THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION IN TECHIMAN MUNICIPALITY

By

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DECLARATION

I hereby declare that this submission is my own work towards the Master of Science Degree and that, to the best of my knowledge, it contains no material previously published by another person, nor material which has been accepted for award of any other degree of the University, except where due acknowledgement has been made in the text.

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ABSTRACT

This study was conducted to assess the role of the private health sector in the provision of health care services in the Techiman Municipality of the Brong Ahafo Region. The study focused on the types of private health facilities in the municipality, the services provided by both public and private facilities, users of the health services, conformity of services provided with national standards and the challenges and prospects of the sector. The study adopted the case study design. Secondary and Primary data were gathered for the study. A sample size of 100 Household Heads was used for the study.

The study revealed that, eleven out of the thirty-five health facilities surveyed in the municipality were privately owned. Five of these are maternity homes, four are private hospitals and two are private Clinics. It was also revealed that the public facilities do not provide major and specialized services due to their nature and level as compared with the private facilities where major, specialized services and professional nurses and midwife training are provided. The study further revealed that Household heads and for that matter users of the health facilities are from all age groups with the majority being youthful and fall within the income group of Gh¢ 100.00 – 299.00. Again, the study revealed that, all the private health facilities in the municipality are registered and supervised by the Ghana Health Service on monthly, quarterly and annual bases as required by the National Health Policy. On the bases of the major findings, the study recommended the need for expansion of the existing health facilities and provision of a district hospital and effective collaboration between the public and private actors to ensure quality service delivery.

DEDICATION

I dedicate this work to my grandfather Mr. E. A Mahama, my mother, Alice Mahama, my lovely and caring wife Seidu Muhabatu and my son Marzooq Nyenchur-Ebore. You have all in many ways contributed to my success.

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LISTS OF ABBREVIATIONS/ ACRONYMS

AHMD	-	American Heritage Medical Dictionary
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
ANC	-	Antenatal Care
CGD	-	Centre for Global Development
CHAG	-	Christian Health Association of Ghana
CHPS	-	Community Based Health Planning System
CT	-	Counseling Testing
CVA	-	Cardiovascular Accidents
CVD	-	Cardiovascular Disease
ENT	-	Ear and Throat
EPI	-	Expanded Programme of Immunization
GDP	-	Gross Domestic Product
GHS	-	Ghana Health Service
GOG	-	Government of Ghana
HH	-	Household Head
HIV	-	Human Immunodeficiency Virus
IFC	-	International Financial Corporation
IMR	-	Infant Mortality Rate
IPT	-	Intermittent Preventive Treatment
ITN	-	Insecticide Treated Net
LB	-	Life Birth
MDA	-	Ministries Departments and Agencies
MDG	-	Millennium Development Goal
MHD	-	Municipal Health Directorate
MMR	-	Maternal Mortality Rate
MOH	-	Ministry of Health
NDPC	-	National Development Planning Commission
NFP	-	Non for Profit
NGO	-	Non-Government
NHIS	-	National Health Insurance Scheme
NHP	-	National Health Policy

NMIMR	-	Nouguchi Memorial Institute for Medical Research
OECD	-	Organization of Economic Co-operation and Development
OOP	-	Out of Pocket Payment
OPD	-	Open Patient Department
PHC	-	Primary Health Care
RMP	-	Rural Medical Provider
SPSS	-	Statistical Package for Social Scientist
STD	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infection
TB	-	Tuberculoses
TBA	-	Traditional Birth Attendant
TFR	-	Total Fertility Rate
TMA	-	Techiman Municipal Assembly
TT	-	Tetanus
URTI	-	Upper Respiratory Truck Infection
USD	-	United States Dollar
WHO	-	World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 Background

The enjoyment of health is one of the fundamental rights of every human being. Health is a precondition for wellbeing and the quality of life. It is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination (WHO, 1998). Every nation exists to assure the collective survival as well as the socio-economic development of its citizens. Chapter six section two of the 1992 constitution of Ghana mandates the President of the Republic of Ghana to ensure the realization of basic human rights, a healthy economy, the right to education and work, and the right to good health. In this regard the Ministry of health has been established to assure good health in Ghana and reduce the impact of ill-health on socio-economic development of the country (GOG, 1992; MOH, 2007).

Over the years Government and Development Partners have sought in various ways to provide the necessary environment and inputs towards improving health delivery. Ghana, like most developing countries in recent times has embarked on Health Sector Reform Programmes. These programmes are aimed at addressing the poor state of health in the country especially at the rural and deprived communities. In these communities, Christian Health Association of Ghana (CHAG) facilities are situated by choice, and based on experience in serving such communities. Services are provided based on Christian operation of service to the poor, marginalized and disadvantaged (MOH, 2006, Abdullah and Vanessa, 2009).

The government's recognition of the role of the private sector in national development, the demonstrated commitment of CHAG to national health goals and outcomes, the evidence that government alone cannot meet the health needs of the people calls for closer collaboration between Government Agencies and all stakeholders in the private health sector. This collaboration recognises the pivotal role of the private health sector, which provides about 42 per cent of Ghana's health care services and has been growing rapidly in recent times, as the engine of growth in the country's socio-economic recovery programme (MOH, 2007).

Faith-based health services in Ghana provide approximately 40 percent of the available health care. The church health care facilities in Ghana numbered 56 hospitals and 83 clinics as at 2005 (Abdullah and Vanessa, 2009).

1.1 Problem Statement

Good health is fundamental to sustainable economic growth. Intersectoral investment for health not only unlocks new resources for health but also has wider benefits, contributing in the long term to overall economic and social development. Investment in outcome-oriented health care improves health and identifies resources that can be released to meet the growing demand on the health sector (WHO, 1998).

The strategic direction of improving human capital makes health central to Ghana's development efforts; only a healthy population can bring about improved productivity and subsequent increase in GDP, and by doing so ensure economic growth. Hence the old adage "a healthy population is a wealthy population" (MOH, 2007).

However, the lower middle income status attained is being threatened by health problems such as; poor environmental conditions, the poor quality of air, water and soil in the country which is mainly due to improper disposal of waste, emission of dangerous gases from industries and vehicles, and smoke from burning of waste and bush fires (MOH, 2007). Despite this situation, the measures for controlling these problems have not been effective. Infrastructure for management has not kept pace with the population growth. Only a third of the waste produced in the urban centre is collected. Access to potable water is also a problem. Less than half of the population in the country has access to potable water, leaving the rest to obtain water from streams and rivers, which are often contaminated with organic and inorganic substances from household and industrial pollutants (MOH, 2007). Poor lifestyle together with known environmental factors most of which are preventable, manifest in a high level of morbidity and mortality in the country (NDPC, 2009).

The majority of the conditions leading to out-patient attendance at clinics in Ghana are malaria, diarrhea, upper respiratory tract infection, skin disease, accident, hypertension, eye infection, pregnancy related conditions, helminthiasis and osteoarpathy (MOH, 2007, GHS, 2009). Over 90 percent of these diseases and

conditions could easily be prevented if appropriate environmental and lifestyle measures were taken. The programmes and projects of the Ministry of Health have focused on curative care, leading to failure of the ministry to make significant impact in the development of promotive and preventive health to the benefit of its people (NDPC, 2009). Coupled with these is the problem of inadequate health personnel which is due to brain drain leading to limited productivity.

The deprived state of public facilities indicate that the public sector alone cannot provide the necessary health services to solve these problems in order to improve upon the health of the citizens. Hence the involvement of the private sector of which Private health care institutions form part (MOH, 2007, MHD 2010). The private health institution in the Municipality cater for all the serious health issues and are the most equipped facilities in the municipality and serve as referral centres.

In 2006, a memorandum of Understanding and Administrative Instructions between the Ministry of Health (MOH) and Christian Health Association of Ghana (CHAG) on the collaboration between Government agencies and all stakeholders in the private health sector focused more on the operations of CHAG members at the expense of individual medical practitioners.

Private facilities have provided health services at the individual and institutional levels in Techiman municipality. However, little is known about their performance in the municipality due to the absence of adequate documentation on their operations (Obuobi et.al., 1999). The research therefore seeks to fill this gap by assessing the role private health institutions, play in the provision of health services. The assessment intends to bring about best and poor practices in health services provision by private health facilities in the municipality.

1.2 Research Questions

1. What types of private health facilities are available in Techiman Municipality?
2. Are the services relatively different from the services offered by the public sector?
3. Who are the beneficiaries of private health facilities?

4. Are the services provided in conformity with the National health care standard?
5. What are the challenges and prospects of private health institutions?

1.3 Objectives

The main objective of the research is to assess the role played by private institutions in the provision of health services and make recommendations to inform policy.

1.3.1 Specific Objectives

The research seeks to achieve the following specific objectives, to

1. Identify the types of private health facilities available in Techiman municipality;
2. Ascer tain the differences in services provided by the Private and Public sectors;
3. Determine the category of people who utilize the services of private health institution;
4. Assess the extent to which services provided by Private institutions meet National health care standards as required by the National Health Policy.
5. Assess the challenges and prospects of private health institutions in health services delivery; and
6. Give recommendation to inform policy formulation.

1.4 Scope of the Study

Geographically, the research is limited to Private and Public health facilities in the Techiman Municipality in the Brong Ahafo Region of Ghana.

Context-wise, the research seeks to study the services provided by private health facilities and covers the types of private health facilities that are available in Techiman, whether there are differences in the services offered by the private and public sectors, the users of private health facilities, whether the services provided conform to the provisions of the national health policy and what the challenges and prospects of private health institutions are.

1.5 Significance of the Study

The research has become necessary because private health facilities exist and provide health care services and serve as referral centres versus public health facilities in the Municipality.

In view of this, results of the research would help shape government's visions on social policy and local experiences of social welfare especially relating to health in the Municipality and the Country at large. Also, the research results would serve as input for effective, efficient and improved services provision in the municipality.

In many locations, private organizations have been in the forefront or alone in the struggle to reduce the suffering of people from diseases. However, little scientific knowledge exists concerning how private organizations, in themselves, influence risk prevention strategies and responses to health at the individual, community, and societal levels. Furthermore, little is known about what aspects of this influence may be unique to the "faith" dimension of such organizations. A scientifically focused knowledge base will contribute to an improved understanding of the factors driving health risk, prevention, promotion and care in the country. This will also lead to the development of innovative prevention, educational, promotional and care strategies that build on the strengths and unique features of private organizations (NIH, 2004).

1.6 Limitations

Some of the limitations encountered during the research include the following;

- Difficulty in obtaining secondary data from facilities;
- Time and resource constraint relating to primary data collection; and
- Inadequate cooperation from respondents

To overcome the above limitations in obtaining secondary data from facilities, the researcher obtained a letter of introduction from the Director of the Municipal Health Directorate to facilitate data collection. As much as possible the researcher used the limited resources and time to collect all relevant data within the stipulated period thereby reducing cost.

The researcher also established good rapport with respondents to gain their co-operation and attention which made them felt at ease in answering the questions. Finally, respondents were assured of the confidentiality of their information.

1.7 Organization of the Study

The study is organised into five chapters. The first chapter introduces the topic and states the problem, the research questions, the objectives to be achieved, the significance of the study and the limitations associated with the study.

The second chapter discusses the literature in relation to the issues under investigation. It analysis the key concepts of the research and concludes with the conceptual framework for the study.

The third chapter discussed the profile of the study area and established a clear methodology for conducting the study.

The fourth chapter dealt with data collection and analysis as well as presentation of major findings. Finally, Chapter Five deals with summary of findings, recommendations and conclusion.

CHAPTER TWO

PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION

2.0 Introduction

This chapter reviews earlier works or literature related to the private sector, health care and services delivery. Literature was also reviewed on the type of health services private institutions provide, how these private institutions provide health services, the category of people the institutions provide services to, services provision within the national health policy and the challenges and prospects of private health institutions in health services delivery. The chapter also discusses case studies on the role of private sector in health services provision in other countries to draw best practices and challenges from those countries. Finally, a conceptual framework that guides the study is discussed.

2.1 The Concept of Private Sector

For many, the term private sector conjure up the image of a business engaged in commerce or manufacturing. However, an analysis of the characteristics of the term private sector leads to deeper understanding of the nature and coverage of the term (OECD, 2004).

The Private Sector, according to the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development is 'a basic organising principle of economic activity where private ownership is an important factor, where markets and competition drive production and where private initiative and risk taking set activities in motion' (OECD, 2004:17). The critical point is that, markets, through the process of competition, determines what is produced and consumed. This distinguishes market-based economies from other organising principles. The term private sector, therefore, covers all private actors such as; the poor and the rich, individuals and businesses who are engaged in risk taking to earn profits and incomes. It applies to the smallholder farmer as well as to the very large, multinational corporation (OECD, 2004).

The world over, the private sector is the major contributor to Gross Domestic Product (GDP) and employment and so is the engine of the economy (OECD, 2004:

8). Growth, as measured by increases in GDP, is simply the sum of the increase in value added by the activities of all participants engaged in production and market exchange. The greater the capability of private actors, including the poor, to add value and create wealth, the faster will be the pace of growth.

Current thinking for the provision of public infrastructure and services is that the private sector should be encouraged to participate in the performance of functions which have been traditionally reserved to the public service including the provision of public infrastructure and services. This trend has gained increased acceptance in both the developed and developing world (GoG, 2000).

The term Private Sector refers to all those health providers working outside the direct control of the state and include; both for-profit and not-for-profit providers, and formally trained providers as well as traditional healers (Obuobi et al., 1999).

2.2 Health

Health according to paragraph two of the preamble of the constitution of World Health Organization is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948).

Health is the extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities (WHO, 1984).

Health is a state characterized by anatomic, physiologic and psychological integrity; ability to perform personally valued family, work and community roles; ability to deal with physical, biological, psychological and social stress a feeling of well-being; and freedom from the risk of disease and untimely death (Stokes et al. 1982 in WHO, 2007).

Health is a state of equilibrium between humans and the physical, biological and social environment, compatible with full functional activity (Appleton and Lange, 1997 in WHO, 2007).

People do not think about health only in terms of sickness or injury, but also in terms of what they perceive as endangering their health and that of their community (WHR, 2008).

According to Amofah (2000), health can be viewed in three different epidemiological paradigms; the traditional medical paradigm that is centered on an organic perspective which views health in terms of the presence or absence of signs and symptoms of disease in individuals with treatment directed at removing the immediate cause(s) of the signs and symptoms of the disease in the individual in a fixed health facility with the hope that he/she will be healthy. The social paradigm expanded the medical model by recognising that diseases have a social dimension placing a lot of emphasis on improving the environment (especially the physical, biological and social environment) with programmes such as water treatment, sanitation improvement, vector control and control of industrial pollution undertaken with the hope that people will be healthy. The socialist paradigm recognises that the determinants of health/ ill health are primarily to be found in the socio-economic and political environment in which people live placing focus on broad socio-economic development to improve upon the health status of the people in the community.

Health is a relative state in which one is able to function well physically, mentally, socially, and spiritually in order to express the full range of one's unique potentialities within the environment in which one is living. In the words of René Dubos, "health is primarily a measure of each person's ability to do and become what he wants to become" (Medical Dictionary, 2012).

For the purpose of this study, health is defined as one's ability to live and function as a complete physical, mental and social being and able to perform his or her natural, biological or reproductive, productive, societal, political or democratic and religious roles.

2.3 Health Care

According to the American Heritage Medical Dictionary (AHMD, 2007) health care is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and

allied health professions. It is also the services rendered by members of the health professions for the benefit of a patient.

In the United States, the spectrum of health care has been defined by the Department of Health and Human Services as encompassing six levels of health care; primary, secondary, tertiary, respite, restorative and continuing care. The first level of care is preventive care, which is primarily provided by school health education courses and community and public health services (AHMD, 2007).

Primary care is the usual point at which an individual enters the health care system. Its major task is the early detection and prevention of disease and education on healthy life style. This level of care also encompasses the routine care of individuals with common health problems and chronic illnesses that can be managed in the home or through periodic visits to an outpatient facility. Providers of care at the primary level include family members as well as the professionals and paraprofessionals who staff community and neighborhood health centers, hospital outpatient departments, physicians' offices, industrial health units, and school and college health units (AHMD, 2007).

Secondary or acute care is concerned with emergency treatment and critical care involving intense and elaborate measures for the diagnosis and treatment of a specified range of illness or pathology. Entry into the system at this level is either by direct admission to a health care facility or by referral. Provider groups for secondary care include both acute- and long-term care hospitals and their staffs (AHMD, 2007).

Tertiary care includes highly technical services for the treatment of individuals and families with complex or complicated health needs. Providers of tertiary care are health professionals who are specialists in a particular clinical area and are competent to work in such specialty agencies as psychiatric hospitals and clinics, chronic disease centers, and the highly specialized units of general hospitals; for example, a coronary care unit. Entry into the health care system at this level is gained by referral from either the primary or secondary level (AHMD, 2007).

Respite care is that provided by an agency or institution for long-term care patients on a short-term basis to give the primary caretaker(s) at home a period of relief (AHMD, 2007).

Restorative care comprises routine follow-up care and rehabilitation in such facilities as nursing homes, halfway houses, inpatient facilities for alcohol and drug abusers, and in the homes of patients served by home health care units of hospitals or community-based agencies (AHMD, 2007).

Continuing care is provided on an ongoing basis to support those persons who are physically or mentally handicapped, elderly and suffering from a chronic and incapacitating illness, mentally retarded, or otherwise unable to cope unassisted with daily living. Such care is available in personal care homes, domiciliary homes, inpatient health facilities, nursing homes, geriatric day care centers, and various other types of facilities

2.4 Service Delivery

Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions. Service delivery is the immediate output of the inputs into the health system, such as health workforce, procurement and supplies and finances. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability and access to health services is one of the main functions of a health system. Such services should meet a minimum quality standard (WHO, 2010).

Good service delivery is a vital element of any health system and is crucial to the achievement of health-related Millennium Development Goals such as reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other disease. Service delivery is therefore a fundamental input to population health status, along with other factors, including social determinants of health. The precise organization and content of health services will differ from one country to another, but in any well-functioning health system, the network of service delivery should have the following characteristics: comprehensiveness, accessibility, continuity, people-centeredness, coordination, accountability and efficiency. This signifies coherent approach to health services organization in which primary, or first contact, level – usually in the context of a local health system/district – acts as a driver for the health care delivery system as a whole (WHO, 2010).

Health services are the most visible part of any health system, both to users and the general public. Health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities (MOH, 2007 and WHO, 2010).

In any health system, good health services are those which deliver effective, safe, good quality, personal and non-personal care to those that need it, when needed, and with minimal waste. While many questions remain about how to improve the organization and management of health service delivery so as to achieve better and more equitable coverage and quality, countries can draw on experiences from elsewhere as they consider what to do (WHO, 2010).

2.5 Health Delivery in Ghana

Regarding Health Delivery in Ghana, Agyepong (1999) writes that, during the 1990s the Ghanaian health sector was decentralized. The 1996 Ghana Health Service and Teaching Hospital Act removed administrative and service delivery responsibilities from the Ministry of Health (MoH) and delegated them to an autonomous body known as the Ghana Health Service (GHS). The MoH has retained responsibility for policy formulation, planning, donor co-ordination and resource mobilization. Teaching hospitals are now responsible for teaching, research, and for the provision of specialist health care.

Agyepong, looking at Private and Faith based providers noted that, private providers account for 35 percent of total health services in Ghana. Private health facilities include hospitals, clinics, company clinics, and maternity homes and that the Government's target is to raise private healthcare provision in the country (Agyepong, 1999). Access to private care is one of the features of the new National Health Insurance System (NHIS).

Faith-based providers also play a very large role in the delivery of health care in Ghana. The Christian Health Association of Ghana (CHAG) plays a complementary role to the public sector and is the second largest provider of health services in the country. It is estimated that approximately 42 per cent of total health services in the country are provided by CHAG's member institutions (Abdullah and Vanessa, 2009).

