	
Stomach pains	X	X	
Waist pains	X	X	X

Expenses on medical treatment

Community members spend between ¢1,000 and ¢500,000 whenever they go the hospital.

One elderly woman also said, "*The system whereby you pay before you receive treatment beats my mind. When my daughter was about to deliver, I paid Ë470,000.00 before she delivered. It means if you don't have money you are in trouble*".

The Exemption Policy

Apart from Abomayaw where no group of people except the elderly men knew about the policy, people in the other two communities had a fair idea of the policy. They had heard about the exemption policy through the newspapers or the radio. One person from Old Akrade said that, "*on the radio it was stated that nobody should collect money from pregnant women and small children when they go to the hospital*".

All three groups applauded the idea of the policy, but complained that even those who knew about the policy and were in the exemption category still paid for health services. The Chief and some of the elderly people in Atimpoku had the impression that because their district had no hospital, they were not benefiting from the exemption. "*Because we do not have any government*

health facility in our community, those 60 years and above are not enjoying free medical care".

They suggested that, "exemption of the aged should start from age 60 to conform with the legal retirement age in Ghana because we don't grow up to that age any longer. People die at forty-five years". One woman also said that the disabled should be exempted.

Pregnant women agreed that they should be exempted because during delivery, they suffer too much and some of them either do not have husbands or their husbands cannot afford the high hospital bills.

They also suggested that there should be a mechanism that allows them to give birth on credit.

The primary health care concept (PHC)

The primary health care concept was defined as, "*At the village level, health care personnel will come around at least once a week to treat minor cases. They will only refer major cases to the hospitals. Health personnel give first aid before we go to the hospital. They check our BP (blood pressure), advise us on diet. Through them, people get to know if they have a disease. They tell us the type of drug to use*".

The groups agreed that primary health care was beneficial to them. The youth from Abomayaw added that "*when the nurses visit, they cut down (the need for people in the communities to travel) to hospitals as far as some minor diseases are concerned*'.

The elderly men also admitted that it helps their communities, especially mothers, with first aid and the children.

All the groups acknowledged the role of nurses and agreed that they were helping people in rural areas.

Cash and carry /user fees

In Atimpoku, one elderly person said of the user fees: "Nothing is free at the hospital. You pay before you are treated. It is the money charged at the hospital".

The group of elderly people referred to the cash and carry /user fee regime as "*ɛkintran*". "The cash and carry means you pay before your treatment. If you put money down, you get your drugs. The system should be discontinued because we are poor."

The youth suggested that patients should be treated before payment. They should leave their address (including their workplace) to facilitate tracing or contact in case of default in payment.

In Old Akrade, some of the groups did not know the rationale of the cash and carry system but the elderly explained that, "*it means that you have to pay for treatment*".

The different groups agreed that the user fees are paid because it helps the government to pay for the medicine and other hospital facilities, but that the fees were just too high for them. "Sometimes you are asked to pay a deposit of ¢400,000 at VRA hospital before treatment."

Therefore, the cash and carry system of health delivery only succeeded in preventing them from using the health facilities available. As a result, they had to resort to other forms of health care such as self-medication and herbal treatment.

Young people stated that, "*the concept is not helping us in this community because we do not have jobs. It is only fishing that we do here and there are no fish in the sea.*"

The Chief stated that because the community was mostly made up of peasant farmers, they found it difficult to foot the high medical bills and that the government should set up a clinic/health post/centre in their community.

All groups in all three communities complained about the cash and carry system saying: "*It is killing us; even if you are dying, you are requested to pay. If you do not have money to deposit, you are not taken care of. The system is bad*".

They complained about the attitude of nurses. They said the nurses were sometimes rude and also allowed their favourites to jump queues.

All the definitions the groups gave highlighted the fact that the cash and carry /user fees meant money for health service.

Elderly women in Abomayaw suggested that the government should see to it that the prices of drugs are reduced and that sick people should be treated before money has to be paid, otherwise people will continue to die in the hospitals. They also urged the government to build more clinics closer to them and in other villages.

<u>Health for All by the Year 2000</u>

All the groups interviewed were aware of "Health for All by the Year 2000" and they interpreted the slogan to mean that "*everybody will be healthy, everybody will enjoy healthcare wherever you are in the country."* One woman from Atimpoku added:*"As at now, it has not been achieved because many are dying. The reasons are people have no money; we don't have a*

government hospital in the district. We travel 15 miles to attend government hospital. Health for all cannot be achieved in this district of Asuogyaman, it is death for all'.

Health insurance

All groups confirmed that although there were different types of 'Susu' schemes and various ways of supporting one another in times of trouble such as bereavement, there was no health insurance scheme available in their respective communities. Nursing mothers said: "W*hen someone is sick and there is no money, we go and borrow from individuals, and the church also helps"*.

With the exception of elderly people, all respondents were interested in setting up a health insurance scheme and suggested that the contributions should be entrusted to reliable members of the scheme. The youth believed that even if there were one, they would use the money for their own personal needs: "They will embezzle the money., If one should be set up, we want the money to be given to somebody who is working, someone who has a job." Their financial situation would only permit them to contribute between ₵1,000 and ₵5,000. They suggested that membership of the scheme should be voluntary and that payment should be at harvest time.

Women's participation in decision making

Women's participation at all levels of decision-making processes is minimal. According to the women, men took most of the decisions. The men beat the women, sometimes during pregnancy. One woman gave her own testimony of when she was beaten so mercilessly that she miscarried.

The team's impression from the interviews held with the groups was that women are not recognised. A pregnant woman confirmed

that after the decisions have been made, '*the Chief will beat gong-gong to inform all women in the community*".

Of those gatherings where women are given the opportunity to attend, one pregnant woman said: *"If we are given the chance to speak and we do so, some of our husbands beat us afterwards and do not provide for us*".

A nursing mother also said: "They don't allow us to talk at all, they say we are women, we should keep quiet. Our views are not taken".

Institutional analysis

All the groups saw the church, the Chief and family members as institutions. The youth in Old Akrade also saw their landlord and their own group, that is, the youth as institutions.

The people of Abomayaw mentioned the assemblyman as an institution but he was put out of the circle (see diagram) because, according to them, although he was in the town they did not feel his impact.

The interesting aspect of the discussion is the fact that although these women complained that they were not regarded by their husbands, and also were victims of domestic violence, they mentioned their husbands as institutions. Another institution mentioned was the unit committee.

Trend analysis

All the groups, especially the nursing mothers, agreed that "childcare/healthcare has been raised (in importance) now compared to 5-15 years ago." They also noted that certain facilities that they enjoyed are no longer available. *"In the past, you were fed when on admission*".

They also agreed in Atimpoku that 15 years ago, health services were better than now because the cash and carry system was not in place. “Bills and drug costs are rather high now. Doctors now prescribe drugs for you to buy and the cost is high. The drugs supplied to patients varied before, but now the same drug (Paracetamol) is given to everyone. OPD cards were free but now they are not”. Traditional medicine is now affordable compared to drugs from the stores.

However, all groups acknowledged that modern machines (like the mammogram) and the technology being used in health centres now were not in use 15 years back.

Elderly men in Abomayaw complained about the rude attitude of the nurses.

Coping strategies

Nursing mothers in all the three communities use herbal treatment – “Nyame dua” - for measles. When it does not work, they then visit the hospitals.

Meanwhile, the people of Old Akrade sleep under mosquito nets, especially in the rainy season to prevent malaria.

Case study of a TBA at Atimpoku

“My name is Adjoa Achiaa or Dora Achiaa. I am a TBA (trained birth attendant). I was formerly practising in Nudu. I came here because of the death of the Chief. I am not staying here permanently so I am not a member of any association.

“My work basically involves delivering babies. I refer complications to hospitals. An average of two pregnant women see me daily. I also give herbal treatment. One of the herbs I use is “gwengwen.”

