

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY**

**KUMASI, GHANA**

**COLLEGE OF HEALTH SCIENCES**

**SCHOOL OF PUBLIC HEALTH**

**DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE**

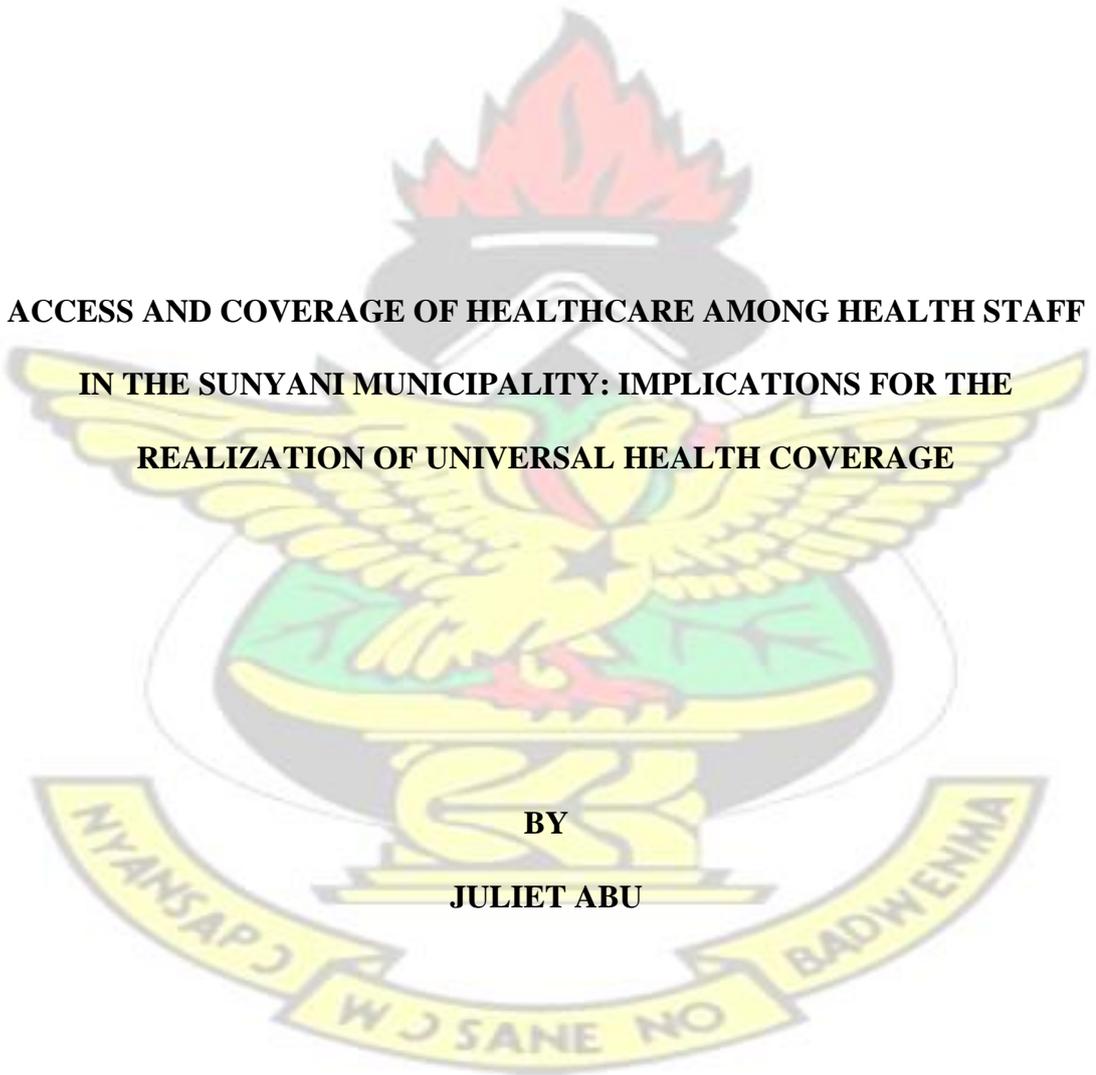
**HEALTH**

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**ACCESS AND COVERAGE OF HEALTHCARE AMONG HEALTH STAFF  
IN THE SUNYANI MUNICIPALITY: IMPLICATIONS FOR THE  
REALIZATION OF UNIVERSAL HEALTH COVERAGE**

**BY**

**JULIET ABU**



**NOVEMBER, 2019**

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**(BSC NURSING)**

**A THESIS SUBMITTED TO THE DEPARTMENT OF POPULATION,  
FAMILY AND REPRODUCTIVE HEALTH OF KWAME NKRUMAH  
UNIVERSITY OF SCIENCE AND TECHNOLOGY, IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF  
DEGREE OF MASTER OF SCIENCE IN PUBLIC HEALTH- POPULATION,  
FAMILY AND REPRODUCTIVE HEALTH**

**NOVEMBER, 2019**

## DECLARATION

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the award of any other degree or diploma at Kwame Nkrumah University of Science and Technology, Kumasi or any other educational institution, except where due acknowledgement is made in the thesis.

Juliet Abu .....  
**Name of student** Signature Date

Certified by:  
Dr. Peter Agyei-Baffour .....  
**(Supervisor)** Signature Date

Certified by:  
Prof. Easmon Otupiri .....  
**(Head of Department)** Signature Date

## DEDICATION

I dedicate this thesis to the Almighty God who has been my source of strength, knowledge and wisdom and to my lovely Husband Emmanuel George Bachan for his unflinching support and encouragement.

## ACKNOWLEDGEMENT

Many individuals and personalities have contributed to the success of this work.

My profound thanks go to the Almighty God in whose strength I rely for help during the course of the work.

My sincere gratitude goes to my supervisor in the person of Dr. Peter Agyei-Baffour for his immense contributions, comments and criticisms which have made this thesis uniquely complete. To him I say God replenish more abundantly whatever he has lost during this period.

I wish to express my heartfelt gratitude to my family for their prayers and motivation and especially to my lovely and supportive Husband for all his sacrifices, encouragement, and above all his love. Sweetheart God richly bless you.

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My thanks also go to all friends and loved ones for their enormous contributions and support during the period. You will always be cherished and loved.

## ABSTRACT

Universal Health Coverage seeks to ensure that everybody has access to quality healthcare without financial challenges. It is one of the global strategies towards the realization of the Sustainable Development Goals. Countries therefore need to track

progress of universal health coverage not just across the national population but within different groups (e.g. by occupation, income level, sex, age, place of residence, migrant status and ethnic origin). The role of health workers in the realization of the universal health coverage cannot be overemphasized. Health workers are vulnerable to varying risks inherent in their profession, as they are exposed to infections, injuries, stress, violence, allergies, contact diseases and many others). There is a dearth of knowledge on access and coverage of healthcare among health staff who are the forefront of the effort at the realization of universal health coverage. It is this regard that access and coverage of health care among health Workers was investigated.

The main objective of the study was to assess the access and coverage of healthcare among health Workers in the Sunyani Municipal. An analytic study type using a cross-sectional design was carried out in the Sunyani municipal. Data was collected using self-administered questionnaires, structured interview guide and subjected to univariate, bivariate and multivariate regression analysis.

The study found that 52% of health staff had a degree, 66% of health staff had worked for a period less than 5 years, 57.1% monthly income was 1,500 Ghana cedis and above and 90% had a valid National Health Insurance Scheme card. Out of the four access and coverage areas the Occupational Health and Safety policy addresses, 71.5% of health staff were assisted during referral, 63.5% supported to access specialist care while 54.1% of health staff did not benefit from the health staff screening and 55.6% did not benefit from free Hepatitis B vaccination due to financial challenges as alluded to by Health Managers.

Physical access and availability to healthcare by Health staff was highly encouraging as 95.9% of health staff had healthcare always available to them when needed and

83.2% of health staff usually visited the hospital, health centre or community Health Planning and Service Compound when ill. In terms of access to healthcare there was a significant association between income ( $p=0.017$ ) and possession of valid National Health Insurance Scheme card ( $p=0.006$ ).

Coverage wise, 62% of health staff were moderately satisfied with their volume of healthcare needed and there was a significant association between income status ( $p=0.006$ ) of health staff and quality of healthcare provided to them. A multivariate regression analysis indicated a highly significant association between volume of care health staff received ( $p=0.001$ ), quality of Healthcare provided ( $p=0.001$ ) and health staff healthcare needs satisfaction.

The study concludes though health staffs of the Sunyani Municipal moderately accessed their needed health care and received moderate volume of their expected healthcare, one needed to be financially sound to access and obtained optimal healthcare needed. This study recommends effective implementation of the OHS policy and institution of special health package for health staff regardless of their income status to ensure health staffs are universally covered.

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## ACRONYMS

ARV	-	Anti Retro Viral
CHE	-	Catastrophic Health Expenditure
CHPS	-	Community Based Health Planning and Services
DHIMS	-	District Health Information Management System
GHS	-	Ghana health Service
HIV	-	Human Immunodeficiency Virus
HW	-	Health workers
ILO	-	International Labour Organization
MDGs	-	Millennium Development Goals
MoH	-	Ministry of Health
NHIS	-	National Health Insurance Scheme
OHS	-	Occupational Health and Safety
OOP	-	Out Of Pocket
RCH	-	Reproductive and Child Health
SDGs	-	Sustainable Development Goals
UHC	-	Universal Health Coverage
UN	-	United Nations
WHO	-	World Health Organization

# CHAPTER ONE

## INTRODUCTION

### 1.0 Introduction

Health is life, it is said, and by extension every living person should have access to good health; Universal Health Coverage (UHC) is therefore by no accident, of paramount importance globally. UHC is high on the global agenda as a means to ensure healthy population, equity in access and social development.

The United Nations (UN) in their Sustainable Development Goals (target 3.8) seeks to afford all people with access to high-class, inclusive, —people-centered health services. This must include promotive, preventive, therapeutic, rehabilitative and palliative health services, as well as secure, efficient, excellent and reasonably priced essential medicines and vaccines (Universal Health Coverage Forum, 2017). Fundamentally, primary health care continues to be the basis of Universal health coverage and to achieve this, Health workers (HW) remains pivotal. Health workers' role in achieving universal health coverage involves the generation of social participation and empowering communities thereby closing the gap between communities and the formal health system. The basic question that needs investigation is, what is the extent of access and coverage of healthcare among health staff who are the forefront of effort at realizing UHC? Does this have implications on the realization of the UHC goal?

Access to health care requires three distinct steps; gaining entry into the health care system (usually through insurance coverage), accessing a location where needed health care services are provided (geographic availability), finding a health care provider whom the patient trusts and can communicate with (personal relationship) (*Access to Health Services / Healthy People 2020*)

In our quest to achieving attractive universal health coverage we need to build a wellmotivated workforce by ensuring they have access to healthcare and are covered by the health system. This is what this study seeks to interrogate.

## **1.1 Current State of Knowledge**

### **1.1.1 Overview of the Problem**

Access to health care impacts on one's overall physical, social, and mental health status and quality of life. Access barriers to health services include; high cost of care, inadequate or no insurance coverage, lack of availability of services, lack of culturally competent care. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, preventable hospitalizations.

According to the 2017 UHC global monitoring report, much remains to be done to achieve universal health coverage.(World Health Organization and International Bank for Reconstruction and Development / The World Bank; 2017).Despite several achievements of the Ghanaian National Health Insurance Scheme (NHIS), coverage still remains an issue. The scheme doesn't involve costly, highly specialized care, such as dialysis, organ transplants as well as Anti Retro Viral (ARVs) for the treatment of HIV/AIDS. Furthermore, the people who cannot afford the subscription and yearly renewal fees, as well as inadequate care and lack of access to medicines for subscribers cannot access the scheme.(*Ghana's Efforts to Reform its Health System and Provide Quality, Affordable Care to All* | HFG, 2016)

### **1.1.2 Healthcare policy for health staff**

Health workers encounter several hazards which may be physical, ergonomic, chemical and psychological. Typically, is the injury some Nurses are exposed to in lifting and

rolling immobilized or disabled patients. In addition to these, health workers are on duty calls, stressed with high work load, dissatisfied patients abuse them verbally, difficult managing work relationships, frustrations due to inadequate resources to work with, very poor remuneration among others, exposes them to psychological hazards such as stress, depression and burnout syndrome. This clearly makes the health worker the most important resource in the process of rendering health care that the health sector therefore considers it judicious to provide a safe and healthy working environment as far as reasonably practicable, for its staff. This is in pursuance with the Ghana 1992 constitution and the Labour Act 2003, Act 651. The Ghana health service is therefore mandated to provide some forms of healthcare to her staff in view of the above per the occupational health and safety guidelines.

### **1.1.3 Access to Healthcare**

Access is defined as the opportunity to reach and obtain appropriate health care services in situations of perceived need for care. Access is seen as resulting from the interface between the characteristics of persons, households, social and physical environments and the characteristics of health systems, organisations and providers.

Access to healthcare involves the ability of health workers to have their healthcare needs met or fulfilled. However, the fact that they work in the health facility does not guarantee their access to health care. This depends on how available the services are and how well they can reach out to such services. Thus, physical accessibility to healthcare involves the availability of good health services within reasonable reach of health workers who need it.

Some health workers might not be able to meet their healthcare needs probably due to their level of income, indirect or opportunity cost such as the cost of transportation to and from health facilities and cost of taking time away from work.

Even though Health workers are supposed to access the best form of healthcare, some health workers might find it difficult to do so probably as a result of sociocultural norms, religious beliefs and practices. Thus, acceptability involves people's willingness to seek services (Evans, Hsu and Boerma, 2013). Acceptability is low when patients perceive services to be ineffective or when social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider discourage them from seeking services (Kieny and Evans, 2013).

