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# Private Health Care Provision in the Greater Accra Region of Ghana

*July 1999*

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# Abstract

Ghana has undertaken numerous health sector reforms in recent years aimed at achieving equity of access to health services and improved quality of services. This study uses Ghana's Greater Accra Region (GAR) as a case study to explore the contribution of private health care providers to health care delivery in Ghana and to recommend policy instruments for enhancing the role of private providers. The study methodology entails the use of both primary and secondary data sources including a series of questionnaires distributed to private practitioners, pharmacists, traditional health providers, and midwives. Key findings of the study include that all socio-economic groups patronize private health care service and that clients' perception of services provided by private practitioners was generally more favorable than of the services provided by public facilities. In light of these findings, the study recommends policy development that supports and regulates the private sector and that responds to the different types of private health care in the region.

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# Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AMA</b>	Greater Accra Metropolitan Authority
<b>CHAG</b>	Christian Health Association of Ghana
<b>CSIR</b>	Center for Scientific and Industrial Research
<b>DDM</b>	Data for Decision Making
<b>DHS</b>	Demographic and Health Survey
<b>FGD</b>	Focus Group Discussion
<b>GAR</b>	Greater Accra Region
<b>GLSS</b>	Ghana Living Standard Survey
<b>GOG</b>	Government of Ghana
<b>GRMA</b>	Ghana Registered Midwives Association
<b>GSMDP</b>	Ghana Society of Medical and Dental Practitioners
<b>GSMF</b>	Ghana Social Marketing Foundation
<b>IGF</b>	Internally Generated Funds
<b>ISSER</b>	Institute of Social Statistical and Economical Research
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
<b>PPAG</b>	Planned Parenthood Association of Ghana
<b>SSNIT</b>	Social Security and National Insurance Trust
<b>STD</b>	Sexually Transmitted Disease
<b>TBA</b>	Traditional Birth Attendant
<b>TMP</b>	Traditional Medical Practitioner
<b>UNFPA</b>	United Nations Population Fund
<b>URTI</b>	Upper Respiratory Tract Infection
<b>USAID</b>	United States Agency for International Development
<b>UTI</b>	Urinary Tract Infection







## Foreword

Part of the mission of the Partnerships for Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact." This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The main objective of the Applied Research program is to prepare and implement an agenda of research that will advance the knowledge about health sector reform at the global and individual country levels.

An important component of PHR's applied research is the Small Applied Research (SAR) program. SAR grants are awarded, on a competitive basis, to developing-country research institutions, individuals, and non-profit organizations to study policy-relevant issues in the realm of health sector reform. The SAR program has twin objectives: to provide data and analyses relevant to policy concerns in the researcher's own country, and to help strengthen the health policy research capacity of developing country organizations. While PHR provides technical advice and support to the SAR grantees, the content and conclusions in the final research reports are the responsibility of the grantees. They do not necessarily reflect the views of USAID or PHR.

A total of 16 small research grants have been awarded to researchers throughout the developing world. Topics studied include health financing strategies, the role of the private sector in health care delivery, and the efficiency of public health facilities.

SAR grant recipients are encouraged to disseminate the findings of their work locally. In addition, final reports of the SAR research studies are available from the PHR Resource Center and via the PHR website. A summary of the findings of each study are also disseminated through the PHR "in brief" series.

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# Executive Summary

Ghana, a low-income developing country located in West Africa, has in recent years adopted health sector reforms and policies aimed at achieving equity of access to services, improved efficiencies in resource allocation and utilization, development of linkages with local communities and other partners, as well as improved quality of health services.

As a result of these developments, the country's Medium Term Health Strategy (Ministry of Health 1995a) has as one of its goals the fostering of closer collaboration and partnership between the public sector and providers in the private sector, with the aim of increasing involvement of the private sector in health care delivery.

Despite the interest in seeking greater utilization of the private health sector, relatively little is known and documented about its current activities. The dearth of research information impedes meaningful policy and strategy development to facilitate public/private-sector collaboration. This study was undertaken to fill the research gap. By adopting the Greater Accra Region (GAR) as a case study, it explored the contribution of private health care providers to total health care delivery with emphasis on the size, scope, and distribution of private provision of services; the actual and potential role of the private sector in health promotion and preventive health activities; and factors affecting its development. It also recommends policy instruments for enhancing the role of private providers.

The study entailed both qualitative and quantitative assessment of the private sector in the region by using primary and secondary data sources. It developed a profile of the private sector by seeking answers to questions such as:

- ▲ Who constitutes the private sector?
- ▲ In what activities is the sector engaged?
- ▲ Where and how does it operate in the GAR?
- ▲ What is its potential?

The study defined the private health sector as all those health providers working outside the direct control of the state. It included both for-profit and not-for-profit providers, and formally trained providers as well as traditional healers.

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## The Greater Accra Region

The Greater Accra Region, in which Accra, the national capital, is located, has several unique characteristics. Despite being the smallest region in size, it is the most densely populated in the country. Greater Accra is the only region in Ghana where the urban/rural population ratio is 80:20, the reverse of the rest of the country. Not surprisingly, most of the GAR's public and private health investments and economic infrastructure are concentrated in the urban centers. The rapid growth in the GAR's population is increasing the pressure on existing infrastructure and demand for basic services such as water, sanitation, sewerage, and drainage, especially in urban areas.

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## The Private Health Sector in GAR

The study revealed that the private health sector in the GAR is complex and made up of a diverse mix of providers ranging from traditional to modern practitioners. These providers also differ in terms of structure, composition, output, and location. For example, the formal private sector, comprising privately owned medical facilities such as hospitals, clinics, and maternity homes, has emerged largely as a consequence of the limited coverage of public-sector and charitable health facilities. Both the rapid population and economic growth of the region have led to the increase in the numbers of pharmacies and chemical shops in the region. The historical growth of the Accra–Tema districts as a metropolis has influenced the concentration of many modern private health facilities in the cities of Accra and Tema. Currently, over 90 percent of for-profit providers are located in the two districts, where there is a proximity to the market, a higher ability of clients to pay, and a better communication infrastructure. The study estimated that collectively, the formal private health sector provides about 60 percent of all curative health care in the GAR.

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## Key Findings

### Private For-Profit Practitioners

Of the over 2,000 physicians registered in Ghana, about 700 are engaged in the public sector while around 300 are in the private sector. The remainder are believed to work outside the country.<sup>1</sup>

About 55 percent of private-sector providers are found in the GAR. The majority of those surveyed (86 percent) were 45 years old and above while only 7 percent were below the age of 45. In the older group, 46.5 percent were age 55–64 years and 16.1 percent were 66 years and above. This finding suggests that private practitioners are an aging population and that few new doctors are entering private practice. The study also found that there were fewer women than men in private practice in the region.

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<sup>1</sup>The issue of brain drain in the health sector is a very serious one. In a study on the migration by graduates of the University of Ghana Medical School, Dolvo and Nyonator (1999) established that 60.9 percent of doctors trained in the University of Ghana Medical School between 1985 and 1994 emigrated to other countries, especially to the United Kingdom and United States.

Of the facilities surveyed, 91.3 percent were classified by the providers as general practice. Providers with specialities were found in surgery (36.2 percent), obstetrics and gynecology (34.8 percent), dentistry (7.2 percent), and orthopedics (8.7 percent). Sixty-one percent of the practitioners surveyed were in solo practice while 39 percent were in group practices that provide basic health services, including curative care (97.1 percent) and preventive care (72.5 percent).

By provider estimates, the majority of private provider clients in the GAR are female and children, and 86 percent of adult consumers who use private health facilities are educated (had at least 10 years of formal education). Contrary to previous assertions that the well-to-do constitute the clientele for private practitioners, the study showed that all socio-economic groups patronize private health care service. In the clinics surveyed, 93.3 percent of the clientele claimed that they represented the low- and medium-income groups.

Clients' perception of services provided by private medical practitioners was generally more favorable than of the services provided by public facilities. Among reasons why consumers preferred private providers to public providers were quality of care, shorter waiting times, availability of drugs, friendly staff, proximity, clean surroundings, availability of credit facilities, and reasonable charges.

When the for-profit providers themselves were asked what they considered to be their business strengths, they mentioned provision of quality service (98.6 percent), good public relations (82.6 percent), and reliable support staff (69.6 percent). The major business limitation cited was lack of access to credit and capital, followed by infrastructure constraints and an unfavorable tax environment. An interesting observation was that the private for-profit providers appeared to be more concerned than public-sector providers about efficiency and quality in the production of health services.

## **Pharmacists**

The private pharmaceutical sector in the GAR consists of retail pharmacies, wholesale pharmacies, and combined retail and wholesale pharmacies. According to the Pharmacy Council, there are 1,085 registered pharmacists in the country. Of these, 487 are in the private sector; 326 of them (66.9 percent) are in the Greater Accra Region.

The majority of the GAR's private pharmacies are retail community pharmacies, located mostly in urban areas. Their major activities comprise dispensing prescription and nonprescription drugs, counseling, health education, and drug information dissemination.

The majority of pharmacies surveyed served as the first point of contact between the public and the health team. The survey found evidence of self-medication and self-care, as 57 percent of the consumers surveyed bought drugs without prescription and 64 percent of those who visited pharmacy shops were not referred. In Ghana, the community pharmacist is permitted by law to provide remedies for minor ailments that do not require the doctor's attention, and therefore many of the consumers consulted the pharmacists for conditions such as malaria, diarrhea, coughs and colds, and aches and pains. Makers of policy for the private pharmaceutical sector should consider strengthening the role of pharmacies as "one stop" sources of health care.



## **Traditional Providers**

The study relied on secondary data and focus group discussions to generate information on the traditional sector. The sector plays a significant role in the treatment of medical cases such as diarrhea, piles, measles, malaria, impotence, hypertension, and sexually transmitted diseases. Surgical practices by traditional practitioners involve male circumcision and the management of fractures. The significant finding was that the traditional practitioners themselves said they require legitimation and professionalization and called for better collaboration between traditional medicine and orthodox medicine.

## **Mission/Non-Governmental Organizations**

The Christian Health Association of Ghana (CHAG) serves as the coordinating body for a large number of mission-run health programs in Ghana. However, CHAG's presence in the GAR is limited to a handful of facilities. There are also a few Islamic facilities, providing largely curative care to populations in the periurban areas. The largest non-governmental organization (NGO) in the region is the Planned Parenthood Association of Ghana, which is involved in reproductive health and family planning services delivery. Other NGOs operating in the region include the Save the Children Fund, which supports local NGOs in reproductive health projects, and the Ghana Social Marketing Foundation, which has established useful links with pharmacists and chemical sellers in the marketing of family planning products.

The value of the NGO contribution to health delivery could be improved by the establishment of more grassroots NGOs in rural communities, to extend coverage of services to those areas of the region.

## **Midwives**

It is estimated that of the 6,000 midwives in Ghana, only about 5.7 percent, or 342, operate in the private sector. Twenty-seven percent of private midwives are found in GAR. As the estimates indicate, there is a gross undersupply of private midwives in the region, given its large population. This shortage undermines efforts to strengthen reproductive health services. Not only did the midwives interviewed in the survey provide delivery services, but they also served as the only source of both curative and preventive care in the areas in which they operate.

There is the need to step up the training of both midwives and traditional birth attendants to enhance reproductive health and safe motherhood initiatives.

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## **Recommendations**

In addition to those cited in individual sections above, the study findings suggest the following overall recommendations:

- ▲ Policies should be developed to respond to the unique peculiarities of the different types of private health care in the region, since the sector is not homogenous.

- ▲ Policies should be developed to support, encourage, and regulate the private sector.

---

# 1. Introduction

This report, based on research carried out in the Greater Accra Region (GAR) of Ghana, is intended to provide a clearer understanding of the role of the private sector in health care delivery.

Particularly useful would be a better appreciation of how the private sector emerged and developed over the years as well as its current role, strengths and weaknesses, and potential. The research findings should inform policies aimed at a more efficient mobilization and effective utilization of private sector resources in the region. The report begins by providing a general background of Ghana and the study area. The principal types of private providers in the region and their distribution are delineated. The study format is presented and the survey material analyzed. The final sections highlight the findings of the research and the policy recommendations that could be considered in enhancing the role of the private sector in the region.

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## 1.1 Country Profile

Ghana is a small country located in West Africa with a population of about 18.3 million (United Nations Fund for Population Activities 1997). It has an area of 238,537 square kilometers and a coastline of 560 kilometers. It is divided into 10 administrative regions, which are further subdivided into 110 districts. English is the official language. Thirty-four percent of the population lives in urban areas, 66 percent in rural areas.

The country's mixed economy consists of a dominant traditional agricultural sector and a relatively small modern sector. In the wake of fundamental economic reforms since 1983, the Ghanaian economy has experienced considerable improvement, including a sustained average annual gross domestic product growth rate of 5 percent. The population growth rate is estimated at 3 percent annually with an average income per capita of around US \$410.

Health delivery in Ghana is provided by the government through the Ministry of Health (MOH), which is the largest modern provider and is assisted by the missions and the private sector, which includes traditional providers.

Health policies and programs of the government of Ghana (GOG) seek to provide health for all by the year 2000 by promoting intersectoral action for health, increasing equity of access to health services, and ensuring improved quality and increased efficiency of service delivery.