(a) Findings in selected communities in AMA: Accra New Town, Old Teshie and Dar es Salaam.

Health facilities available

Through guided walk, in-depth interviews using the semi-structured interview (SSI) guide as the tools, the following health services or facilities in the three areas were mentioned:

Table 24: Health Facilities available

Areas	**Accra New Town**	**Old Teshie**	**Dar es Salaam**
Maamobi Polyclinic	X		
Iran clinic	X	X	
Mission Clinic	X		
Trinity Clinic	X		
Gloria Maternity Home	X		
Mrs. Dua Maternity Home	X		
Vicky Maternity Home	X		
Dr. Asirifi Herbal Centre	X		
Bennet Clinic	X		
Sape Agbo clinic	X		
Newtown Clinic	X		
King David Clinic	X		
Cocoa Clinic	X		
Manna Mission Hospital	X		X
La Polyclinic		X	X
Herbalist/Herbs		X	X
Unicorn at Lascala		X	
Dede Maternity Home		X	
North Clinic		X	
Christian Pharmacy		X	
Bannerman Clinic		X	X
Pharmacy shop		X	X

Private clinics		X	
Teshie Community Clinic		X	
Akpandja Clinic		X	
Dental Clinic			X
Palm Street Clinic			X
Dr. Arthur Clinic			X

The table clearly shows that apart from the Iran Clinic, which is common to Accra New Town and Old Teshie, no health facility is common to the three areas. Old Teshie and Dar es Salaam have a lot more in common.

Prevalent diseases in the three areas

Common diseases that afflicted people in these communities two weeks before the survey include:

- Malaria
- Headache
- Running stomach
- Bodily pains
- Stomach ache

Table 25: Prevalent diseases mentioned by respondents

	Old Teshie	**Dar es Salaam**	**New Town**
Dizziness	X		
Back pains	X		
Waist pains	X		
Bodily pains	X	X	X
Heartburn	X		
Sleeplessness	X		
Headache	X	X	X
Cough	X		
Stomach pains	X	X	X

Running stomach	X		X
Fever	X	X	X
Cholera	X		
Vomiting	X		
Malaria			X
Anaemia			X
Hypertension			X
Typhoid fever			X
Eye		X	

Expenses on medical treatment

In New Town, the cost of treatment ranges between ₵20,000 in private clinics and ₵40,000 at Korle Bu or ₵32,000 for antenatal services at Ridge Hospital.

Among the youth, common conditions for which they seek treatment mostly at Iran Clinic and drug stores are fever, bodily pains, malaria, stomach disorders, headache and typhoid fever. Polio immunization is free. But weighing of children cost ₵500, or ₵1,000 if an injection is included.

It costs respondents ₵30,000 at a private clinic and ₵80,000 at Korle bu. At the latter facility, one person has spent ₵195,000 on drips alone. Some of the youth and men claim that the fee for treatment at the Polyclinic is on average ₵1,200, but at different points. Thus, from OPD consultation through laboratory investigation to treatment/ medication, one would not spend less than ₵30,000 per visit.

For most women with children under 5 years, self-treatment with herbs or drugs without prescription is the practice with respect to certain common diseases – e.g. boiled nim tree for fever. rice water for running stomach.

The men mostly use Maamobi Polyclinic, Bennet Clinic, Sape Agbo, New Town clinic, King David Clinic, which are all private. The 37 Military Hospital and Manna Mission Hospital located at Teshie Nungua Estate. The cost of treatment at a public facility ranges from ¢12,500 at the Polyclinic to ¢50,000 at Korle Bu Teaching Hospital. Some of the men prefer self-treatment with herbs or herbal preparations to buying medication costing ¢1,200.

According to the people at Teshie, services at the La Polyclinic cost ¢15,000 for pregnant women and ¢25,000 for women with children under 5 years. Pregnant women claim they pay between ¢11,000 and ¢40,000 at a private clinic like Iran Clinic. Most mothers, however, claim that it costs on average between ¢30,000 at Bannerman Hospital, a private health facility, and ¢120,000 at Ridge Hospital, a government health facility.

At pharmacy shops, it costs between ¢14,000 and ¢40,000 to buy medication. Among the youth, one person had spent ¢68,000 on drugs from a pharmacy.

The people of Dar es Salaam stated that costs vary little at a government health facility, whether a hospital or a clinic), but vary a lot according to the health problem presented.

At La Polyclinic, charge range between ¢30,000 and ¢40,000, according to women respondents who recently went to the clinic. A man had to pay ¢160,000 for his wife to be admitted for three days at Ridge Hospital and give birth.

The charges at private hospitals are also relatively high. At the Police Hospital, which is a special hospital, total fees charged range from ¢40,000 to ¢112,000. For example, one young man paid ¢5,000 for a registration card, ¢40,000 for consultation, and ¢5,000 for drips, all totaling ¢50,000. Another spent ¢7,000 on

card, ₵20,000 for consultation and ₵85,000 for unspecified reason; all amounting to ₵112,000.

At some of the other private facilities, amounts spent were not spelled out or specified because it was charged to the individual's employer.

Those who resort to pharmacy shops for treatment do so because it is too expensive for them to attend a formal health facility or because it is cheaper to procure a few essential drugs to alleviate pains until they are financially able to attend a hospital. For such people, the cost of drugs from a pharmacy or chemical store ranges from ₵2,000 to ₵25,000. The average is ₵10,000.

Table 26: The range of user fees charged at various health facilities that community members use

Type of facility	**Range of Fees**	**Type of Service**
• Private Clinics		
Bannerman's	20,000 – 30,000	
Iran Clinic	11,000 – 40,000	Antenatal
• Public Clinics		
Maamobi Polyclinic	12,500	
La Polyclinic	15,000	Antenatal
	25,000	Children under 5 years
	30,000	Women's health
• Public Hospitals		
Ridge	32,000 – 120,000	
	160,000	Delivery
Korle Bu (Tertiary)	40,000 – 80,000	Special cases
• Private Hospitals		
Police Hospital	40,000 –	

	60,000	
	112,000	Sum paid at every delivery point

Exemption policy

In Accra New Town, almost all the groups interviewed, the youth, men and women were aware of the exemption policy; mainly through the radio. The apparent ignorance of the policy among women with children under 5 years and opinion leaders is due to the fact that fees are seen to be charged to everyone and for every condition reported at the facilities. The Chief had the feeling that the policy existed only on paper, because every service is charged for, including even emergency cases.

On the contrary, most members of the groups interviewed at Old Teshie claimed initially that they were not aware of exemption from paying for health services for any category of people. The reason for this expressed ignorance seems to be the fact that each of the respondents pays anytime he or she attends a public health facility.

"Nobody is exempted from paying for treatment received except those who attend company hospitals". *"Even if it exists, it can't be possible*. (Nii Sowah, Traditional Priest) *"I know there is a policy to exempt students, the aged, the retired and cripples*".

Who is exempt?

On who should be exempted, the type of services to be made free and for what disease or health problem, the opinions and views of respondents are as follows:

Women, those aged 60, the unemployed, orphans, the poor (all those who do not have money), children whose parents cannot afford health care, teenage mothers, people with deformities, leprosy patients, TB patients, people operated upon, people with headaches, people with breast cancer.

Diseases to be exempted

The groups of respondents said the following should be treated free when they report to the hospital: AIDS patients, cripples, people suffering from stroke and high blood pressure.

Reasons for exemption

The groups were of the view that leprosy and TB should be exempted so as to encourage such patients to seek treatment, thereby preventing the spread of the disease

They also suggested that students and the unemployed should be exempted because they do not have the means to pay. They stated that cholera should be treated free to prevent it from spreading.

Case Studies and experiences in Old Teshie

One woman in Accra New Town said: "I was at the Polyclinic with my childand I did not have enough money but was asked to put money down. I could not, so I brought the child back home without any treatment. Later on, I had to go to Ridge Hospital with the child".