The health, nutrition, and environmental sanitation of any people are linked to the general state of development in the country. The Government of Ghana, for that matter, seeks to improve the health of all people living in Ghana regardless of age, sex, race, ethnic origin, religious conviction, political affiliation, or socio-economic standing. This is believed can only be achieved through strengthening the health system by improvement in its access, quality, efficiency and financing (MOH, 2007)

The structure of the health system consists of national, regional, district, sub-district and community health systems and is built on the Primary Health Care (PHC) System. Services are provided by many partners including the private health care services, the religious bodies' health facilities, the parastatal health system and private clinics. Additionally, traditional herbal and spiritual centres provide services to many Ghanaians (MOH 2007).

Annual progress report of the Ghana Health Service (2011) on health infrastructure describing trends in regional service delivery indicate a general increase in health facilities nationwide from two in 2009 to three in 2011 for teaching hospitals. In the year 2011 there were two psychiatric hospitals, 343 hospitals, 2,089 health centres, 389 maternity homes and 1,675 CHPS compound nationa wide. The number of hospitals for Greater Accra region almost doubled within the period while those in Ashanti region increased by only 6 percent. On the other hand, the number of hospitals in the Central, Volta, Northern and Upper East regions decreased. With regards to health centres, however, substantial increases occurred in all the regions except Central and Greater Accra regions which experienced a fall in the number of health centres and clinics. One major concern is the equitable distribution of health resources. Regions in the northern part of the country have fewer health facilities and lower coverage in preventive health services resulting in high hospital admission rates per capita for the people in those regions.

Statistics from the 2011 progress report showed an improvement in Doctor Population ratio from 1:10,483 in 2010 to 1:10,032 in 2011. Nurse to patient population ratio improved from 1:1,489 in 2010 to 1:240 in 2011. OPD per capita increased from 0.98 in 2010 to 1.07 in 2011. TB treatment success rate increased was 85.5 percent in 2010. Skilled delivery rate improved nationally from 49.5 percent in 2010 to 52.2 percent in 2011. Institutional maternal mortality ratio fell from

169.9/100,000LB in 2009 to 163.2/100,000LB in 2010 but increased to 173.8/100,000. According to the report, Ghana recorded her last guinea worm case on the 11th of May 2010 and, therefore, begun the first precertification year in January 2011. Immunization coverage for measles remained at 88 percent from 2010 to 2011. Penta 3 coverage has also remained at 87 percent from 2010 to 2011. Despite these positive achievements, the fatality rate of meningitis cases in health facilities across the country continues to be high (18.1percent) (GHS, 2011).

Antenatal coverage increased from 93.3 percent in 2010 to 94.4 percent in 2011. A review of the core surveillance indicators in 2011 showed that cholera case fatality rate was 1.0 percent in 2011. Malaria under-5 case fatality rate reduced from 3.7 percent in 2010 from to 1.7 percent in 2011. However, the gradual fall in case fatality stagnated between 2010 (1.6 percent) and 2011 (1.7 percent). The number of functional Community Based Health Planning System (CHPS) zones increased from 1034 in 2010 to 1675 in 2011 and the population covered by CHPS moved from 4.2 percent in 2010 to 5.2 percent in 2011 (GHS, 2011). The increase in the intake and the output of Community Health Officer (CHOs) from the regional schools has contributed to the availability of CHOs to make zones functional. The lack of investment in providing compounds has however resulted in a comparatively slow scale up of completed CHPS zones (GHS, 2009). Sixty-Five Thousand, Fifty-Eight (865,058) people got to know their HIV sero-status in 2009. This figure represents 85 percent increase over the number of people who tested in the previous year. The HIV prevalence among the counseled and tested clients was about four percent as against six percent for 2008 (GHS, 2009)..

Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services (WHO, 2008). Two broad categories of services are available in Ghana, namely, curative services and preventive/ promotive services. The curative services provide diagnosis and treatment to a sick client. In more complex facilities like hospitals, these two broad functions may be distributed among several units like outpatients department, inpatient care, laboratory and diagnostic services, pharmacy, and support services for laundry, catering, transport, and administration. Preventive and promotive services provide clients and communities with services that aim to keeping them healthy. Programmes under this

category include child health, adolescent health, maternal and reproductive health, communicable diseases, non-communicable disease, health promotion and nutrition (MOH, 2007)

2.6 Type of Health Services Provided by Private Institutions

Private-sector providers are a mix of the formal, such as doctors, pharmacists and chemical sellers, and non-governmental organizations (NGOs), and the informal, such as herbalists and traditional birth attendants (TBAs) (Obuobi, et al. 1999 and MOH, 2007). Private medical practitioners provide diagnostic and therapeutic services such as general, surgical, obstetrics/gynecological, ENT, dental, orthopedics, other specialties. Beside, these private health providers offer basic health services such as curative care, minor surgery, antenatal care, post-natal care, deliveries, major surgery, physiotherapy and laboratory service among others (Obuobi et al. 1999).

According to the World Health Organization (WHO), health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities effectively depending on the availability of motivated staff, equipment, information, finance, and adequate drugs (WHO, 2008). Health services are delivered through health systems which form the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. This can be viewed in the form of a system's perspective, with inputs, processes, outputs, and outcomes.

A study by (Obuobi, et. al 1999) indicated that all socio-economic groups, males and females, various age groups, residents and non-residents, educated and non-educated, low, medium and high income earners all patronize private health care service provided by Private providers. Another study in Sub-Saharan Africa indicates that Private sector cares for people from a wide distribution of incomes, including poor and rural populations. In Ethiopia, Kenya, Nigeria, and Uganda, more than 40 percent of people in the lowest economic quintile receive health care from private, for-profit providers (IFC, 2005).

2.7. National Health Policy Guideline for Health service delivery in Ghana

The Ghana National Health Policy is designed within the context of achieving a middle income status by 2015, placing health at the centre of socio-economic development and presenting a clear shift in the role of health in the national and international development framework based on the recognition that health is not only a human right issue but also a key driver of development, and ultimately of wealth creation (MOH, 2007). The theme of the health policy is "creating wealth through health" as demonstrated Millennium declaration, the Ghana Growth and Poverty Reduction Strategy, the Ghana Macroeconomics and Health Initiative Report 2005 and various health sector policies and strategies. The Policy brings to bear the benefit Ghana would derive from greater investment in health and nutrition and the critical role that healthy lifestyle, a healthy enhancing environment, a vibrant health industry and other sectors beyond health care service play in improving health and socio-economic development.

The policy focuses on the promotion of healthy lifestyle through good nutrition, regular exercise, recreation, rest and personal hygiene. It further places healthy lifestyle within the context of the physical and social environment where people live, go to school and work emphasizing potable water, sanitation, and safe food, housing and road, as means of promoting good health and prevention of diseases and injuries.

The policy seeks to build a pluralistic health service that recognizes allopathic, traditional and alternative providers (both private and public) ensuring access to quality health intervention for preventing diseases and injuries, as well as for restoring the health of the sick and disabled. It aims to provide comprehensive health care services comprising preventive, curative and rehabilitative services. Finally, the policy seeks to promote a vibrant local health industry that supports effective, efficient, and sustainable service delivery, creates jobs and contributes directly to wealth creation and attainment of national development objectives.

The policy provides broad guidelines for the development of programmes by key stakeholders namely Government, other Ministries Departments and Agencies (MDAs), local authorities, such as district assemblies, the private sector, civil society organizations as well communities and traditional leaders. It also intends to guide

health enhancing actions of individuals, households and communities and corporate entities as a tool for government.

According to the National Health Policy, health service providers in the public and private sectors as well the formal and informal sectors play key roles in delivering high quality services and being responsive to the needs of their patients and client. Currently, 65 percent of the Ghanaian population use traditional and alternative medical care. However, health providers in both the formal and informal are not regulated or fully integrated into the existing health delivery system (MOH, 2007).

2.8 Arguments for and against Private Sector Involvement in Health Care Delivery

The world over, the private sector is the major contributor to GDP and employment and so is the engine of the economy. GDP is simply the sum of the increase in value added by the activities of all participants engaged in production and market exchange. The greater the capability of private actors, including the poor, to add value and create wealth, the faster will be the pace of growth (OECD, 2004).

The private sector plays a significant role in delivering health care to people in developing countries. By some estimates, more than half of all health care to the poorest people is provided by private doctors, other health workers, drug sellers, and other non-state actors. This reality creates problems and potential. By and large, developing-country health policy and donor-supported health programs fail to address the problems, or capture the potential of the private sector in health. Interest is growing, within the donor community and among policymakers in developing-country governments, to find ways to work with the private sector to accelerate progress toward high-priority health objectives. However, governments in many low and middle-income countries lack the essential skills and tools (for example, public-private partnership guidelines) to do this effectively. Recognizing this constraint to health system development, the Center for Global Development (CGD) convened a working group to design a practical way for donors and technical agencies to support successful public-private interactions.

Governments of developing countries have much to gain by engaging the private health sector. Some of the gains include the following; the private sector already

plays a large role in health care in Africa serving nearly 50 percent of those who seek care outside the home (CGD, 2009). Also patients in developing countries prefer the private sector because they respond more to patients' needs, the private sector fills important gaps in health services and products to those underserved by the public sector, in many developing countries, the private sector owns and manages 40 to 50 percent or more of the country's health infrastructure and it is often the primary employer of health care professionals (CGD, 2009). Many of these services are located in remote and rural areas. The public sector can extend its reach by contracting these providers or by undertaking quality-enhancing activities such as accreditation. Public health services in developing countries often benefit better-off people more than the poor. Policy interventions, such as vouchers or insurance premium subsidies for poor people, can preferentially expand access for poor people to high-priority services or products (CGD, 2009).

Enabling policy changes can motivate increased manufacturing, distribution, and retail of high-priority health products. In many countries, excessive and poorly designed regulatory and tax policies discourage investment in important subsectors. Strategic policy changes (for example, changing entry regulations or tax provisions) can provide incentives for expansion in these subsectors and increase access to and use of important health goods, including bed nets, diagnostic tests, medical equipment, and pharmaceuticals.

Private-sector investment and growth often requires public sector links to reach people in lower-income households or underserved areas. Without contracting or insurance arrangements, or subsidies for poorer patients, much growth of the commercial private sector will occur in the subsectors primarily serving the better off portions of the population (for example, urban hospitals) (CGD,2009).

2.9 Challenges and Prospects of Private Health Institutions in Health Services Delivery

It has been noted that, in Sub-Saharan Africa, because the private sector is diverse and fragmented, service quality can be inconsistent and sometimes poor even when intentions are good. Also the lack of accreditation, the existence of a largely uninformed (in some cases illiterate) population, has created an environment in which an unscrupulous minority can sometimes prevail over responsible providers.

Others are the pursuit of excessive profits leading to unethical business practices such as under or over-servicing, collusion, false billing, price gouging, and unlicensed practice, private health care providers sometimes fail to deliver an appropriate level of care and the existence of substandard drugs (often resulting from small, sub-scale manufacturers without the skills, processes, and technologies required to produce to a higher standard) and counterfeit drugs (often linked to organized crime).

According to the Ministry of health (2007), health care quality in Ghana is bedeviled with challenges such as; users routinely complaining of abusive and humiliating treatment by health providers. Long waiting time, high cost of care and illegal charges are commonly cited as reasons for dissatisfaction with public sector services. They have limited avenues to seek redress. Shortage of equipment, consumable supplies and some essential drugs undermines facility functioning, damages reputation, inflates out-of-pocket costs to patients and fuels a spiral of distrust and alienation. In many health facilities, standard managerial practices that ensure effective use of (limited) resources are not universally practiced.

Poor coordination between different parts of the health care delivery system (even in the same health facility) continues to be a major hindrance to efficient service delivery and poses inconvenience to clients as they shuttle between different departments and referral systems. Weakness or non-existent in many districts and within health facilities, compounds the poor coordination between different levels of care and within facilities and further compromise care of seriously ill patient.

2.10 Case Study of Successful Private Sector Programmes

2.10.1 Private Health Services for the Poor in India

2.10.1.1 Policy Background of India's Health Policy

A 1983 National Health Policy of India gave a general exposition of the policies which required recommendation in the circumstances then prevailing in the health sector. Following changing circumstances relating to the health sector of the country since 1983, a new policy framework National Health Policy (NHP) was formulated in 2002. The NHP of 2002 set out a new policy framework for the accelerated

achievement of health goals in the socioeconomic circumstances prevailing in India at the time.

2.10.1.2 Policy Objectives

The main objective of the policy was to achieve an acceptable standard of good health amongst the general population of the India through increased access to the decentralized health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions with priority given to ensuring a more equitable access to health services across the social and geographical expanse of the country.

The policy sought to enhance the contribution of the private sector in providing health services particularly for the population group which can afford to pay for services giving primacy to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation among others.

The 2002 NHP endeavoured among other goals to eradicate Polio and Yaws by 2005, eliminate Leprosy by 2005, eliminate Kala Azar by 2010, eliminate Lymphatic Filariasis by 2015, achieve Zero level growth of HIV/AIDS by 2007, reduce Mortality by 50 percent on account of TB, Malaria and other vector and Water Borne diseases by 2010, reduce prevalence of blindness to 0.5 percent by 2010 and reduce IMR to 30/1000 and MMR to 100/Lakh by 2010.

The Policy welcomed the participation of the private sector in all areas of health activities such as primary, secondary or tertiary with a substantial contribution of the private sector in the urban primary and tertiary sectors, and moderate in the secondary sector. The Policy encouraged the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages (MHFW, 2002).

2.10.1.3 Growth of the Private Sector in India

A study by Radwan (2005) on Private Health Services for the Poor in India revealed that, at Independence, less than eight percent of all medical institutions in the country were maintained by wholly private agencies. The private sector emerged in response to the fact that, the poor in India are disproportionately affected by disease and have limited access to adequate, medical services, high illiteracy rates, limited access to

safe water, poor sanitation and the inability of the public sector to reach the poor or those in remote areas all contributing to the terrible state of health in which many of the poor live. Similarly, by 1996 the private sector accounted for 54 percent of rural hospitalization and 70 percent of urban hospitalization (National Sample Survey 1995/96 in Radwan, 2005).

2.10.1.3 Structure of India's Private Health Sector

India's private sector is a broad group that includes; for-profit and not-for-profit providers, nongovernmental organizations (NGOs), missionary hospitals, private pharmacies, and blood banks plus unqualified informal providers, some of whom are registered and others not categorized in the following three components; Rural medical providers (RMPs), Not-for-profit (NFP) sector, including NGOs and religious-based facilities and Corporate, or for-profit, sector (Radwan, 2005).

2.10.1.4 Use of the Private Sector in India

The private sector provides the majority of health care in India for both outpatients (more than 80 percent) and inpatients (close to 60 percent) especially in the poorest states, such as Bihar and Uttar Pradesh, where no effective alternatives to the private sector exist. In richer states, such as Punjab and Maharashtra, much of the population who can afford prefers private services. The majority of the population in rural areas use the services of unregulated and often unqualified medical practitioners, such as "Jhola Chap" doctors and faith healers. (Radwan, 2005). The private sector is increasingly involved in primary and even in preventive health care such as maternal and child care, institutional deliveries, antenatal care and immunization. (Matthews et. al 2001, in Radwan, 2005).

2.10.1.5 Challenges of Increased Private Sector Participation in India

Informal providers have low levels of education and poor record keeping skill making them not qualified to provide the type of services that almost all of them are offering, including prescribing and administering powerful drugs and injectable medicines. Overall, the private sector's biggest problem is that it is without any oversight or regulation resulting in duplication of facilities in urban centers, variable quality services in the absence of licensing or accreditation, corrupt practices,

variable charges, and lack of integration with other health issues such as disease surveillance (Radwan, 2005).

Lessons learnt

From the above, the following lessons can be drawn.

1. The private sector caters for the health needs of the poor both in the Urban and Rural areas of India.
2. Private services are easily accessible and affordable in India.
3. The operation of the private sector without regulation could lead to duplication of facilities in urban centers, uneven quality services due to the absence of licensing and accreditation, corrupt practices, erratic charges, and lack of integration with public health issues such as disease surveillance.

2.10.2 Kenya's APHIA II Western Project

Getting the Private Sector Involved in Provider-Initiated Testing and Counseling (PITC)

Kenya has one of the most developed private health sectors. The private sector in Western Province comprises a range of health care workers, including nurses, clinical officers, midwives, doctors, pharmacists, and laboratory technicians, working in a variety of settings from small, private for profit clinics and pharmacies in rural settings, to large, privately owned full-service hospitals and company-run clinics (Muthoni et al. 2010). Estimates of the private health care market in Kenya top 20 billion Kenyan shillings (approximately US$2.7 billion), and the private sector owns nearly two-thirds of health facilities in Kenya (Muthoni et. al, 2010). In Kenya, 45 percent of the lowest-income quintile and 49 percent of rural residents receive their care from private for profit providers (International Finance Corporation, 2005). The private sector plays a major role for Kenyans in many disease areas, including HIV testing and counseling; half of women and over a third of men go to private providers for HIV testing (Muthoni et. al, 2010).

To tap into the potential reach of the private sector, the APHIA II (A2W) project intends to build capacity among private providers to offer HIV services, emphasizing PITC. It focuses on the private sector such as stand-alone, for profit, community

clinics and mission-based clinics, private for profit hospitals and mission hospitals, and company-run health care facilities.

Successes

Several successes emerged from the involvement of private sector providers in PITC. Extending PITC through private providers has proven to be a beneficial system for the private sector and patient. Private providers gain access to MOH resources, including supplies, training, and supervision (Muthoni et. al, 2010). Some of the successes include; extension of services, relationship building, referrals and patient retention, improved data collection and comprehensive programming.

The government estimates that the private sector provides approximately 50 percent of the health care in the country, representing an essential channel for providing preventive and outpatient services to communities throughout Kenya. By extending training opportunities, commodities, and supportive supervision to the private sector, communities have more opportunities for HIV testing and counseling and more access to HIV care and support (Muthoni et. al, 2010).

Private sector involvement in PITC has strengthened the relationship between the private sector and district and national health officials. Private providers are able to refer patients to other facilities. (Muthoni et. al, 2010).

Private sector providers increase indicator reporting to meet district and provincial targets using standardized forms to identify problems with test kits, misdiagnosis, and high rates of discordant results ensuring quality of testing and data (Muthoni et. al, 2010).

Challenges

One of the biggest challenges to PITC among private providers is the intermittent supply of test kits due to shortages of supplies which affect private clinicians, who spend valuable time running between health centers looking for extra stock to borrow or redistribute during stockouts**.** Besides this, Private providers struggle to submit the time-consuming monthly reports required by the MOH to enhance future efforts toward private sector commodity management and improve the integrity of data for HIV testing. (Muthoni et. al, 2010**).**

In addition, Hidden costs which include time spent counseling that could be used with a paying client; consumables such as gloves and cotton, which are not included in test kits; costs associated with travel to the district hospital for training or to pick up supplies; and cell phone air time for communicating with health officials and others to follow-up on a referral or request commodities are seen as burden that affect their long-term ability to provide testing services. Private providers are often the last to be informed about changes to practices, policies, treatment protocols, and requirements for HIV prevention, care, and treatment. Private providers struggle with high staff turnover in their facilities; once staff members get additional training, including PITC, they seek better employment with their new, marketable skills (Muthoni et. al, 2010).

Lessons learnt

From the above case study, the following are some of the lessons learnt;

1. Just like the case of India, the private sector in Kenya plays a major role in health services provision which caters for many diseases
2. The private sector provides trained health workers for other health facilities in Kenya both in rural and urban giving the fact that workers after being trained leave to other facilities that are perceived to offer better pay
3. The private sector make HIV/AIDS testing and counseling more accessible to people living with the disease thereby improving upon their conditions
4. The private sector is limited in terms of information since information on new health practices do not reach the facilities early

2.10.3 Private sector involvement in funding and providing health services in South Africa:

2.10.4 Health care financing

In a study by McIntyre, (2010) of current private sector health care financing and provision in South Africa, private health care services are financed through private health insurance (called medical schemes) and through direct out-of-pocket (OOP) payments.