#### **1.1.4 Coverage of Healthcare**

Healthcare is measured by the coverage with needed services and coverage with financial risk protection. This contributes to achieving universal health coverage. This implies Health workers' healthcare needs will have to be met adequately when they seek for their needed care without barriers in providing such services. The needed healthcare also has to be provided considering flexible and supportive cost payment methods. Affordable access is so important. Like poor health, large payments for services can severely limit well-being and opportunities, not only for the individual who uses the service, but also for his or her family (WHO, 2017).

Affordable access across the entire continuum of care will facilitate the use of preventive services among health staff and these services are often more cost-effective than the corresponding curative services.

Affordability often equates to whether or not a person is insured and can afford to pay insurance premiums to the insurance company that really pays what the provider is willing to accept. (*Five A's of Health Care Access | U.S. Health Care Policy, 2008*)

#### **1.1.5 Factors that influence access and coverage to healthcare**

Factors such as age, religion, income, sex, educational level etc may influence how health workers have access (i.e. physically, financially and acceptably) to healthcare

needs. These factors also influence how well health workers are covered by the services provided and are financially protected.

Age and sex influences health, its perception and its pursuit either alone or in combination with other factors (Musshauser, 2006; Misevičienė *et al* 2013). A Jamaican study found that more female health workers were either not concerned about their health or reported poor health and at the same time they had the highest prevalence of probable mental ill health (Lindo *et al.*, 2009; Mojinyinola, 2008; Portela *et al*, 2013).

A correlation study in the USA found that spirituality was related to well manage stress levels of the critical care nurses (Campbell, 2013). Similarly, a Brazilian and an Iranian study found a strong correlation between religiosity and quality of life among nurses (Lucchetti *et al.*, 2013).

Suckling *et al.* (2006) found that 30% of nurse respondents had been exposed to a needle stick injury. Health workers face uncertainty about the meaning of disease and adopt a wait and see approach (Wallace *et al.*, 2009; Garelick, 2012). Given that they know the implications of illness on their functionality, they tend to trivialize the disease and rationalize both the symptoms and the treatment by delaying help seeking (Kouta and Kaite, 2011), engaging in informal consultations or resorting to selftreatment (Kay and Clavarino, 2008).

## **1.2 Problem Statement**

Universal health coverage (UHC) remains a priority to improving population health, equity and social development. UHC has been included in the new global Sustainable Development Goals (SDGs) adopted unanimously by member states of the United Nations in 2015. However, the progress in translating these commitments into expanded domestic resource allocation for health, and ultimately, equitable, quality health services and increased financial protection has been far too slow. These challenges call

for accelerated progress toward embracing universal health coverage (UHC), whose principle is that everyone receives the needed health services without financial hardship.

Health workers generally have the added benefit to contributing to quality patient care and health system strengthening thereby bolstering universal health coverage. However, it is not clear health workers themselves have access to healthcare using the Sunyani Municipality as a case.

### **1.3 Justification for Study**

The study seeks to assess the extent to which health workers have access to healthcare and the type of care provided to them are covered by the health care system. Previous studies have concentrated on the distribution, quality and performance of the available workforce. A healthy workforce has an invariable effect on achieving universal health coverage since they are the backbone on which health care is built.

This makes it imperative to investigate whether health workers have access to healthcare they need and are covered by the healthcare system in our efforts towards achieving universal Health coverage.

### **1.4 Research Questions**

The study seeks to find answers to the following questions;

1. What are the existing policies on access and coverage of health care among health workers in the Sunyani Municipal?
2. To what extent does health workers have access to health care in the Sunyani Municipal?
3. How well are health workers covered for their needed healthcare in the Sunyani Municipal?

4. What factors affects access and coverage of healthcare among health Workers in the Sunyani Municipal?

## 1.5 Objectives

### 1.5.1 General Objective:

To assess the extent of access and coverage of healthcare among health Workers in the Sunyani Municipal

### 1.5.2 Specific Objectives

1. To examine existing policy on access and coverage of healthcare
2. To analyze access to healthcare.
3. To ascertain the coverage of healthcare
4. To determine factors that affect access and coverage of healthcare

## 1.6 Study Hypothesis Null

hypothesis.

- *H0: Health Workers do not have access to healthcare when in need*

Alternate hypothesis

- *H1: Health Workers have access to health care when in need*

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

This chapter examines the relevant and pertinent literature with respect to the adherence to healthcare policy for health staff, access and coverage of healthcare among health staff. The literature review will focus on the following thematic areas; of access and coverage of healthcare among health staff, theoretical underpinnings, knowledge gap and innovation.

#### **2.1 Overview**

##### **2.1.1. Global access and coverage to healthcare among health staff**

A Lancet Commission in 2017 highlighted the global need to take action when 61 million people are living with serious health-related suffering due to uncontrolled pain and without access to an affordable essential package for palliative care. (Mahiou, 2011)

Worldwide, about 150 million people a year face catastrophic health-care costs because of direct payments such as user fees, while 100 million are driven below the poverty line (Sanders *et al.*, 2019)

##### **2.1.2 Access and coverage of healthcare among health staff in Africa**

Achieving UHC in Sub-Saharan Africa should be of utmost priority as countries in this region trail significantly behind in achieving health outcomes especially the Millennium Development Goals (MDGs) formulated by the WHO. Moreover, millions of Africans fall into poverty annually due to Out Of Pocket (OOP) payment as a result of lack of health insurance in health financing system (Carapinha *et al.*, 2011).

##### **2.1.3 Access and coverage of healthcare among health staff in Ghana and Sunyani Municipal**

Ghana, being one of the few Sub-Saharan African countries advocating for UHC, implemented the National Health Insurance Scheme (NHIS) in 2003, in an attempt to remove financial barriers, protect Ghanaians from catastrophic expenditure, and improve access for everyone (Akazili *et al.*, 2012).

Services covered under the insurance include outpatient and inpatient care, oral health, eye care, maternity care, and emergencies with no copayment upon receipt of services. It excludes cosmetic services, HIV antiretroviral drugs, orthopedics, and organ transplant etc (Aryeetey *et al.*, 2016). Despite enrollment into NHIS being mandatory, overall enrollment remains low at 40% as of 2016 since majority of the population belongs to the informal sector, and there is a lack of formal tracking regulations (Alhassan, Nketiah-amponsah and Arhinful, 2016).

Ghana with its strenuous efforts in making health care more equitable and affordable has made tremendous improvements in health service coverage along with reducing OOP payment. Rigorous health policy implementation, attempts in achieving the MDGs, and the establishment of the NHIS resulted in significant improvement in maternal and child health indicators. However, apparent inequalities were evident at the national and sub-national level since the poor were suffering more catastrophic health expenditure (CHE) and had less access to health services (Agyepong *et al.*, 2016).

#### **2.1.4 Theoretical Underpinnings**

Access is the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled. Five dimensions of accessibility are conceptualized: approachability; acceptability; availability and accommodation; affordability; appropriateness. In the access to health framework, five corresponding abilities of populations interact with the dimensions of accessibility to generate access. Five corollary dimensions of abilities

include: ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage(Levesque, Harris and Russell, 2013).

The Universal Health Coverage (UHC) cube, used in the World Health Report 2010, reflects three dimensions of coverage; population coverage, service coverage, and financial coverage or financial protection. Service quality is an important dimension not reflected in the cube, but is also critical for coverage to be effective. In many cases, choices about which services to include in the benefit package combine all three dimensions; for example, the provision of priority services with no co-payment for the entire population, or for priority population groups(WHO, 2017).

Considering these theories, health workers' ability to access their needed healthcare greatly largely influenced by the availability and implementation of health staff healthcare policy, availability of source of healthcare which is capable of providing the quality and appropriate healthcare at an affordable cost. Income, educational status, age, sex and other predisposing factors also influence health workers access and coverage of healthcare.

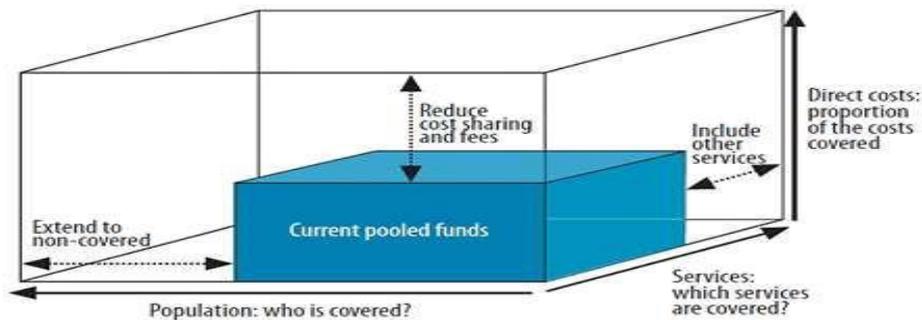
### **2.1.5 Conceptual framework/Hypothesis**

#### **2.1.6 Explanations to Conceptual framework**

This study will use the access coverage model with its axes defined by: (1) the services covered by pooled funds, (2) the population covered, and (3) the proportion of costs covered, to evaluate access and coverage of health services among health Workers in the Sunyani Municipal.

This conceptual framework will best help to explore the extent to which health Workers access and have cover to health services. The framework is made of one independent variable; universal health coverage (Health needs of health Workers) and two

interrelated groups of dependent variables: access factors and coverage factors which determine universal health care.



Three dimensions to consider when moving towards universal coverage

### Definition Of Terms

- **Financial affordability** is a measure of people's ability to pay for services without financial hardship. It takes into account not only the price of the health services but also indirect and opportunity costs (e.g. the costs of transportation to and from facilities and of taking time away from work). Affordability is influenced by the wider health financing system and by household income.
- **Physical accessibility** is the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.
- **Predisposing factors:** These are inherent motivational forces; tied to values and attitudes that provide reasons for an individual to seek help when ill.
- **Universal Access** is the absence of geographical, economic, sociocultural, organizational, or gender barriers.
- **Universal health coverage** is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services

## 2.2 Healthcare policy for health staff

Workload predisposes health workers to occupational hazards and also hinders them from attending to their own health needs (Myers, 2008, ch.1; Frank *et al.*, 2009; Lemaire and Wallace, 2010; Skinner *et al.*, 2011). Health professionals are forced by work demands to resume working even when sick (Fox *et al.*, 2009).

Studies in Canada found that physicians spent an average of 38 hours per week on patient care and an extra 11 hours on other professional activities (Frank *et al.*, 2009), findings that are consistent with longer than 40 hours per week in China (Wu *et al.*, 2013). Long working hours, common in health profession, predispose them to ill health (Trinkoff *et al.*, 2011; Bogossian *et al.*, 2014). Due to endemic shortages of health care providers' world over; nurses are and will continue to be exposed to risks that predispose them to poor health as a result of increased workloads and long working hours that lead to burnout (Frank *et al.*, 2009; Chankova *et al.*, 2009; Collier, 2012; Karanikola and Kaite, 2013).

Unfortunately, though most health workers of the Ghana Health Services when they fall ill sick visits the various level of health care, information on their attendance and illnesses are hardly collect and collated for decision making. This makes it difficult for the health service to be able analyze and disease patterns and incidence among health workers. However, they are known to be at a higher risk of infections than other sub groups of the population.

Some studies carried out by the Occupational and Environmental Health Programme of the GHS show that not only do workers work under conditions that are hazardous to their health, but the staffs are also not sensitized to Occupational Health and Safety (OHS) issues. (Occupational Health and Safety Policy and Guidelines', 2010)

The Health of health workers is monitored at various stage of the employee working period which is term medical surveillance. This is usually a planned and systematic programme which is designed to regularly enable the early detection of disease and ill health among all different types of workers in the health sector. This mandatory for all health workers and the medical monitoring protocol involves monitoring at pre placement, periodic, post sickness absence and exit. This is clearly stated in the OHS guidelines which indicate the need for comprehensive occupational immunization for health workers who handle patients such as Hepatitis B, Tetanus, Yellow Fever & Cerebro-Spinal Meningitis and other diseases that were occupationally relevant.

Secondly, the policy is to ensure that health workers who need essential medical specialist care are facilitate to have it as far as possible. It also ensures health staffs are assisted to obtain referral services by their Supervisors or Management. These referral facilities are also to be made available to enable health workers attain confidential advice.

### **2.3 Access to health care among Health staff**

Globally, considerable advances have been made in the average level of health and access to health care over the last decades. Interestingly, the advancement towards the universal health coverage by several countries is to ensure all individuals can access health care timely, appropriately and affordable. Unfortunately, not all sub groups have benefited equally from these developments. In effect, there have been more an overall effective and efficient health care however it is inequitable because the vulnerable who are the poor and socially left out populations do not equally benefit when it comes to health outcomes and access to health care.

The perceive needs and demand of many people is based on their choices about where and when to pursue health care and this is influence by many socioeconomic and

cultural factors. The interaction with reality of the health system therefore influence peoples perceived needs and demands for and utilization of health services.

Availability, affordability and affordability greatly determine if health services are to be utilized. The variety of health services available relates to people's decision to seek health care considering their various levels of economic affordability and varying quality of health care available. On the other hand, politics, economy, and demographic reality of the areas in which the services are planned, designed, funded and delivered influence the availability of healthcare.

There are two main dimensions of accessibility: physical access and affordability. User fees and transport costs are two major factors that negatively affects access to health care, the provision of health services in inaccessible areas to the poor and vulnerable households. To measure the financial barriers to accessing health care, two important indicators to consider includes out of pocket payments health expenditure as a percentage of total health expenditure and the proportion of population suffering from catastrophic health expenditures.

According to the WHO, social marginalization exists among specific groups leading to these groups finding it difficult to access healthcare. Poor people are ones who suffers the most because they cannot pay extra though they have valid health insurance. Some of these specific population groups based on their sexual orientation, disease or ethnicity are challenged in accessing health care (WHO, 2012).