Despite significant gains since the 1980s, the health situation is still characterized by inadequate access to quality care, potable water, and sanitary facilities for waste disposal management. Infectious, parasitic, and respiratory diseases remain the main causes of disability and death. At the same time, there has been an increase in the incidence of chronic and noncommunicable diseases, cancers, and circulatory disorders, especially among the urban population. Thus, the overall epidemiological picture of Ghana is that of a developing country at the brink of a health transition—acquiring diseases characteristic of affluent

societies without having eliminated those characteristic of poor countries. Table 1 presents some vital health statistics for Ghana.

**Table 1. Selected Vital Health Statistics, Ghana**

<b>Condition</b>	<b>Statistic</b>
Infant mortality rate	66/1,000 live births
Maternal mortality rate	214/100,000 live births
Under 5 mortality rate	119/1,000 live births
Crude death rate	12/1,000 of population
Crude birth rate	42/1,000 of population
Overall life expectancy at birth	55.7 years
Life expectancy at birth (female)	58 years
Life expectancy at birth (male)	54 years
Annual natural increase	3%
Total fertility rate	4.5

Source: Ministry of Health, 1996a, 1998

In the face of these challenges, the GOG has initiated a general reform of the health sector by re-ordering its priorities and spending patterns (MOH 1995a). Public funds are now to be concentrated on the universal provision of good-quality primary health services within the district health system. Cost-sharing for more specialized services is to be stepped up. Current policy reforms propose stronger linkages between public and private health providers, especially as government development policy is predicated generally on the private sector being the engine of growth. Besides attempting to promote greater efficiency in spending on services at all levels of health care, the government has created the Ghana Health Service and moved towards decentralization of the health system by providing management teams at various levels; the teams have greater flexibility in allocating resources according to their own priorities, within the context of general policy guidelines.

Analyses carried out by GOG and other stakeholders over the years have suggested that the major challenges faced by Ghana's health system are related to limited health care coverage and severe financing problems. There is poor access as well as inequality of access to care in both rural and urban areas. From a financing perspective, health expenditures are both inadequate and largely oriented to urban areas and the hospital level. It is recognized that additional resources should be mobilized to improve care delivery and to extend health care to rural areas to ensure equity. One key GOG strategy to achieve these objectives is to mobilize private-sector resources.

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## **1.2 Study Area: Greater Accra Region**

### **1.2.1 Geography, Population, and Administrative Divisions**

The Greater Accra Region is located in the dry southern coastal plain of Ghana. It covers an area of about 3,245 square kilometers and has an estimated population of 2,286,886. The GAR is made up of five districts, namely, Accra, Tema, and the rural districts of Dangbe East, Dangbe West, and Ga. The Accra district is the second largest industrial center in Ghana after the neighboring district of Tema. The city of Accra, the capital of Ghana as well as the principal commercial and investment center, is located in the GAR.

While the region is the smallest in size of Ghana's 10 regions, it has a population density of 704.7 persons per square kilometer as compared to 72.9 persons per square kilometer for the country as a whole (MOH 1996a). As Table 2 shows, Accra district is the most populous, with a population of 1,547,643; Dangbe East is the least populated district. The Accra and Tema districts' population represents over 80 percent of the total GAR population.

**Table 2. Estimated Population of the Greater Accra Region, by District**

	Districts					
	Accra	Tema	Ga	Dangbe East	Dangbe West	Total
Population	1,547,643	316,840	225,631	96,568	100,204	2,286,886

Source: Ministry of Health, GAR

The very high overall population density in the region is due obviously to the presence of the Accra and Tema metropolitan areas. As one moves to the rural districts, the population density decreases. This is the result of rural to urban migration because of poor socio-economic conditions in the rural areas. Thus, the majority of people in the GAR (86.4 percent) are urban dwellers as compared to 13.6 percent of rural dwellers. This is quite different from the general pattern in the country as a whole where, as mentioned above, there are more rural than urban dwellers.

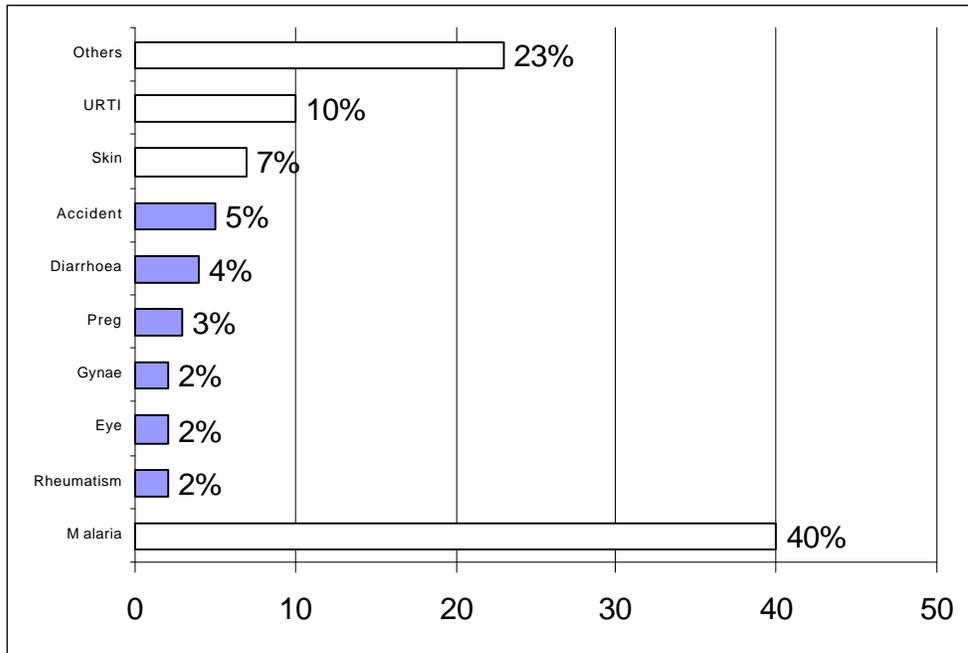
### 1.2.2 Economic Activities

The GAR has the most diversified economy in the country and contributes to between 15 and 20 percent of gross domestic product (Benneh et al. 1993). Light industrial activities, trade and commerce, commercial fishing, and farming constitute the economic backbone of the region.

### 1.2.3 Health Status

In GAR, the causes of death in infancy are low birth weight and diseases of the newborn such as infections, malnutrition, and anemia. Lung disorders contribute significantly to infant death as do infant pneumonia, birth injuries, congenital malformation, and infections. Despite these problems, in 1993 and 1994, the infant mortality rate in the GAR was reported to be 58 per 1,000 live births, childhood mortality 44 per 1,000 (Ghana Statistical Service 1994), appreciably better than for the country as a whole. In addition, using life expectancy at birth for the period 1978–87, GAR appears to have an 11 percent lower mortality than that of Ghana. This is credited to better access to health care for infants, children, and pregnant women, especially in the urbanized parts of the region. The most common cases reported at GAR government outpatient facilities in 1996 were malaria, upper respiratory tract infection (URTI), diarrhea, skin diseases, accidents, hypertension, pregnancy and related complications, acute eye infections, rheumatism, and gynecological disorders. Figure 1 shows the top 10 diseases in 1996.

**Figure 1. Ten OPD Cases (1996)**



Source: Ministry of Health 1996.

Available information suggests intraregional differentials in health status within the GAR. For example, a study done in Accra district shows that diseases of the circulatory system, such as hypertension, cause more deaths for both males and females—a quarter of all deaths in 1991—in that district than in other districts. Even within the Accra district, huge relative health differentials exist between the various urban socio-environmental groups. Mortality differentials also exist for urban adults and the elderly as well as for children (Stephens et al.1994).

The 1996 Annual Report of the GAR MOH reveals that communicable diseases such as buruli ulcer are more prevalent in Ga district than in other districts. However, cases of schistosomiasis can be found in all the districts, with the highest prevalence in Ga, Accra, and Tema. Of the 277 sexually transmitted disease (STD) cases excluding HIV/AIDS reported in 1996, Dangbe West reported 28 percent, Dangbe East 27 percent, Ga 24.1 percent, Accra (district) 15.5 percent, and Tema 3.9 percent. All this implies that it is extremely difficult to make generalizations about the GAR, which displays complex economic, social, and environmental variations. Such diversity should be taken into consideration when health plans and policies are being developed for the region.

### **1.2.4 Private Sector Health Care**

The Ministry of Health delivers health services in the Greater Accra Region through a network of publicly owned health facilities such as hospitals, polyclinics, health centers, and clinics. The delivery of health services is coordinated by the Regional Health Administration which, on behalf of the MOH, pursues policies relating to the provision of health care services, including the supervision of the private

sector. Private-sector providers are a mix of the formal, such as doctors, pharmacists and chemical sellers,<sup>2</sup> and non-governmental organizations (NGOs), and the informal, such as herbalists and traditional birth attendants (TBAs). Table 3 presents the typology of the private health sector in the GAR.

**Table 3: Typology of Private Providers in GAR**

Employer-provided	Non-governmental organizations/ Not-for-profit	For-profit
<b>Industrial Facilities</b> Trust Hospital Vo Ha Aluminum Company	<b>Missions</b> CHAG facilities Islamic organizations e.g., Iran Clinic <b>NGOs</b> Local NGOs Foreign NGOs	<b>Modern/Formal</b> <b>Private Medical Practitioners</b> Private Clinics Private Hospitals <b>Nurse Practitioners</b> Private Clinics <b>Laboratory Services</b> <b>Midwives</b> Maternity clinics Maternity Homes <b>Pharmaceutical Retailers</b> Pharmacies Licensed Chemical Sellers <b>Traditional/Informal</b> Herbalists Neo-herbalists Spiritualists Faith healers TBAs Wanzams Vendors/peddlers

### 1.2.5 Distribution of Private Health Facilities

Reflecting its urban–rural population bias, the majority of the different types of formal/modern private health providers in the GAR are concentrated in the Accra–Tema districts. Historically, MOH facilities were first developed in the then-Accra Town (now part of Accra district), which was made the capital of Ghana in 1877. As Accra grew in importance in the 1920s and 1930s, its infrastructure was developed with the construction of market places and streets and the provision of water and electricity. This period also saw the opening of Achimota School and Korle Bu Hospital, which attracted additional residents to the town. As the population grew, so did the number of educational institutions, commercial firms, and industries. It is on record that the first private physician practice was established in Accra in 1902 by Dr. Quartey-Papafio.

Today over 90 percent of Ghana's private providers are located in Accra and Tema districts. Pharmacies are concentrated in the old parts of Accra, especially the city center in areas such as Okaishie, Adabraka, and Kaneshie. However, efforts are now being made by the Pharmacy Council to spread the distribution of pharmacies to outlying suburbs and newly developing settlements. An existing regulation

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<sup>2</sup> Pharmacists are also called “chemists” in Ghana and operate from facilities and shops where all classes of drugs including prescription and nonprescription drugs are sold. They run pharmacy shops and are professionally trained. Licensed chemical shops, on the other hand, are run by chemical sellers who are not professionally trained and are allowed to sell over-the-counter medication and other nonprescription drugs only.

stipulates that pharmacies must be located at least 400 meters apart in the urbanized areas of GAR to even out their concentration.

Even with these efforts, the number of facilities appears to be lowest in Dangbe East and Dangbe West districts, where there are virtually no private for-profit physicians and only a handful of pharmacies and chemical shops. Instead, most for-profit providers have followed the public sector in establishing their facilities in densely populated and commercial areas. As the case of GAR illustrates, vast numbers of rural people in Ghana remain beyond the reach of the formal health care delivery system. In Ghana, as in many developing countries, urban effective demand is far greater than rural demand, which influences the distribution of facilities. This reality, which has resulted in the inequality in the distribution of facilities between urban and rural areas, poses a real challenge to policymakers.

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## 2. Study Methodology

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### 2.1 Goals, Objectives, and Methodology

The primary goal of the research was to study the private health provision in the Greater Accra Region, with emphasis on its contribution to health care delivery including curative, promotive, and preventive aspects.

The specific objectives were to:

- ▲ define and describe the private health sector in the GAR;
- ▲ identify and describe the professional activities of private providers;
- ▲ determine and assess the contribution of the private sector to national health goals in terms of what it does, who uses its services, and its cost and health impact;
- ▲ describe the current national policy framework within which the sector operates;
- ▲ examine the principles that will guide the promotion of a partnership between the private and public sectors; and
- ▲ based on study findings, to provide policy options for increasing the contribution of private providers to the health goals of the GAR in particular and Ghana as a whole.

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### 2.2 Study Rationale

The desire to integrate private providers into comprehensive national health development underscores the need for empirical data to inform policymakers of the role that the private health sector plays in health care delivery. Information is needed on the sector's strengths, weaknesses, and potential to expand its role. This assessment and evaluation of the private health sector in the GAR should improve the efficient mobilization and effective utilization of non-state resources to strengthen health goals. The region was chosen for this research not because it is representative of other regions in Ghana, but because it has the better-developed private health infrastructure that allows a study of the factors and variables influencing the operations of the private sector.

