



**SOCIAL FRANCHISING OF REPRODUCTIVE AND  
CHILD HEALTH SERVICES:  
A MARKET STUDY IN GHANA**

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## ACRONYMS

- CEA Census Enumeration Area
- CH Child Health
- FGD Focus Group Discussion
- HIV/AIDS Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
- IDI In-Depth Interview
- IUD Intra Uterine Device
- LSM Living Standard Measure
- NHIS National Health Insurance Scheme
- QHP Quality Health Partners
- RCH Reproductive and Child Health
- RH Reproductive Health
- SRN State Registered Nurse
- STI Sexually Transmitted Infection
- TBA Traditional Birth Attendant
- TOM Top of Mind
- TV Television
- USAID United States Agency for International Development

## EXECUTIVE SUMMARY

This report describes key findings from a market study of the feasibility of a social franchising approach to reproductive and child health services (RCH) in selected districts in Ghana. Specifically, this report:

1. Explores the potential of attracting the active engagement and participation of practicing private health care service providers, especially medical doctors and midwives, in the provision of quality and affordable RCH services in selected districts of Ghana.
2. Determines the levels of understanding and awareness of the target market (potential clients for franchised RCH services) of the franchise concept in terms of desired services, motivations for service patronage, and expectations for a franchising program.

A methodological approach using multiple data collection methods was utilized due to the depth and breadth of information required to achieve study objectives. Qualitative methods included Focus Group Discussions (FGDs) and in-depth interviews (IDIs); quantitative data was collected from semi-structured questionnaires. One male and two female FGDs were held with individuals between the ages of 18 to 49 who were actual or potential clients of RCH services. Forty-two IDIs were held with potential franchisees (private practicing doctors and midwives) of RCH services. Potential franchisees were selected from a list of registered private medical practitioners and midwives provided by the Ghana Association of Private Medical Practitioners and the Ghana Registered Midwives Association. Three hundred quantitative semi-structured questionnaires were administered to random potential clients of RCH services. Data was collected from each of the three study locations: Accra/Tema, Kumasi, and Takoradi.

Study results showed that most potential franchisees were interested and willing to join an RCH franchise program, though private midwives showed more enthusiasm than private doctors to join a franchising program. Potential franchisees also identified various factors that would affect their decision to join a franchised program, namely the terms and conditions attached to the proposed program.

Potential clients of franchised RCH services have limited knowledge about franchising of health services. Their overall awareness of RCH services was limited to a few services, such as family planning and immunization services. After receiving explanations of the franchising system and how it would affect health care delivery, potential clients generally expressed interest in the system. Their interest was rooted in the belief that franchising would enable the rich and poor to access quality RCH services for moderate, standard costs at private clinics and maternity homes throughout Ghana. Potential clients were found to prefer government/public hospitals for RCH services due to the affordability of RCH care at these facilities, as compared to private clinics and maternity homes.

The findings of this study show that a market exists for franchised RCH services in Ghana. Thus this study recommends that stakeholders consider instituting social franchising of RCH services. This study also recommends that franchisors determine optimum and affordable charges for RCH service before implementation, since medical charges are the main motivation for social franchising of RCH services.

# 1. INTRODUCTION

## 1.1 Background

Quality Health Partners (QHP), a health project in Ghana funded by the United States Agency for International Development (USAID), intervenes in the areas of family planning, reproductive health (RH), maternal and child health, HIV/AIDS prevention, and surveillance of infectious diseases. QHP's goal is to improve the quality of service and promote equitable access for Ghanaians to a package of reproductive and child health (CH) services in selected deprived districts in Ghana's seven southern regions (Greater Accra, Ashanti, Brong Ahafo, Central, Eastern, Volta, and Western).

One objective of QHP's program is to explore the feasibility that a social franchising system would improve quality and affordable RCH services by increasing the engagement and participation of practicing private health care providers, especially medical doctors and midwives. The goal is that the franchising approach could result in a network of private medical practitioners and midwives who would offer a standard set of RCH services at an affordable cost to clients, thereby providing improved access to these services for (especially) poor clients.

Specifically, QHP's challenge is to determine the practicability, viability, and resources required to implement a social franchising program for RCH services in the three largest urban areas in Ghana- Accra/Tema, Kumasi and Takoradi. This is a logical choice of locations, since most private RCH facilities are located in larger urban areas where rates of utilization of private services are higher.

A market demand study was conducted by Research International Ghana, an independent private research company contracted by Quality Health Partners (QHP), from January to June 2006 to acquire information on the business operations of potential franchisees, the current range of RCH services they provide, the types of RCH service(s) driving their businesses, and the volume and value of these services in terms of turnover and profitability. Additionally, the study aimed to determine the level of understanding and awareness of the target market (potential clients for franchised RCH services) about the franchise concept in terms of desired services, motivation for service patronage, and expectations of a franchising program. This study served as an initial assessment of the feasibility of a social franchising program for RCH services in Ghana.

## 1.2 Research Objectives

The purpose of the study was to assess the acceptability and appropriateness of a social franchise model for RCH service delivery. Following are the specific objectives.

### For Potential Franchisees

1. To assess the interest of selected health service providers (practicing private midwives and private medical doctors) in providing higher quality services and participating in a social franchise program
2. To determine factors that could affect the decisions of these health service providers to join a social franchise program
3. To identify barriers to the participation of these health care providers in a social franchising program
4. To determine RCH services currently provided by these health care providers and client volumes by service types for the past year in order to identify market segments and size

5. To obtain information on the cost of the services provided, fees charged, revenues obtained, and general financial status of medical practices (i.e., are they breaking even? subsidizing their practices?, etc.)
6. To ascertain an optimal package of RCH services (the services that should be packaged for specific provider facilities to ensure quality, cost recovery, and profit maximization) for franchising among various health care providers (doctors/midwives/other types) at private health facilities

For Potential Clients:

1. To assess the level of awareness and sources of awareness of RCH services
2. To determine the market response regarding the types of RCH services accessed, frequency of access to services, and the main reasons for accessing RCH services
3. To identify RCH services desired by potential clients
4. To identify barriers to use of RCH services and to evaluate intentions of clients to use RCH services
5. To determine the level of knowledge about the social franchising concept, and potential interest in using services provided by franchisees

### **1.3 Research Methodology**

Qualitative and quantitative research approaches were used for this study. The qualitative portion (which included IDIs with practicing private doctors and midwives and FGDs with potential RCH clients) defined key perceptions and issues for potential franchisees and clients of RCH services. Findings from the FGDs with potential clients were validated in the quantitative portion.

A semi-structured moderator/interviewer guide was developed and used to collect qualitative information for FGDs and IDIs. A structured questionnaire was to collect respondent's views in the quantitative section of the study.

#### **1.3.1 In-Depth Interviews**

IDIs were conducted with practising private medical doctors and midwives who own or operate health facilities and who are registered members of the Ghana Association of Private Medical Practitioners or the Ghana Registered Midwives Association. IDIs were audio-recorded in order to facilitate their smooth flow and for availability of transcripts to verify completeness and accuracy. In cases where respondents refused to be recorded, detailed transcripts were taken.

It should be noted that information regarding clientele base and costs/finances (objectives four and five from above) was also amassed discreetly and through accessing records (billings, payments from clients, etc.) to corroborate information provided. Furthermore, observations (regarding the level of activity at each facility at the time of the interview, state of the facility, appearance of staff, etc.) provided invaluable insights into views expressed by potential franchisees.

The study aimed for a total of 50 IDIs with practicing private medical doctors and midwives from the three selected locations. The sample was distributed proportionally across the various locations, based on the number of registered private medical practitioners and midwives operating in each area. Only 42 of the 50 interviews were carried out due to the failure of respondents to grant interviews within the data collection period, though contact for the interviews was made well in advance. Although qualitative studies are limited by their lack of effectiveness in making generalizations about the entire population, the achieved sample of 42 of an estimated 372 registered medical practitioners and midwives in the target

localities is statistically representative.<sup>1</sup> This randomly selected sample of greater than 10% is adequately robust to generate actionable conclusions. Please see Figure 1 below.

**Figure 1: Sample size breakdown for in-depth interviews**

Location	Private Doctors		Private Midwives		Total # of Interviews	
	Target	Achieved	Target	Achieved	Target	Achieved
Accra/Tema	13	11	10	8	23	19
Kumasi	5	4	14	11	19	15
Takoradi	2	2	6	6	8	8
<b>Total</b>	<b>20</b>	<b>17</b>	<b>30</b>	<b>25</b>	<b>50</b>	<b>42</b>

### 1.3.2 Focus Group Discussions

FGDs allowed insights into clients' perceptions and attitudes about franchised services. Respondents included men and women in the reproductive age group of 18 to 49 years, who were potential clients of RCH services and residents in the districts in which the FGD was being held. Each focus group had eight to nine participants and lasted for about 90 minutes. All discussions were audio-recorded. As a backup to the audio recording, notes were taken and non-verbal cues were observed and recorded. One FGD was conducted in each study location.

Efforts were made to ensure that each group was comprised of respondents with diverse socio-economic backgrounds. Variations in views based on location, gender, age and demographics were noted and incorporated into the quantitative questionnaire that was later developed for potential clients. Observations at health facilities indicate that a larger number of females patronise RCH services compared to males. Based on this, two FGDs were organised for female respondents in Kumasi and Takoradi and one for males in Accra. One female group was composed of respondents aged 18 – 30 years, and the other female group was composed of older respondents 31 to 49 years of age. The male group was composed of respondents between 18 to 49 years. Please see Figure 2.

**Figure 2: Sample size breakdown for focus group discussions**

Location	Target # of FGDs	# Achieved	# of Respondents	Gender of Respondents	Respondent Age (years)
Accra/Tema	1	1	8	Males	18 – 49
Kumasi	1	1	9	Females	36 – 49
Takoradi	1	1	9	Females	18 – 35
<b>Total</b>	<b>3</b>	<b>3</b>	<b>26</b>	<b>N/A</b>	<b>18 - 49</b>

### 1.3.3 Quantitative Phase

The study used the multi-stage random sampling method to select 300 respondents, according to the following criteria, listed in order of selection process:

1. Census enumeration areas (sampling points) (CEAs)
2. Residential structures/households
3. Respondents

#### **Selection of census enumeration areas (sampling points)**

The Ghana Statistical Service Census Enumeration Area (CEA) was used as the primary sampling unit. From the list of CEAs of urban areas in each region, sampling points for data collection were selected randomly. Working on the basis of ten interviews in each sampling

<sup>1</sup> Numbers provided by the Association of Ghana Private Medical Practitioners and the Ghana Registered Midwives Association

point, the required number of CEAs for each region was computed, and then the fixed interval method was then used to select the required number of CEAs for each region.

### Selection of residential structures/households

All residential structures and households were mapped in each selected CEA. Each household was assigned a unique number, and a set of random numbers was generated to select households. Starting from the top of the random grid and working downwards, the first ten households with the selected random number were chosen.