A study in Ghana that examined the factors that impact on access and utilization of health services shows in a multiple regression analysis that the association between wealth and health is very strong. ((Baxter *et al.*, 2008)

A Brazilian and an Iranian study found a strong correlation between religiosity and quality of life among nurses (Lucchetti *et al.*, 2013).

Self-care in the medical profession is common. In Nigeria, it was found that 98.6% of the respondents had ever self-prescribed, with 68.3% of these having had selfprescribed within the last three months (Agaba, Ocheke and Akanbi, 2011).

#### **2.4 Coverage of health care among Health staff**

Many people who are self-insured will be economically better off getting primary health care as well as specialist care by paying informally instead of health insurance that do not eliminate informal payments. On the other side, possession of health insurance card does worsen attitudes from health workers

There is a persistent out of pocket payments and informal payments and is almost worldwide though health insurance was introduced. This is evident in a cross-country comparative study conducted in 2010 which indicated that that almost all (96.3%) patients had to pay out of their pockets in various forms (Balabanova *et al.*, 2012).

The magnitude of out of pocket payment is in direct relationship to a household's financial capacity – those in the highest quintile spent (on average) 8.3 times more for health than households in the lowest quintile (WHO, 2012).

### **CHAPTER THREE**

#### **METHODOLOGY**

##### **3.0 Introduction**

This chapter presents and describes in details the methods adopted by the researcher for the study. The study employed both qualitative and quantitative approaches with a cross-sectional design. The study population, sample size and sampling techniques have been discussed. The data collection tools, data collection techniques, study variables, analysis, assumptions, ethical consideration, reliability and validity of the study conclusions, application possibilities of Study findings as well as the profile of the Sunyani Municipal have also been described.

### **3. Study Methods**

#### **3.1 Study Design**

The study was an analytic study type and used a cross-sectional design. The design was chosen as little is known about access and coverage of basic healthcare among health workers. Thus, the study sought to make inference to how access and healthcare coverage factors among health Workers may implicate the efforts towards achieving universal health care.

#### **3.2 Profile of Study Area**

The study site is located in Sunyani Municipal which is the capital of the Bono region with a total population of 147,982 inhabitants, six sub municipalities, 78 health facilities and about 1,277 health workers located in the urban and rural settlements of the municipality. The Municipality lies between Latitudes 70 20"N and 70 05"N and Longitudes 20 30"W and 20 10"W and shares boundaries with Sunyani West District to the North, Dormaa District to the West, Asutifi District to the South and Tano North District to the East. There are effective economic and social interactions with the neighboring districts which promote resource flow among these districts. The municipality has a total land area of 829.3 square kilometers (320.1square miles). One third of the total land area is not inhabited or cultivated which provides arable lands for future investment in crop farming. Thus, economically the Municipality is mainly (48%) agriculturally dependent and term as the food basket of Ghana, 15 % commerce and 13% industrial. High quality water and reliable electricity supply drives growth in the Municipality. The provision of health system is widely spread with most health facilities sited in the urban areas and a few in the rural communities of the Municipality. Health staffing therefore is skewed in a similar direction as the health facilities.

#### **3.3 Study population (Exclusion and inclusion criteria)**

All categories of Health Workers working in health facilities within Sunyani Municipal with a minimum working experience of a year or more were included in the study while students, Casual workers and national service personnel were excluded from the study.

### 3.5 Sample Size Calculation

A total of 323 health workers were sampled for the study. This represented a 95% confidence level for the stated population at a 5% margin of error. Using the Cochran formula given as:  $n_0 = (Z)^2 * (p)(q) / (e)^2$

Where:  $n_0$  is the sample size; Z is the Z score value i.e. 1.96 for (0.25 in each tail) at a 95 percent confidence level. p is the estimated proportion of an attribute that is present in the population. q is 1-p. (p)(q) are the estimate of variance. e is the acceptable margin of error for proportion being estimated, so the confidence interval, in decimals.

$$n_0 = (1.96)^2 * (0.70)(0.30) / (0.05)^2$$

$$n_0 = 3.8416 * 0.21 / 0.0025$$

$$n_0 = 0.806736 / 0.0025 \quad n_0 = 323$$

Considering non response among some health staffs, 17 health staffs were added to cater for that, hence a total of 340 health staffs were interviewed.

### 3.6 Sampling Technique

For this analytic study, stratified random sampling was used to select participants from each stratum. Strata was the level of care at which health Workers works; a Hospital, Health Centre and CHPS level of healthcare delivery since universal health coverage is of concern. Therefore, in each stratum, at least one staff from each of the staff category was interviewed giving room for representativeness.

### 3.7 Data Collection Techniques and Tools

#### 3.7.1 Pre testing

The structured questionnaire was pre tested on ten health staff in Kwatire polyclinic of Sunyani West district and the structured interview guide administered on 4 health managers of the Sunyani West Health Directorate. Few changes were made to the questionnaire and interview guide after the pretest.

### **3.7.2 Data Collection**

A structured questionnaire was designed and data was collected with assistance of data collectors who mainly were nursing students. A Likert scaling was used to capture the magnitude of influence of access and coverage factors to meet the needs of health Workers. Closed and opened ended questions were used to elicit experiences on how health Workers access healthcare and are covered. The structured interview guide was administered to Health Managers on healthcare policy for health staff where they were interviewed and the information transcribed in their own words.

For objective one; qualitative and quantitative data on health policies that access and coverage of healthcare among health staff at all levels was collected

Objective two looked at which treatment centres do health Workers patronized most, what were the delays in accessing healthcare, challenges face when seeking healthcare, how health Workers finance their healthcare and overall access to health score was collected to answer the objective.

Objective three, data on which categories of health care were not covered by the healthcare system, what extent are health Workers healthcare needs met, reasons healthcare needs are not covered, is healthcare free health at the point of care, is out-of-pocket health care spending 10% or more of family income and overall coverage of healthcare was collected to answer the objective.

Lastly Objective four data collected included factors that affect access and coverage of health care variables such as age, gender, marital status, religion, and highest level of

education, how long they have been working as a health Workers, category of health Workers, range of income, and whether they had a valid health insurance.

### **3.8 Study Variables**

#### **3.8.1 Dependent Variable**

The dependent variables for this study was access to and coverage of health care among health Workers

#### **3.8.2 Independent Variables**

The independent variable of this study was Universal Health Coverage



**Table 3.1 Study variables**

<b>Objective</b>	<b>Dependent Variable</b>	<b>Independent variable</b>	<b>Conceptual Definition of dependent variable</b>	<b>Scale of measurement</b>	<b>Indicators</b>	<b>Data Collection Method</b>	<b>Type of statistical analysis</b>
To examine existing policy on access and coverage of healthcare	Health workers health care policy	availability, awareness , Utilization and benefits	Decisions and plans that promote access and coverage of healthcare for Health workers	Nominal: Yes, No	Proportions, frequencies	Questionnaire and interview guide	Univariate Analysis
To analyze access to healthcare.	Access to Healthcare	availability, cost and acceptability of services	Healthcare needs met physically, financially and acceptably	Ordinal: 0-None 1Low, 2-Moderate, 3-High, 4-Very High	Proportions, frequencies,	Questionnaire,	Bivariate Analysis
To ascertain the coverage of healthcare	Coverage of healthcare	services covered, financial risk protection	Expected volume of healthcare needs met	Ordinal: 0-None 1Low, 2-Moderate, 3-High, 4-Very High	Proportions, percentage,	Questionnaire,	Bivariate Analysis
To determine factors that affect access and coverage of healthcare	Age, sex, income, educational level, Religion	Access to Healthcare, Coverage of healthcare	socioeconomic elements with impact on access and coverage	Nominal	Chisquares, multivariate regression	Questionnaire,	Bivariate and multivariate Analysis

### **3.9 Data Handling**

The structured Questionnaire was pre-coded prior to data collection exercise. The collected data was validated, cleaned and manually entered and analysed using STATA14.0

### **3.10 Data Analysis**

For objective one (1) and two (2) and three (3) univariate analysis was used to assess the existence of policies for access and coverage of health care among health workers as well as examined how health workers access healthcare and how well their health care needs were covered in frequencies, proportions and represented in the form of tables and graphs. Responses from the structured interview guide data for objective one was collated and used to describe the healthcare policy with regards to how it facilitates access and coverage of healthcare among Health staff. In objective four (4), the hypothesis of the study was tested using the chi square test to find the association between predisposing factors and health staff access to health care rating as well as their volume of healthcare. The p-value from the test was compared with the significance level of  $p \leq 0.05$  (95% confidence interval). The decision whether to reject or fail to reject the null hypothesis was then made.

In concluding, a multivariate regression analysis was carried out to assess the association between health staff health needs satisfaction and universal health coverage factors such as access to healthcare, volume of healthcare, quality of healthcare and out of pocket spending. Deductions were then made to find out which universal health care coverage factors were associated with health staff health needs being met by comparing the p-value from the test with the significance level of  $p \leq 0.05$ .

### **3.11 Ethical Considerations**

Permission to interview Workers was sought from management of each health facilities selected in the Sunyani Municipal. Health Workers participation in the study was voluntarily. The ethical approval was sought to conduct the research from the ethical review Committee on Human Research and Ethics of KNUST. Explanation of the purpose and significance of the study was given to the participants followed by taking a written consent from the participants. The participant's confidentiality was maintained by coding of their responses. If the participants wish to withdraw their participation in the study, they were allowed to do so.

### **3.12 Assumptions of Study**

The conditions pertaining to Sunyani Municipal are not significantly different from those of related studies to which literature is referenced. The analytic nature of study the design enabled health workers to vividly communicate their practices and expectations. The sample size is representative of the study population and statistical analysis helped to appropriately test the study hypothesis.

### **3.13 Limitations of Study**

The analytic nature of this study was not inferring causation of universal health coverage. This study partially relied on self-reports for health care access and coverage. The study may be subject to bias, given the nature of the respondent as health workers may have the compulsion to say socially acceptable thing. However, the use of self-report as a measure of health care utilization has been validated in other studies elsewhere.

### **3.14 Reliability and Validity of the Study Conclusions**

The validity of the study was established through the use of the dimension of universal coverage. Reliability will be tested through test-retest method where the tool will be

given to the same respondents at an interval of four day and reliability coefficient of 0.85 will be established. Although the appropriate time period between the repeated administrations of a questionnaire is at least a week (Terwee et al., 2006), the choice of four days' interval between the administrations of the questionnaires in this study was principally logistical.

### **3.15 Application possibilities of Study findings**

The expected output of this study would be used by policy makers to know how much Ghana is on track to realizing universal health coverage. The outputs included the existing gaps in policy and adherence to healthcare policy for health workers if any, proportion of health workers with access and coverage to health care and factors that affect access and coverage of healthcare among health workers. The outcome of this study determined the prospects and barriers of realizing universal health coverage health coverage among health Workers.

## **CHAPTER FOUR**

### **RESULTS/STUDY FINDINGS**

#### **4.0 Introduction**

The results of both the structured questionnaire and interview guide on how access and coverage of healthcare among health staff in Sunyani Municipality are described in this section. The study was conducted in forty-eight health facility which included CHPS, Clinics, maternity homes, Health centres, Hospitals, medical centres and rehabilitation centres. The result presented covers the specific objective of the study.

#### **4.1 Background Characteristics**

Out of a total of 78 health facilities in the Sunyani Municipal reporting in the district health information systems 2 (DHIMS 2), at least a staff from all 78 Health facilities

was interviewed. Health staffs from the CHPS zones without compounds were mostly found in their mother Health facility hence the reason, though 48 health facilities were visited, at least one health staff from all the 78 health facilities was interviewed. Majority of health staff (73%) interviewed were from government health facilities, 14% from private health facility, 12% from CHAG and 1% from quasi health facilities. The study revealed that, 50% of the health staffs interviewed were single and 47.1% married. A few were widowed (1.8%) and the remaining divorced (0.3%) and separated (0.3%). This implies majority of health staff in the municipality were likely to have an increasing demand for healthcare as single men and women turn to be at risk. Health staffs interviewed were mainly Nurses (39%), Administrative staff (19%), Public Health officers (12%), Midwives (8%), Laboratory scientist/ (6%), Pharmacist/Pharmacy Technician (6%), Physician Assistant (4%), Radiographer (3%), Doctor (3%) and least was Physiotherapist (1%)

**Table 4.1: Background Characteristics**

<b>Background characteristics</b>	<b>Frequency N=340</b>	<b>Percentage</b>
<b>Category of Health Facility</b>		
CHPS	32	9.4
Clinics	44	12.9
Maternity Homes	2	0.6
Health centres	46	13.5
Hospitals	209	61.5
Other (medical centre, Rehabilitation &RCH)	7	2.1
<b>Age Group</b>		
<30	157	46.18
30-39	133	39.12
40-49	31	9.12
>50	19	5.59
<b>Sex</b>		
Male	176	51.76
Female	164	48.24
<b>Marital Status</b>		
Married	160	47.1

Single	172	50.6
Divorced	1	0.3
Separated	1	0.3
Widowed	6	1.8
<b>Years of Work</b>		
<5years	225	66.18
5-10years	77	22.65
>10years	38	11.18
<b>Religion</b>		
Christian	300.0	88.2
Muslim	39	11.5
Traditionalist	1	0.3
<b>Educational Status</b>		
Postgraduate and above	11	3.24
Degree	113	33.24
Diploma	111	32.65
Certificate	83	24.41
No formal education	22	6.47
<b>Income Range &lt;500</b>		
	23	6.76
500-1000	67	19.71
1001-1500	56	16.47
>1500	194	57.06
<b>Possession of valid NHIS card</b>		
Yes	306	90
No	34	10

**Source: Field Data, 2019**

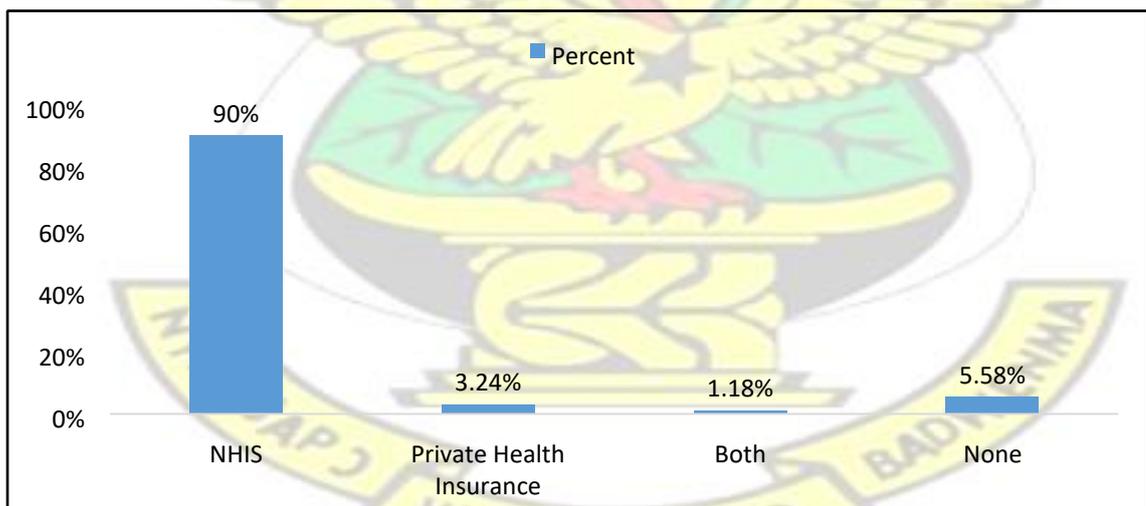
Most Health staffs were males (52%) as compared to female (48%). 88.2% of health staffs were Christians, 11.5% Muslims and a few (0.3%) traditionalist.