Other women shared similar experiences. They confirmed that because of the demand for fees before treatment and the poor attitude of the staff at government facilities, they prefer going to a drug store or private clinics in and outside the area for treatment.

Cost of services (Old Teshie)

"I went to Tema Hospital with a chest problem. I was asked to take an X-ray costing ¢12,000, but I had only ¢8,000 on me; since I did not have the full amount, I did not take the X-ray. I had to go home" (26 year-old man, a footballer).

"We don't go to hospital because it is expensive and we don't have money" (38 year-old driver's mate).

"I have no money; when I have money, then I will go" (Gladys, a 22 year-old pregnant woman).

Women with children shared experiences concerning the bad attitude of health workers. One woman's experience at La Polyclinic was that nurses insulted her for keeping her sick child too long at home before bringing him to the hospital. She waited for a long time before seeing the doctor, yet she had to pay for everything.

Other women claimed that many mothers lost their babies due to the incompetence and unconcerned attitude of nurses.

A church administrator said that nurses do not have patience for patients:
"*I went to visit someone at the hospital yesterday. They made me wait for a very long time until visiting hours were over. I could not see the person*".
"*Doctors do not have time to really examine us to see what is wrong with us*".

Nii O. Sowah, a traditional priest, also stated: "Some few months ago, I went to Korle Bu with stiffness in my body and pains all over. I was admitted for one day and I received very good treatment because I have paid for it. We were 15 on admission that day; all the 14 died while I watched because they did not have money to pay for the drugs needed to treat them. The nurses did not even care".

One traditional birth attendant said: "There (are) no free health services".

The traditional healer/priest Nii Sowah said: *"I don't believe that those who are to be exempted are exempted, I don't believe it is*

happening, because everybody pays. It is not working; it should be made to work. That is when it can be of help to us".

The poor should be exempted, but there should be a way of identifying them. An identity card should be given to them. As soon as such people get employed, a deduction should be effected. SAYS WHO?

The Primary Health Care (PHC) concept

Almost all the groups had heard of primary health care (PHC). But with regard to what it means and why it was introduced, their views varied.

According to the youth, PHC serves as first aid to people. It was introduced to relieve pressure on city hospitals and to cut down on the cost of health services to people living far from the cities where hospitals are located. To one of the men, it means hospitals should be available in every community to help those who are sick. It also means to provide first aid for community members. It was established so that minor cases could be treated at community level, thereby relieving the hospital and doctors of the pressure on them.

PHC was introduced because hospitals were too far from (many of) the people, transportation was not available (apart from its expense), and roads to health facilities were bad. To some women, it means the establishment of health posts and health centres. It was introduced so that everybody could have access to health care since the distance to big hospitals was rather long. Mothers think that PHC is meant to give first aid to people.

According to the Chief (Nii Obo Aduanku), PHC was introduced to help children. "*If a health centre is near to people, everyone will have access to it*". In a similar vein, all responses on benefits to the people varied. Most men did not understand the concept. To most

women, PHC means the building of health posts and health centres. The youth's assessment was that people have benefited from PHC. To them, PHC had impacted positively because it tended to reduce bribery and corruption.

The mothers and women held the view that rural areas and rural people have really benefited from PHC. The men in the mixed group confirmed that PHC was very helpful but partiality and nepotism or preferential treatment is common. The Chief, however, held a negative view. He said people have not really benefited from PHC because they still have to travel long distances to hospitals.

In Old Teshie, knowledge of the concept of primary health care is very minimal among the community members interviewed. The few that have heard of the concept have never really understood it. To some of the youth, primary health care is expected to provide health for all, but feel the aim cannot be achieved because there is no government facility at Teshie.

- PHC was introduced in order to take care of our frequent illnesses.
- People have benefited from PHC, eg. immunisation and weighing.

Church administrator:

- PHC is the programme of the government meant to provide the basic health needs of our people by educating us on how to keep our environment clean in order to prevent sickness.
- It was introduced in order to prevent people from getting sick, but it has not helped us in Teshie at all because there is no toilet, gutter, refuse dump, so we still have the sickness.

Cash and carry/user fees

To most of the participants in Accra New Town, the concepts "user fee" and "cash and carry" are identical or synonymous in meaning. Radio is the main source of information or awareness about user fees.

Participants in Old Teshie appear to be more knowledgeable about the cash and carry system than the user fee concept. In general, women with children under 5 years of age, the church administrator and the traditional priest said that they had heard of the "user fee".

The youth, pregnant women, TBAs and religious leaders, including the traditional priest, said that they became aware of the cash and carry system through radio and television. Some of the views of the youth are as follows: *"Health personnel demand money before anything is done for you, but since we don't work, we don't carry money, so we cannot go to hospital". "It is hurting and killing people*". The youth continued to suggest that the government should take up the responsibility of health care and that the price of drugs needs to be reduced.

In Dar es Salaam, all participants interviewed claimed they knew of the user fee and cash and carry system.

According to landlords, the user fee is "a system where patients pay before receiving treatment at the hospital".

When the team asked the groups why the user fee/cash and carry system was introduced, the women's group said it was introduced to stop people from running away after treatment. It was also meant to secure money to maintain the hospitals and pay the doctors. "If we don't pay, hospitals will break down and doctors will go hungry". "The government alone cannot be footing the medical bills always, hence the introduction of the user fees".

Most participants stated that the system is not helping or benefiting society because many people cannot receive medical care since they cannot afford the fees. Others think the system is discriminatory: "T*hose who can afford are not paying for the service received and those who cannot afford are being made to pay.*"

Health for All by the Year 2000

To the mothers in Accra New Town, the slogan means "everybody can to go hospital free", or that the cost of health services will be reduced. However, they feel this has not been achieved because health facilities are few.

To the Chief, on the other hand, the goal has been achieved because "in my community, people have access to health services".

For the youth in Old Teshie, the goal of health for all has not been achieved mainly because there is no government health facility at Teshie.

To the church administrator, "Health for all" is just a saying.

The traditional priest, however, believes the slogan is *"a plan to bring health service closer to us, and make it affordable for everybody that is sick". He believes that the objectives cannot be achieved because the facilities are not there.*

To a young female in Dar es Salaam, the concept -- as explained to her by her teacher at school-- means that there would be free health services by the year 2000.

To the adult group, the health for all policy was meant to educate people about basic health issues and create awareness of the nearest medical centre.

To most people, the achievement of this goal has not materialised because “we do not have anything to show. The whole of Teshie Nungua and Dar es Salaam does not have a government hospital”.

Health insurance

All three groups stated that there is no health insurance scheme in their community. Nobody, except some members of the youth group, has heard about the scheme or concept of health insurance.

Most welcomed the idea of setting up a scheme to help people who cannot afford the fees because there are some financial or social clubs in existence which could be used to start such a scheme. However, the groups interviewed at Dar es Salaam cautioned that adequate research should first be conducted, proper organisation put in place and honest and trustworthy people be identified to lead the groups.

In Accra New Town, the youth has an organisation or club called “Somu Ye” to which members contribute monthly. However, the contributions do not cover health needs or sickness. They then suggested that this organisation can be used as the base to start the health insurance and the premium stated by most of them is ¢1,000.

The men said they had financial clubs and a Youth Club Fund that aim to help contributors and their dependants who fall sick. It mobilises people to donate freely, spedifically to assist those who cannot pay for health services.

Trend analysis

Youth

According to the youth in all three areas, hospital services were better 15 years ago than today. Drugs were available, conditions at the hospital were good and fewer people were attending hospital.

Health workers were more patient and there were enough facilities then in the hospital than there are now (e.g people were not sleeping on floor). The government provided everything for hospitals.