### Selection of respondents

In each household selected, females and males aged 18 to 49 years were interviewed for eligibility based on their usage or potential usage of RCH services. Where no member of a selected household agreed to be interviewed or where no member was available to be interviewed after three attempts, another household was selected to replace it.

### Sample size and structure

Three hundred potential clients who use or intend to use private health facilities for RCH services were contacted for interviewing. The sample size generated from the total number of male and female adults in the Accra-Tema, Kumasi and Takoradi areas i.e. 2,403,077.<sup>2</sup> Utilizing an error of margin of +/-5.66 at a 95% confidence interval provided a robust and representative sample on which statistical inferences can be based.

Because RCH services are mostly patronised by women in their reproductive years, 80% of respondents were females aged between 18 – 49 years. As males usually have less need for RCH services, the remaining 20% of the sample was composed of males in the same age range. The sample breaks were proportional to the population distribution in the three selected locations. This is shown in the table below.

**Figure 3: Sample structure for quantitative phase**

Location	Male		Female		Total
	Target	Achieved	Target	Achieved	Achieved
Accra / Tema	36	36	144	144	180
Kumasi	19	19	72	72	91
Takoradi	6	6	23	23	29
<b>Total</b>	<b>61</b>	<b>61</b>	<b>239</b>	<b>239</b>	<b>300</b>

## 1.4 Study Limitations and Data Collection Constraints

A number of problems and difficulties limited the smooth execution of the study. Some of these problems were:

- Interviewers had to make several calls before getting respondents for interviews
- Unwillingness of some doctors to declare their charges for various RCH services
- Unwillingness of some doctors to estimate their RCH service charges
- Inability of some respondents to estimate their client volumes for different RCH services
- Inability to obtain information on charges from records departments of some health facilities
- Percentage increase in client volumes over a one-year period could not be determined from the collected data
- Damage/corruption of some recorded interviews led to the inability to provide certain transcripts

<sup>2</sup> 2000 Population and Housing Census: Ghana Statistical Service

## 2. FINDINGS ON POTENTIAL FRANCHISEES

Private doctor and midwife-run clinics and maternities visited for this study had been operational between six and 35 years. Most doctors interviewed had post-graduate qualifications or training in Gynaecology and Obstetrics, and one had a Master of Business Administration in addition to his medical qualification. Midwives who had SRN (State Registered Nurse) and Midwifery qualifications ran a majority (68%) of private maternities. One midwife was also qualified in neonatal care. (Please see Appendix 1.)

In addition, most potential franchisees had received training in business management and book keeping organised by Empretec Ghana Foundation, the Danish development agency (DANIDA), or the Ghana Institute for Management and Public Administration. The ages of potential franchisees varied widely though a majority of respondents were above 55 years of age. Doctors ranged in age from 36 to 73 years and midwives from 47 years to 65 years.

### 2.1 General Views About Reproductive and Child Health Service Provision

On the whole, the views and opinions expressed by franchisee respondents on issues addressed by this study were similar across the three regions surveyed. However, the views and opinions of medical doctors on certain issues differed significantly from that of midwives. For example, while most midwives were willing to access loans to expand their facilities and services, the majority of medical doctors were uninterested in loans, preferring to generate required resources for expansion from their current operations. This is described further below.

All practicing private medical doctors and midwives were interested in delivering high quality health services to their clients. They were confident that the quality of service they provided was very good, with some rating their quality at 85%, class 'A', or first-class. Positive comments by their clients, self-assessments of their facilities, and assessments conducted by the Ministry of Health provided the basis for their assessments. Measures taken to ensure quality of service mentioned by potential franchisees are found in the following table.

**Figure 4: Measures taken to ensure quality reproductive and child health services**

Measure	Internal measure at facility	External measure at facility
<b>By Private Doctors</b>		
1. Doing one's best for patients	Ensuring quality assurance through sterilization of equipment and maintaining good staff attitudes.	Inspection by the Ghana Private Medical Association
2. Reading medical journals to stay informed of new medical practices	Regular supervision of staff	Inspection from the Ministry of Health
3. Giving patients what they need, not what they want	Internal training for staff	Inspection by the Environmental Protection Agency and the Ghana Medical Association.
4. Spending ample time with each patient	Effective administration of facility	Inspection by the Regional Press Directorate
5. Ensuring patients come in crying, but go out smiling	Following routine medical procedures/ guidelines	N/A
<b>By Private Midwives</b>		
1. Providing services that will	Keeping facility in order,	Regular inspection of facility

benefit giver and taker	maintaining competent staff, and ensuring correct drugs are dispensed	by doctors and nurses from the Ministry of Health
2. Providing psychological, personal, and social comfort to the patient through good care	Ensuring good working relationships with all staff	Regular inspection of facility by metropolitan authorities
3. Understanding client's needs, giving counselling, and gaining the confidence of client	Ensuring staff's personal and centre's equipment hygiene	Regular inspection of facility by Community Health Nurses
4. Not wasting patients' time	Regular capacity building of staff through workshops	Regular inspection of facility by district public health workers and the Ghana Registered Midwives Association
5. Listening carefully to complains from patients	Routine checks to ensure that medical procedures / guidelines are followed by staff	N/A

As shown in the figure below, 82% of private doctors expressed willingness to join a franchising program. They indicated that this decision would be strongly based on the terms and conditions attached to such a program. These terms/conditions relate to the benefits to be provided to them, such as moderately-priced quality drugs and medical equipment that will help improve their services. All private midwives were willing to join a franchised program for RCH services, according to responses to questions and cues observed by interviewers. In sum, private midwives were more enthusiastic about joining a franchised program than doctors, who often linked their participation to terms/conditions involved.

**Figure 5: Knowledge and willingness to join a franchising program**

<b>Private Doctors</b>		
Statements	# of respondents	Percentage
Has heard of franchising	8 / 17	47
Understand social franchising	6 / 17	37
Willing to join a franchised program for RCH services	14 / 17	82
<b>Private Midwives</b>		
Statements	# of respondents	Percentage
Has heard of franchising	12 / 25	57
Understand social franchising	2 / 25	10
Willing to join a franchised program for RCH services	21 / 25	100

The majority (about 80%) of private medical doctors indicated they were currently providing basic RCH services, including deliveries, antenatal and postnatal care, immunizations and sick child care, services most commonly demanded of them by their clients. They could not identify any gaps in their service provision but were able to indicate needs, mostly for expansion. Doctors were unable to define an ideal package of RCH services that they would like to provide. Most private midwives, on the other hand, were interested in expanding their facilities to create more space, acquire equipment they lacked, and provide services they currently were unable to provide because of limited resources. Some of these services and equipment are listed below.

Potential franchisees (both doctors and midwives, but a greater percentage of midwives) indicated they would like to see their facility improved further, in terms of both service provision and infrastructure, through the addition of services such as delivery, family planning, laboratory and X-ray services, and dental departments.

Based on the needs indicated in the text boxes to the right, midwives expressed interest in accessing loans or financial services with low interest rates. They proposed interest rates ranging from 4% – 20%. In contrast, most private medical doctors were not interested in accessing loans for expansion, as they believed they could generate funds internally from their operations.

#### **Needs Indicated by Private Doctors**

- Laboratory microscopes
- Scanning equipment
- Surgical theatres
- Bungalows for staff
- X-ray equipment
- Dental services
- Expand health facility (building)
- Put up a surgical unit
- Marketing/advertising of services
- Scanning machine
- Incubator for premature babies
- Equipment to check blood pressure

#### **Needs Indicated by Private Midwives**

- Staff training
- Hiring more staff
- Expand health facility (buildings)
- More beds
- More wheelchairs
- Upgrade maternity to a clinic status

## **2.2 Business Operations**

Respondents who were also the main decision-makers at their health facilities owned 85% of private health facilities. Facilities served as the main source of income for most respondents. About 90% of private doctors and midwives also owned the buildings / structures in which their facilities were located. In most cases, parts of the midwifery/maternity homes also served as residences for the midwives in charge. A minority (15%) of private doctor-run clinics were owned jointly by a group of medical practitioners with different specialities. For private maternity homes, joint ownership was mainly between husband and wife. Please see Appendix 1 for more details.

The number of staff at private health facilities ranged from three to 100. The maternity homes usually had lower staff numbers compared to the private clinics. In most cases, maternity homes did not have separate staff for medical and non-medical duties, such as administration and cleaning, so medical assistants were assigned to all of these duties. On the other hand, staff roles were well-defined in private doctor-run clinics, where, in addition to medical doctor(s), qualified midwives and general nurses provided RCH and other health services. Support services such as administration, laboratory management, and cleaning were assigned to non-medical staff.

Healthcare assistants in both private clinics and maternity homes had no formal training in providing RCH services and other health services; all of their medical training was acquired on-the-job.

About half of the doctor-run private clinics operated for 24 hours; these were also the bigger clinics that had facilities for in-patient care. The other half were only operational from early morning to late afternoon or until the last patient was seen. All midwife-run private maternity homes were operational for 24 hours, as most midwives reside at their health facilities or at nearby locations.

### 2.2.1 Health Services

Generally, all private clinics and maternity homes indicated they offered most or all of the following RCH services:

- Family planning
- Antenatal services
- Delivery
- Postnatal
- Sexually Transmitted Infection (STI) management
- Post abortion care
- Sick child care (treatment of malaria, coughs, diarrhoea in children etc)
- Breastfeeding education and counselling
- Immunizations

Other services offered included:

- Treatment of general ailments (malaria, minor cuts, skin rashes etc)
- Counselling clients on Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) prevention
- Circumcision
- Treatment of piles
- General surgery

### 2.2.2 Client Volumes

From rough estimates given by potential franchisees regarding client volumes over the past year (i.e. one year prior to the commencement of the study), 40% of private doctors indicated a decrease in client volumes, 40% indicated an increase, and the remaining 20% said they did not record any significant change. Seventy percent (70%) of midwives indicated that they recorded a decline in their client volumes, while the remaining 30% recorded an increase. Explanations are as follows:

#### Reasons for Declining Patient Volumes

##### Doctors:

- Unfavourable economic situation in Ghana which renders health services unaffordable

##### Midwives:

- Increase in the number of private and public health care facilities in their neighbourhoods, reducing the patient/provider ratio
- Client's preference for government hospitals because charges there are lower

#### Reasons for Increasing Patient Volumes

##### Doctors:

- Improving transportation infrastructures are increasing physical access to health facilities
- Reputation for high quality of service rendered by the facility

##### Midwives:

- High quality of service rendered by the facility due to hard work of midwives

Rough estimates of monthly client numbers provided by respondents and figures collected from records departments showed the treatment of sick children as the service with the highest annual client volumes. The lowest client volumes were from family planning services and STI – HIV/AIDS management. In most cases, private maternity homes received more clients than private doctor-run clinics. (See Figure 6).