Health staff mostly had a degree (33.2%) and a diploma (32.2%), certificate (24.4%) and a few with No formal education (6.5%), postgraduate and above (3.2%). Health staff could therefore be described highly educated in their area of specialty hence expected to have adequate knowledge of the health system.

Most health staffs (66%) were still young and had served less than 5 years in the service. Only 22.3% of health staff had worked for 5 to 10 years and 11.2% worked for more than 10 years. This implies the Sunyani municipal had an active health working force with possibly average experience of the health system.

More than half (57.1%) of health staff received income above 1,500 Ghana cedis, 19.6% had income range of 500-1000, 16.5% received an income ranging from 1001-1500. The least (6.8%) income range was health staff who received <500 Ghana cedis as salary. It is clear that most health staff were of an average income status. A very good proportion of health staff (90%) had a valid National Health Insurance Scheme (NHIS) card though a few (10%) had no valid card because they either did not register or it was expired and not renewed. This indicated that most health staffs are expected to be able to access healthcare covered by NHIS.

Majority of Health staff used the NHIS (90%), while 5.6% were not using any form of insurance. 3.2% of health staff were using private Health Insurance and 1.2% were using both National and private Health Insurance. Deductions from this results indicates that despite the fact that 90% of health staff were using NHIS, some health staff were not possibly satisfied with the NHIS hence added private health insurance.

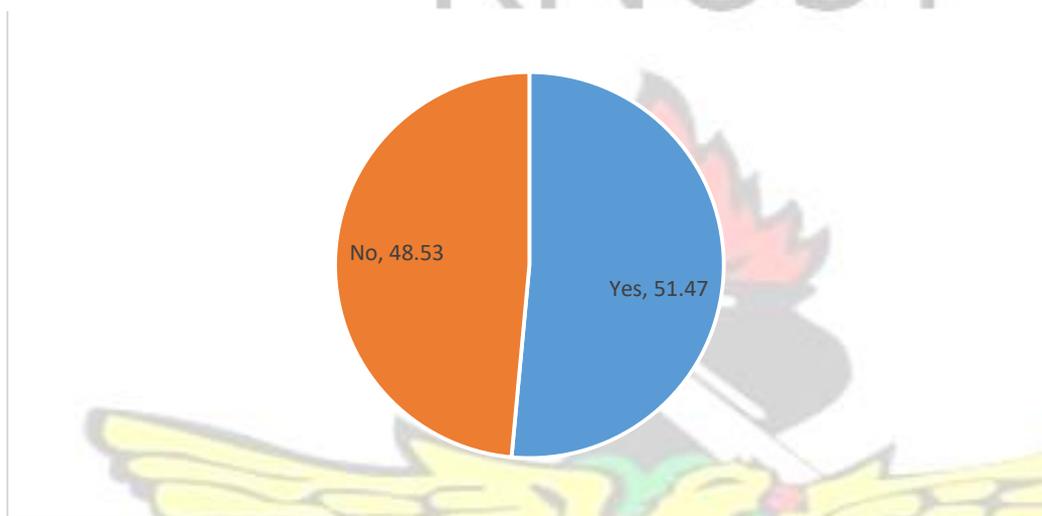


**Figure 4.1 : Type of Health Insurance Health staffs were using**

**Source: Field Data, 2019**

#### **4.2 Policy on Health staff healthcare Needs**

Using the Occupational health and safety policy as a proxy in assessing health staff awareness about policy on health staff healthcare needs, more than half (51.5%) of health staff were aware of the policy while almost half (48.5%) were not aware. This indicates that health staffs were likely not to demand for their expected health needs per the occupational health and safety policy since they were not aware. They might as well have benefited from the policy without knowing.



**Figure 4.2: Awareness about Health policy addressing Health Staff needs**

**Source: Field Data, 2019**

**Table 4.2: Last time heard of Health policy addressing Health Staff needs**

<u>Last time Heard of Health policy addressing Health Staff needs</u>	<u>Freq.</u>	<u>Percentage</u>
This month	21	12.21
Last 2 month	25	14.53
More than 3months	126	73.26
<b>Total</b>	<b>172</b>	<b>100</b>

**Source: Field Data, 2019**

The last time most health staff (73.3%) heard of this policy was more than 3months ago. 14.5% had heard of the policy last month before they were interviewed and a few health staff (12.2%) heard of the policy within the month of the interview.

**Table 4.3: Proportion of Health staff benefiting from some areas of Occupational Health and safety Policy**

Areas of Benefits	% Yes	% No
Benefited from Health staff screening	45.9	54.1
Benefited from free Hepatitis B Vaccination	44.4	55.6
Supported by Health facility to access Specialist care	63.5	36.5
Assisted during Referrals	71.5	28.5

**Source: Field Data, 2019**

Out of the four areas health staff are expected to benefit from the occupational health and safety policy, 71.5% of health staff were assisted during referral when they visit the health facility to seek healthcare and 63.5% supported to access specialist care.

On the contrary, 54.1% of health staff did not benefit from the health staff screening and 55.6% did not benefit from free Hepatitis B vaccination considering the fact that most health staff were single (50.6%), 46.2% aged less than 30 years and 66.8% had worked for less than 5 years.

Reasons given by health staff (mostly Nurses midwives and administrative staff) who did not benefit from the free Hepatitis B vaccination included; *“the health facility did not provide it for us”* from a Nurse in hospital aged 34years, *“no such exercise have been organized”*, *“because there is nothing like free in the health sector”*, *“The vaccine was someone’s business so, it can’t go for free”*, *“because it has not been provided by the health facility in which I work”*, *because of inadequate of resources”*, *“Due to financial crisis of the facility”*, *“My facility failed to vaccinate staff”*, *“Because health administrators who are responsible to organize it don’t even preach it not alone to talk about organizing it”*, *“We always pay for it because we are being told is payable”*, *“I decided to do it myself so I was asked to pay”*, *“I don’t even know*

*I'm to be vaccinated against it”, “our institution doesn't give such opportunities”.*

Reasons given by health staffs (mostly Nurses, pharmacist and administrative staff) who did not benefit health staff screening included;

*“staff are screened by one's own Doctors when needed” “none has been organized in the facility”, “leaders of the facility have not organized such screening and am also not aware that is their duty to organize periodic screening for us”, “the hospital is yet to provide”, “The facility does not organize periodic screening for health workers”, “I have not heard of any periodic screening since I stated work in 2017”, “it has never been organized by the facility”, “we were rejected by the facility that we are not part of the staff, —the hospital has not conducted such thing for us, —because of our bad administrative body, —poor management,*

Health Managers (60%) indicated they were aware of the policy but had challenges implementing it fully due to financial constraints. They however suggested it is necessary to put it in their plans and budgets and requested the Ghana Health Service to include it in the appraisal of Health Managers from the top to down. These they believe will improve and stimulate the needed focus to implement the policy.

#### **4.3 Access to healthcare**

As expected of health staff, 79.7% of them usually sought healthcare from the hospital, 13.5% from health centre and clinic, an indication that they know where to access healthcare when they need it. Only 2.9% of them usually sought healthcare from drug store and chemical sellers, 0.3% from faith healers and 3.5% for other places such as private specialized clinics abroad. This implies though majority of health staff in the municipality would usually seek health care from the hospital, health centre, clinics as expected, others self-medicate and go to faith healers despite their knowledge on quality

health care. Others also have the financial ability to afford specialized healthcare abroad.

**Table 4.4: Place Health staffs usually seek Healthcare**

<u>Health seeking Place</u>	<u>Freq.</u>	<u>Percentage</u>
Hospital	271	79.7
Health centre and Clinic	46	13.5
Faith healer	1	0.3
Drug Store and Chemical Seller	10	2.9
Others	12	3.5
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

The last time majority of health staff (56.7%) visited a source of healthcare was within one to eleven months, an indication that most health staff were likely to seek healthcare at least once in a year, 24.1% at least once in less than one year, and 17.1% at least once in a month. However, 2.4% could not remember the last time they visited a source of healthcare.

**Table 4.5: Last Time Health staff visited source of Healthcare**

<u>Last time visited source of Healthcare</u>	<u>Freq.</u>	<u>Percentage</u>
Less than 1 year	82	24.1
1-11 months	192	56.5
1-4 weeks	58	17.1
I don't remember	8	2.4
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

The most recent place health staff of the Sunyani Municipality visited for healthcare was the hospital (78.8%), health centre and clinic (14.7%) which is expected since they work in these places and this affirms the fact that they usually sought healthcare from hospital, health centres and clinics.

**Table 4.6: Place health staff last visited for healthcare**

<b>Place last visited for healthcare</b>	<b>Freq.</b>	<b>Percent</b>
Hospital	268	78.8
Health centre/Clinic	50	14.7
Drug store/Chemical Seller	9	2.7
Others	13	3.8
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

The study revealed that, 95.9% of health staff said they had healthcare always available when needed, the cracks of the issues had to do with how easy they were able to access their needed healthcare as defined in universal health coverage. Thus, only 11.8% of health staff said they had a staff consulting room assigned to them and 29.4% said they had special healthcare services available to them. This implies the ability of health staff to walk into an assigned consulting room as well as health facilities having special healthcare services for their health staff was not a practice in health facilities visited.

The study affirmed the fact that Health staff when sick do not have internal systems to cater for their own because when asked of what they do when they get sick, health staff gave the following ways of accessing health care; seek treatment, go through normal Out Patient Department, seek for immediate care, report to their facility in charge and visit a preferred health facility, self-medication, seek medical attention and ask for permission to rest at home, consults the doctor for treatment, Take an excuse from the supervisor and go for the treatment and sometimes self-medicate first before going to the hospital.

These reasons except for a few had no dimension of easy accessibility as enshrined in the universal health care coverage.

**Table 4.7: Availability of healthcare to health staff**

<b>Areas of healthcare availability to health staff</b>	<b>% Yes</b>	<b>% No</b>
Healthcare always available when needed	95.9	4.1
Consulting room assigned to Staff	11.8	88.2
Availability of special healthcare services to Health staff	29.4	70.6

**Source: Field Data, 2019**

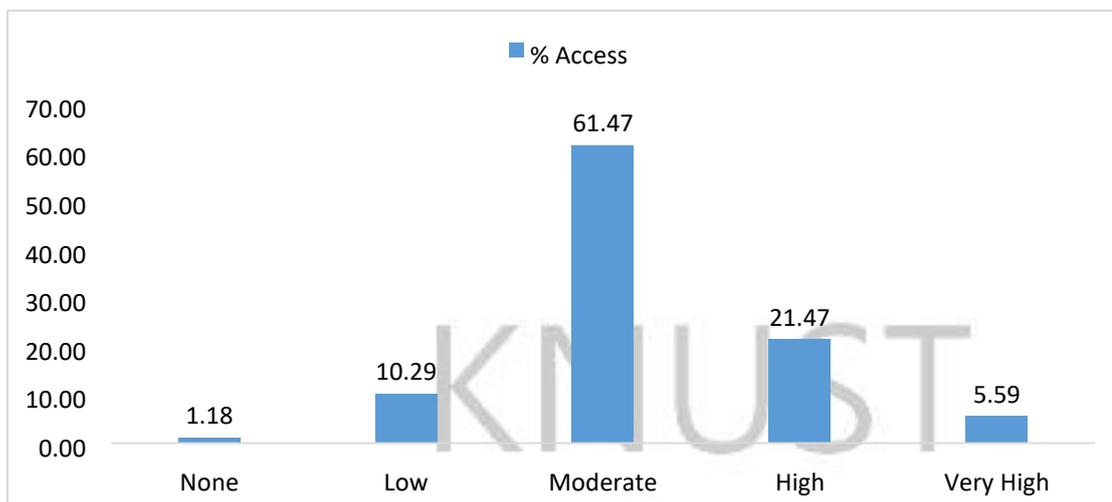
The National Health Insurance from the study was the major mode (61.5%) health staff healthcare cost was usually paid. 28.8% of health staff paid their healthcare cost on their own, 5.9 % by their organization which was mainly the private and military health facilities. Interestingly 3.5% of health staff paid for their healthcare cost through a private health insurance. In all, this implies that though the National Health insurance leads in mode of payment, health staff healthcare cost burden remains a challenge.