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### 2.3 Study Methods and Procedures

The aim of the research was to gather relevant information to assist in developing a profile of private health-sector providers in the Greater Accra Region, having the following variables in mind.

- ▲ Who are the private providers?
- ▲ What do they do?
- ▲ What factors influence their operations and activities?
- ▲ Who uses their services?
- ▲ What linkages if any, do they have with the public sector?
- ▲ To what extent are they involved in preventive health and health promotion activities?

The providers surveyed included private medical practitioners, pharmacists, NGOs, traditional medical practitioners (TMPs), and private-sector midwives, including TBAs.

### 2.3.1 Sampling Procedures

Table 4 provides a sample frame of the different types of providers and consumers surveyed in the GAR.

**Table 4. Overview of Sample Procedures**

Sector/Provider	Methodology	Sample Size
Private-for-profit medical practitioners	Questionnaires	69 providers 150 consumers
Pharmacists/chemists	Questionnaires	56 providers 150 consumers
Traditional healers	Focus group discussion	
NGOs	Interviews	
Private maternity homes/midwives	Focus group discussion	

### Medical Practitioners

The sampling frame consisted of a list of registered members of the Ghana Society of Medical and Dental Practitioners, the professional organization for doctors in private practice operating in Accra and Tema districts. The list contained 138 members, from which 100 were randomly selected. Each came from a different facility. Questionnaires were distributed to the selected members. Sixty-nine completed questionnaires were returned.

## **Consumers of Physician Services**

Consumers surveyed were exit respondents who patronized the selected practitioners. Two hundred consumers were targeted; 150 questionnaires were completed.

## **Pharmacists**

The sampling frame for pharmacists consisted of a list of registered pharmacists who operated under licence from the Pharmacy Council of Ghana. The list included a number of community retail pharmacists who operated mainly in Accra and Tema districts. One hundred pharmacists were randomly selected from the list and provided with questionnaires; 56 questionnaires were recovered.

## **Consumers of Pharmacy Services**

The consumers were exit respondents who patronized the services of the selected practitioners. Two-hundred consumers were targeted; 150 questionnaires were recovered.

### **2.3.2 Data Collection, Instruments, and Methods**

#### **Survey Instruments**

The development of research instruments involved the design of questionnaires, focus group discussion guidelines, and interview guidelines. The survey instruments were developed by the research team and modifications were made following a field test.

#### **Interviewers**

Five research assistants were recruited from the Department of Community Health, University of Ghana Medical School, to assist in the field survey. After the initial training, they pretested the questionnaire on a small sample of private medical practitioners and pharmacists, who were excluded from the main study.

#### **Secondary Data**

The study relied extensively on secondary sources of information, available from existing documents such as GOG policy documents, annual MOH reports on the Greater Accra Region, government statistics, and international reports.

## Primary Data

Primary data were collected through:

- ▲ A survey of providers including medical practitioners and pharmacists in the private for-profit sector using semistructured questionnaires (see Annex A).
- ▲ Exit interviews of consumers who used private facilities, using a simple semistructured interview schedule (see Annex B).
- ▲ Focus group discussion (FGD) with traditional health care providers, i.e., TMPs and TBAs recruited from three of the five districts in the GAR (see Annex C)
- ▲ FGDs with a group of private midwives selected from various subdistricts in the GAR (see Annex D).
- ▲ In-depth interviews with key actors from the MOH, NGOs, and private providers.

Interviewers scheduled appointments with selected practitioners and recruited persons within the practice who could answer questions on the subjects covered by the instruments.

### 2.3.3 Data Processing

The data were edited, coded, and keyed into a microcomputer at the Institute of Social Statistical and Economic Research at the University of Ghana.

Taped FGD data were transcribed by individual language experts recruited from the GAR subdistricts. Data were analysed to summarize similar ideas and opinions and to complement questionnaire data. A statistics and systems specialist guided and supervised data collection, processing, and analysis to ensure appropriate handling of research data.

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## 2.4 Study Constraints

Secondary information needed to support the research was difficult to come by since little documentation on the private sector in the region was available. There was also a general unwillingness of many providers to provide information they considered to be sensitive, especially in areas relating to financial operations and delicate medical practices. In addition, the use of the GAR as a proxy is a limitation; it is unlike any other region in the country.

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## 3. Findings

Study findings are discussed in this chapter in the order in which they appear in the provider and consumer questionnaires. As noted previously, the questionnaires appear in the annexes to this report.

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### 3.1 Private For-Profit Practitioners

Of the 100 private for-profit providers sent survey questionnaires, 69 responded. Areas of interest examined by this survey on private for-profit practitioners included:

- ▲ Characteristics of the providers
- ▲ Number of doctors practicing in clinics/hospitals
- ▲ Major professional activities
- ▲ Attendance (number of patients seen) per week
- ▲ Ranking of conditions commonly seen
- ▲ Characteristics of patients
- ▲ Referrals/referral target
- ▲ Links with traditional practitioners
- ▲ Participation in public health/prevention activities
- ▲ Types of support/incentives required from government

#### 3.1.1 Socio-Demographic Characteristics of Respondents

Table 5 shows the age distribution of the 69 providers who responded to the survey questionnaire. Nearly 86 percent was 45 years and older, while only 7 percent was younger than age of 45. Sixteen percent was 65 years and above. This shows that the population of medical practitioners in private practice is an aging one.

**Table 5. Age Distribution of Private For-Profit Medical Providers**

Age	Number	Percentage
<45	5	7.0%
45-54	16	23.2%
55-64	32	46.5%
65+	11	16.1%
No Response	5	7.2%
TOTAL	69	100.0%

### 3.1.2 Characteristics of Practice

Respondents were asked to indicate the number of doctors practicing in their facilities. Results showed that 60.8 percent of the practitioners were in solo practice while 38.2 percent were in group practice.

As Table 6<sup>3</sup> indicates, of 69 clinics surveyed, 91.3 percent were classified by the providers as general practice. In addition to the general practice, 36.2 percent and 34.8 percent said they practiced surgery and obstetrics/gynecology respectively. On average, the practitioners saw from 150 to 160 patients in a week.

**Table 6. Services Provided by Private Medical Practitioners**

Diagnostic and Therapeutic Services	Number of Responses	Percentage of Practitioners Offering Service
General	63	91.3
Surgery	25	36.2
Obstetrics/Gynecology	24	34.8
Eye	14	20.3
ENT	10	14.5
Dental	5	7.2
Orthopedics	6	8.7
Other Specialties	8	11.6
Male Diseases	2	2.9

### 3.1.3 Conditions Commonly Seen at Private Facilities

Table 7 shows the ten conditions most commonly seen at private health facilities annually, ranked in order of percentage of doctors mentioning them.

<sup>3</sup>Table 6 and many following tables present multiple responses given to survey enumerators. For example, in Table 6, physicians may have responded that they offer more than one of the services. Thus, the number of responses totals more than the number of respondents and percentages total more than 100 percent.

**Table 7. Conditions Commonly Seen at Private Facilities**

Condition	Percentage of Practitioners Seeing Condition
Malaria	78
Upper respiratory tract infection	46
Gastroenteritis	20
Hypertension	24
STDs	13
Urinary tract infection	11
Infertility	9
Hernia	9
Diabetes	7
Bronchial asthma	6

### 3.1.4 Referrals

Of practitioners surveyed, 55.1 percent confirmed that their clinics formed part of a referral network while 44.9 percent indicated that their clinics did not form part of any network; 82.6 percent of practitioners utilized referral networks to receive clients from other sources and 17.4 percent did not.

As Table 8 indicates, 63 percent of facilities received referrals from other private clinics, 58 percent received referrals from pharmacists, 20.3 percent from traditional healers, and 5.8 percent from private laboratories. More than 44 percent of the providers interviewed referred cases to public hospitals, with the number of cases referred ranging from one to 25 daily.

**Table 8. Sources of Referral to Private Providers**

Source	No. of Responses	Percentage of Providers Receiving Referrals
Other private clinics	44	63.8
Pharmacists	40	58.0
Government hospital	20	29.0
Churches	16	23.2
Traditional healers	14	20.3
Private lab	4	5.8

### 3.1.5 Combination of Orthodox with Traditional Medicine

Eighty-seven percent of respondents said they did not combine orthodox medicine with traditional medicine, but surprisingly, 13 percent said they did. However, 92.8 percent of the practitioners said they did not refer cases to traditional healers. Asked why they did not do so, 26.1 percent said they were not conversant with their mode of operation; 17.4 percent had no confidence in the operations of traditional healers; 14.5 percent did not see the need to link up with traditional practitioners, and 23.2 percent did not give any reasons.

### 3.1.6 Basic Health Services Offered

Ninety-seven percent of providers surveyed responded that they were involved in curative care and 72.5 percent said they were involved in preventive care. Over 78 percent said they performed minor surgery while 10.1 percent performed major surgery. Some of the respondents also offered antenatal care (59.4 percent), post-natal care (49.3 percent), and deliveries (34.8 percent) (see Table 9).

**Table 9. Basic Health Services Offered**

Basic Health Service	No. of Responses	Percentage of Practitioners Offering Service
Curative care	67	97.1
Minor surgery	54	78.3
Antenatal care	41	59.4
Post-natal care	34	49.3
Deliveries	24	34.8
Major surgery	7	10.1
Physiotherapy	7	10.1
Lab service	3	4.3

### 3.1.7 Participation in Promotive/Preventive Activities

Nineteen percent provided immunizations, and 20 percent offered family planning services. However, findings indicate that practitioners wish to contribute more to preventive and promotive health goals in the future (see Table 10). Of the practitioners surveyed, 31.9 percent want to be involved in immunizations, 23.2 percent in family planning activities, 15.9 wish to be involved in home visits. These are interesting results because the practitioners are interested in providing comprehensive family services.

**Table 10. Practitioners Contribution to Public Health Activity**

Public Health Activity	No. of Responses	Percentage
Immunization	22	31.9
Control of communicable diseases	17	24.6
Family planning	16	23.2
Medical examinations	13	18.8
Outreach programmes	12	17.4
Home visits	11	15.9

### 3.1.8 Strengths and Constraints of Private For-Profit Businesses

More than 98 percent of the practitioners considered their major strength to be provision of quality services, 82.6 percent cited good public relations, and 69.6 percent cited a reliable support staff.



**Table 11. Business Strengths of Private Practitioners**

	Frequency	Percentage
Provision of quality service	68	98.6
Good public relations	57	82.6
Good management	51	73.9
Reliable support staff	48	69.6
Prudent financial practices	39	56.5
Enabling ext. environment	19	27.5

### 3.1.9 Business Constraints

The major constraints perceived by the practitioners are presented in Table 12. Lack of credit facilities, infrastructure, and taxes were the main business constraints.

**Table 12. Business Constraints of Private Practitioners**

Constraints	Frequency	Percentage
Credit	14	20.3
Infrastructure constraints	13	18.8
Taxes	12	17
Lack of information on health situation	6	8.7
Lack of MOH Support	4	5.8
Policy regulation	3	4.3

### 3.1.10 Incentive Packages Required

More than 81 percent of respondents expected some form of subsidy from the government for contributing to public health activities: 71 percent would like the government to supply them with vaccines, 62.3 percent would like tax exemptions, and 60.9 percent would like a supply of drugs. Moreover, 42 percent would like their staff to be trained by the MOH; 42 percent also would like a scholarship for further training. Another 27 percent of respondents would like MOH staff to be seconded to their facilities (see Table 13).

**Table 13. Incentive Packages for Private Practitioners**

Incentive	Frequency	Percentage
Supply of vaccines	49	71
Tax exemptions	43	62.3
Supply of drugs	42	60.9
Training of practitioners' staff	29	42
Scholarship for further training	29	42
Secondment of MOH staff	19	27.5
Direct Funding	10	14.5

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## 3.2 Consumers of Private-Sector Health Services

Areas of survey interest on the consumers of private practitioners included:

- ▲ Demographic and personal characteristics
- ▲ Conditions seen at clinics
- ▲ Health-seeking behavior
- ▲ Consumers assessment of quality of care

### 3.2.1 Socio-Demographic and Economic Characteristics of Consumers

Of the 135 consumers surveyed, 32.6 percent were male and 67.4 percent were female. The majority of the consumers (no.=104 or 77 percent) were in the age group 15-44, one-fifth (no.=29 or 19.3 percent) were in the age group 45-60, and only 3.7 percent were above 60 years of age. Forty-nine percent of the consumers resided in Greater Accra Region, 48.1 percent resided in Accra city itself, and 3 percent came from other regions. Consumers spent between GHC 100 and GHC 25,000.00 (GHC 3,438=US\$1) on transport to visit private health facilities.

Tables 14 and 15 present the occupational and educational backgrounds of the respondents. As Table 14 shows, the self-employed (48.1 percent) constituted the largest occupational group that used the services of private clinics, followed by civil servants (16.3 percent), and housewives (11.1 percent).

**Table 14. Consumers of Private Health Services, by Occupation**

Occupation	Frequency	Percentage
Self-employed	65	48.1
Civil/public servant	22	16.3
Housewife	15	11.1
Student	12	8.9
Unemployed	8	5.9
Retired	5	3.7
Others	8	5.9
<b>Total</b>	<b>135</b>	<b>100</b>

As Table 15 indicates, consumers with at least primary education (46.7 percent) constituted the majority of people who used private clinic facilities, followed by consumers with secondary technical education (32.6 percent). On the whole, around 86 percent of consumers who used private clinics were educated.