**Figure 6: Annual client volumes for reproductive and child health services**

Service	# of respondents	Range of # of clients/month	Median # of clients/month	Median # of clients/year
<b>Private Doctors</b>				
Family Planning	4	3 – 13	10	120
Antenatal Care	5	1 – 156	8	96
Delivery	3	1 – 40	3	36
Post natal Care	4	1 – 38	5	60
Sick Child Care	4	1 – 210	33	165
STI – HIV management	4	2 – 8	4	48
<b>Private Midwives</b>				
Family Planning	12	3 – 52	10	120
Antenatal Care	8	3 – 66	25	300
Delivery	17	3 – 35	6	72
Post natal Care	9	4 – 34	5	60
Sick Child Care	15	6 – 200	60	720
STI – HIV management	14	1 – 13	4	48

### 2.2.3 Profitability and Charges for RCH Services

All potential franchisees interviewed indicated that their practices were profitable. Some said this was demonstrated by their abilities to stay in business over the years and take care of their personal and family needs. While the majority of medical doctors indicated that profits from their practice were significant and worthwhile, some midwives indicated that their profits were marginal because their clients were mostly from low-income and barely able to pay their medical bills. **The contribution of RCH services to the total income generated at health facilities ranged from 25-80% for private doctor-run facilities and 25-100% for private midwife run facilities.** Please see Appendix 3 for ratios of income from RCH services to total income generated by facility.

In all study locations, 80% of patients who visited private health facilities were walk-ins, and the rest were referrals from Traditional Birth Attendants (TBAs) and Pastors (15%) or business institutions (5%). One doctor indicated that a few of his client were referrals from government hospitals (i.e., when hospital staffs strike). Please see Appendix 4 for sources of clients by health facility.

At both private doctor-run clinics and midwife-run maternity homes, 90% of all patients paid their medical charges out of pocket. A small number of patients (about 4%) had their bills settled by their workplace. Some midwives indicated that a few of their patients were treated free of charge because of inability to pay medical bills.

All private doctors charged consultations fees, which sometimes differed for first-time clients and regular clients, in addition to other charges.<sup>3</sup> In about 90% of cases, private midwives did not charge consultation fees. Midwives profited mainly from “Other Charges”, which include treatment/management of health conditions, drugs, and medical investigations such

<sup>3</sup> Medical practitioners often charge “Consultation Fees” for time spent with clients, listening to their clients’ health complaints and making decisions about treatment.

as laboratory tests conducted at their facilities. Often these other charges were not clearly defined, so they might be inclusive of consultation fees. As shown in the Figure 7 below and Appendix 2, charges for RCH services at private doctor-run clinics were higher than those at private midwife-run maternity homes.

**Figure 7: Estimated charges for reproductive and child health services**

Service	Consultation fees for first visits, in 000s of cedis	Consultation fees for regular clients, in 000s of cedis	Other fees for all clients, in 000s of cedis	Total charges for first visits, in (000s of cedis) / (US\$)	Total charges for regular clients, in (000s of cedis) / (US\$)
<b>Private Doctors</b>					
Family Planning	20 – 500	20 – 250	N/A	N/A / N/A	N/A / N/A
Antenatal	14 – 500	10 – 250	30 – 140	44 – 640 / 5 – 70	40 – 390 / 5 – 43
Delivery	20 – 500	20 – 250	200 – 1,800	220 – 2,300 / 24 – 252	220 – 2,050 / 24 – 225
Postnatal	20 – 500	20 – 250	10 – 110	30 – 610 / 3 – 67	30 – 360 / 3 – 40
Sick Child Care	20 – 500	20 – 250	40 – 250	60 – 750 / 7 – 84	60 – 500 / 7 – 55
STI - Management	20 – 500	20 – 250	30 – 350	50 – 850 / 5 - 93	50 – 600 / 5 - 66
<b>Private Midwives</b>					
Family Planning	No fees	No fees	2 – 40	2 – 40 / 0.2 – 4	2 – 40 / 0.2 – 4
Antenatal	No fees	No fees	10– 54	10 – 54 / 1 – 6	10 – 54 / 1 – 6
Delivery	No fees	No fees	130– 500	130 –500 / 14 – 55	130 –500 / 14 – 55
Postnatal	No fees	No fees	5 – 10	5 – 10 / 0.5 – 1	5 – 10 / 0.5 – 1
Sick Child Care	No fees	No fees	7 – 150	7 – 150 / 0.8 – 16	7 – 150 / 0.8 – 16
STI - Management	No fees	No fees	10 – 180	10 – 180 / 1 - 20	10 – 180 / 1 - 20

The wide range between consultation fees (¢20,000 - ¢500,000) for first-time clients at private doctor-run health facilities is attributed to the fact that some of these health facilities charge consultation fees on a monthly basis. Thus, a client is not charged any consultation fees if he/she re-visits his/her regular health facility within a month of last visit. However, a new consultation fee is charged if he/she revisits the health facility after a month of the last visit. These monthly charges are usually low. (Please see Appendix 2).

As shown in the figure above, delivery stands out as the RCH service with the highest fees, and family planning services consistently have the lowest fees. Postnatal services in midwives' maternity homes/clinics were, in all cases, free for patients who delivered at that health facility, though clients were charged for drugs if they had needs for medication.

In general, normal/uncomplicated delivery was mentioned by the majority of midwives as the most profitable RCH service (mainly because these charges are higher than most other RCH services), followed by treatment of minor ailments (malaria, typhoid, cuts, etc.) in both children and adults. About 70% of doctors indicated the treatment of minor ailments as the most profitable service they provided. After safe delivery services, profitability was found to be directly proportional to the level of patronage/client volumes for that service.

Least profitable RCH services according to both private doctors and midwives were family planning (sale/provision of condoms, contraceptive pills, injections, and advice on the suitable forms of contraception) and STI management.

No private health facility indicated that it had treated any patient under either the National Insurance Scheme (NHIS) or under any health insurance scheme. Respondents did not mention subsidizing their practice to make their services more affordable to patients.

## **2.3 Perception of the Franchise Concept**

Sixty-seven percent of private medical doctors and 57% of midwives reported they had heard of franchising. All private doctors who had heard of franchising indicated that they understood the concept. On the other hand, 90% of private midwives said they did not understand the concept.

After the franchising concept had been explained to respondents, the majority of both doctors and midwives believed the concept could help improve the quality of their practices by offering increased possibilities for staff training, financial support for facility expansion, and other benefits.

The level of enthusiasm shown by midwives in the franchising concept was much higher than that of private doctors. Among the private doctors, 33% were unwilling to join a franchise program for the following reasons:

- Age (believed they were too old to manage any new program). (Two respondents)
- Believed the franchised program had a commercial motive that was unacceptable according to personal principles. (One respondent)
- Preparing to end medical practice. (One respondent)
- Personal difficulty in accepting and introducing new programs/concepts in health facility operations. (One respondent)

For a sample explanation of “social franchising” used in this study and other tools used by the Research International team, please contact QHP.

## **2.4 Expected Benefits from a Franchise Program**

The willingness to join a franchising program for RCH services was mainly driven by expected benefits. The most common expectations, most of which were expressed by both private doctors and midwives, were:

- Possibility of having access to moderately-priced quality drugs
- Possibility of receiving regular supplies of drugs
- Possibility of receiving financial support for facility expansion
- Possibility that health facility staffs could receive additional training
- Regular monitoring of health facilities’ operations by franchisor would ensure quality health delivery and generate competition among franchisees.
- Possible provision of equipment such as a vacuum extractor device for aiding deliveries and oxygen storage for newborn babies by franchisor.

## **2.5 Factors Affecting Decisions to Join a Franchised Program**

Factors affecting potential franchisees’ decisions about whether to join a franchised program are listed below.

### Doctors' Views

- The terms and conditions of the franchising program agreement: specifically what profits and benefits could be gained, not services involved in the program
- Strength of the franchisors' brand (image) should be stronger than franchisees'
- Origin (country) of the franchising organization: franchisors from Western Europe and North America were more acceptable than those from Eastern Europe
- The group that the franchising organization is affiliated with or represents
- Respondent's age: a few doctors were old and not interested in managing any new health service scheme or program

### Midwives' Views

- The terms and conditions of the franchising program agreement
- Ability to maintain standards already established
- Respondent's age: a few midwives were old and not interested in managing any new health service scheme or program

In most cases, potential franchisees could not envisage any barriers to joining a social franchising program. The few barriers mentioned are listed below.

### Doctors' Views

- Unwillingness of well-established private health facilities to share decision making with a franchising organization or allow regular supervision
- Unwillingness of Ghanaian institutions to contribute/pay royalties to other organizations
- Perception of the franchising concept as having only a commercial motive
- Feeling of self-sufficiency/sustainability by some potential franchisees

### Midwives' Views

- Possibility of being cheated by the franchising organization
- Inability to pay back loans or royalties to franchisor if a reduction in client volumes occurs

Both doctors and midwives indicated external organisations such as the Ministry of Health and the Ghana Association of Registered Midwives regularly monitored their work and facilities, and they were not concerned about external supervision by a franchisor. In sum, most private healthcare providers believed that as long as their services were going to be improved by the franchised program, the possibility of adopting a new logo or name or sharing decision-making powers would not affect their decision to join a franchised program.

## **2.6 Composition of an Ideal Franchised Service Package**

The majority of private medical doctors and midwives believed they were offering optimum RCH services for their facilities' capacities (in terms of equipment, staff strength and size of facility.) These services included, in most cases, safe delivery, postnatal and antenatal care, family planning, STI treatment and management, and sick child care.

However, a few doctors were interested in adding specific RCH services, such as delivery, to their package. Midwives were most interested in adding immunizations to their packages of services, as well as obtaining equipment to enable them to offer the following services:

- medical laboratory
- X-ray
- ultra sound scanning
- oxygen for newborn babies
- electric vacuum extractors (for aiding deliveries)

Although the RCH services listed below are part of the Ghana Health Policy and Standards/Protocols, the majority of private doctors and midwives did not offer them at their facilities. Thus these services were identified as gaps in the provision of RCH services by potential franchisees.

#### Reproductive Health (RH)

- Prevention and management of unsafe abortions and post-abortion care
- Prevention and management of cancers of the female and male reproductive systems (including breast cancer)
- Responding to concerns about menopause and andropause
- Discouragement of harmful traditional practices and gender-based violence that affect the RH of women and men
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conception health care and sexual health.