According to the study by McIntyre, services provided by the private sector in South Africa include: independent practitioners working in solo or group practice,

pharmacists at retail pharmacies, specialist doctors, private hospitals employ nurses and other health professionals, ambulance services and Traditional healers with number of health professionals working in the private health sector difficult to determine.

About 15 percent of the South African's population are beneficiaries of medical schemes. Those covered by medical schemes mostly use private sector health services and those not covered use the services of private providers for out-patient services and pay for this on an OOP basis. Only 15 percent of the population use private sector hospitals, and about 32 percent of the population use outpatient services in the private sector.

According to the study, the private health sectors that involve the considerable capital investment in organizations that operate on a for-profit basis are: medical scheme administrators, private hospital groups and pharmaceutical companies (McIntyre, 2010).

The utmost challenge facing the private health sector in South Africa is the rapid increase in spending, particularly by medical schemes. Medical schemes operate on a 'pay as you go' basis, i.e. contribution revenue roughly approximates spending on health services, administration and related activities in any year. As spending increases, so do contributions.

Some of the factors contributing to the increases in expenditure include; increased spending on medicine, high cost services and fee increases in private hospitals, the ageing population, third party payments, and non-health care costs (McIntyre, 2010).

What happens in the private health sector in a particular country certainly impacts on that country's health sector (Tuohy et al, 2004 in McIntyre, 2010), as the South African context clearly illustrates. For example, in the 1990s when medical schemes were deregulated and open schemes were allowed to exclude high-risk individuals from membership and engage in risk rating, there was extensive 'cream-skimming' resulting in the public health sector bearing the burden of caring for South Africans with the greatest risk of ill health.

One of the greatest challenges facing the South African health system is the relative sizes of the public and private sectors, in terms of the amount of resources (financial and human) and the population size served (McIntyre, 2010)

A range of regulations govern the private health sector in South Africa, but these are quite fragmented (contained in a myriad of different pieces of legislation and with different bodies responsible for regulation development and implementation) and sometimes contradictory.

The key focus of private health sector regulation in South Africa has been on protecting the public in relation to quality of health services and products (McIntyre et al, 2010).

There is currently considerable debate about the proposed introduction of national health insurance (NHI) in South Africa, which could have considerable implications for the private health sector. This has followed from the decision at the 2007 policy conference of the ruling African National Congress (ANC) to introduce a NHI.

In conclusion, serious challenges face the private health care sector in South Africa, not least of all very rapid increases in expenditure and, hence, contribution rates in medical schemes.

A range of factors underlying these trends, but these have not been addressed effectively either through government regulation or through action by the private health sector itself. These challenges impact on the overall health system, both in terms of its affordability and sustainability and in terms of the ability to achieve the income- and risk-cross-subsidies needed to achieve a universal system.

The experience of the private health sector in South Africa should be taken into account by policy-makers in other African countries when considering what role they envisage for the private health sector in their country context.

2.10.5 Lessons learnt

Some of the lessons that could be learnt from the Private sector involvement in funding and providing health services in South Africa are;

1. Apart from personal financing, private health sector could also be financed through schemes and direct payment by clients.
2. increased spending on medicine, high cost services and fee increases in private hospitals, the ageing population, third party payments, and non-health care costs are some of the factors contributing to the increases in expenditure in the private health sector
3. The activities of private health sector in one country impacts on the entire country's health sector and that of other surrounding countries.
4. Regulations controlling the development of private health sector in South Africa focus on protecting the public in relation to health services and product quality.

2.10.6 Conceptual Framework

Maxwell (2004) defined a conceptual framework as a visual or written product, one that "explains, either graphically or in narrative form, the main things to be studied - the key factors, concepts, or variables - and the presumed relationships among them".

The conceptual framework is primarily a conception or model of the topic under study and why it is being studied. It is a tentative theory of the topic under investigation. The function of this framework is to inform the rest of the design to help assess and refine the goals, develop realistic and relevant research questions, select appropriate methods, and identify potential validity threats to the conclusions. It also helps to justify the research.

The conceptual framework for this study seeks to explain in visual form the key concepts or variables of the study and the relationship that exist between them as depicted below;

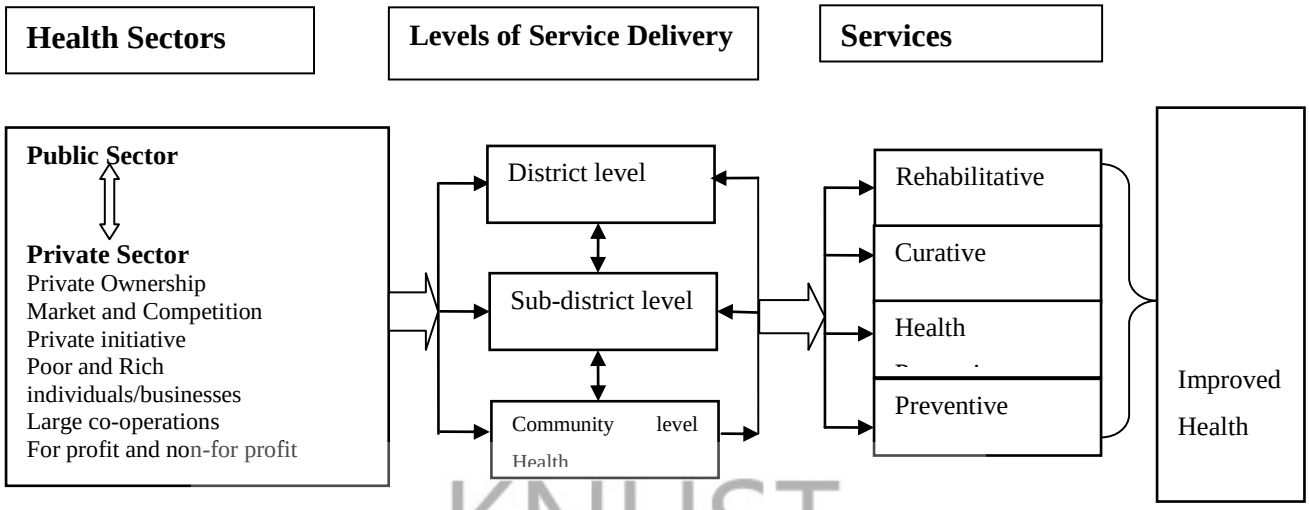


Figure 2.1. Conceptual Framework on the role of Private Sector in Health Service Delivery

Source: Author's Construct, 2012

The framework presents the relationship between the sectors involved in health services provision, the levels of service delivery, health care services and the ultimate goal of health programmes. It presents the sectors (Public and Private) providing services through the community, sub-district and district levels using resources and inputs in the form of allied professionals, medicals, consumables, infrastructure and management services to achieve the ultimate goal of improved health.

From the framework, the private sector which comprises various actors from the individual such as peddler to the large cooperate organizations and the poor to the very rich providers deliver health services either through health systems beginning from at the door step or entry point at the community health centre through the referral system to the regional hospitals or offer direct treatment be it preventive, promotive, curative, treatment and rehabilitative care to clients. It also shows a relationship between the public and private sector given that both sectors depend on each other for one service or the other whenever the need arises.

The framework presents the Private Health sector as earlier on defined, to include; Private Ownership, Market and Competition, Poor and Rich individuals/businesses, Small holders, Large co-operations and For profit and non-for profit organizations.

It also presents the health system from the entry point of Community level, Sub-district level to the District level.

Major lessons from this chapter are that the private sector's participation in health service provision has gained worldwide recognition and that the concept of the private sector is not a new phenomenon in Ghana and for that matter Techiman municipality. Also the private sector has broadened the beneficiaries' choice of service. Finally discussions from this chapter serve as basis for the next chapter to inform the type of research design, sampling methods and data collection tools to be used for the study.

CHAPTER THREE

PROFILE OF THE STUDY AREA AND RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses the profile of the study area, the prevailing health issues in the area and the methodology adopted to undertake the study. Specifically, the methodology adopted for the study include; research approach, research design and study variable, the data required and their sources, data collection procedure, sampling size determination and sampling techniques and data analysis.

3.1 Profile of Study Area

3.1.1 Location and Size

Techiman Municipality is situated in the central part of Brong Ahafo Region and lies between longitudes $1^0 49`$ east and $2^0 30`$ West and latitude $8^0 00`$ North and $7^0 35`$ South. It shares common boundaries with four other districts; three in Brong Ahafo Region and one in Ashanti Region. The Wenchi Municipality lies to the northwest, Kintampo South District lie to the northeast, Nkoranza South District to the South-East and Offinso-North District (in the Ashanti Region) to the south. The Municipality covers an area of 669.7km^2 representing approximately 1.69 percent of the surface area of Brong Ahafo Region. The Municipal capital, Techiman is a major market centre and a nodal town or entrepol, where roads from the three northern regions converge. Trunk roads from Sunyani, Kumasi, Wa and Tamale all meet at Techiman thus making it a bustling food crop market and commercial centre. The Techiman Municipality is among the twenty-two administrative districts in the region.

3.1.2 Population Size

The population of the Municipality is currently estimated at 225,705 with an average growth rate of 2.8 percent per annum. The population density is estimated over 351 persons/Km^2. The population of the Municipality has witnessed rapid increase from a modest 34,642 in 1960 to 174,600 in 2000 and 225,705 in 2010 (TMA, 2010).

3.1.3 Age and Sex Structure

The age structure of the population depicts the general trend indicating a broad base that gradually tapers off with increasing age due to death. This implies more job creation for the larger segment ages 15 – 64 years (55 percent) and an increase in social services like health, education and recreational facilities for the dependent age groups under 15 years and 65 and above constituting about 45 percent. Females dominate the population of the Municipality. The sex ratio, male to females is 99.9 in contrast to the regional ratio of 100.8. The structure also has implications for future population growth (TMA, 2010).

3.1.4 Dependency Ratio

The dependent population of the Municipality is estimated at 80,946 with an economically active population (Age 15 – 64) of 99,591. The dependency ratio of 81.27 is therefore far below the regional average of 90.5. This low dependency could augur well for savings and capital accumulation (TMA, 2010).

3.1.5 Household Composition

The composition and structure of the households reflects the social structure of the society. The average household size is 4.9 as compared to the regional average of 5.2. About 33.1 percent of the households in the Municipality are female headed. The household structure indicates that Techiman has the highest Percent (41.3 percent) of children constituting household members. The household composition and structure indicate that the traditional family structure still exists in the Municipality. The dominance of male headed household also augurs well for the poverty situation of the household (TMA, 2010)

3.1.6 Fertility and Child Survival

The total fertility rate (TFR) is 3.64 with mean children ever born (MCEB) average of 4.89. This is lower compared to the regional figure of TFR of 4.24 and MCEB of 5.02. The fertility levels tend to be lower for urban than rural areas of the Municipality. This is also affected by their educational attainment. Survival rate for children as at year 2000 was estimated at 82.44 comparable to the regional average of 82.34. This implies that less than 16 percent of the children born to women (12 – 49) years ever die. Child survival in the district is high (TMA and MHD 2010).

3.1.7 Health

As a result of poverty and ignorance, many women resort to unorthodox means of seeking health care. Many sick mothers, including pregnant women attend 'Nakaba' when sick and are rushed to hospitals and clinics only at critical point. Women in the Municipality are generally least educated, poorer economically and weaker health-wise. Continued gender inequality in the Municipality will hinder its human development effort if it is not addressed.

Table: 3.1 Health Facilities in the Municipality

Health Facilities	**Number**	**Percentage**
Public Health Centres/Clinic/CHPS	24	68.57
Private Health Facilities	4	11.43
Maternity Homes/Clinics	5	14.29
Mission Hospitals	2	5.71
Total	**35**	**100.00**

Source: MHD, 2010

There are 35 health facilities in the municipality that provide healthcare services. Of these, 24 are public facilities comprising 10 health centres and 14 CHPS compound. The remaining 11 are all private facilities.

3.2 Health Services Organization and Management Arrangement

Health services organization and management in the Municipality is not different from that of the country as presented by the National Health policy and other studies and reports as earlier indicated in chapter two. All the health service facilities in the Municipality are under the supervision of Municipal Health Directorate. It implements policies of the Ghana Health service and has an oversight responsibility over 35 health facilities which include, 10 health centre 14 functional CHPS zones, two mission hospitals, two private hospitals, two private clinics and five Maternity homes all providing health care service delivery. These facilities ensure quality health and nutrition services. The entry point for these services is the CHPS at the community level where available then to the sub-district clinics or health centres and finally to district level where the two mission hospitals provide more services. Where cases cannot be handled by these hospitals, they are referred to the regional hospital in Sunyani, Komfo Anokye teaching hospital in Kumasi or Korlebu teaching hospital in Accra.

The Directorate as a supervisory body among other things ensures quality control measures, challenges faced by the facilities and efforts to improve upon health care delivery.

The Municipal Health Directorate enjoyed a considerable collaboration with private sector providers and other stakeholders. For more effective governance, team work attitude is being adapted. The directorate holds weekly management meetings centred on management and public health issues. Other committee meetings (Epidemic management, Procurements) are being held on quarterly bases.

3.2.1 Staff Situation

As at 2011 the staff distribution in the health sector in Techiman was one Medical Director, 12 General Doctors, three Specialists, 13 House Officers, Ten Medical Assistants, 62 Midwifes, 45 General Nurses, seven Public Health Nurses, 47 Community Health Nurses, two Pharmacists, eight Pharmacy Technicians, five Community Health Technician Officers, four Community Health Field Technicians, 44 Ward Assistants, 65 Health Extension Workers, five Laboratory Technicians, six Medical Record Technicians and eight Disease Control Officers.

The Doctor-Patient ratio for the Municipality is 1:21,363 while the Nurse: Patient ratio is 1:2,500. Compared to the regional and national figures of 1:15,390 and 1:11,479 doctors respectively the figure for the Municipality is higher. In the same vein, regional and national figures of Nurse-patient ratio stands at 1:1,882 and 1:1,510 respectively which are also lower than the Municipal figure of 1:2,500 (MHD 2012, NDPC, 2010).

Disease pattern since 2005

Malaria has been identified as the major disease in the municipality. Tables 3.2 and 3.3 show the trend of top ten causes of OPD Attendance and Admission from 2005 to 2011 in the Municipality.

Table: 3.2 Trend of Top Ten Causes of OPD Attendance 2005 to 2011

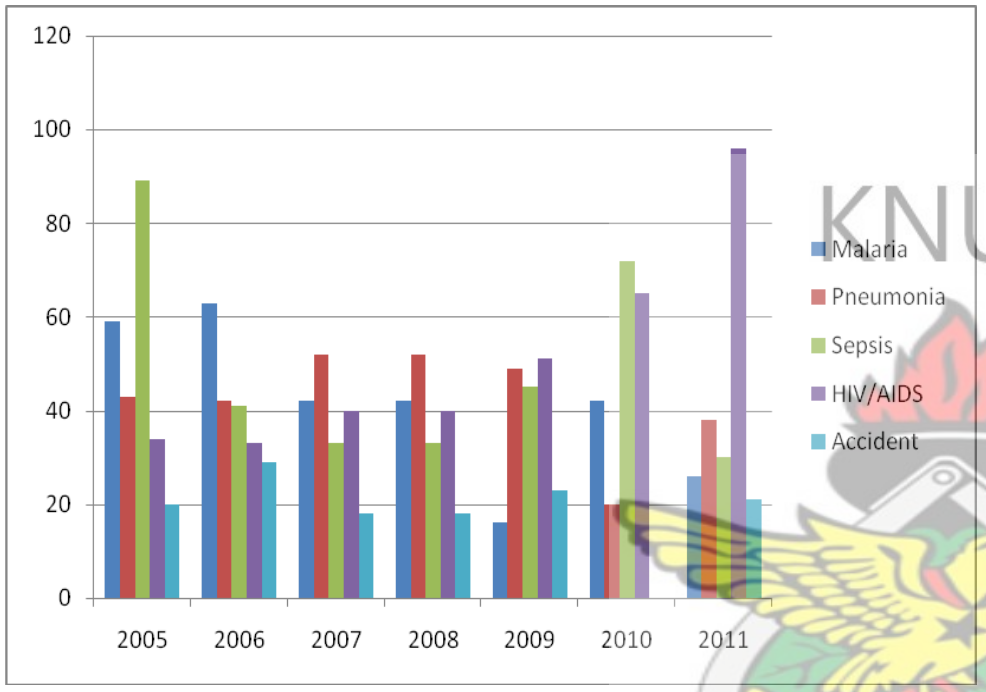
No.	2005		2006		2007		2008		2009		2010		2011	
	Disease	**Nos. Cases**	**Disease**	**Nos. Cases**	**Disease**	**Nos. Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**
1	Malaria	43962	Malaria	54909	Malaria	93284	Malaria	107000	Malaria	91691	Malaria	41081	Malaria	64922
2	URTI	6767	URTI	9272	URTI	14480	URTI	23587	URTI	14956	URTI	7619	URTI	25619
3	Skin Diseases	5132	Skin Diseases	6485	Skin Disease	9990	Diarrhoea	9190	Skin Diseases	9658	Skin Diseases	7193	Skin Diseases	18767
4	Diarrhoea	3325	Diarrhoea	3044	Diarrhoea	7083	Rheumatism	8325	Rheumatism	6054	Acute Eye Infection	4147	Rheumatism	11922
5	Intestinal Worm	2809	Preg. Relat. Complication	2828	Preg. Related complicatio n	6520	RTA	5392	Diarrhoea	5194	Rheumatism	3110	Diarrhoea Diseases	9692
6	Acute eye infection	2255	Intestinal Worm	2587	Intestinal Worm	6080	Home/Occup. Acc	3983	Intestinal Worms	4867	Anaemia	2737	Anaemia	7677
7	Preg. Related complication	2222	Intestinal Worm	2587	Rheumatis m	2597	Intestinal	3769	Hypertension	2627	Intestinal Worms	2632	Intestinal Worm	6854
8	Home/Occupati on Accidents	1764	Rheumatism/J.P	2312	Accidents	2565	Chicken Pox	2938	Anaemia	2349	Diarrhoea Diseases	2380	Acute Eye Infection	6390
9	Hypertension	1726	Home/Occ Accidents	1479	Hypertensi on	2092	Acute Eye Infections	1679	Vaginal Discharges	2082	NutritionDisor ders	1754	Hypertension	3610
1 0	RTA	1268	Hypertension	1311	Pneumonia	2079	Preg. & Rel. Compl	1731	Preg. & Rel. Compl.	2073	UTI	1635	Vaginal Discharge	2719

Source: MHD, 2012.

Table: 3.3 Trend of Top 10 Causes of Admission from 2005 to 2011

No.	2005		2006		2007		2008		2009		2010		2011	
	Diseases	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**	**Diseases**	**No. of Cases**
1	Delivery	2925	Delivery	3038	Delivery	3038	Malaria	2019	Malaria	1999	Malaria	3340	Malaria	5131
2	Malaria	1612	Malaria	1796	Malaria	1796	Anaemia	1152	Anaemia	972	Anaemia	1268	Anaemia	1349
3	Anaemaia	947	Anaemai	768	Anaemia	768	Home/Occu. Acc	563	Home/Occu Acc	393	Sepsis	605	Sepsis	823
4	Inguino scrotal	498	Occp Accident	472	Accident	472	RTA	410	RTA	374	Pneumonia	399	Pneumonia	745
5	Accident	428	Sepsis	371	Sepsis	371	Enteric Fever	315	Pneumonia	374	Hypertension	278	Hypertension	512
6	RTA	309	RTD	337	RTA	337	Pneumonia	297	Septicaemia	249	Urinary Tract Infection	256	Gastroenteritis	494
7	Pneumonia	232	Ing Scrotal	326	Ing Scrotal	326	Gastroenteritis	286	Typhoid Fever	236	Gastroenteritis	238	RTA	408
8	Typhoid	132	Pneumonia	194	Pneumonia	194	Septicaemia	254	Gastroenteritis	234	HIV/AIDS	213	UTI	358
9	Sepsis	261	Typhoid F	154	Typhoid	154	AIDS	261	HIV/AIDS	221	Diabetes	195	Diabetes	269
10	AIDS	121	AIDS	118	AIDS	118	Diabetes Mellitus	189	Hypertension	175	URTI	124	Home Accidents	176

Source: MHD, 2012.