**Table 15. Consumers of Private Health Services, by Level of Education**

Level of Education	Frequency	Percentage
Primary	63	46.7
Secondary/Tech	44	32.6
None	19	14.1
University	9	6.6
Total	135	100

### 3.2.2 Income Level

Table 16 provides the percentage distribution of consumers by income level. Although it was difficult to determine income levels by any quantitative criteria, consumers were asked to subjectively rank their income levels as low, medium and high. From the results in Table 16, it appears that all socio-economic groups utilize the services of private clinics, with 93.3 percent from low- and medium-income groups. This is contrary to popular belief that private clinics are used mostly by the well-to-do.

**Table 16. Consumers of Private Health Services, by Income Level**

Income Level	Frequency	Percentage
Low	64	47.4
Medium	62	45.9
High	9	6.7

### 3.2.3 Health-seeking Patterns of Consumers

#### 3.2.3.1 Frequency of Use of Clinic

Forty-eight (35.6 percent) of the consumers surveyed were regular users of a private facility (clinics/hospital), 44.4 percent were occasional users, and 20 percent were first-time users. When asked to indicate complaints they presented with to the clinics, medical complaints topped the list, mentioned by 103 respondents (76.3 percent). Other complaints were obstetrics and gynecology (11.1 percent), trauma/burns (4.4 percent), skin conditions (1.5 percent), and ophthalmological conditions (1.5 percent); routine check-ups accounted for 5.2 percent of visits. In an attempt to find out the extent to which private practitioners communicated with their clients (an indicator of quality care), respondents were asked whether the provider revealed their diagnosis to them. The answers show that 53.3 percent of consumers were not told their diagnosis, while 44.4 percent were informed of their diagnosis.

Of the 60 respondents who were told of their diagnosis, 50 percent of them were diagnosed as having malaria, followed by 13.3 percent with hypertension, 6.6 percent with upper respiratory tract infection and 5.0 percent with diabetes. Of the 135 consumers interviewed, only 11 (8.1 percent) had been referred to the health facility at which they were interviewed. The vast majority (124 or 91.9 percent), had visited the clinics without any referral. Of the 11 referred respondents, the referrals had been from other private hospitals and clinics and from drug stores.

Table 17 presents the reasons that consumers gave for their choice of facility: 23.7 percent of the respondents said they chose the facility because it was their family clinic, 23 percent chose the facility because it was recommended by a relative (lay referral), and 19.3 percent chose the facility because it was close to their place of residence.

**Table 17. Reasons for Consumer Choice of Facility**

Reasons for Choice	No.	Percentage
Family doctor	32	23.7
Lay referral	31	23
Proximity	26	19.3
Trust and confidence in services	13	9.6
Professional referral	11	8.1
Employer provided service	9	6.7
Availability of service	7	5.2
Moderate charges	3	2.2
Clean environment	1	0.7
Credit facility	1	0.7
Prompt service	1	0.7
<b>Total</b>	<b>135</b>	<b>100</b>

When consumers were asked whether they took any form of first aid treatment before visiting the clinic or facility, their answers indicated that 54.1 percent of respondents had not while 45.9 percent had. Of the respondents who reported treatment before visiting the facility, 66.1 percent of them reported self-medication with modern drugs, while 14.5 percent reported self-medication by herbal preparation. Also 14.5 percent of respondents consulted pharmacists (see Table 18).

**Table 18. Treatment Taken before Visiting Clinic/Facility**

Treatment	Frequency	Percentage
Self-medication (modern drugs)	41	66.1
Self-medication (herbal preparation)	9	14.5
Consulted pharmacist	9	14.5
Consulted traditional healer	2	3.2
Consulted family member	1	1.6

### 3.2.3.2 Use of Traditional Healers

To explore further the health-seeking behavior of consumers, respondents were asked whether they used the services of traditional healers; 65.9 percent said they did not use the services of traditional healers, but 34.1 percent said they did. Of those who used the services of traditional healers, 73.9 percent said they consulted them on medical cases while 21.7 percent consulted them on obstetric/gynecological cases (see Table 19). One person consulted a traditional healer for a psychiatric problem.

**Table 19. Conditions for which Consumers Consult Traditional Healers**

Condition	Frequency	Percentage
Medical	34	73.9
OB/GYN	10	21.7
Surgical	1	2.1
Psychiatric	1	2.1

Respondents who do not use traditional healers, gave a number of reasons for not doing so. Table 20 presents their answers. Forty-five percent said they disliked the approach of the healers, while 15.7 percent said they did not consider traditional healers to be reliable. Another 10.1 percent did not deem it necessary to consult traditional healers.

**Table 20. Consumer-perceived Problems with Traditional Healers**

	Frequency	Percentage
Dislike their approach	40	44.9
Not reliable	14	15.7
Did not deem it necessary	9	10.1
Was not recommended	8	8.9
Incorrect dosage of drugs	5	5.6
No idea about their operations	4	4.4
No opportunity to consult	4	4.4
Not sure	5	5.6

### 3.2.4 Consumer Perception of Modern Medicine and Traditional Medicine

Consumers' three most positive perceptions about modern medicine were that it is scientific (54.1 percent), it provides quality care (27.4 percent), and it provides effective treatment (81 percent) (see Table 21). Of traditional medicine, as many as 74 percent of the respondents could either not think of anything positive to say or were not sure of anything positive, and 13.3 percent did not respond. The remaining clients (12.7 percent) cited strengths of traditional medicine to be the following:

- ▲ It deals with cases that modern medicine can not treat
- ▲ Its herbs are effective
- ▲ It provides low cost medication
- ▲ It employs a holistic approach
- ▲ It employs an effective marketing strategy

**Table 21. Consumer-perceived Benefits of Modern Health Workers**

	<b>Frequency</b>	<b>Percentage</b>
Scientific	73	54.1
Quality of care	37	27.4
Effective treatment	11	8.1
Good reception	8	5.9
Provide health information	2	1.5
Prompt service	1	0.7
Nothing to say	1	0.7
No response	2	1.5

### **3.2.5 Medical Charges**

According to the consumers, the average amount of money that they spent in attending the facilities on the day of the interview was US\$10. The overall average expenditure incurred in seeing Western-trained<sup>4</sup> private practitioners was estimated by consumers to be US\$7 per visit.

### **3.2.6 Consumer Preferences for Hospitals/Facilities**

Consumers cited quality of care (113 responses) and short waiting time (94 responses) as the most important considerations for choice of health care facility (see Table 22). In contrast, about 9 percent of clients interviewed mentioned long waiting time and high charges as criticisms of their health facility of choice.

**Table 22. Reasons for Consumer Choice of Hospital/Facility Visited**

	<b>Frequency</b>	<b>Percentage</b>
Quality of care	113	83.7
Short waiting time	94	69.6
Availability of medicine	66	48.9
Good attitude of health workers	60	44.4
Cleanliness	45	33.3
Proximity	45	33.3
Reasonable charges	39	28.9
Availability of credit facility	30	22.2
Laboratory services	2	1.5

### **3.2.7 Consumer Perceptions of Public Hospitals**

Table 23 lists what consumers dislike about public hospitals and clinics. The reader will note that what consumers considered as public facility weaknesses form the basis for their preferences about private health facility.

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<sup>4</sup> Western-trained refers to doctors or health workers who have been trained locally or abroad by the use of the modern scientific approach to health care.

**Table 23. Reasons for Consumer Dislike of Public Facilities**

	<b>Frequency</b>	<b>Percentage</b>
Long waiting time	96	71.1
Poor patient/staff relationship	42	31.1
Overcrowding	17	12.5
Poor quality of care	16	11.8
Lack of drugs	14	10.3
Nothing	10	7.4
Illegal charges	8	5.9
Long distance	4	2.9
High charges	3	2.2
Untidy surroundings	1	0.7

### **3.2.8 Miscellaneous Data**

The majority of clients (83 percent) obtained the prescribed drugs from the facility they had visited because the drugs were available there. The minority who chose to obtain their drugs from other sources did so because of the proximity of the source to their places of residence and because of the availability of credit facilities at the source. When asked about the exclusivity of their use of private facilities, 69.6 percent of respondents said they sometimes used public facilities, 8.1 percent they used the public facility quite often, and 22.2 percent said they never used public facilities.

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## **3.3 Survey Findings: Pharmacists**

The survey investigated the following aspects of private-sector pharmacists and pharmacies.

- ▲ Socio-demographic characteristics
- ▲ Professional activities
- ▲ Public health activities
- ▲ Business constraints and strengths
- ▲ Contribution to public health activities
- ▲ Incentives required from government

### **3.3.1 Socio-demographic Characteristics**

The survey interviewed of 56 pharmacists, all in solo practice. Twenty respondents (35.6 percent) had been practicing for about 30 years, and 48.2 percent had been practicing for 19 to 28 years; 16 percent of them registered after 1991. Table 24 presents their socio-demographic characteristics. Fifty-seven percent

were male and 43 percent were female. Half of the pharmacists were below the age of 45 years, almost 18 percent were 46-54 and 10.7 percent were 55 years and above. The majority were first degree holders.

**Table 24. Socio-demographic Distribution of Pharmacists**

Characteristics	Frequency	Percentage
<b>1. Sex:</b>		
Male	32	57.1
Female	24	42.9
<b>2. Age:</b>		
<45	28	50.0
46-54	10	17.8
55+	6	10.7
No Response	12	21.4
<b>3. Educational Background:</b>		
B. pharmacy	54	96.4
2 <sup>nd</sup> degree	1	1.8
No Response	1	1.8

### 3.3.2 Drugs Most Frequently Purchased

The pharmacists were asked to rank the drugs most frequently purchased at their shops. The eight top-ranking drugs were analgesics, anti-malarials, antibiotics, multi-vitamins, antacids, dewormers, anti-hypertensives and anti-diarrheal. The list of drugs seem to correspond to with the treatment for the conditions commonly seen at private clinics, i.e., malaria, URTI, gastroenteritis hypertension, urinary tract infection, etc.

### 3.3.3 Activity Levels of Pharmacists

Table 25 presents the major activities performed by pharmacists. In addition to strictly pharmaceutical activities, 37.5 percent of the respondents were involved in health promotive and disease prevention activities (public health activities).

**Table 25. Major Professional Activities of Pharmacists**

Activity	Frequency	Percentage
Retail, dispensing, and counseling	53	94.6
Drug information dissemination	22	39.3
Public health activities	21	37.5
Compounding of preparations	19	33.9
Wholesale	15	26.8
Clinical pharmacy	12	21.4
Manufacturing	3	5.4

### 3.3.4 Volume of Work

The survey data showed a wide range in the volume of work performed by pharmacists. On average, respondents assessed the needs of 2–150 prescription clients a day, filled prescriptions for 2–2000 clients a day and served 20–500 nonprescription clients in a day. One would tend to think that factors such as the size of the shop and its location would partly account for the wide range in the size of clientele for the pharmacies.

### 3.3.5 Other Items Carried by Pharmacies

Only 8.9 percent (five) of the pharmacists interviewed carried only drugs in their shops; the rest (51 or 91.1 percent) offered other items for sale. Those items are listed in Table 26.

**Table 26. Non-drug Items Carried by Pharmacies**

Item	No. of Pharmacies	Percentage
Cosmetics	44	86.2
Herbal preparation	39	76.4
Food	23	45
Gift Items	11	21.5
Sanitary pads	10	19.6
Pet products	1	1.9

### 3.3.6 Referrals

Fifty-three (94.6 percent) of the pharmacists studied referred cases to hospitals, and 67.9 percent of these referrals were for medical conditions. However, surgical (11.3 percent), trauma/burns (15 percent), skin conditions (13.2 percent), and obstetrics and gynecological (11.3 percent) cases were also referred to hospitals by the pharmacies.

### 3.3.7 Pharmacists in Preventive and Outreach Activities

A vast majority of the pharmacists (92.9 percent) would be willing to increase their participation in public health activities for the following major reasons:

- ▲ To provide health education (38.46 percent)
- ▲ To provide community outreach (19.2 percent)
- ▲ To address the preventive health aspects of a pharmacist's work (9.6 percent)

Specifically, the pharmacists surveyed believe that they have the potential to contribute to public health, and Table 27 presents the areas in which they feel their contribution can be strengthened.



**Table 27. Potential Pharmacist Contribution to Preventive Health Activities**

	Frequency	Percentage
Health education	46	82.1
Family planning	44	78.6
Dissemination of information	38	67.9
Control of communicable diseases	26	46.4
Population control	20	35.7
Immunization	13	23.2
Outreach programs	10	17.9

### 3.3.8 Expected MOH Support

The findings indicate that pharmacists in the private sector expect support from Ministry of Health to enable them to play a role in the provision of services for the public. More than 80 percent of the 56 pharmacists surveyed expect the MOH to subsidize their preventive health activities or offer an incentive to defray costs incurred in such activities. Table 28 presents the specified areas for such support of the MOH. Three respondents did not expect any subsidy from the MOH for their preventive health activities, because they believe that pharmacists are obliged to perform such activities. About half the respondents indicated that they have some working relationship with other health service providers, but only four (7.1 percent) perform any services on behalf of the MOH, in the form of giving seminars on STDs/AIDS.