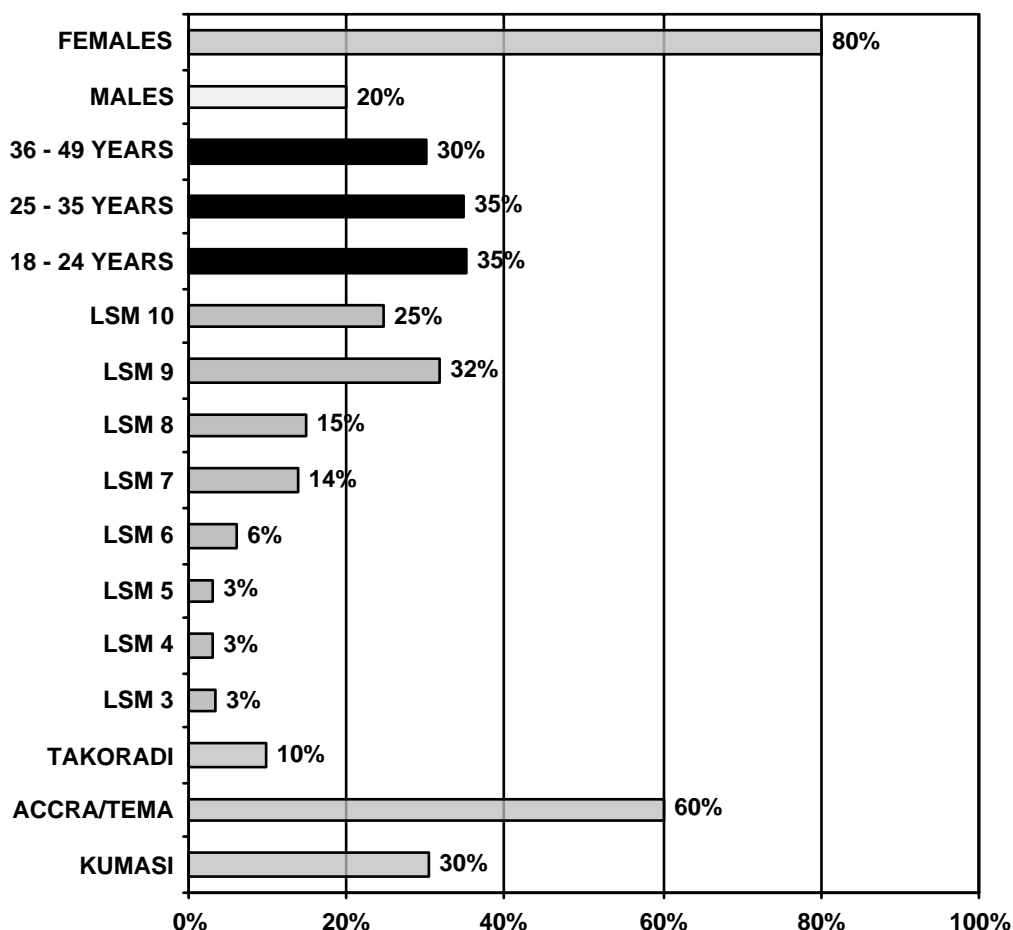
#### Child Health

- School health
- Adolescent RH

### 3. FINDINGS ON POTENTIAL CLIENTS

A total of 300 respondents were randomly selected from 300 households in the three study locations. Respondents were made up of both males (60) and females (240) between the ages of 18 to 49 years who had ever patronized or intended to use RCH services. Respondents fell between the Living Standard Measure (LSM) ranges of 3 – 10.<sup>4</sup> Please refer to Figure 8 below.

**Figure 8: Demographic profile of respondents to the quantitative study**



#### 3.1 Reproductive and Child Health Service Awareness

The majority of respondents associated RCH services with safe deliveries, antenatal and postnatal care, family planning, and child immunization services. Potential clients mentioned sixteen sources of awareness of RCH services, and the electronic media (TV and radio) and information from medical professionals (doctors, nurses, and midwives) were mentioned as the main and preferred sources of awareness on RCH services.

Participants in the survey indicated that the following RCH services were generally available in their residential communities:

- Safe motherhood services, including antenatal care, safe deliveries, and post natal care (including breastfeeding and infant health)
- Family planning

<sup>4</sup> LSM defines the socio-economic status/standard of living of a person.

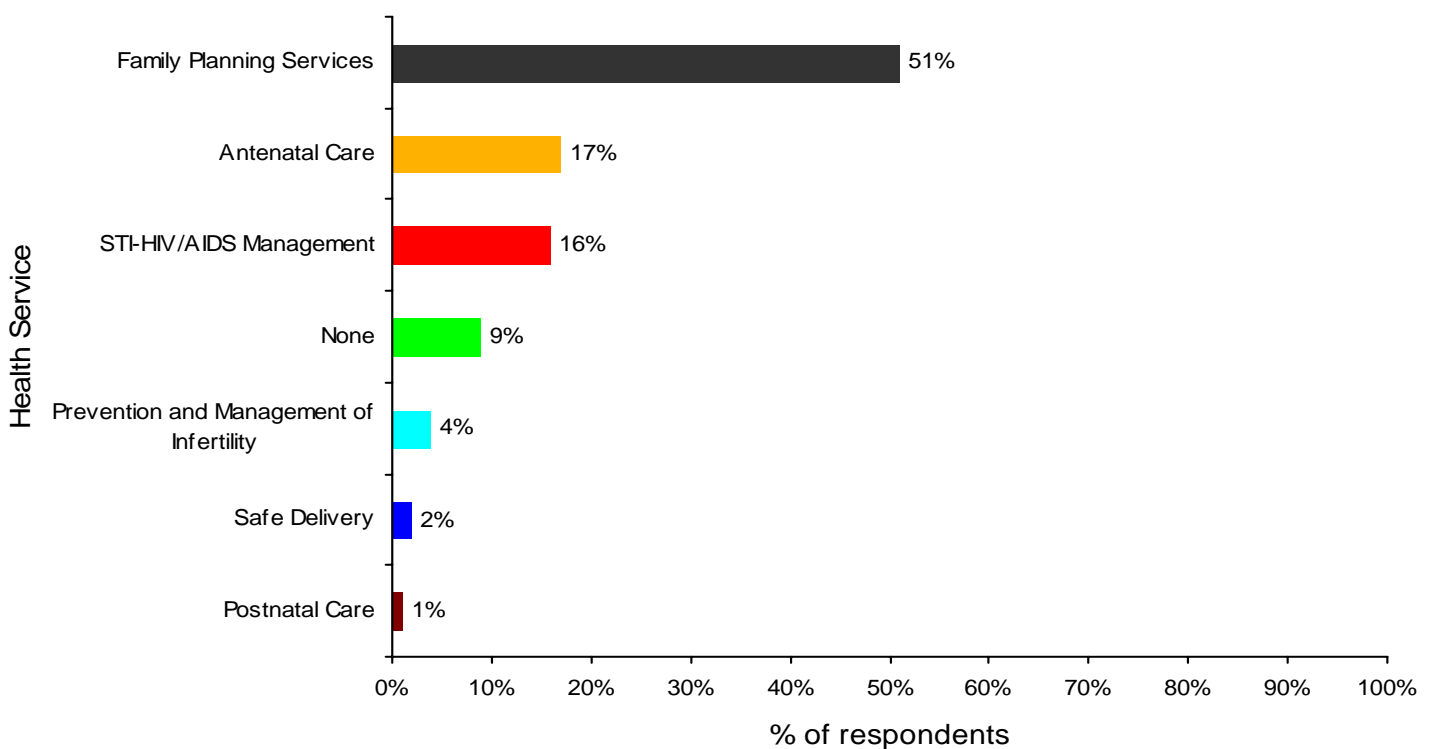
- Immunisations against the six infant killer diseases and others
- Prevention and management of STIs
- Prevention and management of infertility
- Voluntary counselling and testing for HIV

### 3.2 Clients' Definitions of Reproductive Health Care

Findings from the qualitative study showed that the majority of female participants, irrespective of location, equated RH care to antenatal care, safe deliveries, and family planning services, as these services were the most common “Top of Mind” (TOM) responses.<sup>5</sup> A few females and males also defined RH as treatment of infertility in males and females, counselling youth on the reproductive system and adolescence, and voluntary counselling on HIV/AIDS.

Results of the quantitative phase of the study of 300 respondents, as shown in Figure 9, confirm that family planning (51%), antenatal care (17%) and STI – HIV/AIDS management (16%) formed a significant percentage of TOM responses about RH services.

**Figure 9: Top of mind reproductive health services**



<sup>5</sup> Top of Mind (TOM) represents what respondents mention first in their spontaneous responses to questions.

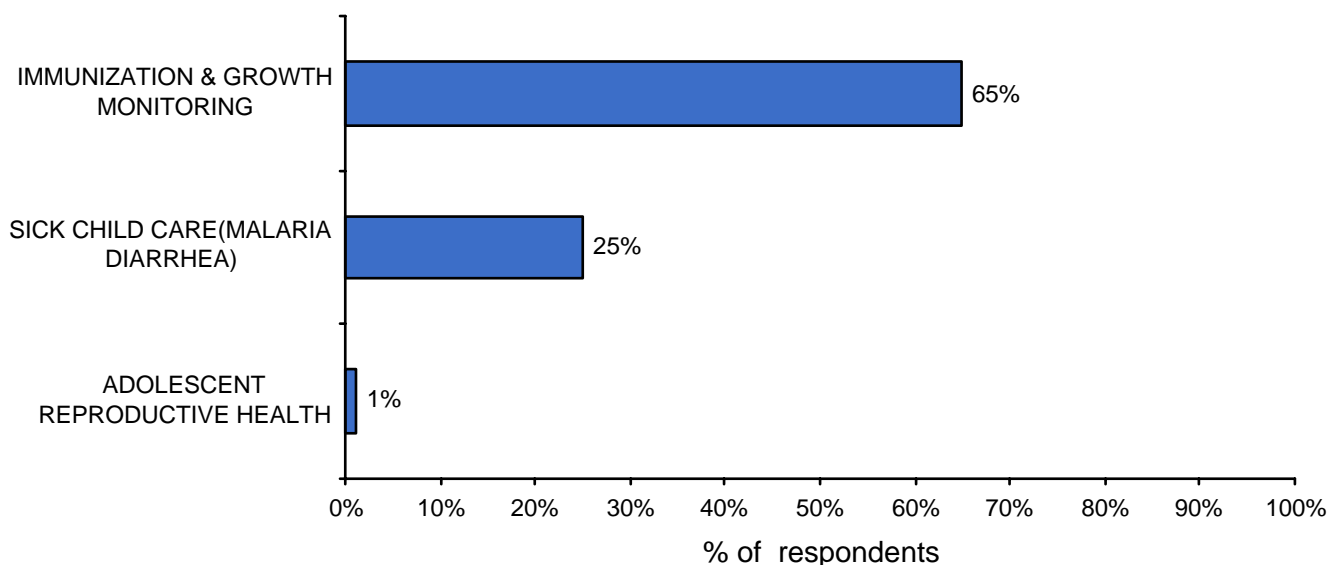
### 3.3 Clients' Definitions of Child Health Care

Participants in the FGDs gave varied interpretations to the phrase "child health care." They generally defined it, irrespective of gender and location, as caring for a child or a sick child. Other interpretations given to CH were:

- Free delivery of babies at government hospitals
- Weighing
- Breastfeeding, feeding, nutrition
- Education on hygiene
- Post natal care
- Immunisations
- Prevention against the six childhood killer diseases
- First aid at home (i.e. for minor cuts, burns, etc.)

As seen in Figure 10, the quantitative study shows that most (65%) of the 300 respondents associated CH services with immunization & growth monitoring.