**Table 4.8: Who usually pay for Health staff Healthcare Cost?**

<b>Who usually pay for Health staff Healthcare cost</b>	<b>Freq.</b>	<b>Percent</b>
National Health Insurance	209	61.5
Private Health Insurance	12	3.5
Self-sponsor/out of own pocket	98	28.8
My Organization/Health facility	20	5.9
Others	1	0.3
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

In Summary, though majority of health staff usually access healthcare from the hospital, health centres and clinic, the accessibility of the available health care at these health facilities is challenged by the fact that there are limited internal systems especially in government health facilities to facilitate the access to healthcare for health staff. The cost burden of the healthcare they access through the frustrating workflow in health facilities is not entirely catered for by the health system as 28.8% of health staff had to pay for their healthcare cost on their own and 3.5% through private Health insurance. These factors have contributed to health staff rating their access to healthcare as being moderate (61.5%) which has its implication of achieving universal health coverage.



**Figure 4.3: Health staff Access to Healthcare Rating**

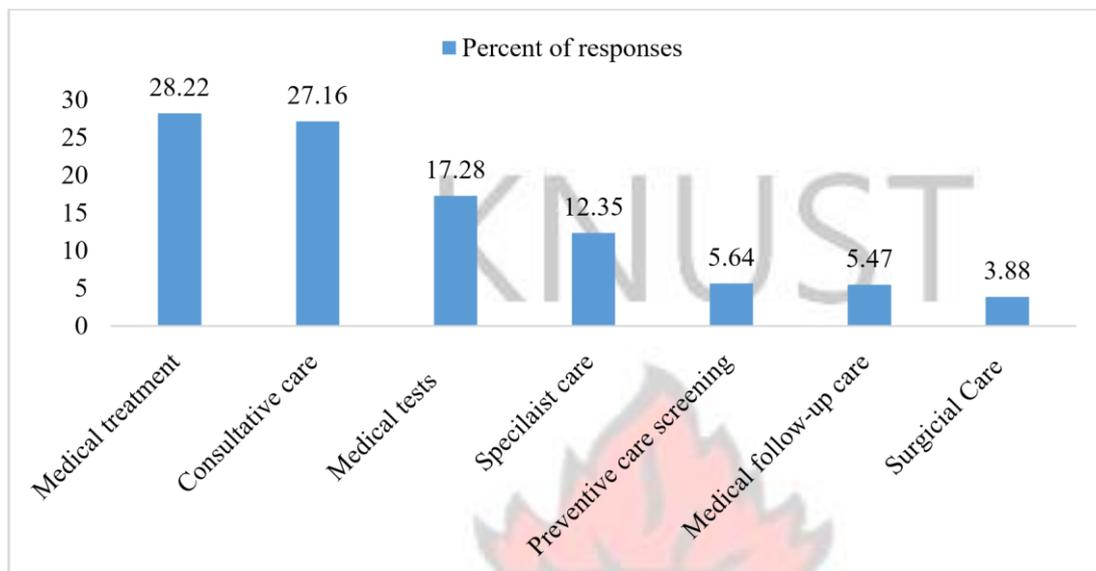
**Source: Field Data, 2019**

#### **4.4 Coverage of health services**

In our bid to achieve universal health coverage several type of healthcare available are expected to be provided in health facilities to meet the demands of clients, in reference to this, health staff said they mostly had Medical treatment (28.2%) and consultative care (27.2%). Medical tests (17.3%) and specialist care (12.4%) were averagely available to health staff. The least of the several type of healthcare available to health staff was preventive care screening (5.6%), medical follow-up care (5.5%) and surgical care (3.9%).

The study revealed that, 93% of Health staff alluded to the fact that these types of healthcare were available when they last visited a source of healthcare but could not have their entire needed healthcare coverage. Thus, 7% of health staff gave the following reason for not been able to get all needed healthcare when they last visited a source of healthcare; specialists care was not available, lack of funds, health facility was a clinic and could not provide some services at its level, health professional to give the type of care I needed was not available. It is imperative that in ensuring universal

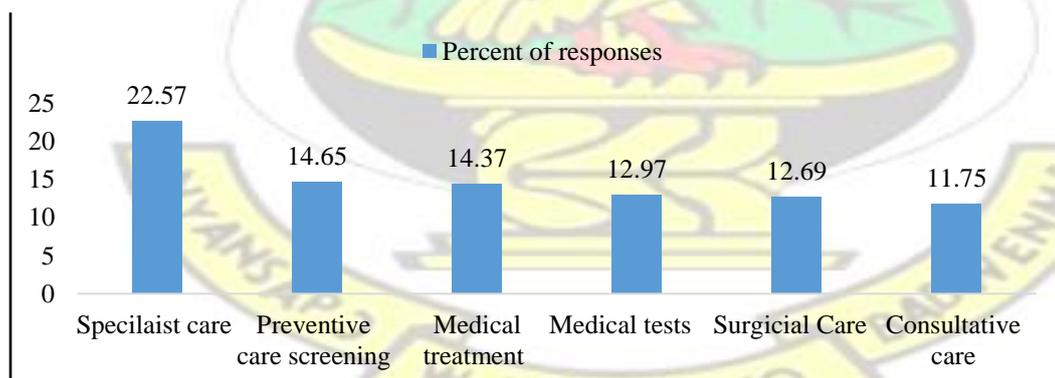
health coverage this should be lesson learnt as no one should be deprived of their needed health care regardless of their status.



Valid cases: 340

**Figure 4.4: Type of Healthcare available to health staff during their last visit to healthcare source Source: Field Data, 2019**

Health staff however, indicated they needed the most in an ascending order specialist care, preventive, medical treatment, medical tests, surgical care and consultative care.



Valid cases: 340

**Figure 4.5: Type of Healthcare Health staff should be covered**

**Source: Field Data, 2019**

Financial risk protection remains a vital element of universal health coverage. It therefore exists to ensure all have access to quality health services devoid of financial hardship. Interestingly, this study revealed that 30.3% of health staff agree that their out of pocket spending was 10% or more of their family spending and 12.4% strong agree to this. Fast forward, 30% of health staffs were neutral, 21.2% disagree and 6.2% strongly disagree. This clearly indicates almost half of health staff suffers financial hardship and its implication on the achieving of universal health coverage might be enormous.

**Table 4.9: Health Staff Out of Pocket spending 10% or more of family spending**

<b>Out of Pocket spending 10% or more of family spending</b>	<b>Freq.</b>	<b>Percent</b>
Strongly disagree	21	6.18
Disagree	72	21.18
Neutral	102	30
Agree	103	30.29
Strongly Agree	42	12.35
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

Access to quality healthcare as embedded in financial risk protection requires all health staff to have quality healthcare when needed at all source of healthcare. Surprisingly, most (61.2%) health staff in the Sunyani Municipality said they received average quality of healthcare when they visit a source of healthcare and only 7.7% received excellent quality of healthcare, hence a possible negative implication in achieving universal health coverage.

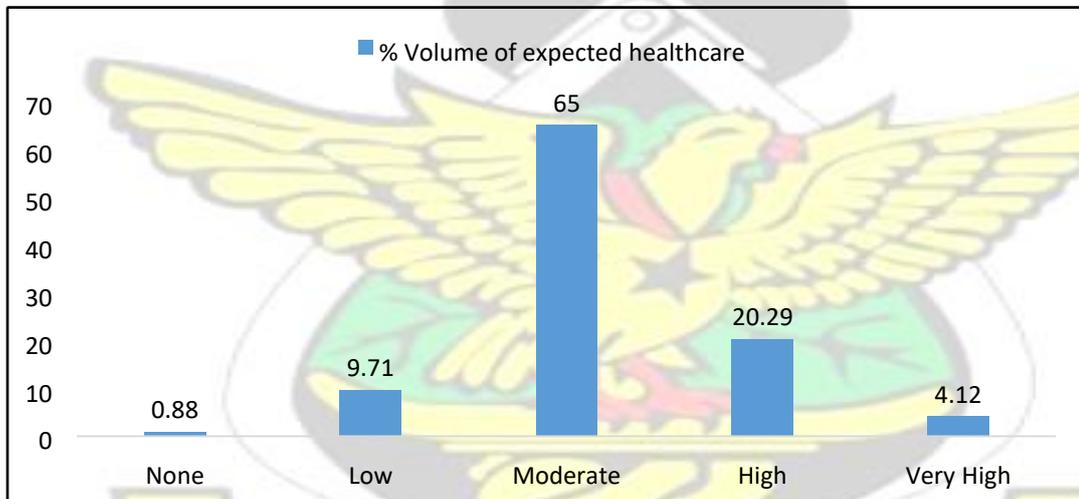
**Table 4.10: Health staff rating of quality of Healthcare provided in health facilities**

<b>Quality of Healthcare provided in Health facilities</b>	<b>Freq.</b>	<b>Percent</b>
Extremely poor	6	1.76
Below Average	50	14.71
Average	208	61.18

Above average	50	14.71
Excellent	26	7.65
<b>Total</b>	<b>340</b>	<b>100</b>

**Source: Field Data, 2019**

In summary, this study revealed that, of the several type of healthcare, health staff said they mostly had medical treatment (28.2%) and consultative care (27.2%), almost half of health staffs suffer financial hardship and only 7.7% received excellent quality of healthcare. This brought the rating of the expected volume of healthcare health staff needed to moderate (65%) with only 24.3% of health staff receiving high volume of their expected healthcare. It ultimately would impact on the attainment of universal health coverage.



**Figure 4.6: Volume of Expected Healthcare rating by Health Staff**

**Source: Field Data, 2019**

The satisfactory level of health staff expected volume of healthcare also remained mostly moderately satisfied and only 15% very satisfied. This affirms the fact that achieving universal health coverage in the midst of moderate satisfaction would be difficult.

**Table 4.11: Health staff Level of Satisfaction with Expected volume of**

## Healthcare

### Satisfaction with Expected volume of Healthcare

	Freq.	Percent
Very Satisfied	51	15
Moderately Satisfied	210	61.76
Neither Satisfied nor dissatisfied	49	14.41
Moderately dissatisfied	13	3.82
very dissatisfied	17	5
<b>Total</b>	<b>340</b>	<b>100</b>

Source: Field Data, 2019

More than half of health staff were moderately satisfied (64.7%) with their health needs, with only 17.7% very satisfied. 10.6% were neither Satisfied nor dissatisfied, a few however were moderately dissatisfied (3.8%) and very dissatisfied (3.2%). Health Staff health needs were moderately satisfied, an indication some health needs of theirs are not met hence the 2.8 % of them moderately dissatisfied and 3.2% very dissatisfied.

Table 4.11: Health Needs satisfaction level

<u>Health Needs satisfaction level</u>	<u>Freq.</u>	<u>Percentage</u>
Very Satisfied	60	17.65
Moderately Satisfied	220	64.71
Neither Satisfied nor dissatisfied	36	10.59
Moderately dissatisfied	13	3.82
very dissatisfied	11	3.24
<b>Total</b>	<b>340</b>	<b>100</b>

Source: Field Data, 2019

## 4.5 Test of association: Factors that affects Health staff access and coverage to healthcare

The study revealed that, p values greater 0.05 were recorded in testing (chi square) the relationship between health staff access to healthcare and some predisposing factors

such as age (0.323), sex (0.563), profession (0.611), education (0.077), religion and years of work. This is an indication that, the relationship between health staff access to healthcare and predisposing factors such age, sex, profession, education, religion and years of work is no statistically significant. In other words, there exist no relationship between health staff access to healthcare and predisposing factors such age, sex, profession, education, religion and years of work.

However, lower p values were recorded by the chi square testing of the relationship between health staff access to healthcare and predisposing factors such as income (0.017) and possession of valid NHIS card (0.006). This implies, health staff access to healthcare is greatly influenced by their income status and possession of valid NHIS card. This alludes to the fact that health staff ability to access healthcare is limited by their income levels hence its negative impact on achieving universal healthcare coverage as the poor health staff would not be able to easily access healthcare.

On the contrary, the chi square test of the relationship between volume of healthcare health staff had and age, sex, profession, income, education, religion, possession of valid NHIS card, years of work showed high hence there was no relationship between volume of healthcare health staff had and age/ sex (0.254), profession (0.263), income (0.866), education (0.676), religion (0.247), possession of valid NHIS card (0.076), years of work (0.062).

The chi square test of relationship between quality of healthcare health staff received and age, sex, profession, education, religion, years of work, possession of valid NHIS card all recorded p values greater 0.05 as shown on table 20 except income with a lower p value of 0.006 which is statistically significant. This implies there is a relationship between quality of healthcare health staff received and their income

status.

It was therefore deduced that coverage of healthcare in terms of quality of healthcare health receive is influenced by the health staff's income status.