Ten years ago, there was free health care at both government and mission hospitals (e.g. St. Dominic's). Families spent less on health; facilities were better at the hospital. There were many maternity and admission wards and emergency cases were treated before fees were collected.

Five years ago, the cost of services was very high. Prescribed drugs were not available on the market and the quality of services was not all that high. More equipment and materials have come, but affordability is a problem.

Men

Men at Accra New Town said that 15 years ago, "h*ealth Services and (the) economy were better*". *"Drugs were available, people got healed whenever they felt sick and there were no queues at the hospitals*". *"Doctors had time for every patient. Governments and NGOs provided all services*".

Men at Dar es Salaam also said that health services were better.

Men at Old Teshie, however, stated: *"Those days were not better than today, neither is today better than those days… because in those days, certain kinds of diseases could not be treated, but now they can be treated*".

According to the men at New Town, about 10 years ago, the cost of services was low and people were encouraged to attend hospitals. Services were of good quality. They said that fiveyears ago, the cost of services was very high. They continued:

“Prescribed drugs were not available on the market and the quality of services was not all that high”.

Women

Women at Old Teshie and Dar es Salaam said that 15 years ago, the economy was better. Doctors were more concerned with saving life than economic considerations. “₵2,000 can take you to the hospital and back safely”, they also observed.

At Accra New Town, women said that 10 years ago, government hospital bills were not as high as private hospital bills. There was better equipment now.

The women claimed that health care has been very poor over the last five years, and the cost of services very high because the high exchange value of the dollar made the importation of drugs very expensive, and hence, the high cost of health services. “The government should import good (quality) drugs and doctors and nurses should be more caring and loving”, they concluded.

DISCUSSION

Demographic and socio-economic characteristics of the study population

In both the urban and rural sample, there are more females than males. This preponderance is more marked in the rural with a sex ratio of 73.0 men per every 100 females compared to a sex ratio of 96.0 per 100 for the urban sample. This higher proportion of females in the sample conforms to the national figure. (GSS 1994, 2000)

The proportion of children under 5 years in the sample is approximately 10%; this more or less corresponds to the national figure (12%). The rural-urban differential in the proportion of elderly people in the sample (household population) -- i.e urban 25%, rural 6% -- confirms studies in the Ga district and AMA conducted nearly 10 years ago (Matilda Pappoe, et al, 1991). This differential, however, exceeds the national percentage of between 3 and 4 per cent.

Unlike the national, average household size of 3.3 for urban areas and approximately 4.0 for rural areas, (GSS 1988, 1993, 1998), the average household size for the areas of Accra in our study exceeds that of rural sample by about 9%. The average household size for the urban sample is 5.8; that of the rural sample is 5.3. The average household size for Greater Accra is 3.6 and that of the Eastern Region stands at 3.2 (GSS, 1998). This may be explained by the fact that most of the households in the sample sub-district are located in a high density indigenous sector (HDIS) -- e.g. Old Teshie-- on one hand, and a medium density, low class area (MDLCS) -- e.g. Nima, Alajo -- on the other hand, where there is overcrowding.

There are more children enrolled in primary school in the Asuogyaman district than in the AMA sample (70% vrs 60%). The latter location has a higher proportion of children in secondary education.

These characteristics will have some implications for access to and utilisation of health services available to the population.

Awareness and utilisation of public health facitilies

The type of health facility in the urban locality known by more than a third of urban households (35%) is a private health facility, including a mission facility. And close to one-third (32%) know of a pharmacy shop. Only 26% know of the existence of a public health facility, and less than 5% know of a community clinic.

Similarly, in the rural sample, the private health facility, including the mission facility, is known to 34% of respondents. The pharmacy shop is the next important health facility known (21%). The community clinic is known to a more sizeable proportion (17%) in the rural sample than in the urban sample (4%).

Proximity and the cost of services are key determinants in utilisation of a health facility. In the urban sample, a pharmacy shop or chemical store is the nearest health facility to more than half of the sample (57%), followed by a private health facility. In the rural area, however, the public health facility is the nearest to 25% of households.

With regard to the use of the nearest health facility, however, over 35% of the urban household “always” visits these in times of sickness. A similar percentage of rural households would always visit the nearest health facility in times of illness. Of the 65% of urban households that “occasionally” or “never” go at all, 34% said it is because of high service and treatment costs; 10% cited the

bad attitude of staff. In the rural study, 71% of respondents go only occasionally or not all, because of lack of money.

Analysis of daily household expenditure shows that in the urban sample, over 50% of households spend amounts ranging from ¢3,000 to over ¢16,000. Nearly 50% spend on average ¢16,000. In the rural sample, a little over 45% of households spend daily an amount ranging between ¢10,000 and ¢16,000 (Table 7b).

Analysis of household expenditure on health services during a sickness in the previous two weeks shows that some spend more on health care than entire household expenditure. For instance, 6 out of 20 of such people (30%) in Ayawaso spent between ¢55,000 and ¢61,000 for health care while two spent between ¢105,000 and ¢115,000. In Apeguso, 18% (4/22) claimed to have spent between ¢25,000 and ¢35,000. Even though such medical expenses occur occasionally, they are quite substantial for a poor farmer, for example.

At the community and individual levels, various social groups – the elderly, women, the youth – have a hazy understanding of the concept of primary health care. The aged in Atimpoku defined primary health care in terms of treatment of minor cases of illness at the village level by health personnel who come round once a week: (they check our blood pressure), advise us on diet and tell us the type of drugs to use. "They will only refer major cases to the hospitals". All groups including the elderly at Abomayaw admitted that primary health care helps communities, especially mothers and children in providing first aid, as well as all those in rural areas.

These expressions implicitly suggest that at the lowest level, people know that primary health care is meant to bring basic health services close to where they live, and are referred to a higher level (hospital) only in cases beyond the control of the primary health providers.

However, not all the groups share the views on the positive roles primary health care plays. There are misgivings among community members, especially opinion leaders, about the effectiveness of primary health care. "*Nobody is benefiting from the primary health care because the health personnel are not doing their work*" [Chief of Atimpoku]. "We don't even have a clinic or a hospital built by the government".

There is much to be done in terms of educating communities on health policies and programmes and on their role in primary health care issues. This would be in line with the meaning of "Health for All by 2000" as proposed by WHO, which explained that "Health for All" does not mean that in 2000, doctors and nurses will provide medical care for everybody…. for all their existing ailments; nor does it mean that in the year 2000, nobody will be sick or diseased (WHO, 1981). It does mean, among other things, that "essential health care will be accessible to all individuals and families, in an acceptable and affordable way, and with their full involvement. (WHO, 1981)

Health workers, and indeed, the District Health Management Team that oversee implementation of the policy at district level, have a crucial role to play in this direction.

<u>User Fees and the cash and carry system</u>

Analysis of the quantitative data shows that over 65% of households have heard of the cash and carry system. Comparatively more urban households (79%) than rural (68%) know of the concept. Forty-four per cent of those in the Accra study who have heard of the concept, heard it from health workers. This contrasts with 65% of those in Asuogyaman who heard it from health workers

The greater proportion of the rest of households in the Accra metro area (51-59%) have heard of the cash and carry system from many different sources including neighbours, friends, the media and a host of others. In the Asuogyaman sub-districts, those who heard of the concept from "other" sources constitute 23%.

With regard to the meaning of the concept, over two-thirds (67-68%) of both the urban and rural households associate the cash and carry system with payment before treatment at a government health facility.

A smaller proportion associates the system with payment of fees before drugs are supplied. Those who do so in the urban area are over twice as numerous (14%) as those in the rural area (6%). In the latter area, approximately 9% of households think that the concept means "payment of deposit before admission". In both urban and rural samples, 11% and 9% respectively say that the cash and carry system means payment for "every single service" provided at a health facility.

Out of the 200 households interviewed in each of the two districts, seven in AMA and 10 in Asuogyaman claim they do not understand the concept of cash and carry.