**Table 28. Areas for MOH Support to Pharmacists**

	Frequency	Percentage
Exemption of drugs from VAT	41	73.2
Relevant health information	38	67.9
Training of staff	36	64.3
Scholarships	28	50
Health insurance	27	48.2
Supply of vaccines	17	30.4
Direct funding	11	19.6
Secondment of MOH staff	10	17.9

### 3.3.9 Business Strengths

The pharmacists ranked in order of importance the major strengths of their businesses as the provision of efficient quality services (71.4 percent), good and capable management (41.1 percent), prudent financial practices (32.1 percent), enabling external environment (30.4 percent), and reliable staff (19.6 percent) (see Table 29).

**Table 29. Business Strengths of Private Pharmacies**

	Frequency	Percentage
Provision of efficient quality services	40	71.4
Good and capable management	23	41.1
Prudent financial practices	18	32.1
Enabling external environment	17	30.4
Reliable Staff	11	19.6

### 3.4 Private Pharmacy Clients

The total number of consumers surveyed was 150. The following areas of interest were looked at by the survey. The study surveyed 150 clients of private pharmacies. Table 30 presents the social-demographic profile of pharmacy clients.

- ▲ Socio-demographic characteristics
- ▲ Health-seeking behavior

**Table 30. The Socio-demographic Profile of Private Pharmacy Clients**

Characteristics	Frequency	Percentage
<b>1. Sex</b>		
Male	90	60.0
Female	60	40.0
<b>2. Age</b>		
15-44	94	62.7
45-60	44	29.3
60+	12	8.0
<b>3. Place of Residence</b>		
Accra city	13	92.0
GAR	81	7.3
Other region	11	0.7
<b>4. Educational Level</b>		
Nil	20	13.3
Primary	7	4.7
Secondary/Technical	47	31.3
University	76	50.7
<b>5. Income Level</b>		
Low	84	56.0
Medium	45	30.0
High	21	14.0
<b>6. Occupation</b>		
Civil Servant	27	18.0
Self-employed	76	50.7
Housewife	10	6.7
Student	5	3.3
Unemployed	23	15.3
Retired	9	6.0
<b>7. Distance Traveled</b>		
On foot	87	58.0
Public transport	33	22.0
Private transport	30	20.0

Sixty percent were male; 40 percent were female. The majority (about 63 percent) were in the age group of 15-44 years. Thirty percent were 45-60 years; 8 percent were over 60. The majority of them (92 percent) lived in the city of Accra. Over half (50.7 percent) were university graduates and only 4.7 percent did not have any formal education. Fifty-six percent were low income. Over half (approximately 51 percent) were self-employed. Civil servants constituted 18 percent, the unemployed 15.3 percent, and students 3.3 percent. Most of the clients reached the shop on foot (58 percent). About an equal percentage used public transport as used private vehicles.

### **3.4.1 Utilization Patterns**

The vast majority (96.7 percent) of the consumers said they had visited the pharmacy to buy drugs; 12 percent to seek advice; another 12 percent to purchase toiletries, and 12 percent to purchase family planning items. Of the consumers who visited the shop to buy drugs, 42.7 percent bought the drugs with a prescription; the rest did so without one. Seventeen of the 150 respondents received services in addition to the service for which they had visited the shop. These services included counseling, drugs given on credit, and the purchase of sundries because they were in the shop.

The majority (over 60 percent) had neither been referred nor been seen by any health worker prior to the visit to the pharmacy; only 36.0 percent had been referred to the pharmacy. Conditions presented to the pharmacists included malaria, hypertension, diabetes, headaches, and other aches and bodily pains.

### **3.4.2 Midwives**

Information on private midwives was obtained through in-depth interviews of the leadership of the Ghana Registered Midwives Association (GRMA), through a review of annual reports, and through focus group discussions. The private midwives in the region are generally middle-aged, sometimes retired, female practitioners who operate maternity homes. The majority of them are in solo practice and are engaged in safe motherhood programs, especially in deliveries. Many of the midwives now belong to GRMA.<sup>5</sup>

Findings of a focus group discussion with a group of private midwives from the GAR indicated that private midwives on average performed 12 to 15 deliveries a month. The midwives claimed they were not doing very well as business entities, since they had problems with bookkeeping and entrepreneurial skills. They thought that they were unfairly treated by MOH public providers, who sometimes refused to cooperate with them in the area of referrals. They also had problems with funding and had difficulty obtaining equipment for their practice. They recommended the government should reintroduce the stand-alone midwifery course instead of combining nursing and midwifery as is currently done, to ensure more professionalism and loyalty in midwifery.

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<sup>5</sup> The GRMA is a national non-profit membership organization open to all midwives registered with the Nurses and Midwives Council. The GRMA was inaugurated in 1935, and its membership is made up of both public and private midwife practitioners. The primary purpose of the GRMA is to improve the standards of midwifery practice, promote the provision of equitable high-quality health services to women, children and their families nationwide, including remote areas, with the aim of reducing maternal infant mortality and morbidity.

### **3.4.3 Traditional Medical Practitioners**

Data on traditional medical practitioners in the GAR were collected through the following means:

- ▲ Secondary analysis of primary data
- ▲ FGD with TMPs
- ▲ FGD with TBAs
- ▲ Review of existing records

#### **3.4.3.1 MOH Study of TMPs**

In June 1996, the MOH carried out a study to identify TMPs in the GAR, their location, their professional activities and their general concerns, among other things. The study involved a total of 473 participants who were randomly selected from all five sub-districts of the GAR. Below is the analysis of primary MOH data about TMPs in the region.

##### ***TMP Characteristics***

The majority of providers surveyed were male with an average age of 54 years; 74 percent were married, 13 percent were widowed, 7 percent were single, and 4 percent were divorced. Regarding religious affiliations, 57 percent were Christian, 30 percent traditional believers and 6 percent Muslim; 7 percent were of other religions. Half of the respondents had no formal education; 27 percent had had middle school education, 12 percent primary education and 9 percent had secondary/commercial education. Focus group discussions revealed that individuals normally became a TMP by working with older relatives to gain knowledge about herbs and other practices.

##### ***Types of TMP Practice***

Thirty-four percent of the respondents referred to themselves as herbalists, 24 percent as TBAs, 13 percent as spiritualists, 7 percent as drug peddlers, 7 percent as manufacturers of preparations, 6 percent as faith healers, 6 percent as fetish priests and 1 percent clinic-based practitioners.

##### ***Diseases Treated by TMPs***

The majority of cases treated by TMPs in the study area were medical cases such as diarrhea, piles, measles, malaria, impotency, hypertension and STDs. Some of the respondents also treated orthopaedic and neurological disorders.

##### ***TMP Associations***

A majority (65 percent) of the respondents said they did not belong to any association while 35 percent did. Of those who belonged to an association, 56 percent said they belonged to the Ghana Association of Traditional Healers; 40 percent belong to other associations, which were not named. TBAs have not constituted themselves into associations, but as one said “we see one another very often so we exchange ideas concerning our work.”

#### **3.4.3.2 Current Study of TMPs**

Focus group discussions with of TMPs confirmed many of the findings of the MOH study. TMPs in one district claimed that they successfully treated cases that orthodox medicine had been unsuccessful in treating, for example, piles, epilepsy, cancers, herpes zoster, ‘va’ (a local name for a wasting disease), rheumatism, fractures, “stroke,” infertility, chronic sores, and “madness,” among other conditions. The TMPs believed they could act as primary care providers by the treatment of common cases as well as helping to prevent illnesses. They were willing to work with orthodox practitioners, provided that the government would provide facilities from which they would be able to practice, either in the existing health facilities or separately. However, the potential contribution of the TMP was greatly hampered by the diverse nature of their practice and the lack of cooperation among the practitioners themselves and their various associations. The major strength of the TMPs was that they are very close to the community and were usually the first point of contact. TMPs normally do not differentiate between charges for consultation and medication. They normally charge one rate for the entire treatment.

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### **3.5 Traditional Birth Attendants**

Most practicing traditional birth attendants were between the ages of 45 and 70 years, and most of their assistants and/or apprentices were younger women. Three-quarters of those who participated in the FGD said they had received training from the MOH. The majority of the TBAs combined herbalism with the practice of midwifery.

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### **3.6 Non-governmental Organizations**

NGOs in Ghana play a significant role in health delivery. A number of them have been associated with missionary work as well as the development of curative and preventive health services. In recent years their number has increased in Ghana. They include World Vision International, Adventist Relief Agency, CARE, Sasakawa Global, and Oxfam. The current survey observed that Planned Parenthood Association of Ghana (PPAG) as well as the Ghana Social Marketing Foundation (GSMF) operate quite extensively in the GAR. For that reason, a description of these two organizations is included here.

The PPAG was launched in 1967 and currently is made up of 160 volunteers. Its mission is to provide clinic-based family planning services integrated with some maternal and child health services. Its activities complement and supplement the government’s effort in the provision of sexual and reproductive health services. PPAG has developed expertise in a variety of projects that include Family Life Education and Community-Based Distribution of Contraceptives. In 1996 the PPAG provided 5,000 sexually active youth with contraceptives. In the GAR some of the PPAG projects include Family Life Education for in-school and out-of-school youth and the operation of youth centers funded by major donors such as International

Planned Parenthood Federation, United States Agency for International Development, and the British Department for International Development.

The GSMF was incorporated in May 1993. Its basic objective is to use the technique of social marketing to improve quality of life through the provision of affordable and accessible family planning and maternal and child health products and services. It is active in the areas of family planning, HIV/AIDS and STDs, oral rehydration therapy, and malaria. In the past few years, the GSMF has used mass marketing techniques to distribute contraceptives into pharmacies and chemical shops nationwide. It offers training to other private-sector providers as well as NGOs to improve their capacity to further the goals of social marketing of family planning products.

In assessing the role of NGOs this study found that, unlike the government agencies, NGOs do not have permanent structures on the ground and, therefore, have to operate through existing bodies and organizations including communities, other NGOs and the private sector. This implies that they have to develop mechanisms and incentives to facilitate the role of these bodies in the achievement of their mission.



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## 4. Conclusions and Recommendations

Using both survey and secondary data, the study attempted to obtain a comprehensive picture of the private health sector in the Greater Accra Region, as well as the dynamics of its development. In the process, an assessment of the contribution of the private sector to total health care delivery, including both curative and preventive aspects, was made. Specifically, the study generated information (albeit limited) about the profile of the providers, the range of services they offer, and aspects of health-seeking behavior on the part of clientele.

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### 4.1 Overall Assessment

The providers who were surveyed included private for-profit medical practitioners, midwives, pharmacists the mission/NGO sector, and traditional medical practitioners. The study results provide a picture of the GAR as a relatively urbanized region burdened with problems of rapid urbanization and a poor physical infrastructure. At the same time, it still has a rural population, especially in Ga, Dangbe East and Dangbe West districts, who have health problems similar to other rural areas of Ghana: communicable diseases such as malaria and diarrhea and public health problems such as buruli ulcer, schistosomiasis, onchocerciasis, and HIV/AIDS.

A significant proportion of the health care in the region, especially curative care, is provided by the private sector. For example, while nationally, private medical practitioners account for about 35 percent of health care delivery, the study estimates that the contribution of the formal private health sector in the GAR falls in the range of 50 percent to 60 percent. It attributes this to the high concentration of private-sector facilities—hospitals, clinics, pharmacies and maternity homes—in the densely populated commercial centers in both the Accra–Tema metropolis.

The study also found that the GAR has a better mix and distribution both public-and private-sector providers than any other region in Ghana, as well as better water, housing and waste disposal facilities. However, given the gross disparity in the distribution of both health facilities between the urban/rural sectors of the region, policymakers need to develop the mechanisms for the private sector to extend the coverage of modern health services beyond the city limits of Accra and Tema.

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### 4.2 Private Health Care Provision

Ghana has a pluralistic health system, and therefore a considerably large private health sector exists in the GAR. The complex health care delivery system in the region is characterized by a blend of orthodox and traditional herbal and psychic practices.

## 4.2.1 Health Care Providers

### *Physicians*

The age range of the private for-profit respondents suggests an aging population of practitioners. The age distribution of the 69 providers who responded to the questionnaire showed that nearly 86 percent were 45 years and above while only 7 percent were younger than 45. This finding supports an earlier finding by Stanton (1995), which suggested that fewer new doctors are entering private practice. Follow-up interviews carried out to find the factors contributing to this situation indicated several reasons including:

- ▲ High start-up costs for the establishment of a new practice, including medical equipment, and the ongoing high cost of drugs
- ▲ High lending rates and the inability of many doctors to secure bank loans due to lack of collateral
- ▲ Preference for public-sector practice by newly qualified doctors to gain some experience before entering private practice
- ▲ Many specialists enter private practice only after retiring from the public sector

Another finding of the survey indicated that the majority of for-profit practitioners (61 percent) were in solo practice while 39 percent were in group practice. The survey found that all the solo practices were relatively small in size and operated with only outpatient facilities that supported the practice of one physician. These physicians worked independently and depended mainly on their personal selling and public relations skills to maintain a loyal clientele. To encourage these independent small practitioners to team up and operate larger group practices would entail the government providing the enabling environment and support for such expansion.