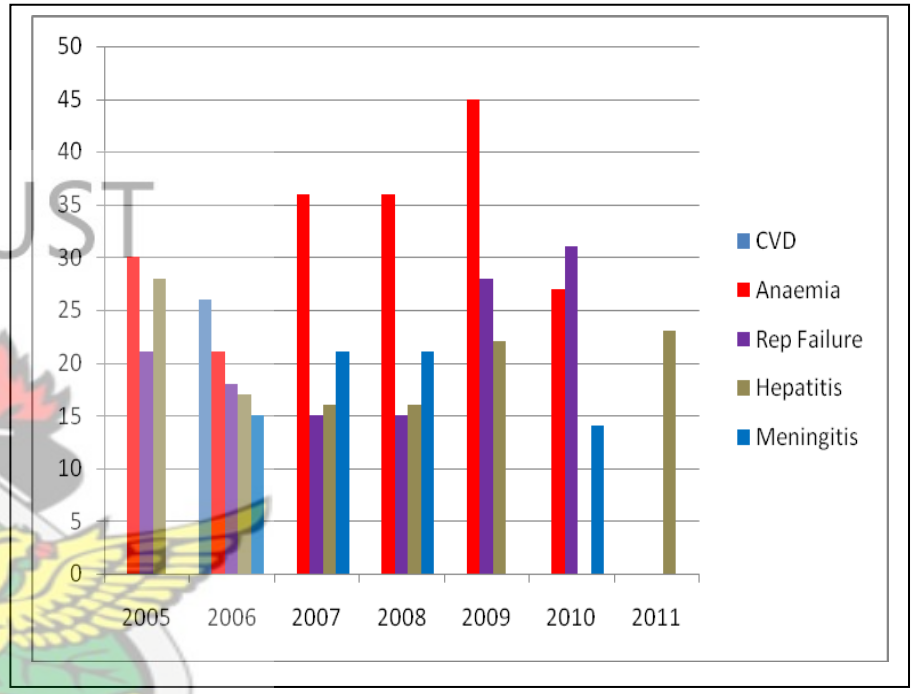


Figure 3.1a Trend of Top 10 Causes of Mortality from 2005 to 2011 **Figure 3.1b Trend of Top 10 Causes of Mortality from 2005 to 2011**

Source: MHD, 2012

From Table 3.2, it is evident that malaria continues to be the leading cause of OPD attendance. It is worth noting that Road Traffic accidents for the 1st time in three years appeared on the municipality's top ten morbidity chart. This indicates the growing importance of the municipality as an accident/ emergency centre in the country, due to it's strategic location. With the introduction of the new anti malaria combination therapy and strengthening of the Home-Based Care component of the malaria control programme, as well as other environmental sanitation measures, it is hoped that there will be a decline in malaria cases.

The Municipality would also need to take a serious look at strategising on non-communicable diseases. Already a diabetic clinic is functional at the Holy family Hospital in Techiman. There is the need to promote healthy lifestyle behaviours through the promotion of recreational activities and facilities.

Table 3.3 (Top 10 causes of admissions from 2006-2012) shows clearly that there has been a reduction in cases of complicated malaria in the municipality. Analysis of the outpatients/ inpatients data in 2007 and 2008 shows clearly that even though higher OPD cases were reported compared to 2009, there was a low in- patient malaria cases of about 1.9 percent in 2008. This therefore calls for intensification of the national malaria control programme to reduce the malaria cases. This represents 14.8% of the total admissions as compared to 17.6% in 2006. For the first time, in 2009, HIV/AIDS featured in the top ten causes of admission. This indicates the rising trend of the HIV/AIDS pandemic in the municipality, which calls for urgent and appropriate response.

Figure 3.1 above shows how positive the Global Fund support for malaria has contributed towards reduction in malaria deaths in the municipality.

3.2.2 Tuberculosis (TB)

Case detection of Tuberculosis in the municipality increased from 116 cases in 2010 to 175 cases in 2011. However, case detection rate is low compared to the national target of 70 per cent. Out of 57 positive cases of TB detected, the most affected age group falls between the ages of 25-34 years representing 28.1 per cent. This requires that active surveillance need to be strengthened to detect more cases, as this age group

is the reproductive age group. TB patients diagnosed to have also been affected by HIV/AIDS constituted 33.5per cent in 2011 as against 26.0 per cent in 2010.

3.3 Disease Control and Prevention

3.3.1 H1N1 Pandemic Influenza:

In June, 2010 the Municipality experienced an outbreak of H1N1. One hundred and eighteen students from Techiman Senior High School reported at the Techiman Holy Family Hospital with symptoms of H1N1. 16 out of 20 (80 percent) samples that were sent to Nouguchi Memorial Institute for Medical Research (NMIMR) were H1N1 positive. They were treated with Tamiflu with no death recorded. The outbreak was controlled by the combined efforts from the Regional Health Directorate, staff of the Municipal Health Directorate, hospital staff, GES office and the School's authorities.

3.3.2 Non Communicable Diseases

In detection, reporting and management of non communicable diseases through public education and screening for cervical cancers, out of 218 women who were screened, 164 were negative while 43 (19.7 percent) were positive and 11 (5 percent) suspected to have cervical cancer.

Hypertension and Diabetes Mellitus are emerging as some of the most common cause of non communicable morbidity and mortality (MHD, 2010). In 2010, the number of hypertension cases of OPD morbidity was 1754 with 17 deaths while Diabetes cases were 810, with 14 deaths (MHD, 2010). There is therefore the need to strengthen nutritional education because of sedentary and affluent lifestyle in taking fatty foods in the municipality.

3.3.3 Expanded Programme of Immunization (EPI) coverage

Data gathered from the Municipal Health Directorate indicated there has been an increase in all target coverage of EPI. The reduction in Tetanus (TT) was said to be due to data inconsistency.

Table: 3.4 EPI Coverage for the various antigens (2008-2010)

Antigen	**2008**	**2009**	**Target (2010)**	**2010 %**
BCG	130.9	128.1	99.0%	141.4
Pennta 3	98.3	93.7	95.0%	96.9
OPV 3	98.2	93.7	95.0%	96.9
Measles	94.2	98.4	95.0%	100
Yellow Fever	94.6	96.6	95.0%	98.8
TT	94.1	80.6	95.0%	87.0

Source: MHD, 2010.

BCG immunization coverage was very high due to the fact that Techiman Holy Family Hospital is a referral hospital for the municipality and other neighbouring districts. Children from the other districts received BCG before they were discharged home as in table 3.4 above.

3.3.4 Strengthening Institutional Care

Out Patient Service utilization rate measures the extent to which the population utilizes OPD services for health care. From the 2010 report of the Municipal Health Directorate, service utilization decreased from 1.28 OPD per capita in 2009 to 1.01 in 2010. This decrease was as a result of the difficulty people go through in accessing or renewing their NHI identity cards or chits. It was realized that majority of those who utilized the services were females as compared to the males as shown below.

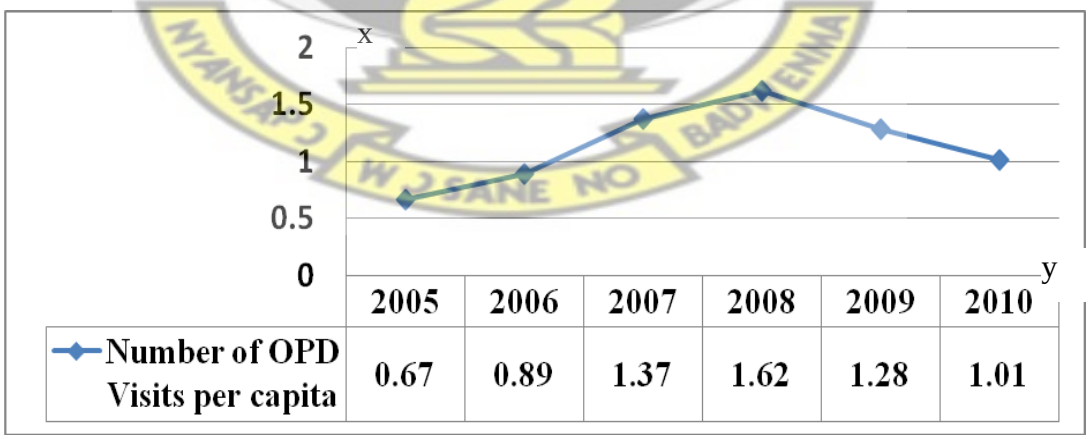


Figure 3.2: Trend in Attendance of OPD per capita (2005-2010)

Source: MHD, 2010

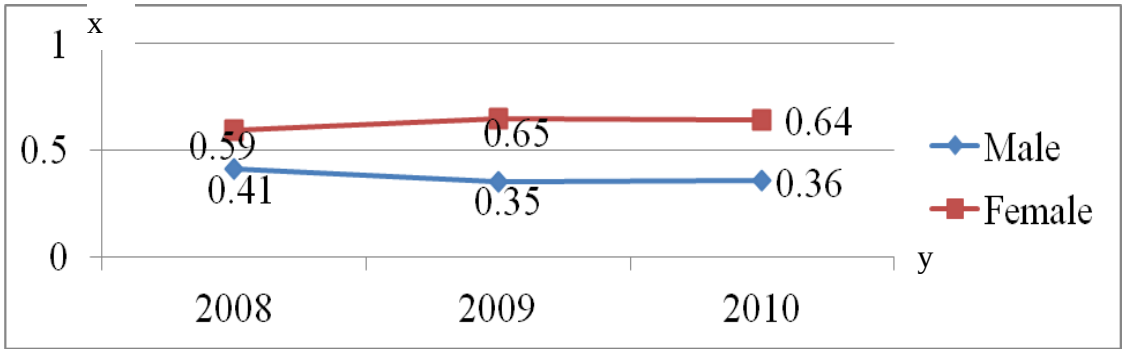


Figure 3.3: Proportion of OPD Attendance by Gender (2008-2010)

Source: MHD, 2010.

From the report, the proportion of males who visited the OPD in 2010 increased by 0.01 percent. Even though the figure for females reduced, in absolute figures, more females visited OPD in 2010 than men. There was a general reduction of OPD attendance during the year under review among both sex (80,997) for males and females (145,224) as compared to 2009 (Males = 100,699, female = 279071). The demand to access healthcare was impeded due to frustration clients went through at NHIS office to get their ID cards or chits. This also affected insurance coverage as illustrated in figure 3.4

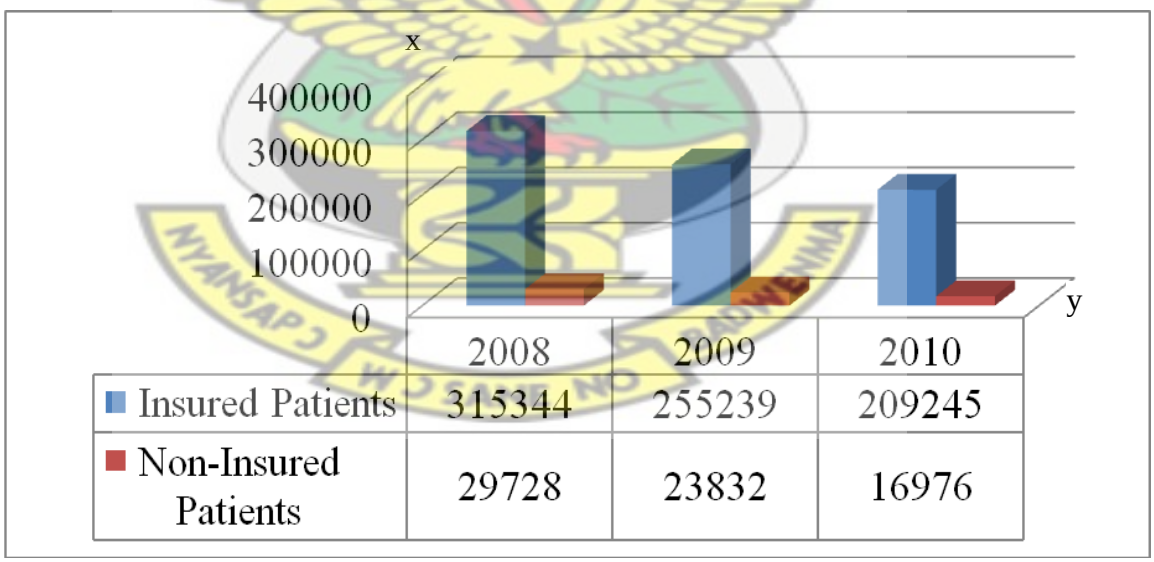


Figure 3.4: OPD Attendance by Insurance Status (2008-2010)

Source: MHD, 2010

Accordingly, 92.5 per cent of all OPD cases were insured. The non insured keep decreasing over the years as shown above. This is very encouraging as financial inaccessibility will soon be a thing of the past.

3.4 National Health Insurance Scheme (NHIS)

The 2011 annual report of the Health Directorate revealed that, the national health insurance scheme started in the municipality in 2004 with an initial number of 58, 339 beneficiaries in 14 health facilities. According to the report as at the end 2011, the municipality recorded 207,804 registered beneficiaries representing 84 percent of the municipality's population. These beneficiaries enjoy benefits from 37 health facilities. The main source of funds for health facilities comes from the National Health Insurance. From the report, 95.6 per cent of OPD patients were insured clients improving on the financial accessibility to health care services in the municipality. In the year 2011, 36,037 were registered and 98, 234 renewed their membership as against 74, 253 renewals in the year 2010. Insured clients who visited the health facilities in the municipality numbered up to 434263 representing 95.6 per cent and non insured numbered up to 19913 (4.4per cent) as against 209245 (92.5per cent) insured and 16976 (7.5per cent) non insured in 2010. Comparatively many insured patients visited the health facilities more than non insured patients. Table 3.5 shows Insured and Non Insured Patients by Institutions 2011 (MHD, 2011). The reason for the increase in the 2011 figures of insured patients was due to the free maternal health care policy and the ease of access to health care with the NHI card since patient were not required to pay cash.

Table:3.5 Insured and Non Insured Patients by Institutions 2011

Institutions	Insured Patients	Percentage (%)	Non Insured Patients	Percentage (%)
Christian Health Association of Ghana (CHAG)	211215	48.6	11672	58.6
Ghana Health Service (GHS)	73752	17.0	3787	19.0
Ghana Registered Midwives Association (GRMA)	68886	15.8	2120	10.6
Private	68916	15.9	2160	10.7
Community based Health Planning Services (CHPS)	11494	14.7	174	1.0
Total	**434263**	**100.0**	**19913**	**100.0**

Source: MHD, 2011

3.5 HIV/AIDS Situation

The strategic location of Techiman as a commercial centre and transit point attract a large number of migrants in and out of the Municipality. There is therefore a high rate of commercial sex activity and high risk behaviours (MHD, 2011). These among others have resulted in the high prevalence rate of HIV/AIDS of 4.2 per cent as compared to the regional rate of 4.7 per cent and national rate of 1.9 per cent as at the year 2009. Techiman has been identified as a high HIV prevalence area. A study conducted by the GAC in 2009 revealed that out of 1,180 people interviewed 54 per cent men and 52 per cent women reported having had two sexual partners in the past four weeks. Another 50.5 percent of the people socializing at the hotspots reported never used condoms (TMA, 2010).

According to the 2011 annual report of the directorate, HIV prevalence rate in the municipality was 0.9 per cent as compared to 0.7 per cent in 2010. In terms of sex, prevalence rate for males was 48.0 per cent in 2011 as compared to 34.2 per cent in 2010. The prevalence rate for females was 52.2 per cent in 2011 as compared to 65.8 per cent in 2010. Death rates in 2011 were 4.5 per cent as compared to 4.0 per cent in 2010 (2011).

3.6 Reproductive Health

3.6.1 Maternal / under five Morbidity and Mortality

The 2010 annual report of the directorate revealed that RCH priorities during the year were on safe motherhood and infant care, Family Planning, STI/HIV/AIDS prevention and management, Post abortion care and prevention of cancers. The Municipal Health Directorate in trying to achieve the MDGs 4 & 5 paid special attention to reducing Maternal and Infant Mortality Ratios. Maternal audits were held for all maternal deaths and also introduced neonatal death audits.

Policies on free maternal care and the national health insurance resulted in an increase in access and utilization of health services resulting in an increase from 4.3 percent in 2009 to 4.5 percent in 2010 for Antenatal care, 75.0 percent in 2009 to 79.5 in 2010 for Safe delivery and 72.0 percent in 2009 to 80.9 percent in 2010 for Postnatal care However family planning acceptor rate and uptake of Intermittent Preventive Treatment (IPT) were unacceptably low.

Table: 3.6 Percentage of Risk Factors Identified among pregnant women. (2008-2011)

Factors	Duration	2008	2009	2010
Age	Early Teens	1.0	0.2	0.4
	Late Teens	13.0	14.0	13.0
	> 35 years	16.0	17.0	14.0
Multiparity		17.0	13.0	11.0
HB < 11 gm @ Registration		11.0	6.7	10.9
HB < 11 gm @ 36 weeks		1.0	0.8	4.4
Height < 5 feet		3.0	0.9	0.3
3rd Trimester		16.0	12.5	11.0

Source: MHD, 2010

From the report, there was a reduction in all the risk factors except with Hb < 11gms at registration. Hb < 11gms at 36 weeks have also increased. There is a need to intensify health education on nutrition during pregnancy see table 3.6 above.

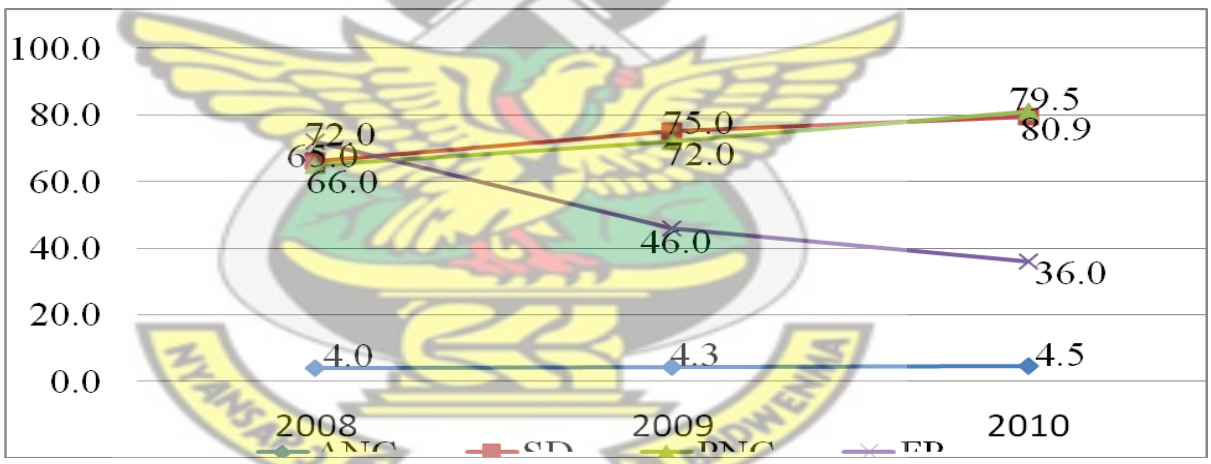


Figure 3.5. Trend in Antenatal, Supervised Delivery, Postnatal and Family Planning (2008-2010)

Source: MHD, 2010

Family Planning keeps on reducing over the years due to shortage of contraceptives supply.

Supervised delivery is indicated to have increased from 6543 in 2009 to 7110 in 2010 an increase by 4.5 percent. ANC increased from 4.3 to 4.5 average numbers of visits per client. The increase was due to government's policies on free maternal care and the operation of national health insurance.