**Table 4.12: Factors that affects Health staff access and coverage to healthcare**

Factors	Access to healthcare rating (Freq/Percent)						P-value (Chi High square)
	None	Low	Moderate	High	Very	Total	
<b>Age group</b>							
<30	3(75)	17(48.6)	88(42.1)	40(54.8)	9 (47.4)	157(46)	0.323
30-39	1(25)	12(34.3)	89(42.6)	23(31.5)	8(42.1)	133(39)	
40-49	0(0.0)	2(5.7)	24(11.5)	5(6.8)	0(0)	31(9)	
>50	0(0.0)	4(11.4)	8(3.8)	5(6.8)	2(10.5)	19(6)	
<b>Sex</b>							
Male	1(25.0)	20(57.1)	108(51.7)	35(47.9)	12(63.2)	176(52)	0.563
Female	3(75.0)	15(42.9)	101(48.3)	38(52.0)	7(36.8)	164(48)	
<b>Profession</b>							
Doctor	0(0.0)	0(0.0)	7(3.3)	0(0.0)	1(5.3)	8 (2.35)	0.611
Physician Assistant	0(0.0)	2(5.7)	8(3.8)	2(2.7)	0(0.0)	12 (3.53)	
Nurse	2(50.0)	10(28.6)	86(41.1)	29(39.7)	5(26.3)	132 (38.82)	
Midwife	0(0.0)	4(11.4)	17(8.1)	5(6.8)	2(10.5)	28 (8.24)	
Pharmacist/Technician	0(0.0)	0(0.0)	15(7.18)	5(6.8)	0(0.0)	20 (5.88)	
Laboratory scientist/ Radiographer	1(25.0)	3(8.6)	10(4.8)	4(5.5)	2(10.5)	20 (5.88)	
	0(0.0)	2(5.7)	7(3.3)	2(2.7)	0(0.0)	11 (3.24)	
Public Health Officer	0(0.0)	2(5.7)	26(12.4)	10(13.7)	2(10.5)	40 (11.76)	
Administrative Staff	1(25.0)	12(34.3)	32(15.3)	14(19.2)	7(36.8)	66 (19.41)	
Physiotherapist	0(0.0)	0(0.0)	1(0.48)	2(2.7)	0(0.0)	3 (0.88)	
<b>Years of Work &lt;5years</b>							
	3(75.0)	20(57.1)	139(66.5)	50(68.5)	13(68.4)	225(66)	0.868
5-10years	1(25.0)	12(34.3)	46(22.0)	14(19.2)	4(21.1)	77(23)	
>10years	0(0.0)	3(8.6)	24(11.5)	9(12.3)	2(10.5)	38(11)	
<b>Religion</b>							
Christian	4(100.0)	29(82.8)	181(86.6)	67(91.8)	19(100)	300(88)	0.653
Muslim	0(0.0)	6(17.1)	27(12.9)	6(8.2)	0(0.0)	39(11)	
Traditionalist	0(0.0)	0(0.0)	1(0.4)	0(0.0)	0(0.0)	1(0.3)	
<b>Educational Status</b>							
Postgraduate&above	0(0.0)	1(2.8)	8(3.8)	0(0.0)	2(10.5)	11(3)	0.077
Degree	1(25.0)	9(25.7)	71(33.9)	26(35.6)	6(31.6)	113(33)	
Diploma	0(0.0)	10(28.6)	68(32.5)	26(35.6)	7(36.8)	111(33)	

Certificate	3(75)	8(22.8)	51(24.4)	18(24.6)	3(15.8)	83(24)	
No formal education	0(0.0)	7(20.0)	11(5.6)	3(4.1)	1(5.3)	22(6)	
<b>Income Range &lt;500</b>							
	1(25.0)	7(20.0)	11(5.3)	3(4.1)	1(5.3)	23(7)	
500-1000	2(50.0)	2(5.7)	39(18.6)	9(12.3)	1(5.3)	67(20)	0.017
1001-1500	0(0.0)	7(20.0)	39(18.6)	9(12.3)	1(5.3)	56(16)	
>1500		1(25.0)	19(54.3)	120(57.4)	42(57.5)	194(57)	
<b>Possession of valid NHIS card</b>							
Yes <u>No</u>	3(75.0)	27(77.1)	190(90.9)	71(97.3)	15(78.9)	306 (90)	0.006
	<u>1(25.0)</u>	<u>19(54.3)</u>	<u>120(57.4)</u>	<u>42(57.5)</u>	<u>12(63.1)</u>	(10)	

Source: Field Data, 2019

Factors	Volume of expected healthcare (coverage) rating						P-value (Chi High square)
	(Freq/Percent)						
	None	Low	Moderate	High	Very	Total	
Age group							
<30	1(33.3)	14(42.4)	101(45.7)	35(50.7)	6(42.8)	157(46)	0.869
30-39	2(66.7)	14(43.4)	84(38.0)	25(36.2)	8(57.1)	133(39)	
40-49	0(0.0)	2(6.1)	23(10.4)	6(8.7)	0(0.0)	31(9)	
>50	0(0.0)	3(9.1)	13(5.9)	3(4.3)	0(0.0)	19(6)	
Sex							
Male	0(0.00)	20(60.6)	111(50.2)	36(52.2)	9(64.3)	176(52)	0.254
Female	3(100.0)	13(39.4)	110(49.8)	33(47.8)	5(35.7)	164(48)	
Profession							
Doctor	0(0.0)	0(0.0)	7(3.2)	0(0.0)	1(7.1)	8 (2.35)	0.263
Physician Assistant	1(33.3)	0(0.0)	8(3.6)	3(4.3)	0(0.0)	12 (3.53)	
Nurse	1(33.3)	8(24.2)	91(41.1)	30(43.5)	2(14.3)	132 (38.82)	
Midwife	0(0.0)	4(12.1)	18(8.1)	5(7.3)	1(7.1)	28 (8.24)	
Pharmacist/Technician	0(0.0)	1(3.0)	17(7.7)	1(1.4)	1(7.1)	20 (5.88)	
Laboratory scientist/ Radiographer	0(0.0)	4(12.1)	9(4.1)	6(8.7)	1(7.1)	20 (5.88)	
Public Health Officer	0(0.0)	1(18.2)	25(11.3)	8(11.6)	1(7.1)	40 (11.76)	
Administrative Staff	1(33.3)	9(27.3)	38(17.4)	12(17.4)	6(42.9)	66 (19.41)	
Physiotherapist	0(0.0)	0(0.0)	1(0.4)	2(2.9)	0(0.0)	3 (0.88)	
Years of Work							
<5years	2(66.7)	19(57.6)	150(67.9)	44(63.8)	10(71.4)	225(66)	

5-10years	1(33.3)	12(36.4)	39(17.6)	22(31.9)	3(21.4)	77(23)	0.062
>10years	0(0.0)	2(6.0)	32(14.5)	3(4.3)	1(7.1)	38(11)	
<b>Religion</b>							
Christian	3(100)	27(81.8)	192(89.8)	64(92.7)	14(100)	300(88)	0.247
Muslim	0(0.0)	6(18.2)	29(13.1)	45.8	0(0.0)	39(11)	
Traditionalist	0(0.0)	0(0.0)	0(0.0)	1(1.45)	0(0.0)	1(0.3)	
<b>Educational Status</b>							
Postgraduate and above	0(0.0)	1(3.0)	7(3.2)	2(2.9)	1(7.14)	11(3)	0.247
Degree	0(0.0)	12(36.4)	68(30.8)	26(37.7)	7(50.0)	113(33)	
Diploma	1(33.3)	7(21.2)	78(35.3)	22(31.8)	3(21.4)	111(33)	
Certificate	2(66.7)	27.3)	52(23.5)	17(24.6)	3(21.4)	83(24)	
No formal education	0(0.0)	4(12.1)	16(7.2)	2(2.9)	0(0.0)	22(6)	
<b>Income Range &lt;500</b>							
<500	1(33.3)	3(9.1)	14(6.3)	4(5.8)	1(7.1)	23(7)	0.866
500-1000	0(0.0)	5(15.0)	44(19.9)	14(20.3)	4(28.5)	67(20)	
1001-1500	0(0.0)	7(21.1)	37(16)	11(15.9)	1(7.1)	56(16)	
>1500	2(66.7)	18(54.5)	126(57.0)	40(57.9)	8(57.1)	194(57)	
<b>Possession of valid NHIS card</b>							
Yes	2(66.7)	27(81.8)	198(89.6)	67(97.1)	12(85.7)	306 (90) 34	0.076
No	1(33.3)	6(18.2)	23(10.41)	2(2.9)	214.3	(10)	

Factors	Quality of Healthcare (coverage) rating (Freq/Percent)					Total	P-value (Chi square)
	Extremely Below Average	Below Average	Average	Above Average	Excellent		
<b>Age group</b>							
<30	2(33.3)	23(46.0)	90(43.3)	29(58.0)	13(50.0)	157(46)	0.505
30-39	3(50.0)	18(36.0)	86(41.3)	14(28.0)	12(46.1)	133(39)	
40-49	0(0.0)	5(10.0)	20(9.6)	6(12)	0(0.0)	31(9)	
>50	1(16.7)	4(8.0)	12(5.8)	1(2.0)	1(3.8)	19(6)	
<b>Sex</b>							
Male	3(50.0)	30(60.0)	98(47.1)	33(66.0)	12(46.1)	176(52)	0.109
Female	3(50.0)	20(40.0)	110(52.9)	17(34.0)	14(53.8)	164(48)	
<b>Profession</b>							
Doctor	0(0.0)	0(0.0)	8(3.9)	0(0.0)	0(0.0)	8 (2.35)	0.656
Physician Assistant	0(0.0)	2((4.0)	7(3.4)	2((4.0)	1(3.8)	12 (3.53)	
Nurse	2(33.3)	20(40.0)	84(40.4)	20(40)	6(23.1)	132 (38.82)	
Midwife	0(0.0)	2(4.0)	18(8.6)	4(8.0)	4(15.4)	28 (8.24)	
Pharmacist/Technician	0(0.0)	4(8.0)	13(6.3)	3(6.0)	0(0.0)	20 (5.88)	
Laboratory scientist/	0(0.0)	5(10)	10(4.8)	3(6.0)	0(0.0)	20 (5.88)	

Radiographer	1(16.7)	2(4.0)	7(3.4)	0(0.0)	1(3.8)	11 (3.24)	
Public Health Officer	0(0.0)	4(8.0)	25(12.0)	8(16.0)	3(11.5)	40 (11.76)	
Administrative Staff	3(50.0)	11(22.0)	35(16.8)	9(18.0)	8(30.7)	66 (19.41)	
Physiotherapist	0(0.0)	0(0.0)	1(0.48)	1(2.0)	1(3.8)	3 (0.88)	
<b>Years of Work</b>							
<5years	3(50.0)	30(60.0)	135(64.9)	36(72.0)	21(80.7)	225(66)	0.167
5-10years	3(50.0)	14(28.0)	49(23.6)	6(12.0)	5(19.2)	77(23)	
>10years	0(0.0)	6(12.0)	24(11.5)	8(16.0)	0(0.00)	38(11)	
<b>Religion</b>							
Christian	5(83.3)	45(90.0)	180(86.5)	45(90.0)	25(96.1)	300(88)	0.934
Muslim	1(16.7)	5(10.0)	27(12.9)	5(10.0)	1(3.9)	39(11)	
Traditionalist	0(0.0)	0(0.0)	1(0.5)	0(0.0)	0(0.0)	1(0.3)	
<b>Educational Status</b>							
Postgraduate& above	0(0.0)	2(4.0)	7(3.4)	2(4.0)	0(0.0)	11(3)	0.549
Degree	1(16.7)	15(30.0)	68(32.7)	20(40.0)	9(34.6)	113(33)	
Diploma	1(16.7)	17(34.0)	63(30.3)	18(36.0)	12(46.1)	111(33)	
Certificate	3(50.0)	10(20.0)	58(27.9)	8(16.0)	4(15.4)	83(24)	
No formal education	1(16.7)	6(12.0)	12(5.7)	2(4.0)	1(3.8)	22(6)	
<b>Income Range &lt;500</b>							
	2(33.3)	6(12.0)	11(5.3)	3(6.0)	1(3.8)	23(7)	0.006
500-1000	0(0.0)	7(14.0)	40(19.2)	13(26.0)	7(26.9)	67(20)	
1001-1500	0(0.0)	3(6.0)	47(22.6)	3(6.0)	3(11.5)	56(16)	
>1500	4(66.7)	34(68.0)	110(52.8)	31(62.0)	15(57.7)	194(57)	
<b>Possession of valid NHIS card</b>							
Yes	4(66.7)	44(88.0)	190(91.3)	47(94.0)	21(80.7)	306 (90)	0.106
No	2(33.3)	6(12.0)	18(8.6)	3(6.0)	5(19.2)	34 (10)	

**Table 4.13: Relationship between health staff health care needs satisfaction and driving factors of Universal health coverage**

Multivariate Regression	Coef.	Std. Err.	t	P>t	[95%Conf.	Interval]
<b>Accesstohealthcarerating</b>						
ValidNHIS	-0.20785	.1358414	-1.53	0.127	-0.47506	0.059356
Incomestatus	0.031402	.0410901	0.76	0.445	-0.04942	0.112229
_cons	3.367598	.2528999	13.32	0	2.870131	3.865064

**Volume of expected healthcare rating**

ValidNHIS	-0.26391	.1256439	-2.10	0.036	-0.51106	-0.01676
Incomestatus	-0.00904	.0380055	-0.24	0.812	-0.0838	0.06572
_cons	3.570504	.2339149	15.26	0	3.110381	4.030626

**Quality of healthcare provided**

ValidNHIS	-0.03474	.1494277	-0.23	0.816	-0.32867	0.259196
Incomestatus	-0.00325	.0451998	-0.07	0.943	-0.09216	0.08566
_cons	3.172919	.2781941	11.41	0	2.625698	3.720141

Health needs Satisfaction	Coef.	Std. Err.	t	P>t	[95%]	
					Conf.	Interval]
Access to healthcare	-0.27169	.0750333	-3.62	0.001	-0.41928	-0.124093
Volume of expected healthcare	0.05812	.0807407	0.72	0.472	-0.1007	0.2169425
Quality of healthcare provided	-0.21462	.065898	-3.26	0.001	-0.34425	-0.0849976
Out of pocket spending 10% more of family spending	0.05075	.0404639	1.25	0.211	-0.02885	0.1303455
Cons	3.294045	.2948331	11.17	0.001	2.714087	3.874002

The health needs satisfaction among health staff is greatly influenced by several factors that come together to ensure they have universal health coverage. From the table above, a multivariate regression analysis indicates that access to health and quality of health care provided recorded a p value of 0.001 respectively showing a significant association between health needs satisfaction of health staff and access to healthcare and quality of healthcare provided. Thus, access to healthcare and quality of healthcare provided to health staff influences their health needs satisfaction hence are important determinants of obtaining universal health care among health staff. On the contrary, volume of expected healthcare and out of pocket spending recorded p values greater than 0.05 therefore shows no significant association between health needs satisfaction of health staff and volume of expected healthcare as well as out of pocket spending. This indicates that volume of expected healthcare as well as out of pocket spending does not influence health staff health need satisfaction.