### *Pharmacists*

Fifty-six pharmacist-owners of retail community pharmacies were surveyed. All were in solo practice. More than a third (35.6 percent) had been operating for about 30 years; 48.2 percent from 19 to 28 years, and 16 percent registered after 1991. There were fewer female pharmacists than male pharmacists. Half of the pharmacists were age 45 and younger, 17.8 percent were between 46 and 54 years, and 10.7 percent were 55 years and older. This age structure of the pharmacists indicates a much younger cohort than the physicians.

### *Mission/NGOs*

The Christian mission system in the GAR is relatively small compared to the other regions. It consists of only two CHAG facilities namely, the Manna Mission Hospital and the Urban Aid Clinic, both in Accra district. However there are a few Islamic institutions, such as the Iran Clinic that provide outpatient curative care to the clientele.

The GAR has a high concentration of secular NGOs that are international, national, and local. The largest is the Planned Parenthood Association of Ghana, which is involved in reproductive health delivery.

The Save the Children Fund is an international NGO that supports other local NGOs such as the May Day Rural Project, which develops reproductive health programs, especially in the Ga district. The Ghana Social Marketing Foundation also operates in the region by working with other partners such as pharmacists and chemical sellers in the private sector to mass market family planning and maternal and child health products.

### ***Traditional Medical Practitioners***

Reliable data on the current numbers and extent of use of traditional practitioners in the region are lacking.

Traditional health care embraces diverse categories of indigenous “folk medicine practitioners,” such as herbalists, occultists, neoherbalists, fetish priests and priestesses, bone setters, traditional male circumcisers (*wanzams*), traditional birth attendants, peddlers and spiritualists. Owing to this tremendous variability, it is extremely difficult to present a general picture of this sector without taking into account variations in ethno-cultural practices and therapies. A review of the secondary data of the TMPs in the region, however, revealed that the traditional practitioners were generally partially educated, middle-aged Christian male adults who became TMPs and gained their knowledge of herbs and other therapies through many years of practicing with their older relatives. TMPs operated mainly in the peri-urban and rural areas of the GAR.

## **4.2.2 Health Care Services Offered by Providers**

### ***Physicians***

As would be expected, the formal private health sector system in GAR is largely oriented towards curative services and structured to deal mainly with conditions associated with a mature epidemiological profile. The majority of for-profit providers (91.3 percent) classified themselves as general practitioners and provided basic health services which included curative care (97.1 percent). The practitioners mentioned malaria, URTI, gastroenteritis, hypertension, STDs, UTIs, infertility, hernia, diabetes, and bronchial asthma as the conditions they commonly saw in their facilities.

In addition to curative services, the physicians also provided some preventive services, mostly related to family health services such as immunization and family planning. In terms of public health, for these providers should be encouraged to provide comprehensive family health services.

### ***Pharmacists***

The survey revealed that private pharmacies in the region are highly patronized. The majority of pharmacies surveyed provided services in drugs retail dispensing and counseling (94.6 percent). They also provided diagnosis and prescribed drugs for conditions such as malaria, coughs and colds, and aches and pains. The pharmacies are a popular source of services because they do not charge consultation fees and operate as one-stop sources of health care services. In the area of preventive health, the community pharmacists conducted health education and sold family planning services/products.

## *NGOs*

The NGOs operating in the region were involved mainly in promoting reproductive health. Most of the NGOs offer information and education with regard to reproductive health but only a few of them provide direct services. The PPAG offers family planning, some antenatal and nutrition services, STD, infertility, and other counseling services.

### **4.2.3 Business Environment**

The study looked at the advantages to consumers of using private providers as well as obstacles faced by the providers. The majority of providers considered major strengths to be their provision of quality service, good public relations, good and capable management, and reliable support staff. It must be stressed however that these perceptions were the providers' own evaluation and there is the need to test the validity of these assertions in future research.

The major business constraints identified by the providers were lack of access to credit and capital and the high government taxes on imported drugs, medical supplies, and equipment. To overcome these constraints, the practitioners suggested that the government accord them tax exemptions on medical equipment and that banks provide them with credit. Interestingly, pharmacists expressed sentiments about their businesses similar to those of the medical practitioners.

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## **4.3 Consumer Analysis**

The survey results show that the demand for private health services, especially for private for-profit and pharmacy services, is high in the region. On the whole, around 86 percent of consumers who used private clinics were educated. Although it was difficult to determine the income levels of respondents who used private health facilities by any quantitative criteria, when asked to subjectively rank their income as low, medium, or high, 93.3 percent of consumers indicated their income group as low or medium. This might not be the most valid way of indicating consumer use of facilities by income levels; however, it appears that all socio-economic groups, not only the well-to-do, utilize the services of private health facilities.

Regarding health-seeking behavior of consumers, the study showed that consumers dealt with illnesses using a multiplicity of mechanisms; from self-treatment to the use of diverse providers both traditional and modern.

There was evidence of a high rate of self-medication, as almost 62 consumers out of the 135 interviewed at private health facilities self-medicated before visiting the health facility. There is the need for further studies to judge the appropriateness of self-medication.

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#### **4.4 Policy Framework**

Current economic policies by the government of Ghana favor privatization and trade liberalization and therefore the promotion of private-sector involvement in the delivery of health services. MOH policy initiatives in recent years have sought new ways of promoting private-sector participation, contracting health services, providing direct support to the private sector, promoting the development of traditional and alternative medicine, and reviewing the regulatory framework of the private sector. One must, however, exercise caution in advocating broad policy reforms on the private sector without taking into account the complex composition, nature, and orientation of the different segments of the private health sector. As the study of the GAR private sector has revealed, the private providers in the region are not homogenous and therefore different policies are needed for different providers and areas of the region.

The most critical areas which need to be addressed by policy in the GAR relate to:

- ▲ The gross, poor distribution of health facilities and resources between urban and rural areas
- ▲ The private sector's seemingly strong orientation toward the provision of curative care
- ▲ The constraints limiting private-sector expansion

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#### **4.5 Conclusion**

Although the private sector already contributes quite significantly to the total health delivery effort in the GAR, much needs to be done to promote its development. For example, as a result of their market orientation, most private health facilities in the region, including clinics hospitals and pharmacies, are strategically situated in the urban centers. This has, however, denied the rural areas of access to modern health care. The potential for greater reliance on private sector providers to expand access to health services should be explored. In addition, the private practice physicians seem significantly older than their colleagues in the public sector. There is the need therefore to encourage younger doctors to enter private practice to replace aging doctors. Although private pharmacies are very well-utilized, pharmacists need additional training to offer better ambulatory care services. Private midwives need more government support to improve their practices.

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#### **4.6 Recommendations**

Using the findings from the research, policy recommendations may be grouped into two categories.

- ▲ General ones relating to improving the contribution of the private sector to health delivery to the region as a whole
- ▲ Policies relating to specific providers

### 4.6.1 General Policies

At the regional level, the general objective of policymakers should be to assist private-sector providers to improve the quality of their curative care services, and to increase their contribution to preventive care, where they show the greatest potential.

One of the major constraints faced by the study was the absence of comprehensive information and databases on the private sector, which limited the validity of some of the assessments made. There is the need therefore, to establish a comprehensive information system that will be used to collect and analyze data on the private sector to improve the understanding of its role in total health care delivery in the region.

Another weakness of the GAR health system is its inability to reach its rural population with facilities and services. Policies should be designed to encourage the private sector to extend coverage to the rural areas. In this regard, the government should develop policies aimed at providing incentives, relaxing entry restrictions, offering tax breaks and bonuses, providing subsidies for start-up costs, and other reform measures to ensure the equitable distribution of private health care.

### 4.6.2 Specific Policies

#### *For-profit facilities/physicians*

- ▲ Private for-profit providers should be encouraged to develop group practices, instead of the present small-scale independent operations, to take advantage of tax concessions for companies and also to pool resources in the face of mounting economic constraints.
- ▲ The providers should be given continuing education to improve their skills in clinical practice and management, especially in the area of family health.
- ▲ Providers should be given continuing education in management of information systems relating to their medical practices so that they can improve the existing systems of assembling, storing, processing, and delivering information relevant to their respective practices.
- ▲ Mechanisms should be developed to provide financial credits to the providers so that they can acquire modern tools and equipment to provide better services to their clients.
- ▲ Existing policies regarding entry into the private practice market should be reviewed to improve the options for the formation of new private practices, especially in the underserved areas of the region. Doctors who are willing to serve in rural and peri-urban areas should be offered assistance in the form of subsidies for start-up costs and for patient care. Without some form of creative incentives from the government, it might prove rather difficult to motivate market-oriented, private for-profit practitioners to establish practices in rural areas, given the current demand and income constraints.

### ***Pharmacists***

Evidence from the survey indicated that the clientele base of the pharmacists is very large and many of them visit the facilities for self-medication. There is a need to train pharmacists in advanced medical diagnosis so that they can offer better ambulatory services.

Pharmacists should also be trained in principles of health education and social mobilization, and techniques of information, education, and communication.

Pharmacists should be trained to promote rational self-medication through the development and use of easy-to-understand product information, translation of product instructions into local languages, and effective use of advertising. Pharmacists can work closely with doctors in minimizing the risks associated with self-medication.

### ***NGOs***

Established international NGOs should assist local communities to develop expertise in social mobilization for development and resource mobilization in order to tap into more private-sector skills and resources at the community level and thereby enhance health development. The existing problem is that only a handful of local NGOs operate at the community level in the rural districts of the region. There is the need for more grassroots NGOs.

### ***Traditional Medical Practitioners***

Policies on traditional medical practitioners should:

- ▲ Streamline the association of TMPs
- ▲ Strengthen the MOH Directorate for TMP for effective advocacy on the merits of traditional medicine
- ▲ Encourage more studies into the practices of TMPs to facilitate the documentation of the concepts and practices of traditional medicine
- ▲ Create the opportunity for better collaboration between the traditional practitioners and orthodox practitioners

### ***Traditional Birth Attendants***

Policies should mobilize TBA apprentices for more in-depth training to ensure continuity of TBA practice. The capacity of TBAs should be strengthened to enable them to educate and counsel women for the following:

- ▲ Nutrition

- ▲ Immunization
- ▲ Family planning
- ▲ HIV/AIDS
- ▲ Oral rehydration salts for diarrheal management

TBAs can also be trained to serve as community-based distributors for some contraceptives.

# Annex A. Questionnaire: Private for-Profit Medical Practitioner

The objective of this questionnaire is to solicit the views of private for-profit providers on their professional activities and their contribution to health care delivery. (Please circle or fill in the appropriate answer)

**PART I PROVIDER CHARACTERISTICS**

- |   |                      |        |
|---|----------------------|--------|
|   | District             | Region |
| 1.1 Name of Locality .....  | .....                | .....  |
| 1.2 Name of Clinic/Hospital Facility .....  |                      |        |
| 1.3 Age of Principal Owner/Provider .....   |                      |        |
| 1.4 Number of doctors participating in the clinic   |                      |        |
| Total Number .....  |                      |        |
| Number on Full-Time.....  |                      |        |
| Number of Part-Time .....   |                      |        |
| 1.5 Range of diagnostic and therapeutic procedures offered by the clinic/hospital/facility. |                      |        |
| Please indicate   |                      |        |
| 1. General  | 6. ENT               |        |
| 2. Surgery  | 7. Dental Surgery    |        |
| 3. Gynecology   | 8. Orthopaedic       |        |
| 4. Obstetrics   | 9. Other Specialties |        |
| 5. Eye  | 10. Psychiatry       |        |
| 99. Others (Please specify)   |                      |        |

**PART II FACILITY /CLIENT CHARACTERISTICS**

- 2.1 The Clinic is owned by:
- |  |              |
|--|--------------|
| a. An individual Practitioner/Provider | 1. Yes 2. No |
| b. Group Practitioners                 | 1. Yes 2. No |
- 2.2 Average number of patients seen per week in your busiest week .....
- 2.3 Average number of patients seen in your leanest week. ....
- 2.4 Which of the following conditions are commonly seen at your facility annually? (Please rank in order of importance numerically)
- |  |     |             |     |                  |     |
|--|-----|-------------|-----|------------------|-----|
| Malaria                                | [ ] | UTI         | [ ] | Bronchial Asthma | [ ] |
| URTI                                   | [ ] | Infertility | [ ] | General Surgical | [ ] |
| Gastroenteritis                        | [ ] | Fibroids    | [ ] | Family Planning  | [ ] |
| Hypertension                           | [ ] | Hernias     | [ ] | Diabetes         | [ ] |
| STDs                                   | [ ] |             |     |                  |     |
| Others (please specify and rank) ..... |     |             |     |                  |     |

- 2.5 By your estimate what percentage of your clients are:  
 Male .....  
 Female .....  
 Children .....
- 2.6 By your estimate, what proportion of your patients are:  
 Low Income .....  
 Middle Income .....  
 High Income .....
- 2.7 Is your clinic facility part of a referral network? 1. Yes 2. No
- 2.8 Does your clinic receive client/patients from other facilities? 1. Yes 2. No
- 2.9 Which facilities do you receive referrals from?  
 1. Government hospitals  
 2. Other private clinics  
 3. Pharmacy shops  
 4. Traditional healers  
 5. Churches  
 6. Others (Please specify) .....
- 2.10 Do you refer patients to public/government hospitals? 1. Yes 2. No  
 If yes, how many cases in a month? .....
- 2.11 Do you employ both modern and traditional methods of care in your clinic? 1. Yes 2. No
- 2.12 Do you refer patients to traditional medical practitioners?: 1. Yes 2. No  
 If yes, how many cases in a year? ..... and what types of cases?.....  
 If no, why not? .....