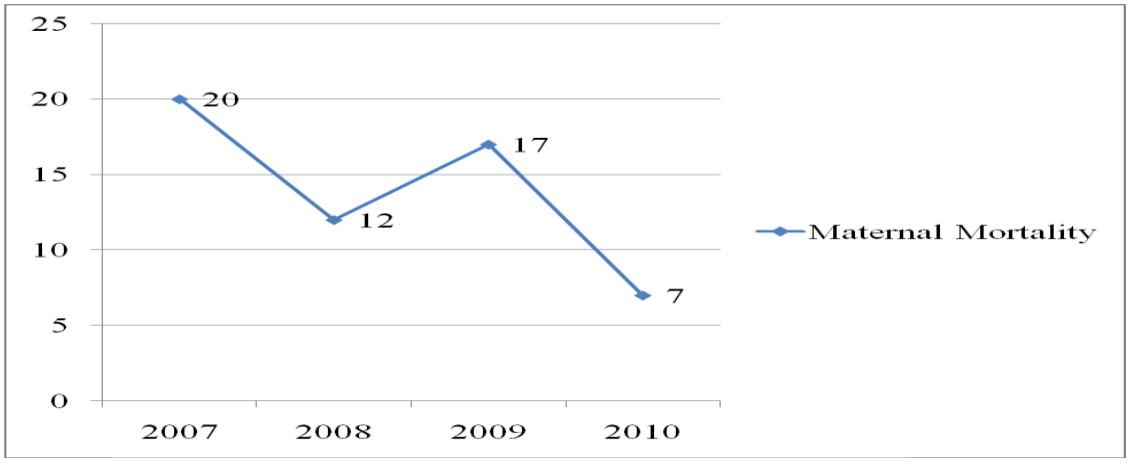


Figure: 3.6 Trend in Maternal Mortality (2007-2010)

Source: MHD, 2010

Maternal Mortality has been a great concern to the directorate and the institutions as a whole and over the years attempts have been made to reduce it to a single digit if not totally reduced to zero (0). Maternal mortality reduced from 17 deaths in 2009 to 7 deaths in 2010.

3.7 Child Health

According the report, the priority interventions under child health was on neonatal health, prevention and management of nutritional disorders, prevention and control of infectious diseases and injuries, clinical care of the sick and the injured, adolescent health and school health. Still births reduced from 198 in 2009 t0 174 in 2010.

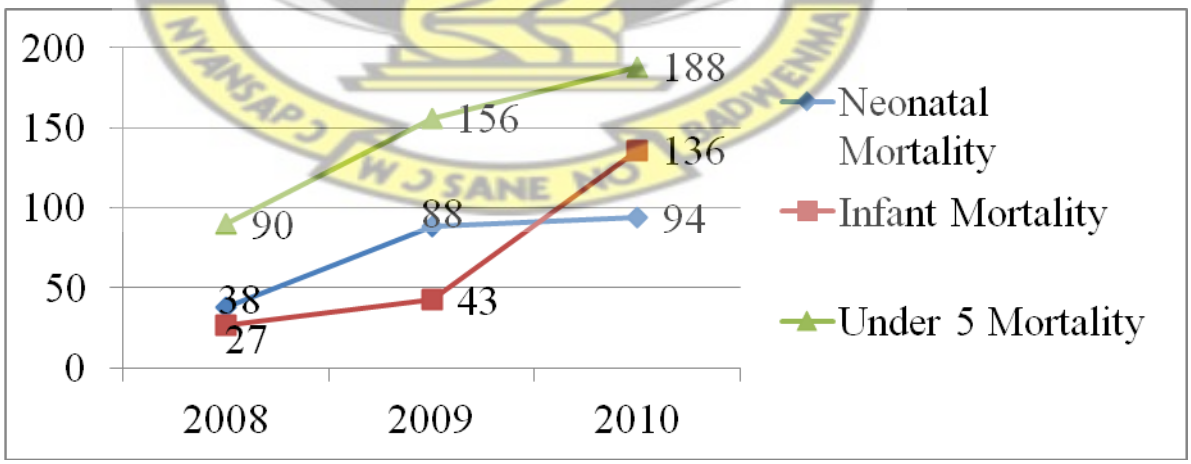


Figure: 3.7 Trend in Neonatal Mortality, Infant and Under 5 Mortality (2008-2010)

Source: MHD, 2010

Child health services have reduced following the rapid increase of deaths for neonatal, infant and children under five years (figure 3.7). To improve on the health status of these children, the municipality has mapped strategies such as training of health staff, community volunteers, teachers, opinion leaders and the media in nutrition education to intensify health education on nutrition during pregnancy and after birth.

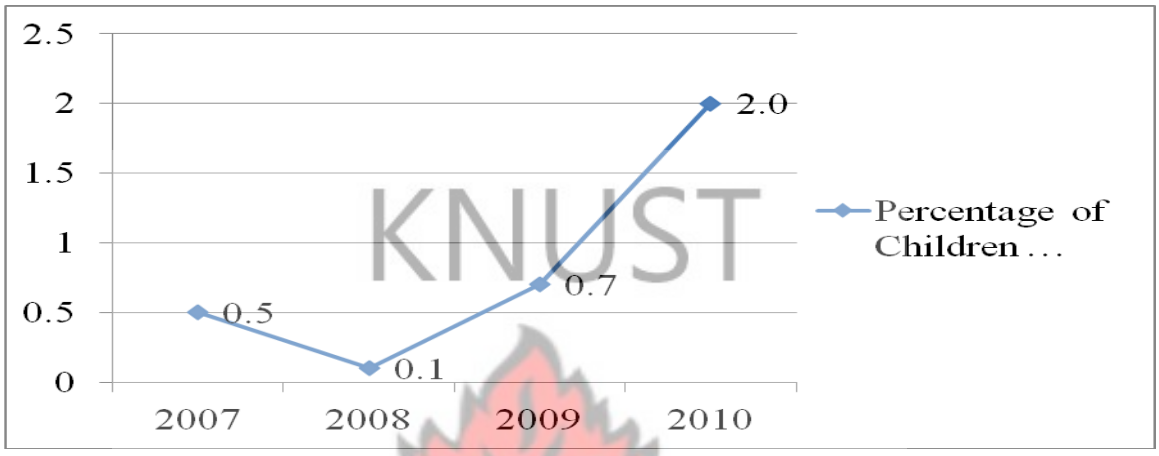


Figure: 3.8 Percentage of Children Underweight (2007-2010)

Source: MHD, 2010

It was revealed that the number of children underweight increased over the years as a result of nutritional disorder. There is therefore the need to intensify nutritional education.

3.7.1 Malaria

According to the 2011 annual report of the directorate, malaria continues to be among the leading cause of all OPD diseases. In 2011 malaria constituted 54.5 per cent (64922) of all OPD cases as against 26.8 per cent (77715) in 2010 and 26.6 per cent in the year 2009. Confirmed malaria OPD cases were 5789. Admissions due to malaria were 5131 (2489 for under 5 and 2642 for above 5). Deaths due to malaria were 19 for under5 and 16 for above 5 in the year 2011. Though there was percentage increase in 2011, there has been significant reduction in absolute cases of malaria in 2011 by 12,993. This was due to the policy on Rapid Diagnostic Tests to confirm the cases and the other malaria control activities put in place (MHD, 2011).

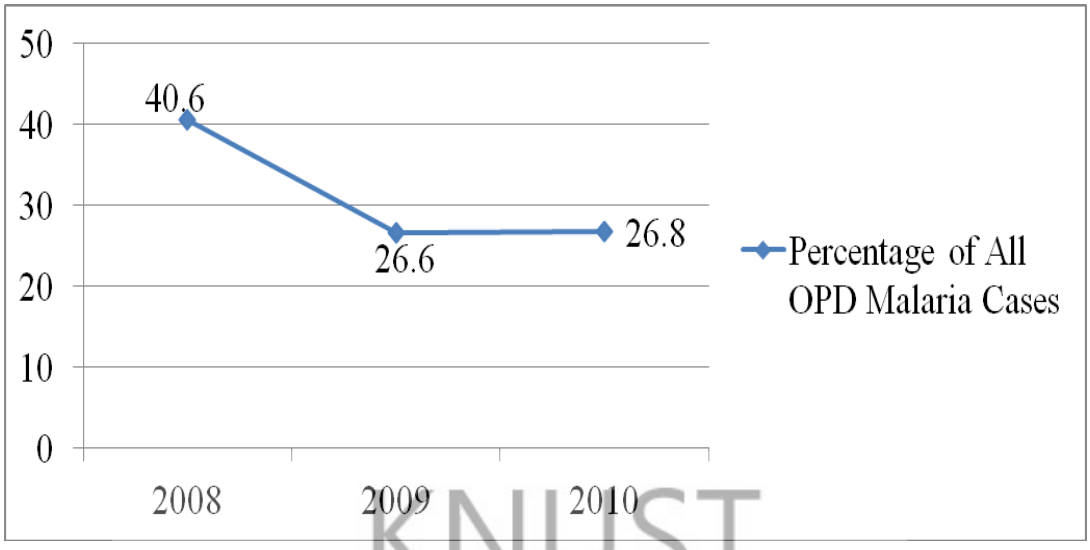


Figure: 3.9 Trend of Percentage of All OPD Malaria Cases (2008-2010)

Source: MHD, 2010

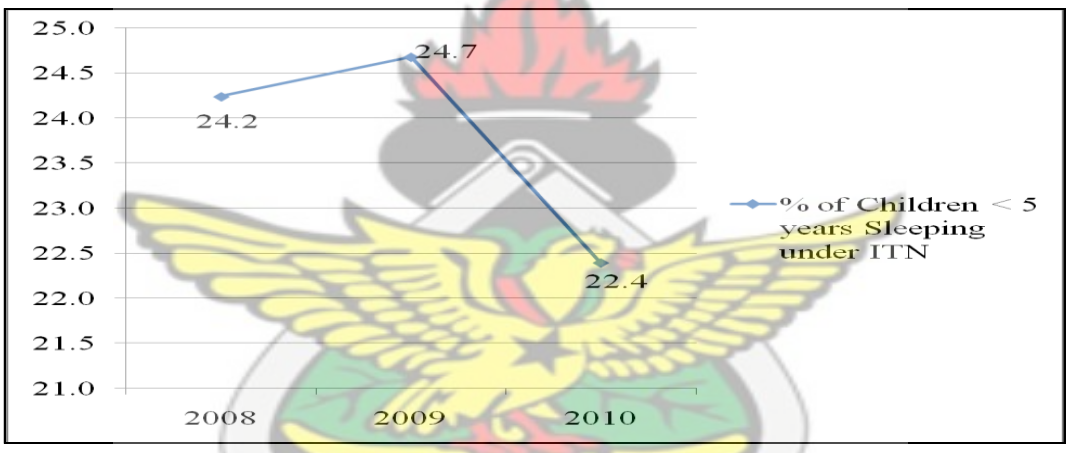


Figure: 3.10: Percentage of Children under 5 sleeping under ITN (2008-2010)

Source: MHD, 2010

There was a reduction of children under five years who slept under Insecticide Treated Net (ITN) during the period under review as compared to the year 2009 as showed in Figure 3.9 above.

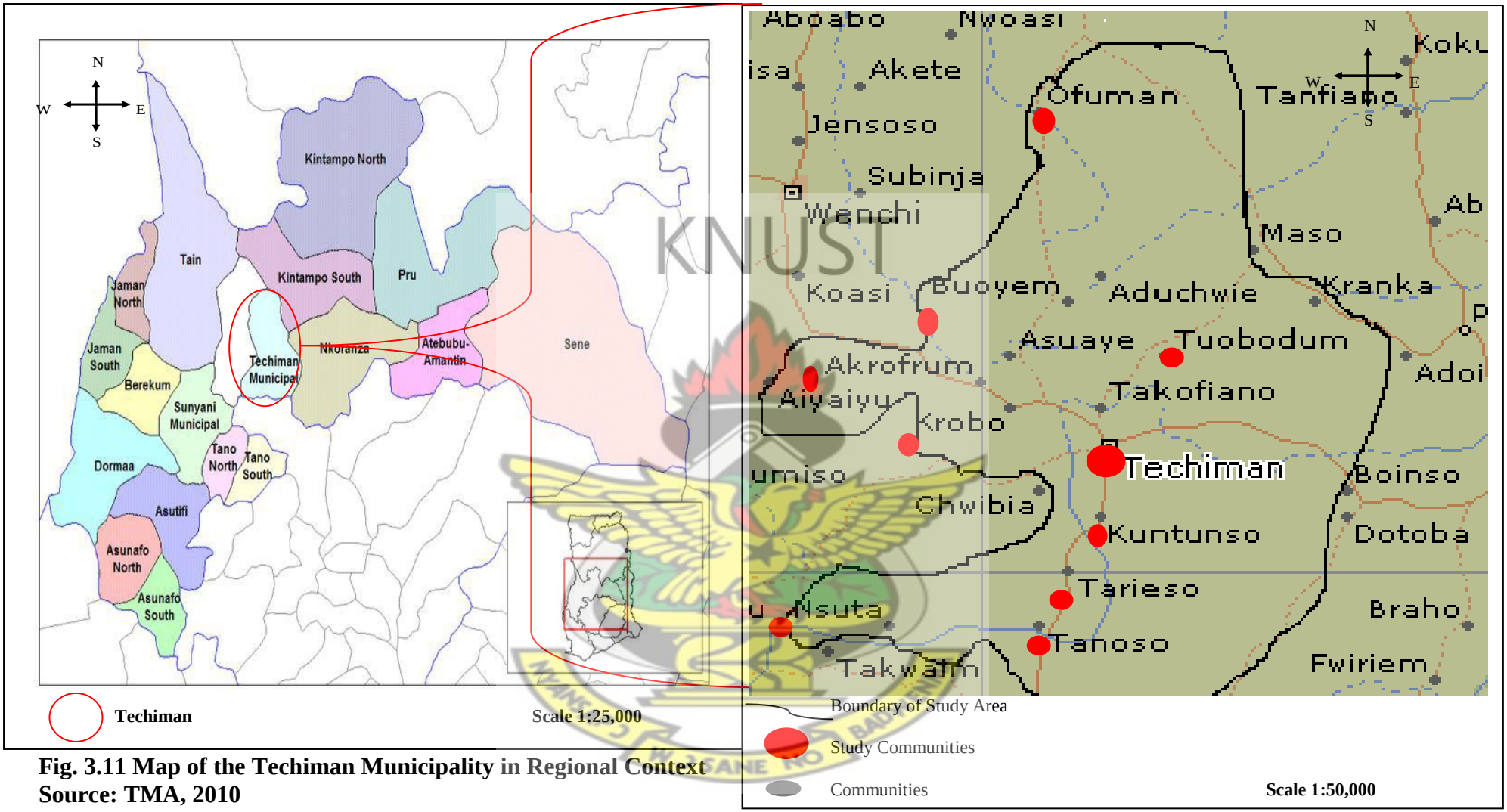


Fig. 3.11 Map of the Techiman Municipality in Regional Context
Source: TMA, 2010

Fig 3.12 Map of the Study Communities in Techiman Municipality
Source: TMA, 2010

3.8 Research Methodology

This section of the chapter discusses the; research approach, research design and study variable, the data required and their sources, data collection procedure, sampling size determination and sampling techniques, data analysis and some ethical consideration.

3.9 Research Design and Study Variables

The research design that guided the study was the case study approach. It is an empirical inquiry that investigates a contemporary phenomenon within its real life context especially when the boundaries between phenomenon and context are not clearly evident. The case study as a research strategy comprises an all encompassing method covering the logic of design, data collection techniques and specific approaches to data analysis (Yin, 2003). The Case study design was employed to investigate the role of the private sector in health services delivery as a contemporary phenomenon using private health facilities, owners of the facilities and their users.

3.9.1 Data Required and Data Source

The main sources of data for the research were both secondary and primary sources. Secondary sources of data from books, articles and the Municipal Assembly profile were collected and analysed. Publications related to the health services and service delivery by Private sector were also carefully analysed. In addition, relevant data on the population of the District were collected from relevant bodies such as the Municipal Planning and Coordinating Unit specifically the Municipal Health Directorate and analysed. Primary data were collected from the Municipal Health Directorate, Public and Private health facilities and users of their services. Data collected were analysed and carefully interpreted. Table 3.7 shows the data required based on the objectives of the study, their sources and the instruments required to collect the data.

Table: 3.7 Data Required and Source

Objective	Data Required	Sources	Instrument/ Mode
To identify the types of health services provided by Private institutions in Techiman	Types of Health services Types of private health institutions	Primary and Secondary	Interview/ Questionnaire
To ascertain the differences in services provided by the Private and Public sectors	Mode of service delivery	Primary	Questionnaire
To determine the category of people who utilize the services of private health institution	PWDs, children, pregnant women, aged, PLHIV	Primary and Secondary	Interviews/Questionnaire
To assess the extent to which services provided by Private institutions meet National health care standards	National Health Policy provisions. Level of Adherence to policy provision	Secondary Primary	Interviews
To assess the challenges and prospects of private health institutions in health services delivery.	Successes of Service delivery Challenges of Service delivery	Primary	Interview

Source, Author's construct, 2012

3.9.2 Target Population

The target population of the study included household heads, private and public health service providers located in the municipality and the district director of Ghana health service of the Techiman municipality.

3.9.3 Sampling Size Determination

In order to determine the sample size, a sample frame of 72,744 Households (HH) was obtained from the Statistical Department of the Municipal Assembly (TMA, 2010). The sample size refers to the number of households selected from the sample frame of 72,744 to constitute the sample. Kothari (2004) defines sample size as the number of items to be selected from the universe to constitute a sample. The sample size (100) of the study was determined while ensuring that it was neither excessively large nor too small but optimum so as to fulfill the requirements of efficiency, representativeness, reliability and flexibility. The sample size for this research was

determined at a confidence level of 90 percent in order to minimize errors. The Sample size was determined as follows;

$$n = \frac{N}{1+N(\propto)^2}$$ Where

n= Sample size,

N= Total Population (72,744)

∝= Confidence interval (0.01)

$$n = \frac{72,744}{1 + 72,744\,(0.01)^2} \qquad n = \frac{72,744}{1 + 727.44} \qquad n = \frac{72,744}{728.44} \qquad n = 99.86$$ n= 100

3.9.4 Sample Size Distribution

In order to avoid bias in the selection procedure and to achieve maximum precision, the ten Urban and Town Councils (sub-districts) were considered as Clusters. Using proportional stratified sampling technique, the number of households that were studied in each of the sub-district was determined by calculating the proportion of the population of the sub-district as a percentage of the sample size. Having determined the number of HH that were studied in each sub-district, simple random sampling technique was used to select the communities from which the HH were selected.

Systematic sampling technique of every 5th house in a community was selected for the selection of HH. This technique was employed to obtain the sample size of 100 houses (HH). Where there was more than one HH in a compound, only one was randomly selected hence all 100 HH were studied.

Purposively, Techiman Township was selected because of the concentration of the 11 private health facilities. All owners of chemical shops and pharmacies were interviewed the Municipal Health Director, 10 administrators, 10 nurses and five midwives were all interviewed. Tables 3.8 and 3.9 show the category of respondent interviewed and questioned and the number of HH studied respectively.

Table: 3.8 Category of respondent

Department	Location	Respondents	Number	Percentage
Municipal Health Directorate	Techiman	Director of Health	1	0.57
Public Health Centre/Clinic	Sub-district Capitals	Head of Department	10	5.71
Mission Hospitals	Techiman	Medical Superintendants	2	1.14
Private Hospitals/Clinics	Techiman and Tuobodom	Staff	6	3.43
Maternity Homes	Techiman	Mid wives	5	2.86
Pharmacies	Techiman	Pharmacists	3	1.71
Chemical Shops	Techiman and other communities	Chemical Sellers	48	27.43
Households	Municipal wide	Household heads	100	57.14
Total			**175**	**100.0**

Source: Authors Construct, 2012

Table: 3.9 Number of Household Heads Interviewed

Community	Number of HH	Number Interviewed
Techiman Zone	12366	17
Tano	10184	14
Krobo	10184	14
Tanoso	7274	10
Nsuta	4365	6
Aworowa	5092	7
Tuobodom Urban	5820	8
Offuman	8002	11
Forikrom	6547	9
Buoyem	2910	4
Total	**72744**	**100**

Source: TMA, 2012

3.9.5 Data Collection Procedure

In order to gain an in-depth understanding of the research problem, a number of data collection methods were used including; secondary material review, interviews, observation and questionnaires. Before the actual data collection, the researcher contacted operators of private health facilities, pharmacists, drug sellers and the directorate of health to schedule appropriate dates for interviews and discussions.