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## CHAPTER FIVE

### DISCUSSION OF STUDY FINDINGS

#### 5.0 Introduction

This chapter seeks to discuss the adherence to healthcare policy for health staff as indicated in the occupational health and safety policy, how accessible healthcare is to health staff, factors that influence health care accessibility and coverage among health staff and health needs satisfaction of health staff.

#### 5.1 Characteristics of Respondents

The health profession in Ghana is one of the multidisciplinary work forces where each profession is dependent of the other. This study therefore obtained information from ten (10) categories of the health profession in the Sunyani Municipal of which majority were Nurses, Administrative staff and Public health officers.

Background characteristics of health staff in this study worthy of mentioning in relationship to achieving universal health care were; most health staffs were highly educated as 52% had a degree and 33% had a diploma. More than half (66%) of health staff had served less than 5 years in the service. Thus, health staffs in the Sunyani Municipality were knowledgeable, active and expected to demand and have access to their needed health care.

Financially accessibility wise, more than half (57.1%) of health staff of the Sunyani Municipal received income above 1,500 Ghana cedis which falls within the average income bracket of formal workers in Ghana and 90% had a valid National Health Insurance Scheme(NHIS) card which positioned them well to be able to access and afford their needed health care.

#### 5.2 Policy on healthcare policy for health staff

Policies addressing the access and coverage of healthcare among health staff in the Ghana Health Service are mostly found in the occupational health and safety guidelines which exist to ensure that the essential measures needed to detect and aid in the management of ill health of the health sector employees. This policy though vital in facilitating access to healthcare among health staff was partially implemented by Managers as confirmed by health staff. Thus, out of the four areas the policy addresses, 71.5% of health staff were assisted during referral when they visit the health facility to seek healthcare and 63.5% supported to access specialist care. On the contrary, 54.1% of health staff did not benefit from the health staff screening and 55.6% did not benefit from free Hepatitis B vaccination considering the fact that most health staff were single (50.6%), 46.2% aged less than 30 years and 66.8% had worked for less than 5 years. Clearly, more than half Health staffs (55.6%) were at risk of hepatitis B infection and other non-communicable diseases such as Diabetes mellitus, Hypertension, stroke, cancers etc since Health Managers (60%) indicated they were aware of the policy but had challenges implementing it fully due to financial constraints.

Considering the fact that studies indicate that Long working hours, common in health profession, predispose them to ill health (Trinkoff *et al.*, 2011), the young and active health staff of the Sunyani Municipality were denied their needed healthcare as some were asked to pay for Hepatitis B vaccination and others were not informed about the need for vaccination though it a known fact that workload predisposes health workers to occupational hazards and also hinders them from attending to their own health needs (Myers, 2008, ch.1; Frank *et al.*, 2009; Lemaire and Wallace, 2010; Skinner *et al.*, 2011).

The 54.1% of health staff who did not benefit from the health staff screening complained that they were rejected by the facility management and attributed lack of screening arrangement for health staff to poor management and bad administrative practices.

### **5.3 Access to healthcare among health staff**

The Health facilities in the Sunyani Municipality varied from well-established private health to government, quasi, rehabilitation centres etc which offers varied quality health care hence, 79.7% of health staff usually sought healthcare from the hospital, 13.5% from health centre and clinic. However, 2.9% of health staff sought their needed healthcare from drug Stores and chemical Sellers an indication that a few health staff in Sunyani Municipal self-medicate which is on the low side as compared with a study conducted in Nigeria among medical professionals which found that 98.6% of the respondents had ever self-prescribed, with 68.3% of these having had self-prescribed within the last three months (Agaba, Ocheke and Akanbi, 2011).

Though 96% of Health staff had healthcare always available to them when needed, easy access to this available health care for health staff of the Sunyani Municipal was challenged by the fact that no designated consulting rooms were readily available to 88% of staff Health staff and 71% had no special healthcare services package provided by the health facilities to cater for their special health care needs as health staff work for Long working hours, common in health profession, predispose them to ill health (Trinkoff *et al.*, 2011)

Interestingly, the National Health Insurance from this study was the major mode (61.5%) health staff healthcare cost was usually paid. 28.8% of health staff paid their healthcare cost on their own, 5.9 % by their organization which was mainly the private

and military health facilities. Low p values were recorded by the chi square testing of the relationship between health staff access to healthcare and predisposing factors such as income ( $p=0.017$ ) and possession of valid NHIS card ( $p=0.006$ ). Thus, health staff access to healthcare is greatly influenced by their income status and possession of valid NHIS card. This alludes to the fact that a higher proportion of specific groups are social excluded and has challenges in accessing their needed health care especially the poor ones who mostly cannot pay extra even when they have health insurance. Also this applies to some specific population groups based on their sexual orientation, disease condition or even ethnicity.(WHO, 2012)

A multivariate regression analysis indicates a highly significant association between health needs satisfaction of health staff and access to healthcare (p-value of 0.001) bringing to bear that, though health facilities may exist to always provide the needed healthcare for health staff when needed, their income levels and possession of valid NHIS card greatly influence access to Healthcare among health staff which in turn influences their overall health needs satisfaction.

#### **5.4 Coverage of healthcare among health staff**

The expected volume of healthcare need by Health staff contributes greatly to achieving universal health coverage. Health staff in Sunyani Municipality had the following out of their expected volume of care as the least of their expected volume of care received; preventive care screening (5.6%), medical follow-up care (5.5%) and surgical care (3.9%). It is however important all needed health care in term of volume are met without financial hardship. This study affirms the fact the financial risk protection remains an area of concern in our bid to achieving universal health coverage as 30.3% of health staff agree that their out of pocket spending was 10% or more of their family spending which is on the low side as compared to a cross-country comparative study conducted

in 2010 reported that almost all (96.3%) patients had to make OOP payments in various forms (Balabanova *et al.*, 2012). In addition, only 7.7% received excellent quality of healthcare hence only 15% of health staff rated their expected volume of care received very Satisfied.

The chi square test of relationship between quality of healthcare health staff received and age, sex, profession, education, religion, years of work, possession of valid NHIS card all recorded p values greater 0.05 as shown on table 20 except income with a lower p value of 0.006 which is highly statistically significant. This implies there is a relationship between quality of healthcare health staff received and their income status and affirms the fact that millions of Africans fall into poverty annually due to Out Of Pocket (OOP) payment as a result of lack of health insurance in health financing system (Carapinha *et al.*, 2011). Though in this study 90% had valid NHIS cover they income status determined the quality of healthcare received.

A multivariate regression analysis indicates a highly significant association between health needs satisfaction of health staff and quality of healthcare provided to health staff (p-value of 0.001). Thus, Health staffs were very satisfied with their health needs when it is provided in a quality manner. However, the quality was determined by the income status of the health staff as those in higher income bracket who could pay out of pocket received quality healthcare which contributed to 62% of health staff rating their volume of care as Moderately Satisfied.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.0 Introduction

This chapter seeks to draw conclusions based on the findings of the study and present recommendations necessary to address factors influencing the access and coverage of healthcare among health staff.

#### 6.1 Conclusions

##### 6.1.1 Demographic characteristics

In total, 340 health staff made of ten (10) professional categories was interviewed from five (5) types of health facilities in 78 health facilities of the Sunyani Municipal.

Out of the 340 health staff interviewed, 90% of them possessed a valid NHIS card, 57% received monthly income of 1500 Ghana cedis and above, 33% with degree in a health related areas, 88% Christians, 66% worked less than 5 years, 50% Single, mean age of 32, age range of 19-79 years and 52% Males.

##### 6.1.2 Policy on healthcare policy for health staff

The Occupational Health and safety policy though vital in facilitating access to healthcare among health staff was partially implemented by Managers due to financial constraint, no budget line in plans and budgets of Health facilities to cater for OHS activities, inadequate commitment and some managers not aware of OHS. Thus, out of the four areas the policy addresses, 71.5% of health staff were assisted during referral when they visit the health facility to seek healthcare and 63.5% supported to access specialist care. On the contrary, 54.1% of health staff did not benefit from the health staff screening and 55.6% did not benefit from free Hepatitis B vaccination though. The health sector is mandated by the 1992 constitution and the Labour Act

2003, Act 651 to ensure that but have failed to fully implement.

### **6.1.3 Access to healthcare among health staff**

Health facilities were physically availability in the Municipality to always provide the needed healthcare for health staff when needed, Lower p values were recorded by the chi square testing of the relationship between health staff access to healthcare and predisposing factors such as income ( $p=0.017$ ) and possession of valid NHIS card ( $p=0.006$ ). Thus, health staff ability to access and receive their need healthcare depended on their income status and possession of valid NHIS card hence there was highly significant association between health staff health needs satisfaction and access to healthcare ( $p= 0.001$ ). In conclusion, income status and possession of valid NHIS card influenced how accessible healthcare was to health staff and therefore how well their health needs were satisfied in the Sunyani Municipal.

### **6.1.4 Coverage of healthcare among health staff**

The quality of healthcare provided to health staff was determined by the income status of the health staff as those in higher income bracket who could pay out of pocket received quality healthcare. Lower p values of 0.006 were recorded by the chi square testing of the relationship between quality of healthcare health staff received and income. There was a highly significant association between health needs satisfaction of health staff and quality of healthcare provided to health staff (p-value of 0.001). In conclusion, income status solely determined volume of care health staff received at health facilities as those who could pay out of pocket received quality healthcare and quality of Healthcare provided determine how satisfied health staff were with their health needs.

## **6.2 Recommendations**

### **6.2.1 Government/MOH/GHS**

#### **Short term**

1. Regional and District Health Directorate to budget for the four areas of OHS in their plans and budgets yearly

#### **Medium term**

1. Ghana Health Service Council and Office of the Director General to include the full implementation of OHS in appraisal of Health Managers from the top to down to stimulate the needed focus to implement the policy

#### **Long term**

1. To enable health staff, have easy access and get fully their needed volume of healthcare need without having to who pay out of their packets for healthcare needs not covered by NHIS, Mutual health insurance schemes should be instituted for health staff and managed by the Ghana Health Service to cater for her staff.

### **6.2.2 Municipal Assembly**

#### **Medium term**

1. Sunyani Municipal Assembly to support (Financial and logistics) the Municipal Health Directorate to provide special health care package for the health staff of the Municipal to attract and retain them

#### **Long Term**

2. Sunyani Municipal Assembly to support the implementation of OHS policy for health staff and other workers in the Municipality to improve the

accessibility of health care to health staff.

### **6.2.3 Health staff**

#### **Short term**

1. Staff welfares of the Health facilities as well as professional unions should ensure some part of their funds are used to purchase logistics to enable them screen staff periodically and not wait for the health facility to do so alone.
2. Individual Health Facility Staff Welfares should negotiate with management to assign consulting rooms to staff and create easy access to special care and referrals for all health staff when needed regardless of their income status.

#### **Long term**

1. Health staff through their professional unions should advocate for the amendment of the occupational health safety policy to address adequately issues of accessibility and coverage of healthcare among health staff

### **6.3 Concluding Remarks**

In a nutshell, health staffs of the Sunyani Municipal moderately accessed their needed health care and received moderate volume of their expected healthcare. Health staff income status and possession of a valid NHIS card facilitated their optimum access and coverage to healthcare needed hence have implications on achieving universal health coverage among health staff.

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## APPENDICES

### Ethical Clearance

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KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY  
**COLLEGE OF HEALTH SCIENCES**



SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL  
**COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS**

Our Ref: CHRPE/AP/415/19

3<sup>rd</sup> July, 2019.

Miss Juliet Abu  
Department of Population,  
Family and Reproductive Health  
School of Public Health  
KNUST-KUMASI.

Dear Madam,

**LETTER OF APPROVAL**

**Protocol Title:** *"Access to and Coverage of Healthcare among Health Workers in the Sunyani Municipality: Implications for the Realization of Universal Health Coverage."*

**Proposed Site:** *Sunyani Municipality.*

**Sponsor:** *Principal Investigator.*

Your submission to the Committee on Human Research, Publications and Ethics on the above-named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 6<sup>th</sup> June, 2019 from the Sunyani Municipal Health Directorate (study site) indicating approval for the conduct of the study at the Municipality.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Protocol.
- Questionnaire.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, beginning 3<sup>rd</sup> July, 2019 to 2<sup>nd</sup> July, 2020 renewable thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you, Madam, for your application.

Yours faithfully,

Osomfo Prof. Sir J. W. Acheampong MD, FWACP  
**Chairman**

Room 7 Block J, School of Medical Sciences, KNUST, University Post Office, Kumasi, Ghana  
Phone: +233 3220 63248 Mobile: +233 20 5453785 Email: chrpe.knust.kath@gmail.com / chrpe@knust.edu.gh



KWAME NKURUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY  
COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL  
COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS



Our Ref: CHRPE/AP/487/19

15<sup>th</sup> August, 2019.

Miss Juliet Abu  
Department of Population,  
Family and Reproductive Health  
School of Public Health  
KNUST-KUMASI.

Dear Madam,

**LETTER OF APPROVAL**

**Protocol Title:** *“Access to and Coverage of Healthcare among Health Workers in the Sunyani Municipality: Implications for the Realization of Universal Health Coverage.”*

**Proposed Site:** *Sunyani Municipality.*

**Sponsor:** *Principal Investigator.*

Your submission to the Committee on amendment to the above protocol refers.