**Figure 10: Top of mind child health services**



### 3.4 Awareness of Reproductive and Child Health Services

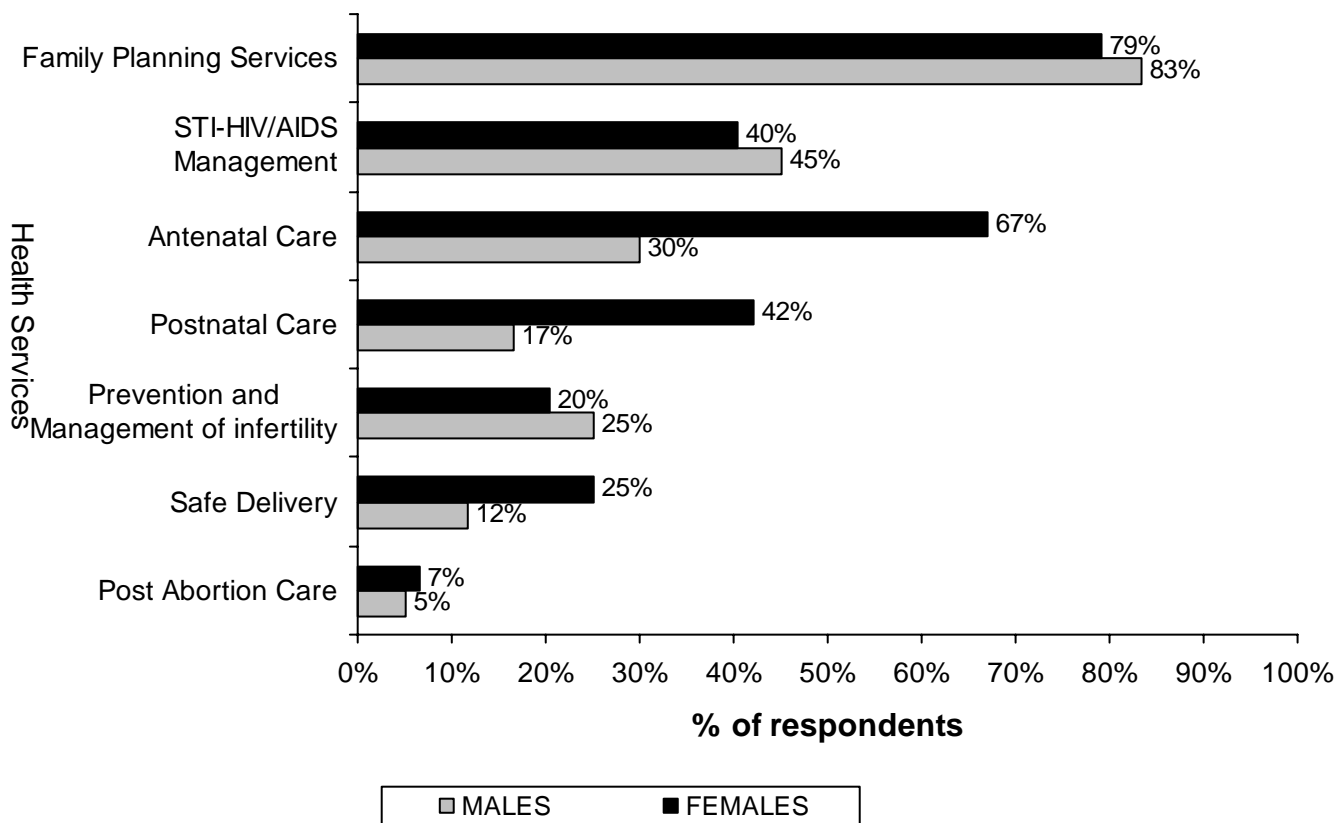
Females were significantly more aware of antenatal and postnatal care and safe delivery than males, as shown in the Figure 11 below. Males were, however, more aware of family planning services and STI/AIDS management than females. Figure 12 shows that awareness of all the CH services was higher amongst female respondents than males.

***“Child health means taking good care of children so that they don’t fall sick, preventing children from getting mosquito bites and malaria, giving them a balanced diet so that they will grow well”.*** Older Female Respondent, Kumasi

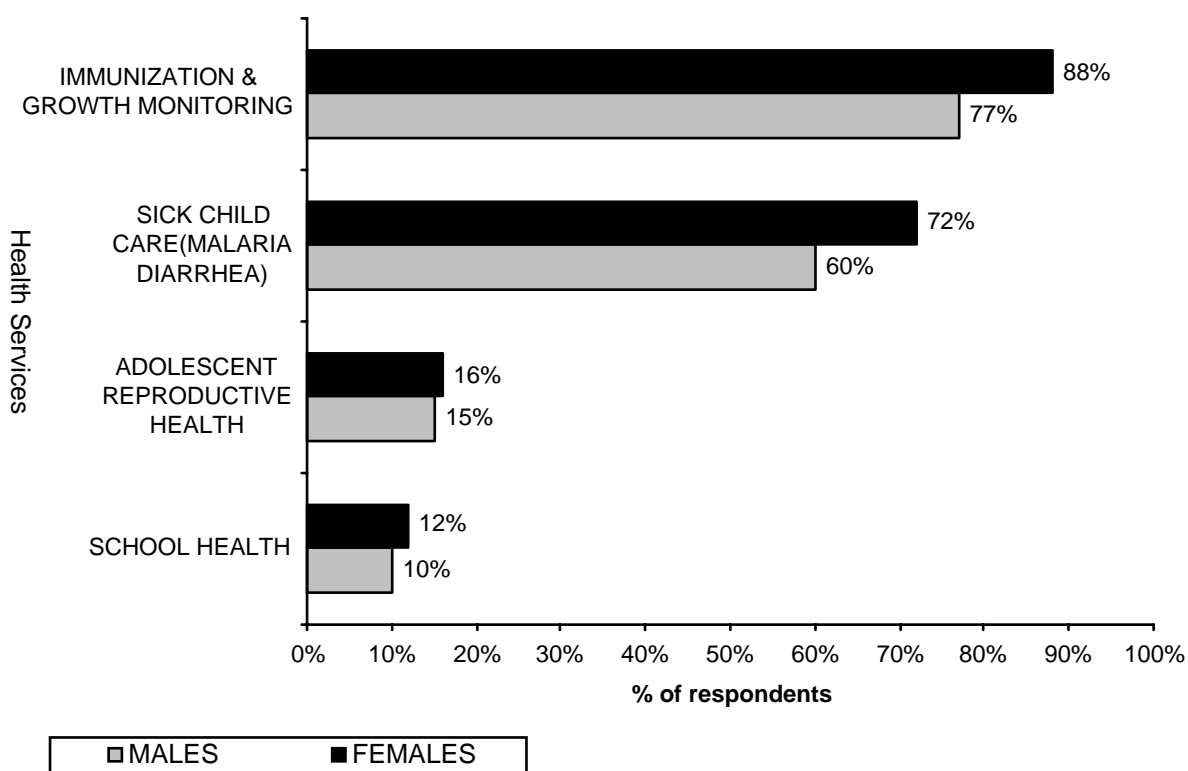
***I have heard of it and the little I have to share is that for instance when a child is delivered in some government hospitals you don’t have to pay. After delivery you take the child to the hospital for weighing”.*** Male Respondent, Accra

***“Child health service happens if you are not in the house and the child is not well. Lets say you have a child who usually eats well and you realise he cannot eat, then you notice there has been an increase in the child’s temperature, you wash the child to reduce his temperature”.*** Younger Female Respondent. Takoradi

**Figure 11: Awareness of reproductive health services by gender**



**Figure 12: Awareness of child health services by gender**

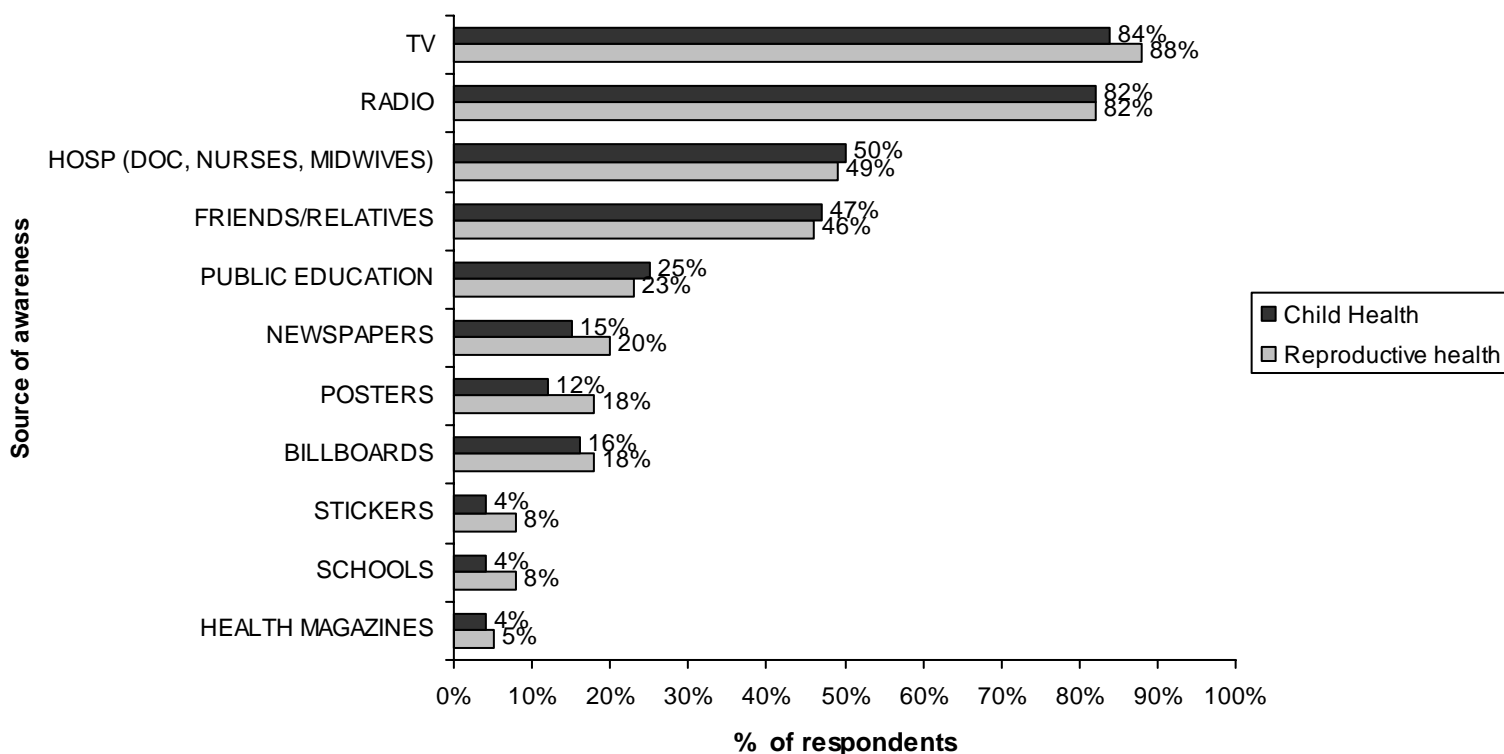


### 3.5 Usual Sources of Information

Electronic media (radio and television) were the usual source of information about RCH services for FGD and quantitative study respondents. Respondents usually gathered information through listening to or watching “talk shows” on health-related issues and advertisements. Other media forms mentioned were newspapers, health magazines, posters and hand outs/leaflets.