Secondary data on Private institutions and health services were collected from municipal directorate of health and the health facilities. Others are national health

policy document, annual report of the National Development Planning Commission and the Ghana Health Services. Primary data was collected using questionnaire, semi-structured interviews and observation.

3.9.6 Questionnaire

The study used both open and closed ended questions on health facilities in the municipality to capture data on the type of health services and private health institutions as well as the category of people who utilize the health services.

3.9.7 Interviews

An interview schedule consisting of specific questions was used to gather data from the patients at the facility point. This technique was used because it is the appropriate method for all segments of the population (Twumasi, 2001). Responses to interview were voice recoded and typed.

3.9.8 Reliability and Validity of research instrument

To ensure the reliability and validity of the instruments used in collecting data, two research assistants were recruited and trained. The instruments were pre-tested by the researcher on private maternity homes. The exercise revealed certain shortfalls which were corrected before the main survey was conducted.

3.9.9 Ethical consideration

According to Kumar (2005) data collection through any method may involve some ethical issues in relation to the participants and the researcher. In order to ensure good ethics in the research, the researcher, sought for the informed consent of respondents and assured them of the confidentiality of the information collected.

3.9.10 Data Analysis

In order to make the data gathered meaningful and useful, both quantitative and qualitative applications such as statistical and descriptive applications were used to analyze the data. In order to eliminate errors in the questionnaire, editing was done and the answers coded and categorized before the analysis was done. Having edited the questionnaires to detect and correct the errors, the Statistical Package for Social Sciences (SPSS V20) was used to analyze the data so as to make it useful.

CHAPTER FOUR

THE PRIVATE SECTOR IN HEALTH SERVICES PROVISION

4.0 Introduction

This chapter discusses the processing, analysis and presentation of the data gathered for the study. These were done to ascertain the available types of private health facilities, services offered by the private and public sectors, users of private health facilities, conformity of services offered to the National health care standard and the challenges and prospects of private health institutions in Techiman.

4.1 Types of Private Health Facilities

As noted earlier, the term private sector refers to all those health providers working outside the direct control of the state and include; both for-profit and not-for-profit providers, and formally trained providers as well as traditional. An interview with the Municipal Director of Health Services (MDHS) in March, 2013 revealed a total of 35 health facilities in the municipality. This comprised of ten public health centres/clinics and 14 CHPS compounds. The remaining 11 are five maternity homes, four major private hospitals two of which are CHAG facilities (Holy Family Hospital and Ahmaddiya Hospital) and the other two are owned by private individuals (Mount Olive and Opoku Agyeman). The maternity homes are Arms, Alice, Nkwa Hia, Kristo Nti and Gina's Maternity Homes. Other private facilities are; Clean Hands and Awurade Naye Clinc. According to the Director all the private facilities have been accredited to operate. Field survey on types of health facilities in the municipality confirmed the above revelation. Unlike similar studies on the topic which indicated that CHAG facilities are mostly located in rural areas to service the poor, in Techiman municipality, the facilities and other major hospitals are located in the capital town.

From table 4.1 there are 24 Public Health facilities representing 68.57 percent. This figure comprises health centres, Clinics and CHPS compounds. The 11 Private facilities representing 31.43 percent include four private facilities, five maternity homes and Clinics and two mission hospitals. The number of private health facilities is high as a result of good service delivery and patronage therefore encouraging private individuals to provide health services.

Table 4.1 Types of Health Facilities in the municipality

Health Facilities	Number	Percentage
Public Health Centres/Clinic/CHPS	24	68.57
Private Health Facilities	4	11.43
Maternity Homes/Clinics	5	14.29
Mission Hospitals	2	5.71
Total	**35**	**100.00**

Source: Field Survey, March 2013

4.2 Services offered by the Private and Public Sectors

A study by Obuobi et. al (1999) revealed that private medical practitioners provide diagnostic and therapeutic services such as general, surgical, obstetrics/gynecological, eye, ENT, dental, orthopedics, other specialties, basic health services such as curative care, minor surgery, antenatal care, post-natal care, deliveries, major surgery, physiotherapy and laboratory service among others. The study revealed that, some of the services provided by the health facilities in the municipality are; Out and In Patient care, Emergency and Ambulance services, Reproductive and child health, counseling and testing services, laboratory services, x-ray and ultrasound, pharmacy, eye services, obsterics and gynaecology, internal medicine, surgery and operative care, paediatrics services, physiotherapy services, family planning, delivery, health care training, dental, ophthalmolgy, electrocardiography, endoscopy and mortuary services (Table 4.2).

From the study, services mainly provided by the public facilities are; general OPD, deliveries, counseling and testing, reproductive and child health, family planning and maternity. No major services are provided because of the nature and level of the facilities. They are mainly sub-district level facilities such as the health centres and CHPS compounds.

The study revealed that, out of the 11 private facilities, only two; Holy Family and Opoku Agyeman Hospitals (18.18 percent) provide all the services mentioned above. The rest (81.81 percent) of the private facilities do not provide specialized services like ophthalmolgy, electrocardiography and endoscopy. In addition to the services provided, two private facilities, Holy Family and Mount Olive Hospital (18.18 percent) provide professional nurses training (see table 4.2 and figure 4.1).

The above suggests that in terms of equipment and qualified personnel, the private facilities are better off as compared to their public counterparts. These services have been categorised into antenatal, rehabilitative, curative, promotion and preventive services which are provided through the health system in Ghana. The entry point of the health system is the community, followed by sub-district and district.

Table 4.2 Type of Services rendered by facilities to HH/Patients

No.	Private	Public
	Services	**Services**
1	Out-Patient Care	Out-Patient Care
2	Emergency and Ambulance Services	Reproductive and Child Health
3	Laboratory Services	General OPD
4	Delivery	Delivery
5	Consultancy services	Family Planning
6	Treatment	Counselling and Testing
7	Consultancy & Treatment	Antenatal
8	Medication &Consultancy	Postnatal
9	Out-patient Care,In-patient Care, Consultancy	
10	General services	
11	Nurses and midwifery training	

Source: Field Survey, March 2013

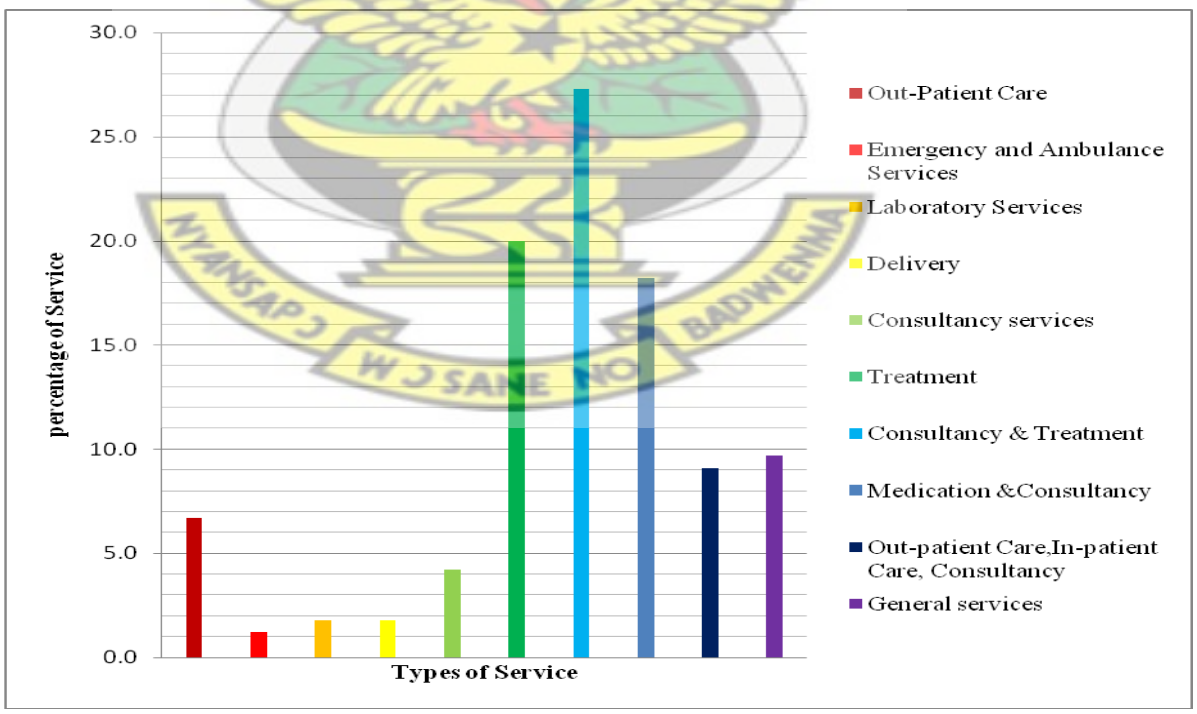


Figure 4.1 Percentage of Services rendered by private facilities to HH/Patients

Source: Field Survey, March 2013

Table 4.3 shows the number of private health facilities that render each of the services identified. From the table, 11 facilities render both Outpatient and General services, nine facilities offer both consultancy and treatment. Deliveries are done by seven facilities. Only two facilities do consultancy services. This data depicts that, the needed services are provided by the facilities.

Table 4.3 Number of Private Health Facilities that render the services identified

Service	Number of Facilities
Out-Patient Care	11
Emergency and Ambulance Services	3
Laboratory Services	4
Delivery	7
Consultancy services	2
Treatment	5
Consultancy & Treatment	9
Pharmacy &Consultancy	9
Out-patient Care, In-patient Care, Consultancy	5
General services	11

Source: Field Survey, March 2013

4.3 Users of Private Health Facilities

4.3.1 Social, Demographic and Economic Characteristics of respondents (Household heads)

According to Obuobi et. al (1999), all socio-economic groups, males and females, various age groups, residents and non-residents, educated and non-educated, low, medium and high income earners all patronize private health care service provided by private health facilities. Also the private sector cares for people from a wide distribution of incomes, including the poor and rural populations (IFC, 2005).

This study revealed that, users of private health facilities were both male and female household heads of all age groups. Out of the 100 respondents, 34.0 percent of them were between the ages of 20-29 years followed by 26 percent between 30-39 years. Only four percent were 60+. Fifty-four percent of the household heads belong to the Akan group particularly Bono followed by 18.0 percent the Mole Dagbani ethnic group. The least was five percent the Grusi ethnic group. Other ethnic groups such as the Zabarama, Mosi, Hausa, Fulani and Wangara constituted 16.0 percent (Table 4.4).

This implies that planning should be participatory with enough consultation through all stages of the planning process to ensure consideration of diversity of needs within the community especially of the minority ethnic groups who face serious economic, political and social discrimination as a result of losing in competition for limited resources and job opportunities.

From the study, 66.0 percent of the household heads were Christians while 33.0 percent are Muslims. Only one percent belonged to the traditionalists. This implies that, planning should focus on encouraging an environment in which different religious institutions and organizations can thrive and citizens can actively practice their faith-both privately and publicly.

In terms of educational attainment, 45.0 percent of the respondents had attained tertiary level education, followed by 19.0 percent who attained Senior High/Secondary education. Only three percent had attained primary education. Those who do not have any form of formal education are 14.0 percent. This means that majority of the respondents are educated and have given fair responses to their question since they are well informed about the role of the health facilities.

The study further revealed that, 71.0 percent of the heads of household are employed with 33.0 percent of them employed in the service sector, 18.0 percent employed in the Agriculture sector, 16.0 percent engaged in commerce and four percent engaged in industry. The remaining 29.0 percent are not employed but comprises of 17.0 percent student and 12 percent not employed (Table 4.4). With only 12 percent not employed compared to the national unemployment rate of 25.6 percent (GoG, 2012).

Table 4.4 Social, Demographic and Economic Characteristics of Respondents

Characteristics	Frequency	Percent
Sex		
Male	46	46
Female	54	54
Total	100	100
Age		
less than 20	2	2
20-29	34	34
30-39	26	26
40-49	24	24
50-59	10	10
60+	4	4
Total	100	100
Ethnicity		
Akan (Bono)	54	54
Mole Dagbani	18	18
Grusi	5	5
Guan	7	7
Others	16	16
Total	100	100
Marital Status		
Married(Monogamy)	47	47
Married (Poligamy)	7	7
Single (not in relationship)	14	14
Single (in relationship)	19	19
Divorced	6	6
Widow	7	7
Total	100	100
Religion		
Christian	66	66
Muslim	33	33
Others	1	1
Total	100	100
Education Level		
Primary	3	3
JHS/Middle School	17	17
SHS/Secondary School	19	19
Tertiary	45	45
None	14	14
Total	100	100
Employment Status		
Employed	71	71
Unemployed	29	29
Total	100	100
Occupation		
Agriculture	18	18
Commerce	16	16
Service	33	33
Industry	4	4
Student	17	17
None	12	12
Total	100	100

Source: Field Survey, March 2013

4.4 Income and Expenditure of Household Heads

The study revealed that sources of income of household heads are mainly from agriculture, commerce, service, industry and remittances. Eighteen percent of them earn their income from agriculture, 16.0 percent from commerce, 33.0 percent from service, another 29.0 percent from remittance and four percent from industry. Majority (61.4 percent) of the respondents who are employed in the service sector earn incomes above Gh₵500.00.

From the expenditure side, it was revealed that respondents spend mostly on food, clothing, rent, utilities and health. Out of these items, 94.0 percent of the respondents spend their income on food, 66.0 percent on utilities, 50.0 percent on clothing, 46.0 percent on rent and 73.0 percent access health care using health insurance compared to four percent for the region and five percent for the national (GHS, 2011). Majority, 93.9 percent of the respondents spend less than Gh₵ 50.00 of their income to pay for utility bills mainly water and electricity, 75.3 percent access health care using health insurance, 23.8 percent spend less than Gh₵ 50.00 mainly on some of the drugs that are not covered by insurance and other pain killers bought due to the non seriousness of the ailment and finally, 2.7 percent spend between GH₵ 50.00 and Gh₵ 99.00 on health care (Table 4.5). This is as a result of delay in renewing their insurance before they fall ill and sometime because of the non-coverage of the insurance.

Table 4.5 Items and Amount of Expenditure of households per month

	Expenditure on food (94.0 percent)		**Expenditure on Clothing (50.0 percent)**		**Expenditure on Rent (46.0 percent)**		**Expenditure on Utilities (66.0 percent)**		**Expenditure on Health care (73.0 percent)**	
Income Level GHC	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Less than 50	29	30.9	30	60.0	42	91.3	62	93.9	66	21.9
50- 99	16	17.0	17	34.0	3	6.5	3	4.5	7	2.7
100-299	47	50.0	3	6.0	1	2.2	1	1.5	-	-
300-499	2	2.1	-	-	-	-	-	-	-	-
Total	94	100.0	50	100.0	46	100.0	66	100.0	73	100.0

Source: Field Survey, March 2013

4.5 Household heads' level of satisfaction with Facilities and Services

Data on the level of satisfaction by household heads with the facilities and services offered by private health facilities revealed that, on the average, 40.4 percent are very satisfied with the amenities and services offered by the facilities. About 45 percent were satisfied and 14.8 percent were unsatisfied (figure. 4.2). This and other reasons such as having all the facilities (33.0 percent) and proximity (29.0 percent) as indicated by the respondents explains why majority 76.0 percent prefer private to public (24.0 percent) health facilities.

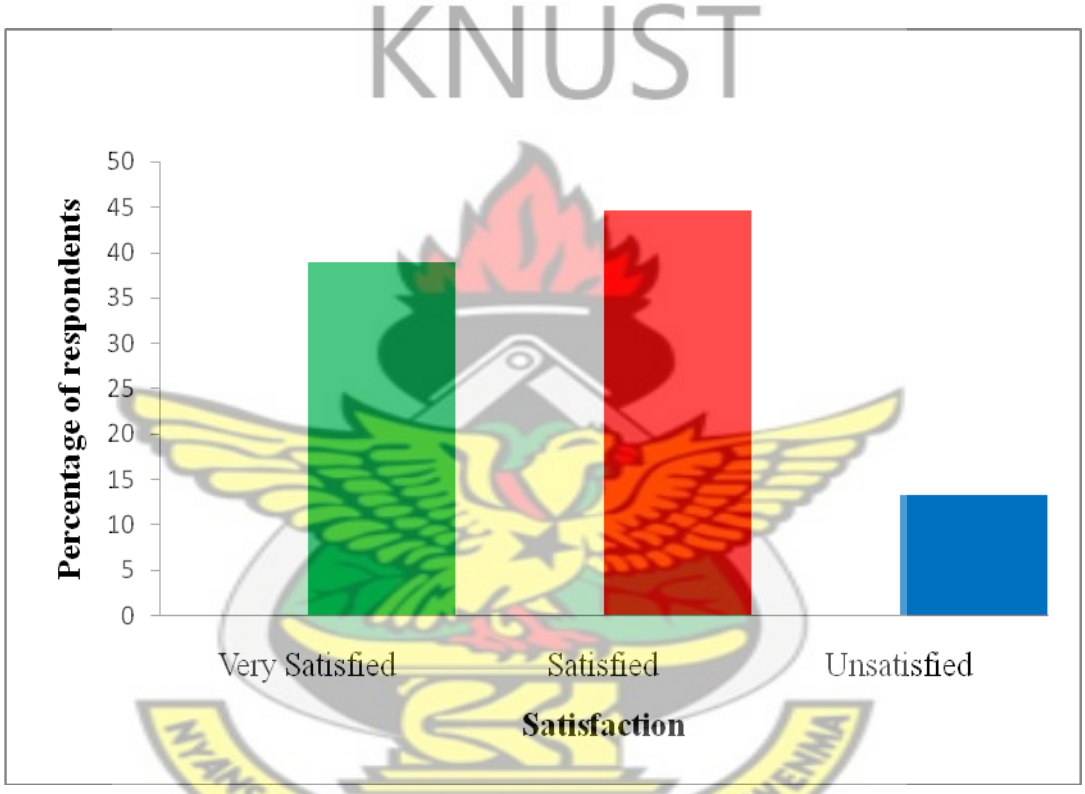


Figure 4.2 Household heads' level of satisfaction with facilities and services

Source: Field Survey, March 2013

Sixty-three percent of household head visit private facilities first when sick (Table 4.6).

Table: 4.6 First point of call for Treatment when Sick

Facility	Frequency	Percent
Public Hospital/Clinic/CHPS	27	27
Private Hospital/Clinic	63	63
Chemical Shop	8	8
Public/clinic, Private hosp./clinics	2	2
Total	**100**	**100**

Source: Field survey, March 2013

4.5.1 Frequency of visits to nearest health facility

On the frequency of household heads visit to the nearest health facility, 31 percent accessed the nearest health facility on quarterly bases and 23 percent accessed any time they are not feeling well. The least is two percent who visit irregularly and weekly (Table 4.7).

Table 4.7 Frequency of visits to Nearest Health Facility

Frequency of Visit	Frequency	Percent
Weekly	2	2.0
Monthly	23	23.0
Quarterly	31	31.0
Annually	16	16.0
Others(when necessary)	26	26.0
Irregular	2	2.0
Total	**100**	**100.0**

Source: Field Survey, March 2013

On choice of health facility, 30.0 percent of household heads responded they visit private health facilities because they have all the facilities, 23.0 percent responded that they are the better alternatives available, 21.0 percent responded in favour of proximity and 7.0 percent responded for both proximity and better alternative, 16 percent responded in favour of affordability and three percent responded in favour do not know as in figure 4.3. This means that demand for a health facility is determined by the quality of facilities and services provided, better alternative, affordability and facility's proximity.