At the community level, through participatory methods, the knowledge and meaning of and the reasons for the introduction of the cash and carry system appear to be more incisive than at the household level

Urban communities (AMA)

To most participants in group discussions and individuals in in-depth interviews, the concepts of user fees and cash and carry system are identical in meaning. Radio is the mainsource of awareness of user fees.

Individuals

- A Chief (of Accra New Town) believed that the user fee was necessary in order to import more drugs.
- At "ar es Salaam, the Chief (of the Akan community) explained that the user fee is "*what you pay when you use facilities at hospital*". The chairman of the Ewe community said "*it is the system which says that we have to pay before we are treated.*"
- At Old Teshie, a traditional priest, (Nii Sowah) observed that some time ago, "*we were not paying for the use of hospital facilities, but now we are being made to pay*".

Thus among some opinion leaders, the cash and carry system or the user fee is associated with payment for drugs, for use of hospital facilities, or for treatment received at health facilities.

The views of individuals about the usefulness of the cash and carry/user fee system are summarised as follows:

- "The drugs that are imported with money accruing from the cash and carry system eventually become expensive". (Chief of Accra New Town)
- "The fees being charged at the health facilities are rather high, and not everybody can afford (Traditional Priest) e. g. the unemployed and students".
- "It is only the rich who can pay for health services received; hospital bills are too high for people with no jobs or in low income employment". (Church Administrator. Old Teshie).
- A TBA says the system is a means to get money to pay health personnel. "If people are not made to pay, they will run away after treatment. Paying for services will make people value the treatment".

Groups

- According to male youth (in Accra New Town), the cash and carry system is a system where people pay before they are treated at the hospital.
- To men, the concept means "if you fall sick and go to hospital, you have to pay before treatment".
- The women think that it is a system where patients pay before they are treated.
- Mothers of children under 5 years think that it is a system where you have to deposit money before treatment is given.
- To a women's group in Dar es Salaam, the cash and carry system was introduced to stop people from running away after treatment. It was also means to receive money to maintain the hospital and pay doctors, and that the government alone cannot foot medical bills always.

According to landlords, the user fee is a system where patients pay before receiving treatment at the hospital. But they maintain that " the majority could not attend hospital because of the user fee", and that high treatment fees are discouraging people from attending hospital when they are sick. The youth think that it is discriminatory, saying that, "those who can afford are not paying for the services received and those who cannot afford are being made to pay".

At Old Teshie, mothers with children all agreed that, "unless one pays, one would not be treated at the hospital". The youth said that "health personnel demand money before anything is done for you, but since we don't work, we cannot go to hospital".

The various views expressed by pregnant women include "we know we have to pay when we go to hospital; we don't know why it was introduced"; "I do not know the type of service we are paying for at the hospital, because you pay at every room you enter" (a 28 year-old, cooked rice seller). Even though most

mothers think the system is justified because drugs are very expensive, they complain that the system encourages bribery, as people have to pay in advance before they are treated.

Rural communities (Asuogyaman)
Almost all the groups and the few individuals that participated in the qualitative survey at community level in the district seem to have been aware of the cash and carry system.

Individuals
At Old Akrade, the Chief explained that because the community is largely one of peasant farmers, people find it difficult to foot the high medical bills. He has appealed to the government to set up a clinic/health post/health centre in the community.

Groups
At Atimpoku, all the definitions the groups gave explained the fact that the cash and carry /user fee system means "money for health services".

The Youth who heard of the concept on the radio learned that one has to have a lot of money when you go to the hospital. They said that it was introduced because the government needs equipment to use at the hospital. But they feel that patients should be treated before payment, and called for its abolition, for "if our children or spouse are sick and we are not around, it means they will die".

The young people at Old Akrade stated that the "concept is not helping us in this community because we have no jobs". "It is not good because they treat you and ask you to go and buy your own medicine". [Youth at Abomayaw]

Pregnant women think the cash and carry system is not good because "we are made to pay deposit (of ¢50,000) before we are treated, the bills are too high" (pregnant women at Atimpoku). But

the pregnant women at Old Akrade agreed that the user fees are paid because it helps government to pay for the medicine and other hospital facilities.

According to mothers with children under 5 years [Old Akrade] the system means, "you have to pay before you receive treatment" and "because of this people have not been going to the hospital, but rather use traditional medicine (herbs)…."

Elderly women feel that "the system whereby you pay before you receive treatment is bad; the user fee must be abolished". A similar group at Abomayaw suggest that government see to reduce prices of drugs, sick people be treated before money is collected, and that government build more clinics closer to them and other villages.

A mixed group of the aged (at Atimpoku) said that cash and carry means you pay before treatment; and that it was introduced because some people are not able to pay after they have been treated. " The system should be discontinued because we are poor"

Those at Old Akade did not know the rationale behind its introduction, but noted that, "you have to pay for treatment".

Thus all the groups intimated that the cash and carry system implies that one has to pay for whatever service one receives at the health facility. They all, however, agreed that the system should be abolished because many are poor, even though there is some advantage in charging fees.

At the household level, more health workers seem to be involved in informing rural communities than in urban areas.

Exemptions

The ability of individuals, families, households or communities to access health care services can be linked to a number of factors including age and gender of the individual, type of sickness the person is suffering from, the type of health services being provided and the ability to pay for the services. In many cases, the latter factor, singly or in combination with the others listed, can prevent people from using health services.

Two factors underpin the need to review and extend the exemptions policy to include more people that are potentially vulnerable.

First, as noted earlier, Ghana's population continues to grow y at the annua rate of 3.0%. This rapid growth and the young structure of the population pose special challenges to the health sector. The proportion of the population aged 60 years and of women in the reproductive age group (15-49), as well as children under 5 years has been on the increase. Given the susceptibility of these two groups to high levels of morbidity and mortality, they require a high level of per capita health expenses, implying in turn higher average per capita expenditure on health if decent levels of care are to be maintained. The period is also characterised by rapid urbanisation and the creation of urban slums.

Secondly, the PHC programme aimed at providing basic health care to the poor in urban slums and rural areas is largely ineffective due to insufficient funding, shortage of manpower and equipment and lack of logistic support (Ghana/UNICEF, 1990).

Consequently, most people, especially in rural areas, have to travel long distances for health care in urban hospitals and clinics. However, due to the cash and carry system of drug management, they are unable to pay for the full cost of drugs and treatment in government health facilities, in addition to the travel cost to the

health facility and the opportunity cost of seeking health care, such as lost of time for agriculture activities or home-keeping.

Paradoxically, since the late 1980s, government employees and employees of parastatal organisations, public boards and corporations, in addition to health staff and their dependents, have been exempted from the payment of charges for drugs and treatment, or are reimbursed with the cost of care in government health facilities. This has made the attempt to enhance efficiency in the introduction of health reforms appear to have been at the expense of equity. The real beneficiaries - the poor, the elderly, mothers and children -- have thus been excluded.

Analysis of the quantitative study shows that only 27% of the sample households in AMA are aware of the existence of a public health facility. In the Asuogyaman sample, 19% know of public health facility in the area. However, 17% know that there are community clinics in the locality.

Household heads were asked whether they or any member had ever been treated free at any government health facility. In the 200 households studied in AMA, only six (3%) had someone treated free (i.e exempted). In the rural sample, only three (1.8%) had ever received free treatment. In the former case, 24 households have someone who had been treated free but for whom someone had paid (their own employer or that of their spouse). In the rural sample, 7 out of 10 people that had had free treatment had someone paying for them.

These findings imply that even though the background of those treated free are not known, it is clear that only a few people enjoy free medical care. A greater proportion of those who claimed to have received free treatment had someone paying for them eventually. And some of these people may have been in a position to pay on their own.