**AMENDMENT:**

1. *To modify the study objectives and study variable table.*

The Committee has considered the ethical merit of your proposed amendment and approved the amendment above.

Please note that any further amendment to this approved protocol should receive prior CHRPE approval before implementation.

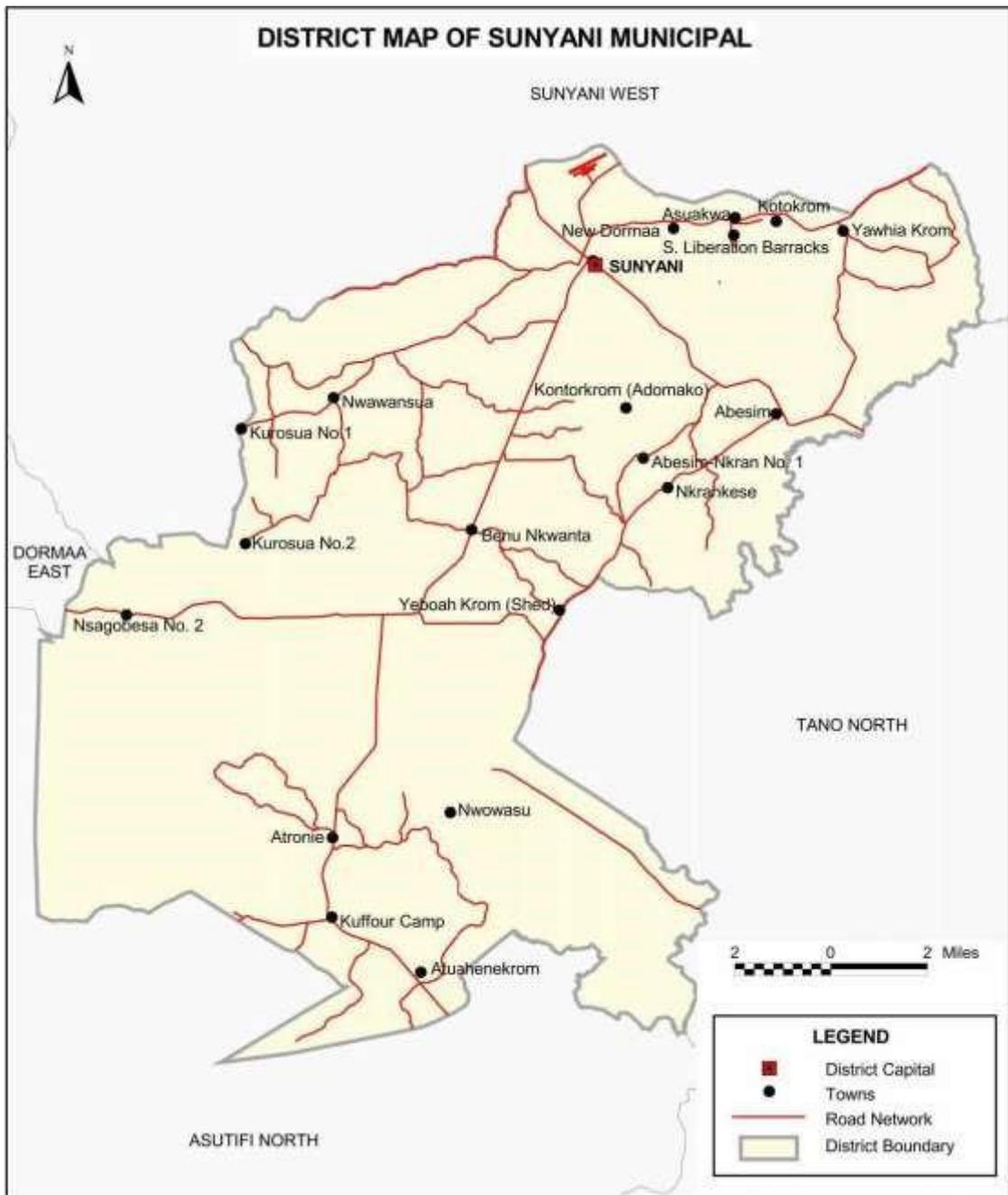
Thank you, Madam, for your application.

Yours faithfully,

Osonifo Prof. Sir J. W. Acheampong MD, FWACP  
**Chairman**

Room 7 Block J, School of Medical Sciences, KNUST, University Post Office, Kumasi, Ghana

**Map of the study site**



Approval letter from study site

- OUR CORE VALUES
1. PEOPLE-CENTRED
  2. PROFESSIONALISM
  3. TEAM WORK
  4. INNOVATION
  5. DISCIPLINE
  6. INTEGRITY



GHANA HEALTH SERVICE  
MUNICIPAL HEALTH DIRECTORATE  
P. O. BOX 311  
SUNYANI

6<sup>TH</sup> JUNE 2019

My Ref. No. GHS/BA/MHD/HR  
Your Ref. No. ....

E- Mail Address:  
Mhdghissun@yahoo.com Tel: +03520-23438

THE HEAD OF DEPARTMENT  
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH  
KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY  
KUMASI

### LETTER OF ASSURANCE

Reference is made to your letter number SPH/CHS/SA/12/vol.1 dated 3<sup>rd</sup> May 2019, requesting for our support and cooperation to enable Ms. Juliet Abu carry out her research work in our facility.

Approval is hereby granted to your student, (Ms. Juliet Abu) to do her research work.

We hope she will cooperate with management to make her short stay successful.

Thank you.



MRS. SARAH AGYEPONG  
MUNICIPAL PUBLIC HEALTH NURSE  
FOR: MUNICIPAL DIRECTOR OF HEALTH SERVICES



### Questionnaire

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY  
COLLEGE OF HEALTH SCIENCES/SCHOOL OF PUBLIC HEALTH  
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE  
HEALTH**

**Research Title: Questionnaire for access and coverage of healthcare among Health Workers in the Sunyani Municipal: implications for the realization of Universal Health Coverage**

**Introduction**

Good morning/afternoon. I am a student at School of Public Health, KNUST. I will be conducting several meetings with people like you in the hospital to find out your views and ideas about access and coverage of healthcare among Health Workers in the Sunyani Municipal: implications for the realization of Universal Health Coverage. Your opinions are highly essential as it will help us to improve the kind of healthcare we provide. Whatever you say will be treated confidential, so feel at ease to express your candid opinion. Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by **circling, ticking or writing** the appropriate answer when needed.

**THANK YOU**

Questionnaire number: \_\_\_\_\_ Date of Interview: \_\_\_\_\_

Name of facility \_\_\_\_\_

**SECTION A: Background Characteristics**

1. What is your age? \_\_\_\_\_ years
2. What is your sex?            a. Male                            b. Female
3. What is your marital status?
  - a. Married
  - b. Single
  - c. Divorced
  - d. Separated
  - e. Widowed
4. What is your religion?

- a. *Christian*
- b. *Muslim*
- c. *Traditionalist*
- d. *Others, specify*\_\_\_\_\_
5. What is the highest level of education?
- a. *Postgraduate and above*
- b. *Degree*
- c. *Diploma*
- d. *Certificate*
- e. *No formal Education*
6. How long have you been working as a health staff? \_\_\_\_\_years
7. Which professional category of health staff do you belong?
- a. *Doctor*
- b. *Physician Assistant*
- c. *Nurse*
- d. *Midwife*
- e. *Pharmacist*
- f. *Laboratory scientist/Technician*
- g. *Radiographer*
- h. *Public health Officer (DC, HI, Nutrition, FT)*
- i. *Administrative Staff (administrator, HR, Estates, Labourer, Cleaner, etc)*
8. How much do you earn as income from working in the health service? \_\_\_\_\_GHS
9. Do you have valid health insurance card as at the time of this survey?
- a. *Yes*
- b. *No*
10. What type of Health insurance cover do you have?
- a. *National Health Insurance*
- b. *Private Health Insurance*
- c. *Other, Specify*\_\_\_\_\_

11. In the past 6months, how will you describe the extent to which your health needs have been met? *1-Very satisfied 2-Moderately satisfied. 3-Neither satisfied nor dissatisfied 4-Moderately dissatisfied. 5-Very dissatisfied.*

**SECTION B. Policy on Health staff healthcare**

12. Are you aware of any healthcare policy (occupational health and safety policy) for Health staff? **If Yes Skip to Q.14**      a. *Yes*      b. *No*

13. If No why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. When was the last time you read or heard about this health policy?

- a. *This month*
- b. *Last Month*
- c. *More than 3months*

15. What are the key issues this health policy addresses?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. In the past 6-12 months, have you benefited from the health system periodic screening for health staff? a. *Yes* b. *No*

17. *If No, why* \_\_\_\_\_  
\_\_\_\_\_

18. Have you received any vaccination against hepatitis B and other diseases for free provided by the health system? a. *Yes* b. *No*

19. *If No, why* \_\_\_\_\_  
\_\_\_\_\_

20. Does your health facility support you with the necessary measures to access specialist care when you need it? a. *Yes* b. *No*

21. If No, why \_\_\_\_\_

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22. Does your Health facility management or Supervisors assist you to obtain referrals to access healthcare you need? a. Yes b.No

23. If No, why \_\_\_\_\_

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### SECTION C: Access to healthcare

24. Where do you usually seek healthcare when you are sick?

- a. Hospital
- b. Health centre/Clinic/CHPS
- c. Herbal Centre
- d. Faith healer
- e. Drug store/ chemical seller
- f. Witch doctor
- g. Self-medication
- h. Others, Specify \_\_\_\_\_

25. What motivate(s) you to seek healthcare from this source?

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26. When was the last time you fell sick and visited a source of healthcare? \_\_\_\_\_

27. The last time you were sick where did you seek care?

- a. Hospital
- b. Health centre/Clinic/CHPS
- c. Herbal Centre
- d. Faith healer
- e. Drug store/ chemical seller
- f. Witch doctor
- g. Self-medication
- h. Others, Specify \_\_\_\_\_

28. Is healthcare always available when you need it?

- a. *Yes*
- b. *No*

29. When a staff is sick, what does (s)he do? \_\_\_\_\_

30. Does staff have a consulting room assigned to them?

- a. *Yes*
- b. *No*

31. Are there special healthcare seeking packages for staff?

- a. *Yes*
- b. *No*

32. Who usually pay for the cost of your healthcare?

- a. *National Health Insurance*
- b. *Private Health Insurance*
- c. *Self-sponsor/ out of own pocket*
- d. *My Organization/Health facility*
- e. *Others, Specify* \_\_\_\_\_

33. Per your own estimation, how would you rate your access to healthcare?

- 0-None                  1-Low                  2-Moderate                  3-High                  4-  
Very High

#### **SECTION D: Coverage of Health services**

34. During your last visit at the source of healthcare, which services were available to you?

- a. *Specialist care*
- b. *Consultative care*
- c. *Surgical Care*
- d. *Medical tests*
- e. *Medical Treatment*
- f. *Medical Follow-up care*
- g. *Preventive care screening*

35. Are these services always available to you when you visit? **If Yes, Skip to Q.37** a. *Yes*

- b. *No*

36. If No, why were you not covered by these health services?

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37. What health services should be covered for health staff?

- a. *Specialist care*
- b. *Consultative*
- c. *Surgical Care*
- d. *Medical tests*
- e. *Medical Treatment*
- f. *Medical Follow-up care*
- g. *Preventive care screening*

38. How would you rate the amount (volume) of your expected healthcare provided to you at your last visit?

*0-None                    1-Low 2-Moderate    3-High                    4-Very High*

39. How satisfied were you with the amount (volume) of your expected healthcare provided?

*1-Very satisfied 2-Moderately satisfied. 3-Neither satisfied nor dissatisfied 4-Moderately dissatisfied. 5-Very dissatisfied.*

40. What in your opinion determines the amount (Volume) of healthcare you are expected to receive at the source of healthcare? \_\_\_\_\_

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41. How would you rate the quality of healthcare provided to you?

*1-extremely poor 2-Below average    3-Average    4- Above average    5-Excellent*

42. What do you think of the statement: My out-of-pocket health care spending over the past one year was 10% or more of family income?

- a. *Strongly Disagree*
- b. *Disagree*
- c. *Neutral*
- d. *Agree*
- e. *Strongly Agree*

**THANK YOU**

**Structured Interview Guide**

**STRUCTURED INTERVIEW GUIDE FOR HEALTH MANAGERS ON  
HEALTHCARE POLICY FOR HEALTH STAFF**

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY**

**COLLEGE OF HEALTH SCIENCES/SCHOOL OF PUBLIC HEALTH  
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE  
HEALTH**

**Introduction**

*Good morning/afternoon. I am a student at School of Public Health, KNUST. I will be conducting several meetings with people like you in the hospital to find out your views and ideas about access and coverage of healthcare among Health Workers in the Sunyani Municipal: implications for the realization of Universal Health Coverage. Your opinions are highly essential as it will help us to improve the kind of healthcare we provide. Whatever you say will be treated confidential, so feel at ease to express your candid opinion. Be assured that your responses will not in any way be linked to your identity. You are kindly requested to answer the questions below by **writing** the appropriate answers.*

**THANK YOU**

**Questionnaire number:** \_\_\_\_\_ **Date of Interview:** \_\_\_\_\_

**Category of manager** \_\_\_\_\_

1. What are the key areas the Occupational Health and safety policy and guidelines for the health sector addresses?
2. To what extent does the Occupational Health and safety policy and guidelines for the health sector address access to healthcare among Health staff?
3. To what extent does the Occupational Health and safety policy and guidelines for the health sector address risk protection and the needed healthcare of Health staff?
4. What recommendations do you have to improve the Occupational Health and safety policy and guidelines for the health sector to address access to healthcare among Health staff?

5. What recommendations do you have to improve the Occupational Health and safety policy and guidelines for the health sector to address risk protection and the needed healthcare of Health staff?

# KNUST