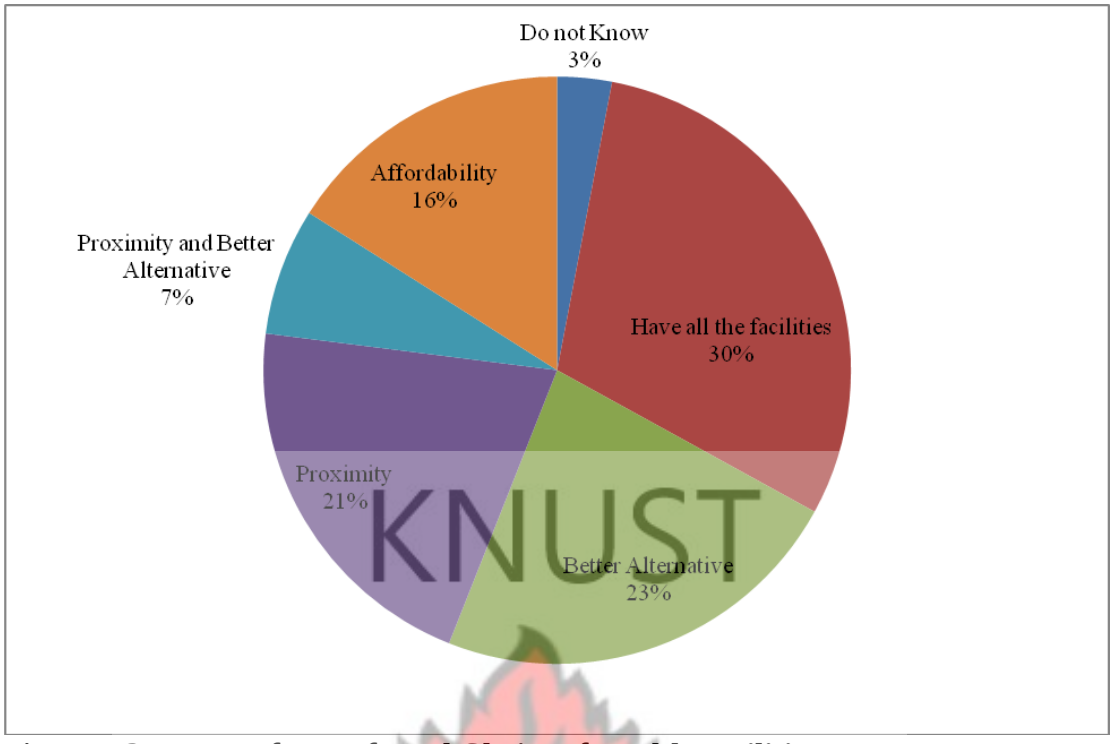


Figure 4.3 Reasons for Preferred Choice of Health Facilities

Source: Author's construct, March 2013

4.6 Household heads' Utilization of National Health Insurance

The study revealed that, about 75 percent of household heads are insured. This represents 0.05 percent of the total active membership of 154,829 on the scheme in 2012 (Municipal Health Insurance Office, Techiman, 2012). Twenty-five percent household heads are not insured. The insured clients responded they paid GHc 14.00 to register. The 25 percent of the household heads who visit health facilities without insurance pay in cash due to reasons such as not being insured, frustration in its utilization, not interested in it and use of expired insurance cards. All those insured (75 percent) responded that the facilities they visit accept health insurance. Table 4.8

Table 4.8 Household heads' utilization of National Health Insurance

Response	Frequency	Percent
Registration with National Health Insurance		
Yes	75	75
No	25	25
Total	100	100
Minimum amount paid		
GHC 14.00	75	75
> GHC 14.00	25	25
Total	100	100
Renewal of membership		
Yes	75	75
No	25	25
Total	100	100
Mode of payment without NHIS		
Cash	25	25
Acceptance of Insurance by health facility		
Yes	75	75
No	25	25
Total	100	100

Source Field Survey, March 2013

4.7 Nearness of Health Facility from Household heads' Location

The study revealed that 51.0 percent of households live within one to two kilometers from the health facilities, 42.0 percent live between two to five kilometers and seven percent live within five to ten kilometers. Those who live within seven to ten kilometers come from the nearby communities where there are only public health centres and CHPS compounds. This attests to the fact that most of the users of private facilities are both urban and rural dwellers.

4.8 Referrals

According to the Ghana Statistical Service, the structure of the health system in Ghana consists of national, regional, district, sub-district and community health systems and is built on the Primary Health Care (PHC) System (GSS, 2008).

From the interview with the Municipal Director of Health, referral of case from one facility to another follows the national structure. Here referral is based on the classified system of health facilities provided by government. These classifications are type 'A', 'B', 'C' and 'D'. Here cases are been referred from smaller facilities to

bigger facilities such as Holy Family hospital and then to the regional hospital at Sunyani. The interview also revealed that referral of cases is the major link between the public and private health facilities. The study revealed that 98.0 percent of household heads were referred from either a public or private facility of a lower level to a private facility with the needed facilities and equipment.

About two percent visited facilities without being referred. Data from private health facilities also revealed that complicated cases which occasionally could not be handled in Techiman are referred to either Sunyani regional hospital or Okomfo Anokye Teaching Hospital in Kumasi. In a statement by the municipal director of health "*if not for the private facilities, work load would have been too much to handle considering the population and this would have affected the quality of service delivery"*. From the side of the managers of the private health facilities, one of the Medical Superintendents said *"our services are reliable because even in times when staff of public health facilities are on strike we are working 24 hours, 7 days in a week. In fact that is the advantage we have over them"*.

4.9 Midwifes

Out of the five targeted midwives to be interviewed; only four agreed and granted the researcher interview. Eighty percent of the midwives are all females and fall within the ages of 26 to 60 years with different years of experience ranging from one year to 35 years. Forty percent work full time in CHAG facilities while the other 40 percent operate on their own privately. One of them was trained as a community health nurse who later specialized as a midwife. Another (Alice maternity) was a nurse who resigned from Berekum hospital to practice on her own. They provide antenatal care, delivery care and post natal care, family planning, education on safe abortion, HIV/AID, STDs and Hepatitis B. The interview revealed that on the average each of the facilities deliver 83 births in a month totaling 332 births. In addition to the above activities, Alice and Arms maternity treat patient with minor ailments. Asking about the causes of maternal deaths during and after delivery, reasons such as post partum haemorrhage, severe anemia, sepsis and irregular and late attendance to antenatal care were given. Enquiry about the state of health in the municipal without the midwives revealed that, without the private sector in general, the available public facilities could

not have been able to cater for the health needs of the people in the municipality and the situation would have been worse.

4.10 Staffing situation

Health workforce according to WHO (2008) is the input that combines with others inputs to ensure service delivery in the health system. Increased inputs should lead to improved service delivery and enhanced access to services and ensure availability and access to health services leading to the attainment of minimum quality standard services.

This study revealed that, Ghana Health Service staff strength in the municipality was 214 as at 2012 comprising both professional and non-professional staff. In terms of distribution, each sub-district has one midwife, two community health nurses, two enrolled nurses, one ward assistant and one disease control officer. In addition to the above the municipal director of health service is a doctor.

The staffing situation in the private health sector revealed a total of 400 staff of all the categories listed with a difference of 186 staff compared to that of the public. About nine percent of this constituted doctors, 29 percent nurses, 14 percent midwives, six percent pharmacists and 42 percent constituted other staff like ward assistants, lab technicians, X-ray operators and cleaners or labourers. About 25 percent of the total staff and 59 percent of the doctors in the private health sector work in Holy Family Hospital. Holy Family and Ahmaddiya Hospitals are private non-for profit (CHAG) facility hence the higher number of staff and doctors (20) in Holy Family Hospital. In addition, the number of doctors is high in Holy Family Hospital because some of the doctors are specialists who come weekly and monthly to attend to patients. About 21 percent of the doctors work in Mount Olive Hospital. Fifty-seven percent of this are permanent and 43 percent are visiting doctors. About 38 percent of the nurses, nine percent midwifes, 29 percent pharmacists and 18 percent other staff in the private sector work in Mount Olive hospital in addition to the doctors. Because the hospital provides professional nurses training, there are students nurses who also assist the nurses (Table 4.9).

The percentage of staff who work in Opoku Agyeman hospital is four doctors, 15 nurses, 12 midwifes, four pharmacists and 25 other staff including cleaners and labourers (Table 4.9).

The nurses of Holy Family Hospital, Ahmmadyya Hospital, Mount Olive Hospital and Opoku Agyeman Hospital run morning, afternoon and evening shift.

Arms and Alice maternity homes do not have permanent doctors and nurses but visiting doctors. According to the operators, they arranged with the doctors to attend to some of the clients who need special services. Nurses work in these facilities because apart from their core business of delivery, they also treat ailments.

According to the municipal health director of health services, the number of staff required in a facility is determined by the WHO and country specific standard. According to WHO standard, one doctor was expected to serve 5,000 people and one nurse, 9,404. At the national and district levels, a doctor serve 10,380 and 23,456 people respectively (WHO, 2008). On this base, the Techiman Municipality with total population of 225,705 was expected to be served by 10 doctors and 24 nurses. To ensure sustainable and adequate supply of staff, some of the private facilities have established health training schools to train nurses and midwives.

The data available suggests that the facilities have adequate staff. Based on the data, the doctor population ratio in the municipality is 1:6,638, nurse population ratio is 1:1,896 and midwife population ratio is 1:1,4179. Compared to the regional and national figures, doctor population ratio is 1:16,103 and 1:10,034, nurse population is 1:1,495 and 1:1,240 and midwife population ratio is 1; 1,515 and 1:1,478 (GHS, 2011). It is evident from these data that the municipality is better off in terms of health staff compared to the region and the rest of the country.

Table 4.9 Staffing situation in the private health sector in Techiman Municipality

Name of Facility	**Doctors**		**Nurses**		**Midwife**		**Pharmacists**		**Others Staff**	
	Available	**Required**	**Available**	**Required**	**Available**	**Required**	**Available**	**Required**	**Available**	**Required**
Holy Family Hospital	20	6	42	45	16	16	8	10	15	25
Ahmadiyya Hospital	1	1	7	8	9	9	1	2	90	50
Mount Olive Hospital	7	4	45	45	5	5	7	7	30	30
Opoku Agyeman Hospital	4	2	15	25	12	15	4	4	25	25
Alice Maternity	1	1	5	0	9	9	2	2	4	4
Arms Maternity	1	1	5	0	3	4	2	2	5	5
Total	34	15	119	95	54	58	24	27	169	139

Source, Field Survey, March 2013

4.11 Pharmacies / Chemical Shops

Information gathered from interview with three pharmacies, revealed that all those interviewed were males between the ages of 20 and 40 years. About 67 percent have attained tertiary education and are practicing pharmacists and 33.3 percent have attained secondary education and acting as an administrative manager though not a pharmacist. Only one of them is the actual owner of the pharmacy. The interview revealed that, highly patronized drugs from the pharmacies are; Anti-Malarial, Anti-Rheumatics, Anti-biotics, pain killers, Appetite Stimulants, and Blood Tonics. Of these drugs anti malaria drugs (25.0 percent) and painkillers (25.0 percent) are the most patronized drugs. All the pharmacies have licenses given by the Ghana Pharmacy Council to operate. The pharmacy shops are also service providers for the national health insurance scheme.

In addition to the pharmacies, all the 48 chemical shops that operate in the municipality are licensed shops operating under the supervision of the Ghana Pharmacy Council and the Association of Chemical sellers of the municipality. Apart from the sale of drugs and education, these shops neither gives injection nor treat patients. Owners of these shops are mostly workers who established them to complement their income or retired health personnel who engage themselves with the operation of the shop to earn income from their profit.

4.12 Compliance of Private Operators with National Health Standards

According to the Municipal Director of Health Services, the National Health Policy calls for a mix of technical, managerial and logistics capacities on the part of health systems to promote, protect and improve health in the country. Emphasis is on the creation, expansion and upgrading capabilities in health systems in order to fill capacity and service gaps. In this light all health facilities both public and private have drawn up strategic plans to ensure the attainment of the objectives of human (technical and managerial) infrastructure, equipment, drugs and logistics. Besides this, all the private health facilities have accreditation from Ghana Health Service to operate and are been supervised quarterly by the Municipal Directorate of Health.

Again, each of the private health facilities has a patient charter as a directive from the Ministry of Health. These are posted at accessible point in the facility environment to educate patient and client who can read and write on their rights at the facility.

Because most of the private facilities are owned by professional health workers who have retired, resigned from active service or practicing as additional work, government policies are strictly implemented in their facilities. For example it was observed that, all the private health facilities have accessibility ramps to enable people with disability access and use the facilities.

Apart from the private hospitals and clinics, all the three pharmaceutical shops and 48 drug stores interviewed have operating licenses. The pharmacies only sell certain drugs to clients' upon receipt of prescriptions and others like painkillers and food supplements without prescription. The drug stores apart from sales of drugs do not treat patients but advice them to go to the private facilities for treatment. According to the drug sellers the pharmacy council occasionally organizes refreshers training courses in what is known as 'baby care' to improve their customer services and knowledge about drug handling. In his concluding remarks, the Director of Health Services indicated that, so far all the private health facilities are doing well in the provision of their services. Their presence has brought about quality health services and helped to reduce pressure on the incapacitated public health centres located mainly in the sub-district capitals.

From the side of the managers of private health facilities, it was gathered that, the Municipal Health Directorate headed by the Municipal Health Director supervises their operations on quarterly bases to ensure compliance with government standards. One of them indicated that, "even though, this facility is a mission hospital, the Director of Health Services in the municipality controls it. The facility apply all the Ghana Health Service regulations, report monthly, quarterly and annually to the municipal health directorate and do presentation of our activities at annual review meetings. Certain times, staff such as midwifes from the public sector come on secondment to our facility". This should have been the reverse where staff of private facilities go to public facilities on secondment because of skills and equipment availability. Another private operator explained that, "it is collaboration between us and the Ghana Health Service. The health director supervises our operations to ensure that our activities are not different from what is expected at the public facilities".

4.13 Funding of Private Health Facilities

On funding of private health facilities, the study revealed that, national health insurance premiums, and cash payment by non-insured clients (out-of-pocket) are the main funding sources of private health facilities. Out of these sources, health insurance premiums form the major (80 percent) funding source while Out-of-pocket payment by patients form 20 percent.

4.14 Prospects and Challenges

4.14.1 Challenges

Some of the challenges gathered during the study are; delay in reimbursement of premiums by national health insurance scheme, inadequate cooperation between private actors, irregular or late attendance of patients and expectant mothers to health facilities and inadequate staff. In addition, most of the staff recruited and trained by both the public and the private facilities leave to seek employment with other private facilities either within or outside the municipality. This makes it a challenge for the private facilities as earlier on indicated in the case of Kenya's APHIA II project in chapter two. From the Municipal Health Directorate, it was said that most of the staff of the private health facilities are trained on the job unlike their public counterparts who go through the required period and type of training, also the private facilities contract the services of retired, old and part time workers and finally the private facilities delay in the submission of their monthly and quarterly reports.

4.14.2 Prospects

It was revealed that, the private health sector in Techiman has the capability to serve the whole of the Sub-Saharan African Region. This is mainly because of the strategic location and function of Techiman, the capital of the municipality. Considering the fact that Techiman is a market centre for the sub-region where traders from other regions and neighbouring countries of Ghana come to trade, the health sector in Techiman has a very great responsibility to cater for the health care needs of the residents and non-residents who come for business. The private health sector should therefore be expanded and equipped according to international standards to take this responsibility. Also given this expansion, the sector could employ more people thereby reducing poverty and increasing incomes. This in the final analysis would

increase the production of consumer goods and services and other consumables thereby creating market for these goods and services. The private health sector would also ensure sustainable and reliable health care services since the staff do not go on strike.

CHAPTER FIVE

FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

This chapter discusses the major findings, recommendations and conclusions of the study. The findings are presented based on the objectives set to be achieved by the study.

5.1 Findings

5.1.1 Types of private health facilities available in Techiman Municipality

There are 35 health facilities in the municipality. Out of this 11 facilities were surveyed, of which there are five maternity homes, four major private hospitals two of which are CHAG facilities (Holy Family Hospital and Ahmaddiya Hospital) and the other two are owned by private individuals (Mount Olive Hospital and Opoku Agyeman Hospital). The maternity homes are Arms, Alice, Nkwa Hia, Kristo Nti and Gina's Maternity Homes. Other private facilities are; Clean Hands and Awurade Naye Clinic.

5.1.2 Services provided by the Private and Public sectors

The study revealed that, services provided by the Public facilities are; General OPD, deliveries, HIV/AIDS counseling and testing, Reproductive and Child Health, Family Planning and Maternity. No major services are provided due to the nature and level of the facilities.

Out of the 11 private facilities, only two; Holy Family and Opoku Agyeman Hospitals provide all the services. The rest of the nine private facilities do not provide specialized services like Ophthalmology, Electrocardiography and Endoscopy among others. Holy Family and Mount Olive Hospital provide Nurses, Midwifery and other specialized training in addition to the services they provide. In view of the fact that the private health facilities are relatively resourced and equipped, they provide higher level specialized services compared to the public health facilities which are mainly clinics and CHPS compound.

5.1.3 Users of services of private health facilities

Users of private health facilities are both males and females beneficiaries who fall below 20 and 60+, 34.0 percent of them fall between the age cohort of 20-29 years and 26.0 percent between 30-39 years. Only four percent are 60+ while two percent is below 20 years. A further analysis of available health records attests to this finding. Thirty-four percent of the respondents falling between 20-29 years imply that the respondent population is youthful.

Agriculture, commerce, service, industry and remittances are the main sources of household heads' income with the majority of the household heads falling within the income group of Gh₵100.00 and above Gh₵ 299.00 per month. Items mostly spent on are food, clothing, rent, utilities and health. This income and expenditure levels suggests low saving since they earn less and spend mostly on their basic needs.

Seventy-six percent of household heads prefer private to public health facilities compared to 24.0 percent who preferred public to private facilities. This is so because the private facilities have all that is needed to provide health services and are closer in terms of proximity.

The study revealed that 63.0 percent of sick people first go to private hospital or clinic which suggests that people have confidence in private hospital or clinic.

The study revealed that 75.0 percent of respondent are insured representing 0.05 percent of the total active membership of 154,829 on the scheme in 2012.

About 75 percent of household heads who are insured, attended facilities that accept health insurance. This implies that the provision and utilization of health insurance services is high and therefore calls for adequate measures to gain a complete coverage by registering foreigners who come into the municipality to ensure its sustainability.

Fifty-one percent of household heads live within one to two kilometers from the facilities, 42.0 percent between two to five kilometers and seven percent live within five to ten kilometers. This attests to the fact that most of the users of private facilities were both urban and rural dwellers and that government's policy of making health care accessible to all is being achieved.

Eighty percent of the midwives interviewed were females and fall within the ages of 26 to 60 years with different years of experience ranging from one year to thirty-five years. The services they provided include antenatal and post natal care, family planning, delivery and education on safe abortion and HIV/AID, STDs and Hepatitis B. On the average each of the facilities delivers 83 births in a month totaling 332 births.

The study revealed that, there were a total of 65 doctors, 288 nurses, 91 midwives, 51 pharmacists and 352 other staff like ward assistants, lab technicians and X-ray operators. This implies that, the health directorate can collaborate with the private facilities for the services of these specialists.

5.1.4 Conformity of services provided by Private Health Institutions with National health care standards

From the study, all the private health facilities were being supervised by the Ghana Health Service and their operations were monitored on monthly, quarterly and annual bases to ensure quality service delivery to their users, each of the facilities report to the Municipal health directorate every quarter and yearly at annual review meetings where the reports are being harmonized into one report.