Four out of 14 households (29%) among those who received free treatment from a government facility less than five years ago said that antenatal/postnatal services were free. According to nine of them (64%), “everything” was free. In the Asuogyaman sample, 4 out of 12 households claim that medication was free; two others each claimed that treatment, admission and everything were free.

Pregnant women and exemptions

Almost all (89/90) the households that reported pregnancies among women members within the last five years in the AMA had received antenatal services; 93% (80/86) had done so in the Asuogyaman sample.

In both study areas, almost all the most recent pregnant women had paid for the antenatal services.

The sick and exemptions

Those who visited a public health facility for treatment during the two weeks before the interview were asked whether they knew they were not expected to pay. Nearly all (31/33, or 94%) did not know that they were meant to get free treatment. In the Asuogyman district, 38 out of 43 people (88%) did not know that they were not expected to pay for services received from the public facility.

Awareness of exemptions at household level

Every household was asked if they knew about the exemption policy, who should be exempted, and which services were exempt from charges.

In the urban area, 40% of the households (79/200) knew that government facilities give free treatment to some people. Out of this, 51% mentioned the elderly, 15% mentioned children under 5 years and 11% mentioned pregnant women as those exempted. In

the rural sample, on the other hand, 22% (44/200) of the households knew of the exemptions granted to some people. Fifty per cent (50%) of them mentioned the aged, 5% mentioned children under 5 years and 18% mentioned pregnant women as those exempted.

On the kind of diseases that were listed for exemption at government health facilities, approximately 50% of those in the urban area did not know. A higher proportion, over 70% of households in the rural sample, was not aware of the diseases to be treated free.

Thus, only a small proportion of households know of exempted diseases: less than 20% in AMA and about 9% in Asuogyaman mentioned tuberculosis. The next disease category mentioned by urban households is mental illness, followed by HIV/AIDS, while a few rural households listed leprosy (5% in Atimpoku) and snakebite (4% in Apeguso).

On what kind of health services those eligible for the waiver are to be exempted from, nearly 50% (48% in the urban sample and 53% in the rural sample) said, “all types of services”, meaning registration, consultation and treatment, including injections, and/or drugs received. Others less frequently mentioned are registration cards and drugs supply (15%), and laboratory services (7%).

<u>Opinion of households of the exemption policy</u>

Having been sensitised on the exemptions through the above series of questions, households were asked their opinion of the exemptions policy with regard to whether or not some people should be exempted, who should qualify, which diseases should be treated for free and which kind of services should be offered free.

As much as 95% of urban households and 74% of rural households believe that some people should be exempted. Those mentioned in both urban and rural households that are not already on the government list, are: orphans (20% and 14%); disabled people (7% and 5%) and the youth (2% and 1%) (see Table 14). Respondents in rural households further mentioned “everybody” (4%).

According to urban households, the common reasons why certain selected services for the persons mentioned should be free are (See Table 12):

- They have no money/they cannot afford (28%)
- They are not working/unemployed (14%)
- They cannot work/too weak to work (disabled) (8%)

The reasons given by the rural households are mostly:

- They cannot work/too weak to work (27%)
- They have no money/they cannot afford (26%)
- Costs too high/It’s expensive (8%)

From the above, it is clear that while less than 50% of urban households and less than 25% of rural households are aware of that some people are exempt from paying for services at government health facilities, fewer people know of the diseases that are to be exempted, and still fewer people know exactly what kind of services are to be exempted. It is, therefore, not surprising that 50% of the respondents said, “all types of services” should be exempted.

Most of the respondents think that some people should be exempted and extend the list of such people to cover the disabled and orphans. Their main reason is that these people cannot afford the charges, as they are not in a position to earn money that they can use to pay.

Perception of the exemptions at community level

In both the urban and rural communities where the participatory method was applied, various groups, based largely on age and gender, expressed their knowledge and opinion of who is exempted, which disease and services are to be exempted and the reason for such exemptions. Views of individuals interviewed in depth are rather limited. Views of the bulk of group members are discussed briefly as follows:

Elderly people

In Abomayaw, which is one of rural study areas, the group of elderly people interviewed seemed to have vague knowledge of the exemption policy. They stated: "*The policy was there to help those who could not afford the health services*". They also said that *although they knew the policy existed*, "*everybody paid whenever we visit the hospital*". Elderly people in Atimpoku (a rural community) had some knowledge of the exemption policy. They suggested that disabled people, pregnant women and children under 5 years should be exemp from paying. One older person suggested that the exemption age should be reduced because, "the people are dying young".

This suggests that many participants in the discussion groups did not know about the exemption policy as announced by government and had therefore no knowledge of whether it is being practiced or not.

Women with children under 5 years

There seemed to be some ignorance about the exemption policy among women with children under 5 years in the rural communities. This stemmed from the fact that they eventually paid for everything anytime they visit the health facility. At Teshie, an urban community, it was stated, "*Nobody is exempted from paying for treatment except those who attend company hospitals. Even if it exists, it can't be possible*".

This assertion by women with children under 5 years old is suggests that most of them do not enjoy the exemption due them whenever they visit the health facility. The health worker may play on their ignorance and charge them accordingly.

Mothers at Teshie (an urban community) suggested that exemptions should include the following: teenage mothers, people aged 60 or more, the unemployed and single parrents.

Trained birth attendants

At Teshie, an urban community, a TBA said that there is no free health service.

Chiefs

In the urban samples, the chiefs interviewed felt that the policy only existed on paper because every service is charged for, including even emergency cases.

A Chief in Atimpoku (a rural community) said: *"Because we do not have any government health facility in our community those aged 60 years and above are not enjoying free medical care*". This statement indicates that the Chief knew about the exemption policy and those who are supposed to be exempted.

Perception of the youth

A young man at Abomayaw who seemed to understand the exemption stated that, *"it was to help the poor, and those that cannot work, the disabled and pregnant women to have access to health care*". Those who should be exempted should include women, people older than 60 and the unemployed. However, at Old Akrade (also a rural community) the youth do not know anything about the exemptions policy.

Both male and female youth at Dar es Salaam (an urban

community) mentioned the following as those who should be exempted: people with deformities, pensioners, leprosy patients, TB patients, schoolchildren, orphans, the poor, cripples HIV/AIDS patients and children under 5.

Pregnant women

Pregnant women interviewed at Teshie (an urban community) said: "*We pay each time we go to the hospital*". When asked whom they think should be exempted, they mentioned the following: the orphans, the poor, the unemployed and children whose parents cannot afford the charges.

At Atimpoku, the pregnant women said that they should be exempted from paying whenever they visit the health facility.

Individuals/opinion leaders/Chiefs

Though the individuals and opinion leaders at Dar es Salaam are not very aware of the exemptions policy, they suggested that exemptions should embrace students, TB patients, the unemployed, leprosy patients, cholera cases, poor people and anybody with any communicable diseases.

From the above, it is obvious that not many people at community level are aware of the government exemption policy. Even if they knew, in their opinion, it is non-existent because almost everyone pays whenever they go to the hospital.

In their opinion, more people should be exempt because they are poor or are physically incapable of working to earn money with which they can pay for health care. People with communicable diseases should be included in the exemption, according the groups, to encourage them to seek treatment, thereby preventing the spread of diseases such as leprosy, tuberculosis and cholera.

The opinion of community members concerning who or what kind

of services or diseases should be exempted are summarised by residence (urban/rural) and by gender and age.