**PART III Services Offered:**

- 3.0 What range of basic health services does your facility/clinic offer?: Please circle as many as apply.  
 1. Curative care  
 2. Preventive care  
 3. Antenatal care  
 4. Deliveries  
 5. Post-natal care  
 6. Minor surgery  
 7. Others please specify .....
- 3.1 In which of the following ways do you currently contribute to Ghana's public health agenda? (Please rank which ever applies in order of importance numerically)
- a. Immunizations ( )
  - b. Family Planning ( )
  - c. Population Control ( )
  - d. Community Health ( )
  - e. Home Visit ( )
  - f. Medical Exam ( )
  - g. Out-Reach Programmes ( )
  - h. Control of Communicable Diseases ( )
  - i. Others(Please specify) .....

- 3.2 What do you consider as the major strengths of your business entity? (Please circle which ever applies)
1. Provision of efficient and quality services.
  2. Good Public Relations
  3. Prudent Financial Practices
  4. Reliable Support Staff
  5. Enabling External Environment
  6. Good and Capable Management
- 3.3 If no past/current contribution to the public health agenda, in what ways would you wish to contribute, in future?
- |                                  |                                    |
|----------------------------------|------------------------------------|
| 1. Immunizations                 | 4. Medical Exam                    |
| 2. Family Planning               | 5. Outreach Programmes             |
| 3. Home Visit                    | 6. Control of Communicable Disease |
| 7. Others (Please specify) ..... |                                    |
- 3.4 Do you provide any official services such as death certification, filling of police reports, insurance reports on behalf of the Government of Ghana?      1. Yes   2. No
- 3.5 Do you get paid by the government for providing such services?      1. Yes   2. No
- If no to Q3.5 should you be paid for those services?      1. Yes   2. No

**PART IV CONSTRAINTS**

- 4.0 Do you usually face constraints in your operations?   1. Yes   2. No
- 4.1 If yes, what types of constraints do you face? (Please rank numerically in order of importance)
- |  |            |
|--|------------|
| a. Policy/Regulation                       | {        } |
| b. Infrastructural constraints             | {        } |
| c. Credit                                  | {        } |
| d. Taxes                                   | {        } |
| e. Lack of support from MOH                | {        } |
| f. Lack of information on health situation | {        } |
| g. Others (Please indicate) .....          |            |

**PART V INCENTIVES**

- 5.1 Do you think the Government of Ghana should subsidize your public health activities   1. Yes   2. No
- 5.2 In which specific areas would you suggest that government provides for private-for-profit practitioners to enable them to participate more effectively in public health activities? (Please circle which ever applies)
1. Direct Funding
  2. Supply of Vaccines
  3. Supply of Drugs
  4. Secondment of MOH staff
  5. Training of your Staff
  6. Scholarship for further training
  7. Tax Exemptions

5.3 Which of the following institutions do you think has the most potential to enhance your practice?

1. Your Professional Association
2. The Ministry of Health
3. The Ministry of Local government
9. Others (specify) .....

**GENERAL COMMENTS**

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# Annex B. Questionnaire: Consumers of Private Sector Medical Practitioners

The objective of this questionnaire is to solicit the views of users of the services of private health providers on the factors which influence their demand and on the quality of services they have received.

Circle or fill in the appropriate answer.

## 1. Personal Data on Respondent

### 1.1 Sex:

1. Male                      2. Female

### 1.2 Age:

1. 15-44                      2. 45-60                      3. More than 60

### 1.3 Place of usual residence:

- Accra City  
Greater Accra Region (Please specify by name)  
Other Region

### 1.4 Distance Traveled:

How did you get to this clinic/hospital?

1. On foot                      2. By public transport.      3. By private transport.

If by public or by private transport, how much did it cost you?

.....

### 1.5 Occupation:

- |                         |        |
|-------------------------|--------|
| Civil/Public servant    | 1      |
| Self-employed           | 2      |
| Housewife               | 3      |
| Unemployed              | 4      |
| Student                 | 5      |
| Retired                 | 6      |
| Others (please specify) | 9..... |

### 1.6 Educational level:

1. None                      2. Primary                      3. Secondary/Tech                      4. University

### 1.7 Income Level:

1. Low    2. Medium                      3. High

2. How often do you come to this hospital/clinic?
  1. First time
  2. Occasionally
  3. Often
  
3. What complaint brought you to this hospital/clinic today? (Spontaneous answers)
  - 3.1 Were you told the diagnosis?
    1. Yes
    2. No
  
  - 3.2 If yes, what did the doctor say is wrong with you?
    1. Malaria
    2. URTI
    3. Gastroenteritis
    4. Diabetes
    5. Diarrhoea
    6. Hypertension
    9. Others (please specify).....
  
4. Were you referred?
  1. Yes
  2. No
  - 4.1 If yes, from which of the following facilities?
 

Facility out of town	1
Private clinic	2
Drug Store	3
Traditional healer	4
Spiritual Church	5
Others (please specify)	9 .....
  
  - 4.2 If no, why did you decide to come to this particular hospital/clinic?  
(Spontaneous answers)
  
5. Did you take any first aid action about your current condition before coming to this facility?
  1. Yes
  2. No
  - 5.1 If yes, what first aid action did you take?
    1. Self medication (Western drugs)
    2. Self medication (herbal preparation)
    3. Consulted traditional healer
    4. Consulted pharmacist
    5. Consulted pastor
    6. Consulted a friend
    7. Consulted a family member
    8. Others (please specify) .....
  - 5.2 Do you ever use the services of traditional healers?
    1. Yes
    2. No
  - 5.3 If yes, what conditions do you normally consult traditional healers on?
  - 5.4 If no, why not?
  - 5.5 What do you like about:
    1. Western trained health workers
    2. Traditional healers
  - 5.6. How much money did you spend on your visit today?

5.7 On the average how much money do you spend when you visit this facility?

6. Mention the positive things you found during your visit to this hospital/facility

- Availability of Credit facility 1
- Availability of medicine 2
- Quality Care 3
- Good attitude of health workers 4
- Clear kept surroundings 5
- Short waiting time 6
- Proximity 7
- Reasonable charges 8
- Others (please specify) 9 .....

7. What do you dislike about this hospital/clinic? .....

- Long waiting time 1
- Poor patient-staff relations 2
- Charges too high 3
- Poor Service/Care 4
- Lack of drugs 5
- Untidy surroundings 6
- Others (please specify) 9 .....

8. Where do you, normally obtain your drug requirements after consultation?

- This hospital/clinic 1
- Private drug store 2
- Vendors 3
- Others (please specify) 9 .....

9. Reasons for preferred source of drugs?

- Proximity 1
- Availability 2
- Good Staff 3
- Credit facilities 4
- Convenient hours 5
- Others (please specify) 9 .....

10. Do you use government-owned facilities?

- 1. Often      2. Sometimes      3. Never

11. Why do you prefer the services of the privately owned facilities to those of publicly-owned ones?

- The good attitude of staff 1
- Medicines/drug are always available 2
- The quality of care is good 3
- Charges are moderate 4
- Because waiting time is short 5
- Others (please specify) 9 .....

12. What do you not like about public-owned hospitals (Spontaneous answers)

**General Comments:**

---

# Annex C. Questionnaire: Private Pharmacists

The objective of this questionnaire is to solicit the views of private pharmacists on their current professional activities and how they can, effectively contribute to Health Care Provision in the Greater Accra Region. (Please tick or answer as appropriate)

## **SECTION I: Personal Data**

Area of Location of Pharmacy Shop.....

Region .....District .....

Q1.1 Sex (of Pharmacist-in-charge) 1. Male 2. Female

Q1.2 Age (of Pharmacist-in-charge)

Q1.3 Educational Background

1. B Pharm
2. First Degree
3. Second Degree
4. Any other Qualification (please specify) .....

Q1.4 Year of registration as pharmacist .....

Q1.5 Last year of Renewal of License.

Q1.6 Do you employ other pharmacists? 1. Yes 2. No

Q1.7 If you do employ pharmacists

How many are full-time?

How many are part-time?

## **Section II: Activities**

Q2.1 Which of the following best describes your normal activities:

- Manufacturing
- Wholesale Invoicing and Distribution of Pharmaceuticals
- Retail Dispensing and Counseling
- Clinical Pharmacy Services
- Compounding of Extemporaneous Preparations
- Public Health Activities
- Drug information Dissemination/Education Services



Q4.2 Do you usually face constraints in your operations? 1. Yes 2. No

Q4.2.1 If you face constraints, tick types of constraints you face

- Policy
- Regulation
- Credit
- Infrastructural
- Taxes
- Import Constraints
- Lack of support from MOH
- Lack of information from MOH

Q4.3 Which of these constraints influence your ability to contribute to Ghana's Public Health Agenda?

- Policy
- Regulation
- Credit
- Infrastructural
- Import Constraints
- Lack of support from MOH
- Taxes
- Others (Please indicate)

**Section V Incentives**

Q5.1 Would you wish to increase your participation in Public Health activities?

1. Yes 2. No

Q5.1.1 If yes give reasons .....

.....  
.....

Q5.1.2 If no give reasons .....

.....  
.....

Q5.1.3 To which Public Health activities do you think as a private pharmacist you can potentially make your greatest contribution ?

- Immunization
- Family Planning
- Population Control
- Health Education

Outreach Programmes  
Control of Communicable Diseases  
Information Dissemination

Q5.2 Do you think the MOH should subsidize your Public Health activities ?

1. Yes      2. No

Q5.2.1 If yes, give reasons .....

.....

.....

Q5.2.2 If no, give reasons .....

Q5.3 In which areas would you suggest that the MOH provide for private pharmacies to allow them to participate more effectively in Public Health activities?

- Direct Funding
- Supply of Vaccines
- Secondment of staff from MOH
- Training of Staff
- Scholarships/Fellowships
- Health Insurance
- Exemption of Drugs from VAT, if passed.    Relevant health information

**Section VI: Professional/Business Strengths**

Q6.1 What do you consider as the major strength of your business entity? (Please use 1,2,3 .... to indicate order of importance)

- Provision of efficient and quality services
- Good Public Relations
- Prudent Financial Practices
- Reliable Staff
- Enabling External Environment
- Good and Capable Management.

**SECTION VII: Relationship with other Health Providers**

Q7.0 Do you have any working relationship with other health providers such as Traditional Birth Attendants (TBAs=), Private Medical Practitioners, Herbalists, Spiritual Healers, etc?

Yes  
No

Q7.1 Do you currently perform any official services on behalf of the Ministry of Health?

Yes  
No

Q7.2 If yes, what are these services .....

.....

.....

**General Comments**



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# Annex D. Consumers of Private Sector Pharmacists

The objective of this questionnaire is to solicit the views of users of the services of private sector pharmacists on the factors that influence their demand for these services and on the type and quality of services they have received.

Circle or fill in the appropriate answer.

## Personal Data on Respondent

1.1 Sex:

1. Male            2. Female

1.2 Age:

1. 15-44                      2. 45-60                      3. More than 60

1.3 Place of usual residence:

- |                      |   |
|----------------------|---|
| Accra City           | 1 |
| Greater Accra Region | 2 |
| Other Region         | 3 |

1.4 Distance Traveled:

How did you get to this shop?

1. On foot            2. By Public transport.    3. By private transport

If by public or by private transport, how much did it cost you?

.....

2. Occupation:

- |                               |   |
|-------------------------------|---|
| Civil/Public servant          | 1 |
| Self employed                 | 2 |
| Housewife                     | 3 |
| Unemployed                    | 4 |
| Student                       | 5 |
| Retired                       | 6 |
| Others (please specify) ..... |   |

3. Educational level

1. None            2. Primary            3. Secondary/Tech            4. University

4. Income Level

1. Low            2. Medium       3. High

How often do you use this pharmacy shop?

1. First time    2. Occasionally 3. Often

6. What reason(s) brought you to this pharmacy shop?

- |                                 |         |
|---------------------------------|---------|
| To buy drugs                    | 1       |
| To seek advice                  | 2       |
| To buy family planning products | 3       |
| To buy toilet items             | 4       |
| Others (please specify)         | 9 ..... |

7. Are you buying drugs with a prescription ?    1. Yes            2. No

8. Are you buying without a prescription?       1. Yes            2. No

9. How often do you use this pharmacist shop?

1. First time            2. Occasionally       3. Often

10. If you are ill, what condition brought you to this pharmacy?

- |                   |                                  |
|-------------------|----------------------------------|
| 1. Malaria        | 5. Hypertension                  |
| 2. Cough          | 9. Others (please specify) ..... |
| 3. Diarrhea       |                                  |
| 4. Skin condition |                                  |

11. Apart from buying drugs, did you receive any other services from the pharmacy?

1. Yes            2. No

12. Were you referred?    1. Yes            2. No

13. Did you see any health worker or doctor before visiting the pharmacy shop?

1. Yes            2. No

14. On the average how much do you spend per visit to the pharmacy shop?

.....