Yet another important source of information on RCH was from medical professionals (doctors, midwives, nurses) at both public and private health facilities. This information is usually given when clients go for routine check-ups – antenatal, postnatal, weighings, etc. Please see the figure below.

**Figure 13: Sources of information about reproductive and child health services**



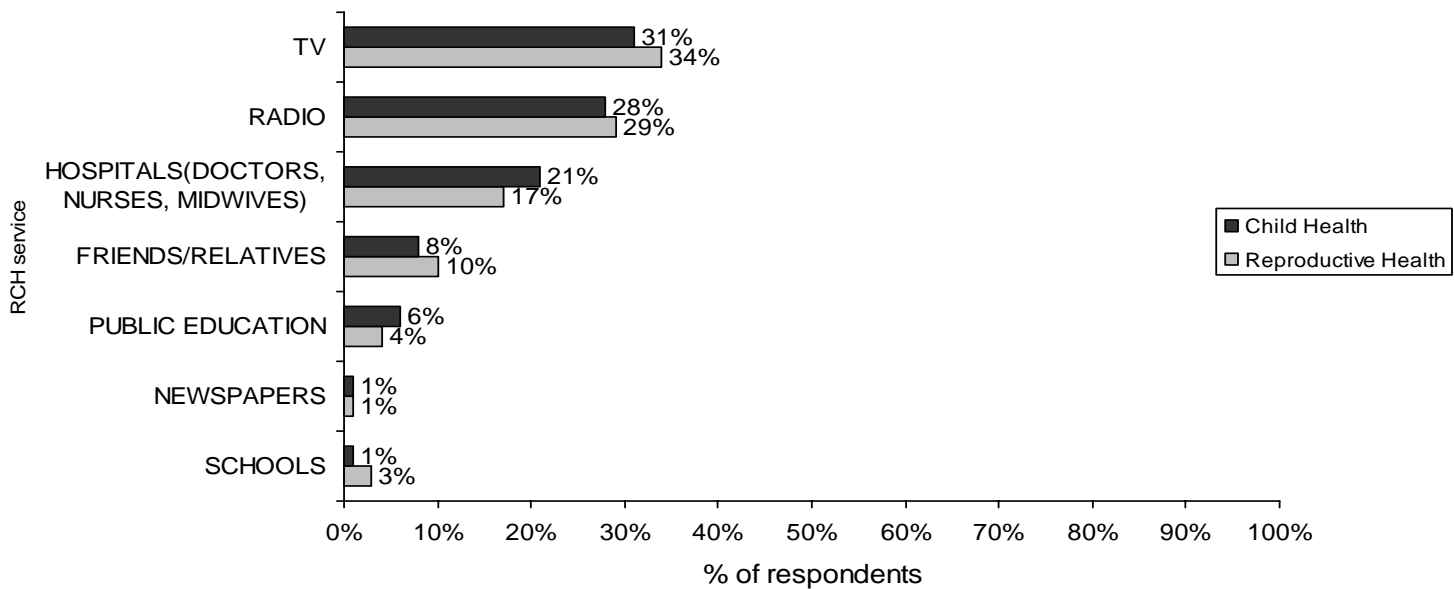
### 3.6 Preferred Sources of Information

The two preferred sources of information on RCH services by respondents were the same as the sources of obtaining information on RCH services, i.e. electronic media and medical professionals as shown in the figure below. This finding was also the same for both the FGDs and the quantitative leg of the study. The electronic media were most preferred since respondents perceived them as a source of expert information because knowledgeable people in the medical field gave the talks on health topics. In clients’ opinions, accessibility to information through the electronic media was much higher than accessibility to information from health professionals. The media also gave listeners the opportunity to ask questions and seek solutions to issues through “phone-in” segments. Medical professionals were the most preferred source of information after electronic media because respondents believed they were well-versed in health issues

**“...information from health centres, doctors, and nurses are credible and reliable because they are trained on such issues, unlike friends who talk from experience only” -Younger Females, Takoradi**

and were available to talk to patients when they visited their regular health facilities. Please see the figure below.

**Figure 14: Preferred sources of information about reproductive and child health services**



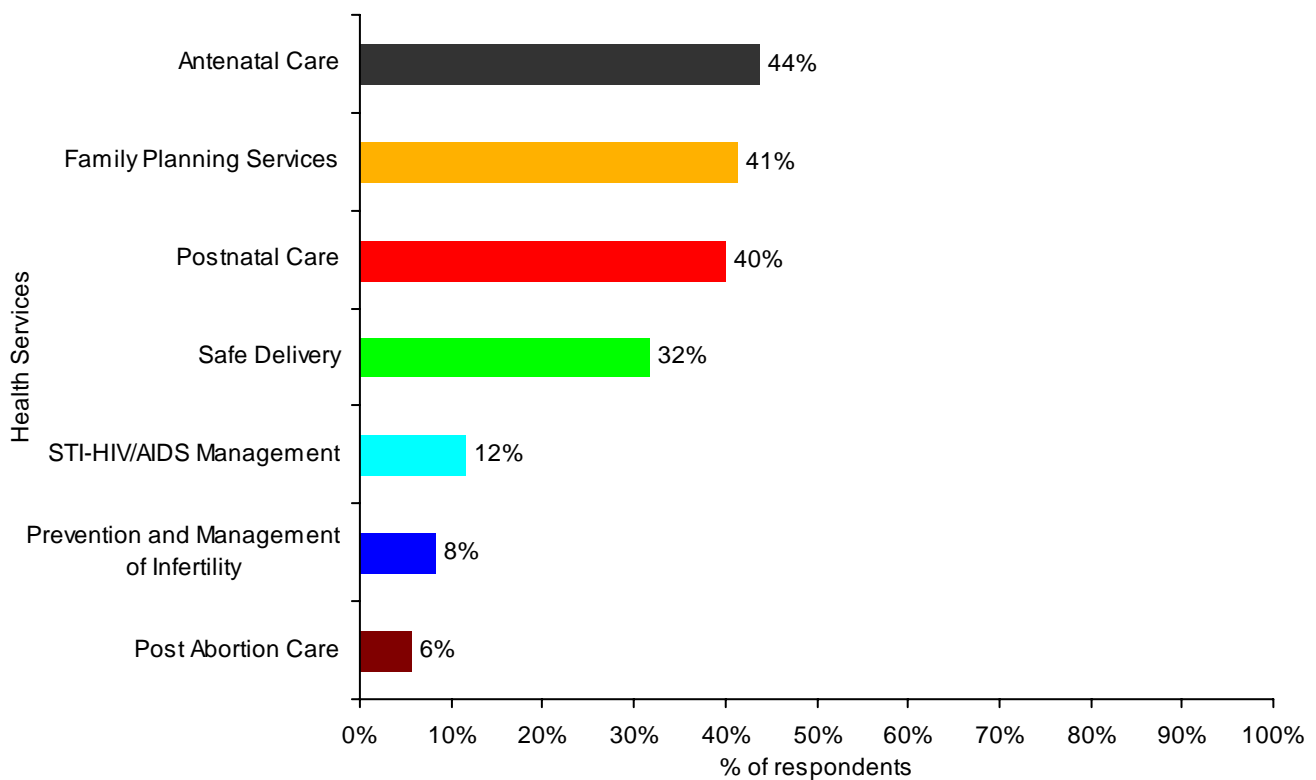
### 3.7 Usage of Reproductive and Child Health Services

The FGDs for potential clients of RCH services showed that most male participants were not using RCH services at the time of the study. Those who did were mainly using male condoms to prevent unwanted pregnancies or reproductive tract infections, including STIs. A few men also mentioned having used services in the past to prevent or manage infertility.

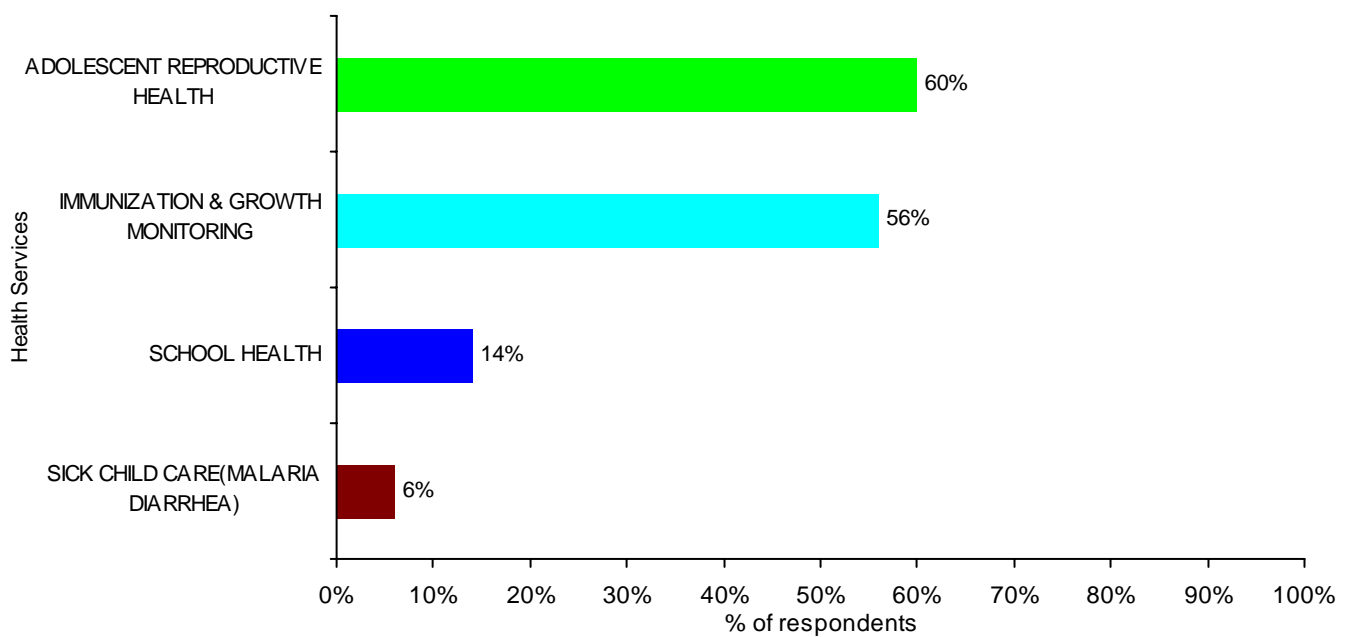
Female participants (irrespective of age) were regularly accessing RCH services since the majority of them were in the prime reproductive age category. RCH services most commonly used by participants included family planning services, safe motherhood services, and STI-HIV/AIDS management.

In terms of CH, sick child care (60%) and immunization and growth monitoring (56%) recorded the highest rates of use in the quantitative leg of the study. Antenatal care (44%) and family planning services (41%) were found to be the RCH services most commonly used. Please see the figures below.