Table 27a: Gender/Age perspective on who should be covered by exemption

People to be exempted	Men	Women*	Youth	Aged
People aged 60+		X	X	X
The poor	X	X	X	
Unemployed people		X	X	
Teenage mothers		X		
Single parents		X		
Orphans	X	X	X	
Pregnant women		X	X	X
Children of poor parents		X		
Pensionerss	X		X	
Disabled people	X		X	X
Leprosy patients	X		X	
TB patients	X		X	
Schoolchildren	X		X	
HIV/AIDS patients	X		X	
Children under 5 yrs			X	X
People with communicable diseasea			X	
Youth	X			

**Includes women with children under 5 years and pregnant women*

Table 27b Exemption: Community Perspective by Residence (As expressed by a majority of group members in FGD)

People to be exempted	**Urban**	**Rural**
People aged 60+	X	X
The poor	X	

Pregnant women		X
Women	X	
Children under 5 years	X	X
The unemployed	X	
Disabled people	X	X
Leprosy patients	X	X
TB patients	X	
Orphans	X	
Pensionerss	X	
Students	X	
Streetchildren	X	
Teenage mothers	X	

Healthcare financing: Community Perceptions and Views

Analysis of both the quantitative and qualitative studies and data has revealed varying views among the community members at various levels about how disadvantaged or vulnerable groups can be supported financially to pay for health services.

Health financing at household level

More than half of households interviewed – 50% in the AMA sample and 65% in the Asuogyaman sample -- feel that the central government should finance those who cannot afford health services. A little over 10% of urban households think that household members should support such people. However, a greater proportion of respondents in the rural sample – 17% in Atimpoku and 21% in Apeguso – think that household members should pay for such people. Support from community members or a community-based financial scheme seems to be unpopular with households both in the urban and rural samples. Among respondents in both areas, only 6% of those in Ayawaso (an urban sub-district) and 6% of those in Apeguso (a rural sub-district) suggest that community members should finance those who cannot afford the charges; and only 4% of households in Ayawaso and 2%

of those in Kpeshie sub-metro areas recommend a community-based financial scheme; none from the rural sub-district mentioned this.

Even though a majority of households believe that the central government should finance those who cannot afford health services, direct government involvement in that direction does not seem practicable. As reported elsewhere, MOH expenditure on health has remained fairly steady in real terms since 1987, accounting for between 9% and 11% of the recurrent budget. But the bulk of the funds go to curative services, mainly at urban hospitals. Also, the share of the recurrent budget devoted to PHC has increased from 25% to 40%, but most of this goes into salaries, leaving very little for actual health delivery. (MOH, 1998).

The District Assembly is expected to play a vital role as a partner in the development of health delivery at the district level, where PHC is managed by the District Health Management Team. The result of the household survey shows that it's the Assembly's role in providing health care for the "poor", albeit indirectly, has not been recognised. In both study areas, less than 2% felt that the District Assembly should support those who cannot afford health charges. It is not clear whether the District Assembly allocates part of the District Assembly Common Fund to the health sector in general and to vulnerable groups in need of health services in particular. Currently, the central government channels allocations for the exemptions to the District to manage, just as it does directly to the regions and hospitals. This is to enhance local decision making

The contribution of households to financing of health care would be an alternative method of solving the problem of inadequate public health expenditure. Studies have shown that the contribution of households to the financing of health is quite substantial: almost

three time that of public input in per capita term, namely $12.44 as against $4-$5 (GLSS 1991/92).

Our study shows that between 10% and 20% of respondents recommend that household members should pay for those who cannot afford health fees. The reason for this rather low proportion may be the fact that most households already have relatively large, daily household expenditure: approximately 20% of urban households spend ¢10,000 - ¢13,000 daily, and 30% of rural household spend a similar amount (Table 7[b]). Expenditure on health alone is also quite high for many of the households. For (any) action taken by those who had been ill two weeks prior to the survey, households spend substantial amounts. For example in Ayawaso, out of 20 households, four spent between ¢15,000 and ¢45,000 each; another two spent between ¢105,000 and ¢115,000. Presumably, the latter attended a private health facility. (Data were not analysed on facility basis). The relatively high household expenditure might be a reason for the low recommendation of the household as a source of help to those who cannot afford health charges.

Again, the household survey data show that only about 6% would recommend that community members or a community-based financial scheme should be used to enable poor people to obtain health services. However, analysis of the qualitative study points to the possibility of developing a scheme that would serve as an insurance strategy to help not only poor people, but also every household, family or community member. Institutional analysis (a technique for PRA analysis) by participants has revealed that institutions – relatives, neighbours, community leaders, chiefs, religious leaders, as well as informal associations – are used as coping strategies during crisis. A few examples are instructive:

At Abomayaw: pregnant women see their husbands as "institutions"; for elderly women, it is their families and the church

that give them support. According to the team's information during the guided walk, the chief was an "institution" to the people for the good work he was doing. The resondent also listed the church and unit committees as institutions.

These institutions can be mobilised to form the basis of any health insurance scheme that would serve the vulnerable as well as the community as a whole in gaining access to health services.

Health financing at community level

In absence of a health insurance scheme in the community, participants in group discussions and individuals interviewed in depth suggested ways in which those who cannot afford health services can be supported. Most of these have been used as coping mechanism or strategies in times of crisis. They include voluntary welfare or social/financial associations within the specific communities.

The following are the suggested means by communities in the AMA.

Accra New Town

- "Somu Yie" (social club)
- "Youth Club Fund" (financial/welfare club)
- "Susu" Scheme (financial/social club)
- Husband and wife (mutual support)

Old Teshie

- Classmates (social club)
- Women's Fellowship (religious/welfare club)
- Voluntary neighbourhood association
- Church welfare fund (religious/welfare)
- Households

Most participants suggested that in the absence of organized groups such as those listed above, the cost of health services for disadvantaged groups should be shared among

- Individual family members
- Community members

Dar es Salaam.

Identifiable groups that do assist those who cannot afford health services include

- Neighbours and co-tenants
- Family members
- "Atlanta and Money" (voluntary youth association)
- Ethnic-based association (welfare) e.g. "Akan Mboa Kuw"

Rural communities

In Atimpoku, those who want to give financial support to people:

- Neighbours and co-tenants
- Family members

At Old Akrade, there are no organised or formal groups that can assist those who cannot afford health services.

At Abomayaw, there is a "susu" scheme.

In conclusion, whereas most households are looking up to the central government to provide financial support to those who cannot afford health services, individuals and groups within the district feel that social/voluntary organisations within the various communities can be used in providing funds for health care. These can also be used as the basis for establishing a health insurance scheme.

Community-based health insurance

From the in-depth studies and focus group discussions (FGD) in all the selected communities (both in AMA and Asuogyaman), it was clear that there is no formal health insurance scheme in the communities. Most participants welcomed the idea of setting up such a scheme that they feel would help people who cannot afford health charges. The few financial or social clubs that exist as listed above could be used to start the scheme. The views of the various groups and some concerns about the practicality of the scheme are briefly discussed below.

In the urban communities, it was observed that most of the welfare systems or voluntary associations that exist or were established with contributions by members, were essentially to help members in times of financial need or for social events such as marriages, the outdooring of new babies or funerals. They exclude health needs or sickness and were exclusive to members.

However, in view of the acknowledged need for contributions from neighbours or co-tenants in times of emergency or sickness, the desire to change or modify the voluntary association to serve as a health insurance scheme was expressed by all the groups.

The main concern was the premium levels, the premium collection system, coverage and management of the scheme.

On the premium level, a majority of women, including mothers with children under 5 years, suggested payments of ¢2,000 per week per family. Most of the other groups suggested payments of ¢1,000 per week per family. A couple of women advocated a premium of between ¢100 and ¢500 per day.

The men think that husbands and wives should pay to cover children under 18 years of age. Women suggested the agreed

premium should be limited to a maximum of five members of a family.

Mothers think the household head, husbands and wives should contribute. An Assembly member or a committee member should be enlisted or formed to collect the premium. Money must be entrusted to responsible and honest people selected from the community.

Participants at Old Teshie did not discuss or agree on a specific level of premium. But the youth suggested that females and males should share the contributions. The scheme should be open to all employed people.