15. Are you buying drugs with a prescription?            1. Yes            2. No

16. Are you buying drugs without a prescription? 1. Yes 2. No

17. Mention the positive things you found during your visit to this pharmacy shop

- Credit facility 1
- Wide range of drug stocks 2
- Quality Care 3
- Good attitude of staff 4
- Well kept surroundings 5
- Short waiting time 6
- Nearness to your residence 7
- Reasonable prices 8
- Others (specify) 9 .....

18. What do you dislike about this pharmacy shop? (Spontaneous answers)

.....  
.....  
.....  
.....

19. Do you use government-owned facilities?

1. Often 2. Sometimes 3. Never

20. How do you compare the government-owned pharmacy that you know to the one you have just visited?

.....

21. Do you ever use the services of traditional healers? 1. Yes 2. No

If yes, what conditions do you normally consult traditional healers on?.....

If no, why not? .....



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# Annex E. Draft FGD Guide for Private Midwives

## 1.0: General Warm Up Questions

- 1.1 What are some of the qualities which make a private midwife popular in the community in which she is located?
- 1.2 Why do you think some women choose to use the services of a private midwife?
- 1.3 Why do you think some women choose to use far-away government facilities, when there is a private midwife in their communities?
- 1.4 Why do you think there are male TBAs but no males trained by the modern sector to practice midwifery?
- 1.5 How do you think private midwives are faring in the present day Ghana? Are they getting enough patients to make a decent living? Probe for reasons for answers given.
- 1.6 What do you think about TBAs and their role in the promotion of the health of women and children in Ghana?
- 1.7 Can you please give an idea of the kind of basic training you had before you started practicing?
- 1.8 Were you all working with government facilities before setting up your own facilities? Probe for number of years with government facility and reasons for decision to set up own facilities.
- 1.9 Any in-service training/workshops in the past 5 years, Probe name type training/workshop and organizing agency?
- 1.10 Do you make use of assistants at your facility? If so, what is the training background of assistants?

## 2.0: **Knowledge, Attitudes and Practices of Private Midwives**

- 2.1 What is the current MOH policy, where private midwives are concerned?
- 2.2 Which government agency or NGO do you have the closest working relationship with?
- 2.3 What are some of the rules and regulations which private midwives have to abide by, in the operation of their facilities?
- 2.4 Which agency/organization enforces the existing rules and regulations, and what are your feelings about the extent to which the rules and regulations are being enforced?

- 2.5 What are some of the sanctions applied to private midwives who fail to abide by the laid down rules and regulations?
- 2.6 Do you/does your facility receive any support from the government/MOH?  
If yes, probe for type and level of support.
- 2.7 In what ways are you/your facility expected to account for any support received from government/MOH?
- 2.8 Why do you think government/MOH should support private practitioners, who are in business to make profit for themselves?
- 2.9 What is the range of services offered by your facility?
- 2.10 What arrangements do you have in place to ensure your facility runs without interruption, in case of your indisposition?
- 2.11 To what extent do you use traditional procedures/ techniques and/or medicines in your practice?  
Probe for which procedures/techniques, etc. and reasons for their use.
- 2.12 Do you perform any health-related service(s) to pregnant women, young children and others, for which you are compensated for?  
If so, probe for type of service(s), form of compensation and agency providing the compensation.
- 2.13 What linkages do you have, if any, with any of the following?
- Government polyclinics/hospitals etc
  - TBAs
  - Private medical practitioners
  - The Christian Health Association of Ghana (CHAG)
  - Any NGOs
  - Pharmacy/Drug store
- 2.14 Under what conditions and/or when do you refer patients to a higher level facility eg. Polyclinic/hospital/ specialists clinic?
- 2.15 Under what conditions and/or when do other facilities refer patients to your facility?
- 2.16 Which factors/situations do you think people take into consideration when selecting a facility for maternity care and delivery?

2.17 To what extent do you involve opinion and other leaders in your catchment area, in the activities of your facility? What form does this involvement take?

2.8 Please explain how you see your role, in the following:

- Prevention of disease and promotion of healthy and problem-free pregnancies;
- Prevention of disease, among infants and young children;
- Promotion of healthy behaviors, among women and adolescent girls and boys, in your community;
- Promotion of health among the general membership of the community.

2.19 What specific public health activities should private midwives be involved in and why?

2.20 What specific problems do you encounter in your work and how do you think government/MOH may assist you solve these problems?

### **3.0: Wrap Up Questions**

3.1 On the whole, what do you feel about your roles in the health delivery system of the country now, as against when you first started your practice?

3.2 What do you think about the level of collaboration existing among private midwives in your districts?

3.3 What are your feelings about the level of working relationship existing between private midwives and government health facilities in your districts?

3.4 In your opinion, what can be done to ensure that the efforts of private midwives effectively complement the services being offered by government facilities?

3.5 Any additional Comments?



---

# Annex F. Traditional Medical Practitioners

## REMINDER TO FACILITATORS

- **Welcome participants and introduce yourself and note taker. Thank everyone for coming.**
- **Explain purpose and procedures of the group discussion.**

Example: Those of you in this room share one thing in common; you are known to provide relief and cure to many sick people in our communities. The purpose of our meeting is to examine the nature of the work you do and what can be done to make your work more beneficial to our society. We need your help, to learn more about issues which affect health and delivery of health care in this region. We need to learn about some of the challenges you face in your work and what you think can be done about these challenges. The information we obtain, will help to develop policies and programmes which can benefit you all and our country, in general.

- **Explain purpose of the note-taker; confidentiality**

Inform participant that in order NOT to miss any of their important ideas, the discussion will be recorded. Ensure that there are no objections to recording the discussion and note taking. Emphasize that all comments will be kept confidential.

- **Introduction**

We will start, by introducing ourselves (first names are adequate). To start with, I am ..... (facilitator to introduce him/herself). Allow all participants to introduce themselves before you introduce the recorder and any other observers.

- **Introduce Ground Rules**

- That everyone's opinions and ideas are important;
- There no right or wrong answers;
- All comments, negative and positive, are welcome;
- Participants should feel free to disagree with one another. "We would like to have many points of view."
- Please speak one at a time.

## I Warm Up Questions

1. In your opinion what constitutes traditional medical practice? What are the various aspects of TMP? Who is a Traditional Medical Practitioner?
2. How does an individual, normally, become a traditional medical practitioner?
3. What distinguishes traditional medical practitioners from other healers?
4. What role does gender play in TMP? Are there certain aspects of TMP which are restricted to either males or females? If so, probe for details.

## **II Knowledge, Attitudes, Perceptions and Practices of TMPs**

5. In your opinion, what does it mean when you say someone is “healthy.” How would you define “health”?
6. How would you describe the health status of most Ghanaians? Would you consider most people you meet as healthy or what?
7. In what ways are traditional medical practitioners contributing to the health of Ghanaians? (Are you satisfied with the performance of all traditional medical practitioners?)
8. In what ways do you think traditional medical practitioners can help improve the health status of Ghanaians?
9. Which disease/conditions are best treated by traditional medical practitioners?
10. What do you normally do when you encounter a disease/condition which in your opinion would be best treated by a western-trained practitioner?
11. In your opinion what are some of the diseases which must be treated by Western-trained practitioners?
12. It has been suggested by some people that to meet the health needs of Ghanaians adequately traditional and Western-trained medical practitioners must work together. What do you think about this?
13. In your opinion, what form should any such collaboration take?
14. There is a saying that “there is strength in unity.” How does this apply to traditional medical practitioners in Ghana? (Are you united and what groups do you belong to?)
15. Should all traditional medical practitioners belong to one association? (Probe for reasons for answers).
16. Should the activities of traditional medical practitioners be monitored and/or controlled? If majority answer yes, probe for how and by whom: if no, then why?
17. There is a saying that “Prevention is better than cure.” In what ways do you think this saying applies to traditional medical practitioners in Ghana?
18. What are some of the methods/means traditional medical practitioners use to:
  - prevent disease?
  - promote health?
  - avoid complications in pregnancy and childbirth?
  - protect children and adults from diseases?
19. Which of the diseases you treat do you think can be prevented and how?
20. In what ways do you think traditional medical practitioners can work with the MOH, private hospital/clinics and District Assemblies, to prevent disease and promote health in our communities?

## **III Wrap Up Questions**

21. What do you think about the kind/level of collaboration, existing between traditional and Western-trained medical practitioners?
22. Are you happy with the current image of traditional medical practitioners in Ghana? If not, probe for possible ways through which this image can be improved.
23. What can be done (by Government, NGOs, etc) to improve upon the working conditions, performance, status, etc. of traditional medical practitioners in Ghana?
24. What is the role, if any, of the supernatural and or occultism in traditional medical practice? Probe for details.

---

# Annex G. Traditional Birth Attendants (TBAs)

## REMINDER TO FACILITATORS

- **Welcome participants and introduce yourself and note taker. Thank everyone for coming.**
- **Explain purpose and procedures of the group discussion.**

Example: Those of you in this room share one thing in common; you are known to provide relief and cure to many sick people in our communities. The purpose of our meeting, is to examine the nature of the work you do and what can be done to make your work more beneficial to our society. We need your help, to learn more about issues which affect health and delivery of health care in this region. We need to learn about some of the challenges you face in your work and what you think can be done about these challenges. The information we obtain, will help to develop policies and programmes which can benefit you all and our country, in general.

- **Explain purpose of the note-taker; confidentiality**

Inform participant that in order NOT to miss any of their important ideas, the discussion will be recorded. Ensure that there are no objections to recording the discussion and note taking. Emphasize that all comments will be kept confidential.

- **Introduction**

We will start, by introducing ourselves (first names are adequate). To start with, I am ..... (facilitator to introduce him/herself). Allow all participants to introduce themselves before you introduce the recorder and any other observers.

- **Introduce Ground Rules**

- That everyone's opinions and ideas are important;
- There no right or wrong answers;
- All comments, negative and positive, are welcome;
- Participants should feel free to disagree with one another. "We would like to have many points of view."
- Please speak one at a time.

## I Warm Up Questions

1. In your opinion who is a traditional birth attendant? Who is and/or can be classified as a TBA?
2. How does an individual, normally, become a traditional birth attendant?
3. What distinguishes traditional birth attendant from other relative who attends a pregnant woman before and during delivery?
4. What role does gender play in TBAs? Are there certain aspects of the work which are restricted to either males or females? If so, probe for details and not get further details.

## II Knowledge, Attitudes, Perceptions and Practices of TMPs

5. In your opinion, what does it mean when you say that a pregnant woman is carrying a "normal" pregnancy? How would you define "normal."
6. How would you describe the health status of most pregnancy women you come into contact

- with? Would you consider most women you meet as healthy and able to carry a normal pregnancy or what?
7. In what ways are traditional birth attendants contributing to the health and welfare of Ghanaians? (Are you satisfied with the performance of all traditional birth attendants?).
  8. In what ways do you think traditional birth attendants can help improve the health status of women and children in Ghana?
  9. Which types of pregnant women are best attended to by traditional birth attendants. When you first encounter a pregnant woman, how do you decide that you are in a position to meet the needs of that woman?
  10. What do you normally do when you encounter a pregnant woman with a condition which in your opinion would be best handled by a professional health worker?
  11. In your opinion which groups of pregnant women must be attended by professionally-trained health workers?
  12. It has been suggested by some people that to meet the health needs of Ghanaian women and children, adequately, traditional and Western-trained health workers must work together. What do you think about this?
  13. In your opinion, what form should any such collaboration take?
  14. There is a saying that "there is strength in unity". How does this apply to traditional birth attendants in Ghana? (Are you united and what groups do you belong to?)
  15. Should all traditional birth attendants belong to one association? (Probe for reasons for answers).
  16. Should the activities of traditional medical practitioners be monitored and/or controlled? (If majority answer yes, probe for how and by whom; if no, then why)
  17. There is a saying that "Prevention is better than cure." In what ways do you think this saying applies to traditional birth attendants in Ghana?
  18. What are some of the methods/means traditional birth attendants use to:
    - prevent disease?
    - promote health?
    - avoid complications in pregnancy and childbirth?
    - protect children and adults from diseases?
  19. Which of the diseases you treat do you think can be prevented and how?
  20. In what ways do you think traditional medical practitioners can work with the MOH, private hospital/clinics and District Assemblies, to prevent disease and promote health in our communities?

### **III Wrap Up Questions**

21. What do you think about the kind/level of collaboration, existing between traditional and western-trained birth attendants?
22. Are you happy with the current image of traditional medical practitioners in Ghana? If not, probe for possible ways through which this image can be improved.
23. What can be done (by Government, NGOs, etc) to improve upon the working conditions, performance, status, etc of traditional birth attendants in Ghana?
24. What is the role, if any, of the supernatural and or occultism in traditional medical practice? Probe for details.

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