**Figure 15: Reproductive health services used at least once in the last year**



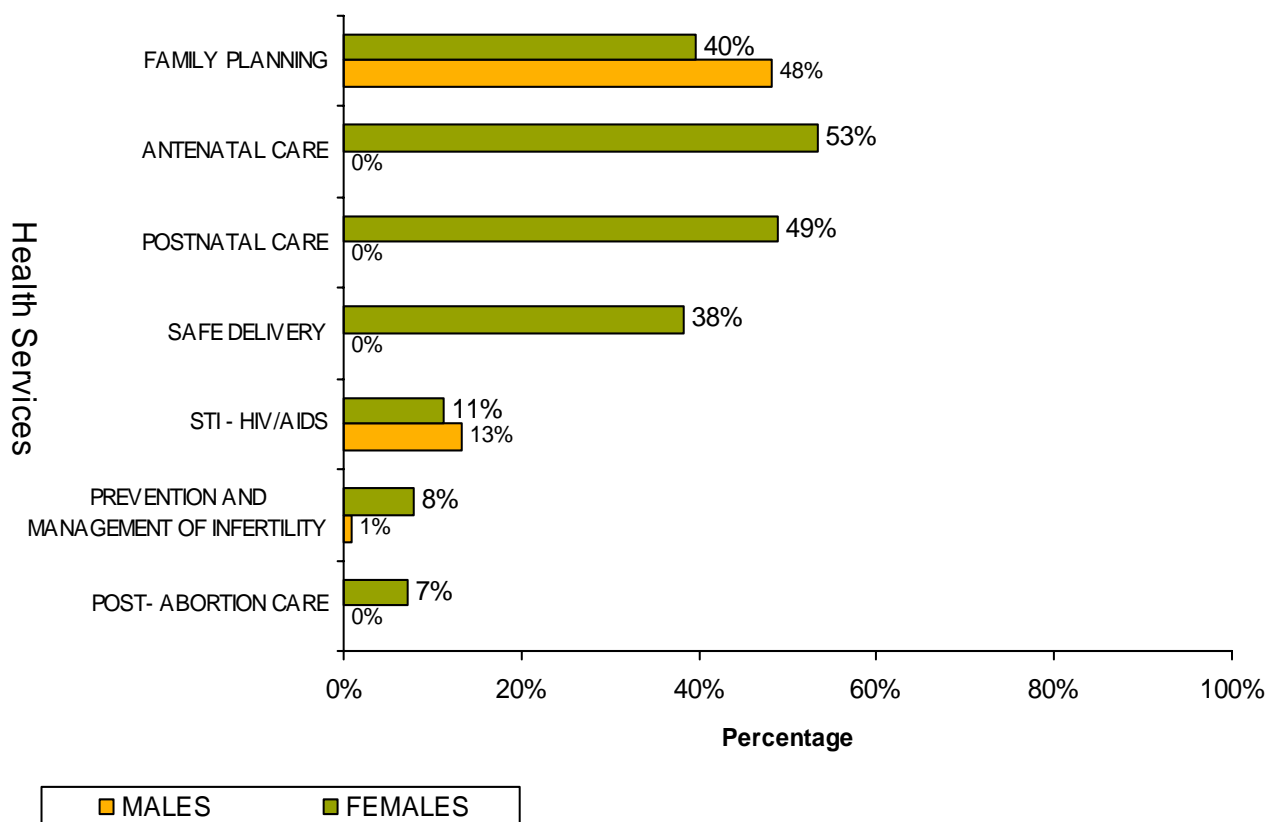
**Figure 16: Child health services used at least once in the last year**



The quantitative study showed that family planning services had high rates of use among both males and females, as shown in the figure below. This finding confirms results from the FGDs and may be attributed to the more frequent use of condoms as a form of contraception

in males compared to females. Predictably, females were found to be the sole users of antenatal and postnatal services as well as safe delivery services.

**Figure 17: Reproductive services used at least once in the last year, by gender**



Immunization and growth monitoring and sick child care were found to be patronized by both sexes; however more females patronized these services than males. This trend, also recorded during the FGDs, is likely due to the role played by females as primary caregivers for children as well as the ratio of male to female respondents in this study.

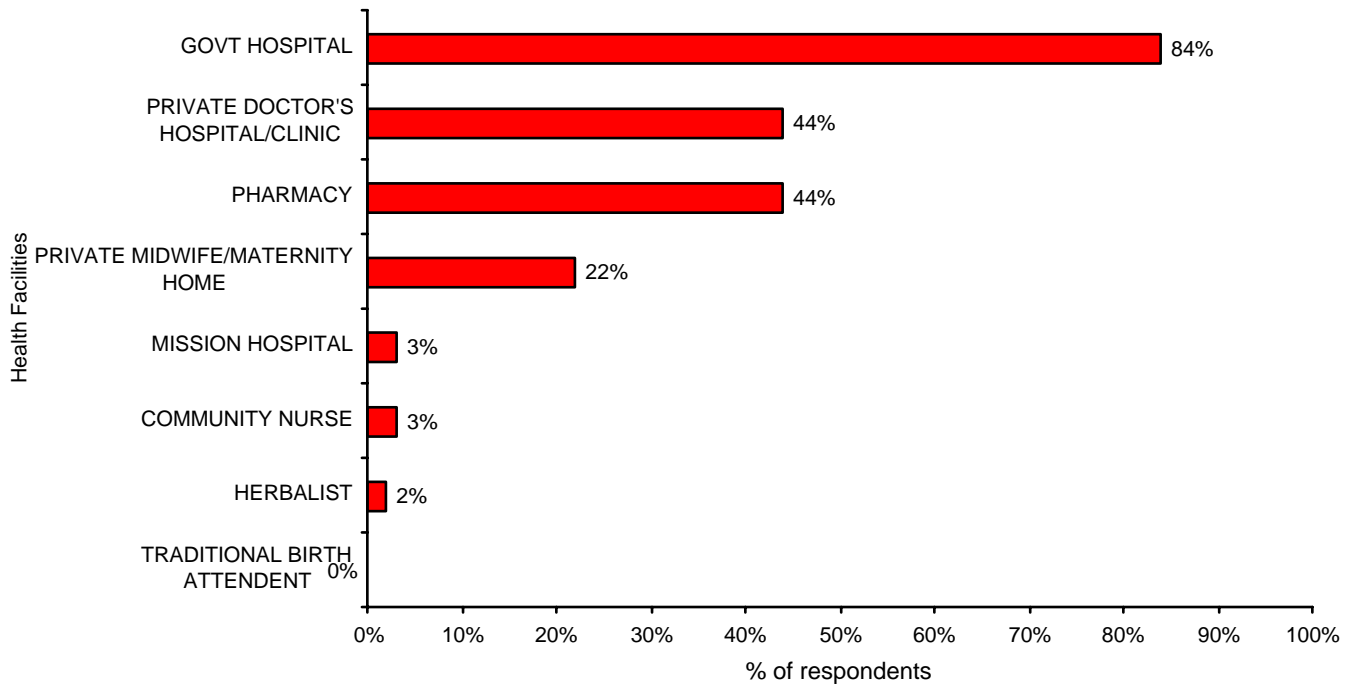
### 3.8 Types of Health Facilities Used

Results from the FGDs showed that respondents preferred using different health facility outlets for particular RH services. For example, it was found that the majority of respondents preferred using pharmacy/drug stores for the prevention and management of STIs and infertility. A few others either resorted to self-medication or the use of herbal preparations for the treatment of STIs.

As shown in the figures below, potential clients *usually used* RH services at government hospitals (84%), private doctor-run hospitals/clinics (44%) and pharmacy outlets (44%).<sup>6</sup> Compared to these three main outlets, private midwife maternities had relatively low usage (22%). The least-used service outlets for all locations were herbalists and TBAs.

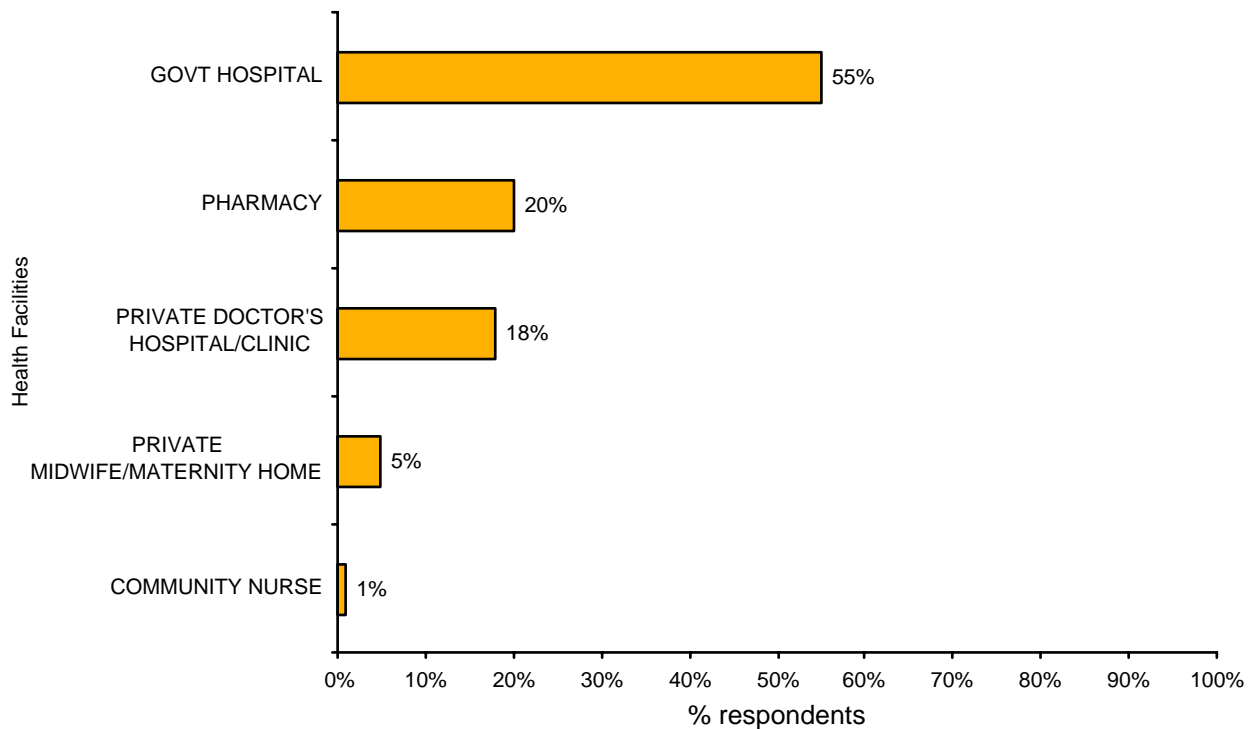
<sup>6</sup> *Usually used* health facility means the mention of one or more health facilities by respondents.

**Figure 18: Usually used health facilities for reproductive health services**



The majority of respondents also indicated government hospitals (55%) and pharmacies (20%) as their *preferred* health facilities for their RH services needs.<sup>7</sup> Five percent of respondents preferred to use midwives/maternity homes for their RH needs.