The study revealed that, all the pharmacies have licenses granted by the Ghana Pharmacy Council to operate and are also service providers for the national health insurance scheme. Highly patronized drugs from the pharmacies are; Anti-Malarial, Anti-Rheumatics, Anti-Biotics, pain killers, Appetite Stimulants, and Blood Tonics. Anti malaria drugs (25.0 percent) and painkillers (25.0 percent) are the most patronized of the drugs.

Health insurance premiums form the major (80 percent) funding source while self-funding (facility owner's own financial resources) 10 percent and out-of-pocket (direct cash payment) by patients 10 percent.

5.1.5 Challenges and prospects of private health facilities in health services delivery

It was revealed that, the private health sector in Techiman municipality has the potential to serve a very large population. This is mainly due to the strategic location and function of Techiman, the capital of the municipality.

Some of the major hindrances identified from the field survey includes; delay in reimbursement to facilities by National Health Insurance Authority, poor cooperation between private actors, irregular or late attendance of patients and expectant mothers to health facilities and inadequate number of staff. Again, most of the staff recruited and trained by the private facilities leave to seek employment with other private facilities perceived to have better reward.

5.2 Recommendation

The World Health Organization, Government of Ghana, Non-governmental Organization, Religious Bodies and Philanthropists should assist to expand and equip especially the private non-for profit health facilities to enable them cater for more complex situations by the end of 2015. This is in view of the fact that, Techiman is a market centre for the sub-region where traders from other regions and neighbouring countries of Ghana come to trade. Therefore, the health sector in Techiman municipality has a very great responsibility to service all residents and the non-residents who come to trade. In addition, there is the need for government to establish a District Hospital in the municipality to ease the pressure on Holy Family Hospital which is the major service provider and referral centre. This is because as the work load increases on Holy Family Hospital, eventually, the quality of satisfactory service provided will diminish leaving patients without any option.

Also, the Ministry of Health and the National Health Insurance Authority should facilitate reimbursement of funds to enable accredited service providers to provide the needed services to clients.

The Municipal Health Directorate in collaboration with the various Health Administrators should see to an effective cooperation between the public and private and the various private actors through regular meetings and experience sharing.

Finally, the Ghana Health Service and the Information Units of the various health facilities should educate the public on the need to regularly visit health facilities most especially pregnant women to prevent the occurrence of maternal mortality by December, 2015.

5.3 Conclusion

In conclusion, the existence and operation of both public and private health facilities in the municipality has made health services accessible and affordable to all categories of people both residents and non-residents. Their existence has also broadens people choice of health facility in the event of illness. However, it is worth noting that, the private facilities play the major role in providing specialized services and professional training.

The case of Techiman Municipality is in contrast to the norm where the public facilities are believed to be the most resourced, equipped and staffed in the provision of health services.

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APPENDICES

APPENDIX (I)

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUESTIONNAIRE FOR CLIENTS/HEADS OF HOUSEHOLD

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

Background

1. Sex

( ) Male 1 ( ) Female 2

2. Age…….

3. Ethnicity

( ) Akan (Bono)1( ) Mole Dagbani 2 ( ) Grusi 3 ( ) Guan 4

( ) Other (Specify) 5.....

4. Religion

( ) Christian 1 ( ) Moslem 2 ( ) Traditional 3 ( ) other specify 4

5. Level of Educational attained

( ) Primary 1 ( ) JHS/Middle school 2 ( ) SHS/Secondary 3

( ) Tertiary 5 ( ) None 6

6. Employment status

( ) Employed 1 ( ) Unemployed 2

7. Occupation

( ) Agriculture 1 ( ) Commerce 2 ( ) Service 3 ( ) Industry 4 ( ) Student 5( ) None 6

8. Marital status

( ) Married (Monogamy) 1 ( ) Married (polygamy) 2 ( ) Single (not in relationship) 3 ( ) Single (in relationship) 4 ( ) Divorced 5 ( ) Widowed 6

Household Income and Expenditure

9. What are the sources and amounts of your household income?

Source	Amount/month GH₵	Amount/annum GH₵
Agriculture 1		
Commerce 2		
Service 3		
Industry 4		
Remittances 5		
Other (specify) 6		

10. On what items and how much do you spend the household income?

Item	Amount/week	Amount/month	Amount/annum
Food 1			
Clothing 2			
Rent 3			
Utilities 4			
Fuel 5			
Health care 6			
Transportation7			
Education 8			
Donations, gifts and remittances 9			
Savings 10			
Levies 11			
Credit payment 12			
Other (specify) 16			

Availability and use of Health Facilities

11. What are some of the health facilities you have around?

( ) Public Hospital 1 ( ) Clinic 2 ( ) Private Hospital 3 ( ) Other (specify) 4

12. How far is the nearest health facility from your house?

( ) Between 1- 2km away 1 ( ) Between 2 – 5km away 2 ( ) Between 5 – 10km away 3 ( ) More than 10km 4

13. Where is the first point of call for treatment when someone in your household gets sick?( ) Public Hospital/Clinic 1 ( ) Private Hospital/Clinics 2 ( ) Chemical shops 3 ( ) CHPS 4

14. How often do you visit the nearest health facility? ( ) Weekly 1 ( ) Monthly 2 ( ) Quarterly 3 ( ) annually 4 ( ) other (specify) 5……

15. By what means do you often go to the health facility? ( ) Walking 2 ( ) Commercial Vehicle 3 ( ) Private vehicle 4 ( ) other (specify) 5……

16. Which health care facility do you prefer? ( ) Public 1 ( ) Private 2

17. Why do you prefer the facility to other health institutions? ( ) Proximity 1 ( ) Better alternative ( ) Have all the facilities ( ) Don't know 4 ( ) Only type available

18. In your own estimation, are the health personnel at the facility you have been visiting adequate? ( ) Yes 1 ( ) No 2

19. In your own views do you think all the health personnel in the facility are trained? ( ) Yes 1 ( )No 2

20. Are you always satisfy with the services/medication from the facilities ( ) yes 1 ( ) No 2

21. How long do you spend at the health facility when you visit? ( ) 1 – 2 hours ( ) 2 – 3 hours 2 ( ) 3 – 4 hours 3 ( ) other (specify) 4 …….

22. Are private services satisfactory to you? ( ) Yes1 () No2

23. What services does the facility render to clients? ……..…

24. What do you think are some of the problems you encounter when you attend the private hospitals?

25. Do the private facilities refer cases to the regional hospital? ( ) Yes 1 ( ) No 2

26. Have you registered with the National Health Insurance Scheme?

( ) Yes 1 ( ) No 2

27. What is the minimum amount of money you pay? ……

28. Do you often renew your membership? ( ) Yes 1 ( ) No 2

29. If No, why? ……

30. If you have not registered with the NHIS, how do you pay at the private hospital? .....

31. Does the health facility you have been visiting accept insurance? ( ) Yes 1 ( ) No 2

32. What do you think are some of the main challenges of private health facilities? ……

33. What will you suggest to improve the contributions of the private health sector? .....

34. To what extend do you agree with the services provided by the health facility you visit in terms of the following:

Indicator	5 Very Satisfied	4 Satisfied	3 undecided	2 Unsatisfied	1 Very unsatisfied.
Goodness of available amenities					
Equipment(s) used in services delivery					
Safety measures put in place in delivery service					
Having enough time during consultation					
Having enough privacy during consultation					
Behaviour of Health Personnel					
Technical competence of staff					
Services provided					
Cost of treatment					
Efficiency of the health institution					

APPENDIX (II)

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUESTIONNAIRE FOR OFFICIALS OF MUNICIPAL ASSEMBLY

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

Background

(i)Position of respondent: …… (ii) Age of respondent …….

(iii). Date of interview: ……

1. Does the Assembly have any bye-laws on the operations of health facilities?
2. What are the byes – laws for the operation of private health facilities?
3. What are the processes involved in establishing private health facility
4. How will you access the contributions of private facilities to health care delivery?
5. Who inspect the services provided by the private health facilities?
6. How regular do they inspect their work?
7. How will you describe their services in terms of quality?
8. How will you describe their work environment?
9. How will you describe their charges?
10. What is the Influence of Municipal Assembly over private health facilities
11. Contributions of the private health facility to the Municipal Assembly
12. Problems private health facilities pose to the Municipal Assembly
13. What are the challenges of private health facilities?
14. What will you suggest to improve the contributions of private facilities?

APPENDIX (III)

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUESTIONNAIRE FOR OPERATORS/MANAGERS OF PRIVATE HEALTH FACILITIES

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

I. Name of Health facility ……

II. Location of health facility ……

III. Position of respondent: ……

IV. Date of interview ……

1. What are the infrastructural facilities available in your health facility ……
2. Are these facilities adequate? ( ) Yes 1 ( ) No 2
3. If No, what measures are put in place to ensure their adequacy?
4. What are the major equipment in your facility?
5. Are the equipment in your facility adequate? ( ) Yes 1 ( ) No 2
6. Are all the equipment available in your facility functioning? ( ) Yes 1 ( ) No 2
7. How many doctors/Nurses/pharmacists/midwives are available in your facility and are they adequate? ( ) Yes 1 ( ) No 2.

Year	**2008**		**2009**		**2010**		**2011**	
Staff	**No. Avail.**	**No. Req.**	**No. Avail.**	**No. Req.**	**No. Avail.**	**No. Req.**	**No. Avail.**	**No. Req.**
Doctors								
Nurses								
Midwives								
Pharmacists								
Others								

9. If No how many more are needed?

Staff	**Number needed**
Doctors	
Nurses	
Midwives	
Pharmacists	
Others	

10. How many supporting staffs are available in your hospital?

Staff	**Number Existing**	**Number Required**
Supporting staff		

11. Are all supporting staffs given in-service training? ( ) Yes 1 ( ) No

12. What types of services are rendered in your facility? ( ) curative 1 ( ) preventive 2 ( ) rehabilitative 3 ( ) promotive 4 ( ) others ((specify) 5

13. What attract people to visit your facility? () nearness to clients 1() short waiting time 2 () good quality of services 3 () good attitude of staffs to clients 4 () others (specify) 5…..

14. Is your facility accredited by the National Health Insurance Scheme? ( ) Yes1 ( ) No 2

15. If yes, is the facility reimbursed by the NHIS on time? ( ) yes1 ( ) No 2

16. How many of your clients were registered on the NHIS?

Renewals				**No. Insured**			
2009	2010	2011	2012	2009	2010	2011	2012

17. How do you obtain funds for the running and maintenance of your facilities? () Non-governmental Organization 1 ( ) self-funding 2 ( ) charges from clients 3 ( ) government 4 ( ) others (specify) 5……

18. Does the Municipal Assembly have any influence over your activities? ( ) Yes 1 ( ) No 2

19. Whose enforces the law governing your facility operations?

20. How often do they supervise the activities of your facility?

21. Do you receive any assistance from the |Municipal Assembly? ( ) Yes 1 ( ) No 2

22. If Yes what kind of assistance do you receive?

23. Does your facility refer cases it cannot handle to the public facilities? ( )Yes 1( ) No 2

24. Does your facility also receive referrals from the public facilities? ( )Yes 1( ) No 2

25. What relationship exists between your facility and other private facilities?

26. How do you ensure Quality Health Care Delivery in terms of the following?

Indicator	**Ways of Ensuring Quality Health Care Delivery**
Access to your facility	
Waiting time	
Safety of services delivered	
Affordability of service	
Interpersonal relation of staff and client	
Technical competence of staff	
Ensuring equity	
Level of satisfaction of clients	
Adequacy of staff	
Adequacy of infrastructure and equipment	
Others	

27. On the average how many patients do you attend to/treat in a (day/week/year)?

Period	**Average Number of patients attended to**
Day	
Week	
Month	
Year 2011	

28. What are the common diseases that are reported in your facility?

29. What are the challenges you face in your facility?

30. What are the prospects of your facility?

31. When did you obtain your accreditation to commerce work?

APPENDIX (IV)

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

CHECK LISTS FOR THE MUNICIPAL HEALTH DIRECTORATE (MHD)

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

1. What kind of health facilities do we have in Techiman Municipality? And are they all accredited to operate?
2. Do they all have qualified professionals working in them? How will you assess their contribution in terms quality delivery of services?
3. What support do the MHMT often give to both public and private health facilities?
4. How will you describe the work environment of these facilities?
5. How will you describe the fees paid by clients to facilities?
6. From which facilities are cases referred to the regional hospital?
7. What relationship exists between the public and the private facilities?
8. Do you think that chemical shops in Techiman are managed by trained and qualified people?
9. What do you think would be the state of health without both the public and the private facilities working?
10. What are the main challenges of health facilities?
11. What can you suggest to improve upon the health services delivery?

APPENDIX (V)
THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUSTIONAIRE FOR STAFF OF PUBLIC FACILITIES

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

BACKGROUND

1. Age: ( ) Below 30 ( ) 30 to 40years ( ) above 40 years
2. Sex

( ) Male 1 ( ) Female 2

3. Religion

( ) Christian 1 ( ) Moslem 2 ( ) Traditional 3 ( ) Other specify 4

4. Educational level attained

( ) Primary 1 ( ) JSS/Middle school 2 ( ) SHS/Secondary 3 ( ) university 4 ( ) college 5 ( ) none 6

5. Employment status

( ) full time employment 1 ( ) part time employment 2

6. Marital status ( ) Married (Monogamy) 1 ( ) Married (polygamy) 2 ( ) Single (not in relationship) 3 ( ) Single (in relationship) 4 ( ) Divorced 5( ) Widowed 6

ROLES AND PROFESSION

7. What is your profession? ( ) Nurse 1( ) Doctor 2 ( ) Pharmacist 3 ( ) Lab Tech 4 ( ) Other (specify)……
8. What is your role in the facility? ( ) preventive 1( ) curative 2 () educative 3 ( ) administrative 4 ( ) promotive 5 ( ) others 6 (specify) ……
9. How many clients do you receive in a day/week/year (averages)?

Period	**Number of client**
Day	
Week	
Year	

10. Do you have all logistic and equipment required for your work? ()Yes ()No

11. If No list those lacking? ……...

12. Besides here do work for other private health facilities? ( )Yes ( )No

13. If Yes where? .....

14. Do you receive cases from private health facilities?( )Yes ( )No

15. Do you refer cases to private health facilities? ( )Yes ( )No

16. If Yes what cases do you refer to private health facilities? ( ) lab test 1 ( ) some drugs 2 ( ) curative 3 ( ) preventive 4 ( ) educative 5 ( ) others 6 (specify)……

YOUR VIEWS ABOUT PRIVATE HEALTH FACILITIES

17. How will you describe their services to clients? ( ) good 1( ) very good 2 ( ) satisfactory3 ( ) others (specify) 4

18. How will you describe their attitude towards clients? ( ) very good1 ( ) satisfactory 2( ) bad 3( ) others 4(specify)……

19. Are their activities regulated? ( )Yes 1( )No 2

20. Who regulate their activities? .....

21. How often do they inspect their activities……

22. Do they receive regular in-service training? ( ) Yes 1( ) No 2

23. How will you describe their work environment? ( ) always clean 1( ) dirty 2 ( ) always noisy 3( ) others 4(specify)……

24. What are the challenges of private health facilities? .....

25. What is the level of education of most of those who work in these private facilities? ( ) health professionals 1 ( ) JHS/Middle School 2 ( ) SHS () others 3 (specify)……

27. How do you ensure Quality Health Care Delivery in terms of the following?

Indicator	Ways of Ensuring Quality Health Care Delivery
Access to your facility	
Waiting time	
Safety of services delivered	
Affordability of service	
Interpersonal relation of staff and client	
Technical competence of staff	
Ensuring equity	
Level of satisfaction of clients	
Adequacy of staff	
Adequacy of infrastructure and equipment	
Others	

APPENDIX (VI)

THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUESTIONAIRE FOR PRIVATE HEALTH STAFF

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

Background

1. Age

(a) 15-20 [ ] (b) 21-25[ ] (c) 26-30 [ ] (d) above 30 years [ ]

2. Sex

(a) male [ ] (b)female [ ]

3. Profession

(a) Doctor [ ] (b) (c) Midwife [ ] (d) Nurse [ ] (e) Pharmacist [ ]

(b) (f) Others [ ] please specify…….

4. Religion

(a) Muslim [ ] (b) Christianity [ ] (c) Traditional [ ] (d) others [ ] (specify) ……

5. Income per month

(a) Below GH₵200 [ ] (b) GH₵300- GH₵700 [ ] (c) GH₵800- GH₵1,000 [ ] (d) above GH₵1000 [ ]

6. Level of education

(a) Primary [ ] (b) JHS/Middle School [ ] (c) Secondary [ ] (d)Tertiary[ ]

7. Name of facility …….

8. What role do you play in the facility [ ] curative 1[ ] preventive 2 [ ] testing 3 [ ] administrative [ ] others (please specify)……

9. How long have you been working in the facility? .....

10. How many clients do you receive in a day/week/month/year (averagely)?

Period	**Average number of clients**
Day	
Week	
Month	
Year 2011	

11. What equipment are available in your facility?

12. Are the equipment in your facility adequate? (a)Yes [ ] (b) No [ ]

13. Are all the equipment available in your facility functioning? (a)Yes [ ] (b) No [ ]

14. What are the common cases you receive here? (Top 10 diseases)

2009		2010		2011		2012	
Disease	No. of Cases	Disease	No. of Cases	Disease	No. of Cases	Disease	No. of Cases

15. Do you refer cases to public facilities? (a) yes [ ] (b) no[ ]

16. Have you ever received complains for referring cases to these facilities? (a)Yes [] (b) No [ ]

17. Do you receive cases from the public facilities? (a)Yes[ ] (b)No[ ]

18. If yes what are some of the cases you receive from the public facilities?

19. How will you describe your work environment? [ ] very good 1[ ] good 2 [ ] satisfactory 3 [ ] others (please specify)

20. Who regulates your activities?

21. How regular do they inspect your facility?

22. What are the main challenges of the facility?

23. What will you suggest to improve private health facilities?

25. How do you ensure Quality Health Care Delivery in terms of the following?

Indicator	Ways of Ensuring Quality Health Care Delivery
Access to your facility	
Waiting time	
Safety of services delivered	
Affordability of service	
Interpersonal relation of staff and client	
Technical competence of staff	
Ensuring equity	
Level of satisfaction of clients	
Adequacy of staff	
Adequacy of infrastructure and equipment	
Others	

APPENDIX (VII)
THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE SERVICE PROVISION THE CASE OF TECHIMAN MUNICIPALITY

QUSTIONAIRE FOR PHARMACIST/CHEMICAL SELLERS

This research is strictly for academic purpose hence; all information given will be treated with confidentiality and reference would not be made to you by name.

BACKGROUND

1. Age:

[ ] Below 30 [ ] 30 to 40years [ ] above 40 years

2. Sex:

[ ] Male 1 [ ] Female 2

3. Religion:

[ ] Christian 1 [ ] Moslem 2 [ ] Traditional 3 [ ] other specify 4

4. Educational level attained:

[ ] Primary 1 [ ] JSS/Middle school 2 [ ] SHS/college 3 [ ] tertiary 4 [ ] none 6

5. Occupation:

[ ] business 1 [ ] nurse 2 [ ] teacher [ ] others (specify) ……..

6. Marital status:

[ ] Married (Monogamy) 1 [ ] Married (polygamy) 2 [ ] Single (not in relationship)

3 [ ] Single (in relationship) 4 [ ] Divorced 5[ ] Widowed 6.

7. Who own this shop? [ ] myself [ ] somebody [ ] relative [ ] others (specify)

8. Which drugs are more patronize in your shop? .....

9. Do give injection here? [ ] Yes [ ]No

10. Are you having licenses to operate the shop? ……

11. Have you had any in-service training on the sale and use of drugs? [ ]Yes [ ] No

12. If yes who gave you this training? [ ] owner of shop [ ] Ghana National Chemical Sellers Association [ ] Pharmaceutical Manufacturers Association of

Ghana [ ] others (specify)…

13. Do they inspect your drugs regularly? [ ] Yes [ ]No

14. How regular do they inspect your work? .....