At Dar es Salaam, although all the groups agreed that the health insurance scheme was welcome and could be tried, they cautioned that:

- Adequate research be conducted prior to its introduction
- Proper organisation be ensured
- Trustworthy and honest people be identified to lead the scheme

All the groups agreed that it was worthwhile setting up a community-based health insurance scheme based on the pattern and principles of the voluntary/welfare and socio-financial scheme such as "Susu". Community members of various types should be encouraged to set up committees to study those associations to identify loopholes and guidelines for forming an effective health insurance scheme. The premium levels should be agreed after a thorough discussion. Honest and responsible adults in gainful employment should be identified and appointed as the management committee for the scheme.

In the rural communities, with the exception of the elderly people, all were interested in setting up a health insurance scheme. They suggested that contributions and the collection of premiums should

be entrusted to reliable members of the scheme.

At Atimpoku, the youth said: *"If one should be set up, we want the money to be given to someone who is working*". "*We don't have plans to institute a health insurance scheme because we don't have people who can be trusted", said one woman.*

At Old Akrade, all the groups (except the aged) were ready to contribute a premium of between ₵1,000 and ₵2,000.

At Abomayaw, the groups were prepared to contribute between ₵1,000 and ₵5,000. But the youth suggested that membership should be voluntary and that contributions should be made at harvest time.

In order that community-based health insurance schemes conform to the government/MOH national health insurance proposal, a social health insurance type should be introduced to the community. However, it should not be compulsory and/or organised directly by the government, with the premiums being paid by both employer and employee.

The government/MOH should only play an oversight role since most community members are not in formal employment. The MOH should provide the package of benefits detailing which aspects of health care the scheme can cover.

SUMMARY/CONCLUSION

The introduction of health reforms was part of a wider Economy Recovery (Structural Adjustment) Programme to arrest the decline of the economy.

Under these reforms, policies such as “user fees” and “cash and carry” were established.

The introduction of user charges for health services meant that some people would be excluded due to poverty and inability to pay.

To mitigate this problem, the exemption policy was introduced. The rationale behind this was to exclude certain categories of people from paying for health services received. These included: refugees, the poor, children under 5 years, pregnant women, disabled people, elderly people (70+ years).

Implementation of this policy, however, has had its own peculiar problems.

A SAPRI-funded research project was undertaken to identify how effective the policy has been and also map out the bottlenecks that have affected those exempted.

A field study using both quantitative and qualitative data collection instruments was conducted and analysed using a special technique, namely the SAPRI methodology of political economy, gender and participatory rapid appraisal (PRA) in two districts -- Accra Metropolitan Area, an urban and coastal location, and Asuogyaman, rural, forest location.

A total of 200 households from each district were interviewed on their knowledge of health facilities and prevalence of diseases in

the area, and knowledge of selected health policies and concepts – primary health care (PHC), Health for All (HFA) by 2000, user fees (cash and carry system), and exemptions.

This quantitative survey covered a total of 2,212 individuals, made up of 1,162 in the AMA and 1,050 in Asuogyaman. A majority of the household population is female. Children under 5 constitute between 9% and 12% in the AMA and between 10% and 12% in Asuogyaman, proportions lower than the national figure.

The PRA, using a semi-structural interview (SSI) schedule, was conducted in three communities in each district. The main objective was to validate the quantitative data and to cover issues not covered by the latter, such as community-based insurance for vulnerable groups. The main targets of the study were women with children under 5 years, pregnant women, the elderly – all of who are among those exempted from paying for services received from government health facilities. Also included in the PRA were men and women and youth, as well as individuals – chiefs, religious leaders and opinion leaders.

Of the health facilities in the area, private health facilities are those used by many of the people (36% in AMA and 34% in Asuogyaman). However, pharmacies are nearer to most people (57%) in AMA. In Asuogyaman, the public health facility is nearest to 25% of households; but only 35% of the sample visited the nearest health facility in each of the two districts. Quite a large proportion of the people (50% in AMA, and 71% in the Asuogyaman) only occasionally, sometimes, or never visited those nearest facilities. The main reason for such occasional visits or no visits at all is the high cost of health services.

In both quantitative and qualitative studies, a series of questions elicited answers on knowledge or awareness of the government policy on exemptions of people, disease conditions or health

services. The personal opinions of respondents on exemptions were also sought.

As a prelude to exemption issues, the respondents' knowledge, understanding, and assessment of selected health policies in a historical context were ascertained: On the PHC-related concept of health for all, less than 50% of both urban and rural households had heard of the slogan. A little over one-third of urban households and two-thirds of rural households in our sample claimed that health for all means everyone will enjoy free medical care or there will be health facility in every community in Ghana. Various groups in the qualitative study expressed varied views, but these invariably concluded that health services would be available to many in the country. For over 90% of households in AMA and Asuogyaman, the goal of the health for all has not been achieved because many places lack health facilities. But groups in the PRA study at Asuogyaman generally acknowledged that PHC has been beneficial to them.

PHC, the strategy for achieving health for all, is still relevant today. It is expected to bring health services close to everybody, irrespective of age, gender or location or revenue. But a high proportion of the population studied in urban and rural locations is ignorant of the concept. About 10% of those who were aware did not understand it. The community-based health worker has more to do by way of education and dissemination of health messages.

On the cash and carry system, over 60% of the households have heard of the system, mainly from health workers. Urban households have more sources of such information than those in the rural (Asuogyaman) area. For most of the households as well as groups in focused discussions, the cash and carry system is associated with payment for drugs, consultation or treatment. They all agreed that the system should be abolished because "many are

poor". Women (pregnant women and those with children under 5 years) were more emphatic on this.

On exemptions, only 40% of urban households and 22% of rural households knew of the exemption policy granted by government facilities. Very few people at the community level were aware of the exemption policy, for almost "everybody pays for all services received at the public health facility".

More than 50% of these mentioned the aged as an exempt group, while a smaller proportion of respondents mentioned other categories such as children under 5 years and pregnant women. The majority (50-70%) did not know the kind of diseases that are treated free of charge. A similar proportion claimed that all types of services are exempted by the government policy.

In their own opinion, an overwhelming majority of households felt that some (more) people as well services must be included in the exemption category. The main reasons for this were that many people cannot afford the charges, they are unemployed or are too weak to work and earn money to pay for health services.

The government spends about 5% of its health budget servicing the implementation of the exemption policy and it needs alternative sources to sustain this policy.

Most of the households in the study area feel the central government should be responsible. Funding or support from household members or community-based financial schemes to assist those who cannot afford health fees was suggested by a handful of respondents. Few considered the District Assembly asa possible source of funding.

The coping strategies adopted in times of sudden illness by community members and their institutional analysis had opened their eyes to some of the welfare clubs and financial associations that can form nucleus of a kind of community-based, health insurance scheme.

Gender perspective

Most of the women interviewed acknowledged the need to support health care with treatment. As a result of this, they mentioned spiritual churches in addition to the health facilities they patronise.

Most of them had to rely on family members, such as their parents, to foot their hospitals bills.

They do not have any say in the decision-making process and are victims of domestic violence. A woman in one of the communities said, "*at meetings, if we are given the opportunity to speak, some of our husbands beat us afterwards and do not provide for us*".

Both males and females think the policy exists only in theory because, although they know that they are not supposed to pay for health services, money is collected from them before they are given the necessary health services.

Conclusion

Findings have proved that the exemption policy has not been as effective as it was meant to be. A 26 year-old footballer in Old Teshie said, "I went to Tema Hospital with a chest problem. I was asked to take an x-ray costing ¢12,000. I had only ¢8,000 on me. Since I did not have the full amount, I did not take the X-ray; I had to go home".

People still pay for health services and their expenses range between ¢14,000 and ¢120,000.

They see the system as “killing” them and are prepared to do something about the situation. In addition to imploring the government to fund those who cannot afford to pay, they are prepared to contribute to a health insurance scheme

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