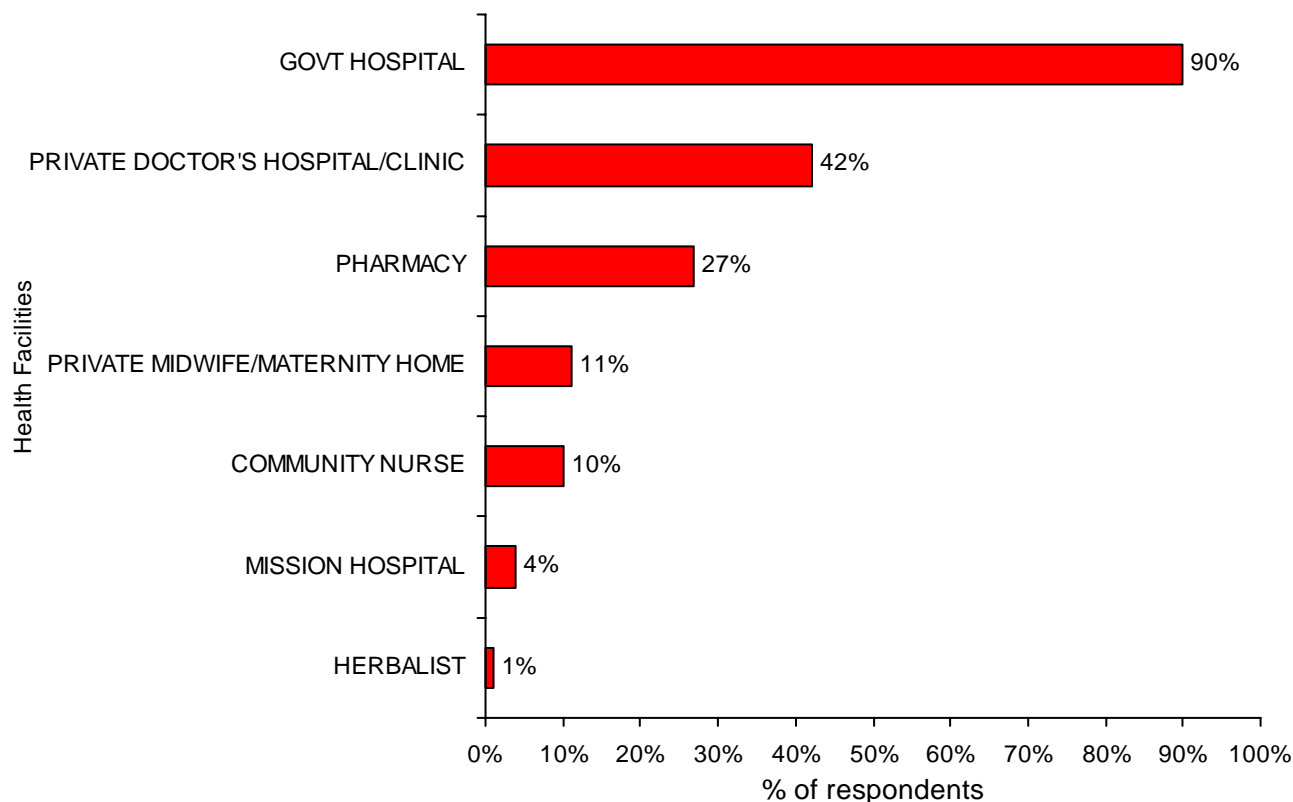
**Figure 19: Preferred health facilities for reproductive health services**



<sup>7</sup> Preferred health facility refers to the health facility that will be used under favourable socio-economic conditions)

As shown in the figure below, most respondents used government hospitals (90%) and private doctor hospitals/clinics (42%), as well as pharmacy outlets (27%), for CH service needs. Eleven percent used private midwives/maternity homes for accessing CH services. The least used service outlet was herbalists (1%).

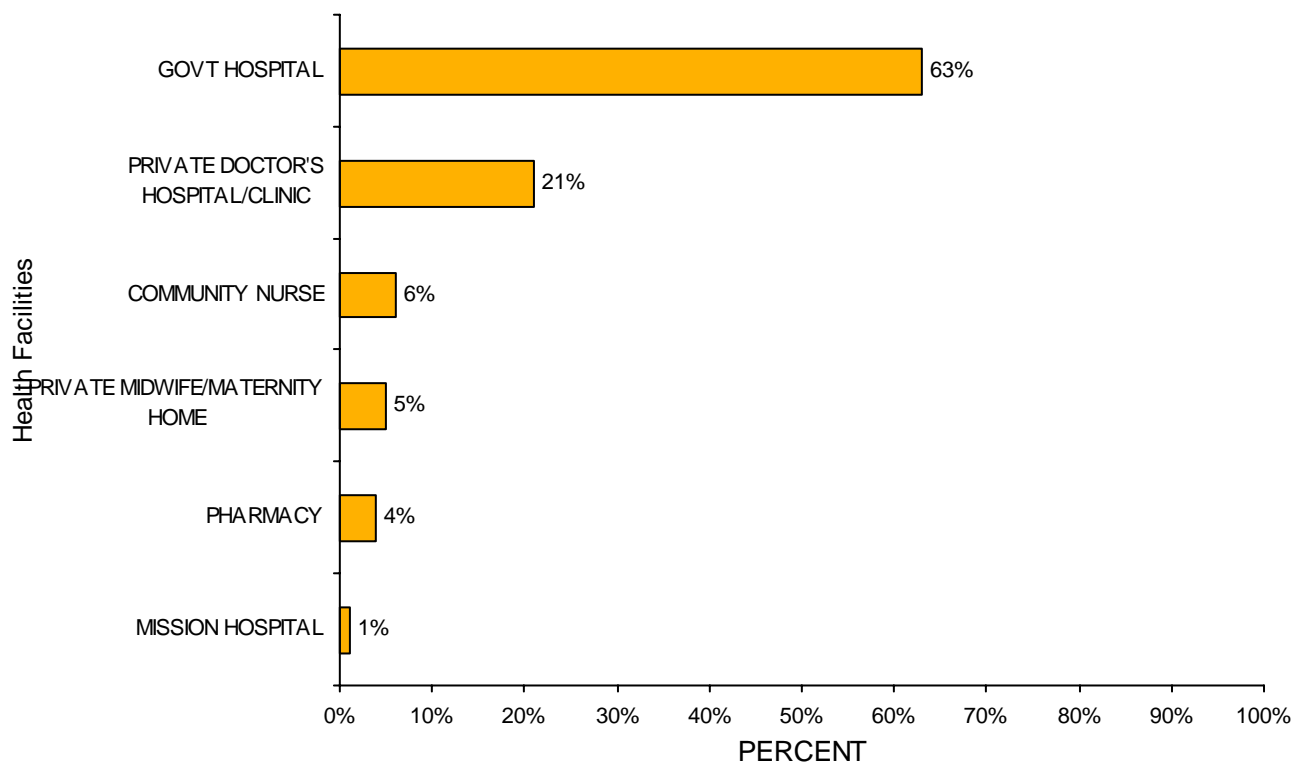
**Figure 20: Usually used health facilities for child health services**



Preferred health facilities for CH services were similar to the facilities actually used. Sixty three percent preferred government hospitals and 21% preferred hospitals with private doctors. Six percent of respondents preferred community health nurses.<sup>8</sup> Private midwives/maternity homes recorded a 5% preference and mission hospitals were the least preferred CH service outlet.

<sup>8</sup> Community health nurses are government-trained nurses who render health services from their homes or move from one residency to another in a community to render health services. Unlike private midwives, they do not have operational maternity homes or clinics and their services are restricted to first aid and the treatment of ailments such as malaria, diarrhoea, coughs, child immunization, and providing breast feeding advice etc.

**Figure 21: Preferred health facilities for child health services**



### 3.9 Perceived Benefits of Preferred Health Facilities

Participants who obtained their RCH services from public health facilities did so because:

- Their charges were moderate, and civil servants were more likely to get a refund on money spent on medical bills from their employers when they attended public hospitals for medical care.
- They were better-equipped than private health facilities and thus capable of handling more critical health problems/issues.
- They have well-trained staff/professionals.
- They stock needed drugs.
- They serve as the last resort for critically ill patients.

***“I attend the public hospital because their charges are low or moderate and they have the professionals and the facilities. To support my point, in Ghana we all know that very serious cases are treated at Korle-Bu because that is where we have the best trained doctors for our health care. So when I am sick, I like to go to the public hospital.”*** Male group, Accra

***“I go to the government hospital because I have a special problem when it comes to delivering babies, so I shouldn’t go to the private hospital. In difficult cases, when you attend the private hospitals, they refer you back to the government hospitals, so it is better to go to the government hospitals in the first place.”*** Older female group, Kumasi

Although the majority of respondents preferred accessing public health facilities to address their RCH needs, private health care facilities (i.e. clinics and maternities) were mentioned by some as their preferred source of health care for the following reasons:

- The health professionals take time to talk to patients.
- They do thorough medical examinations of patients.
- They deliver quality service.
- They are convenient.
- They treat their patients with respect.

As shown in the figure below, most potential clients preferred using government health facilities because of affordability (72%), the quality of equipment (71%) and staff qualifications (74%). Private doctor-run clinics and midwife-run maternities were mainly preferred for their good human relationships.

***“Private clinics do better with regard to the quality of service they deliver because they really take good care of you as a patient. The way they receive the patients and talk to them kindly even relieves the patients. Before you get to the doctor, you feel relieved, as compared to public hospitals where the patient’s sickness is even worsened because of the kind of treatment he receives from the nurses.” Male group. Accra***

***“If I have a lot of money, I prefer to go to the private hospital. They have a lot of time and they will not mix the drugs. They examine the child very well and know what is wrong with the child. They will let you go to the lab and all that, so they are preferable.” Older female group, Kumasi***

**Figure 22: Reasons for preferred facilities**

Reason	#s	Preferred Health Facility (%age)							
		Govt. Hospital	Mission Hospital	Private Maternity	Private Doctor	Herbalist	Pharmacy	CHM	TBA
Affordable	124	71.8	0.8	2.4	2.4	1.6	19.4	0.8	0.8
Provide quality care	105	56.2	1.0	7.6	30.5	0	4.8	0.0	0.0
Close to home	74	39.2	1.4	6.8	8.0	1.4	39.1	2.7	1.4
Good human relations	31	12.9	0	19.4	64.5	0	3.2	0	0
Thorough examination	45	40.0	0	13.3	42.1	0	4.4	0	0
Treat me with respect	22	13.7	0	13.7	63.6	0	4.5	4.5	0
Professionals	95	73.7	1.6	3.2	18.9	0	4.2	0	0
No wasting time there	62	16.1	1.6	8.1	38.7	1.6	30.7	1.6	1.6
Well-equipped with machines	42	71.4	0	7.1	21.4	0.0	0	0	0
Stock/provide all prescribed medicines	27	51.9	0.0	7.4	25.9	0.0	14.8	0	0

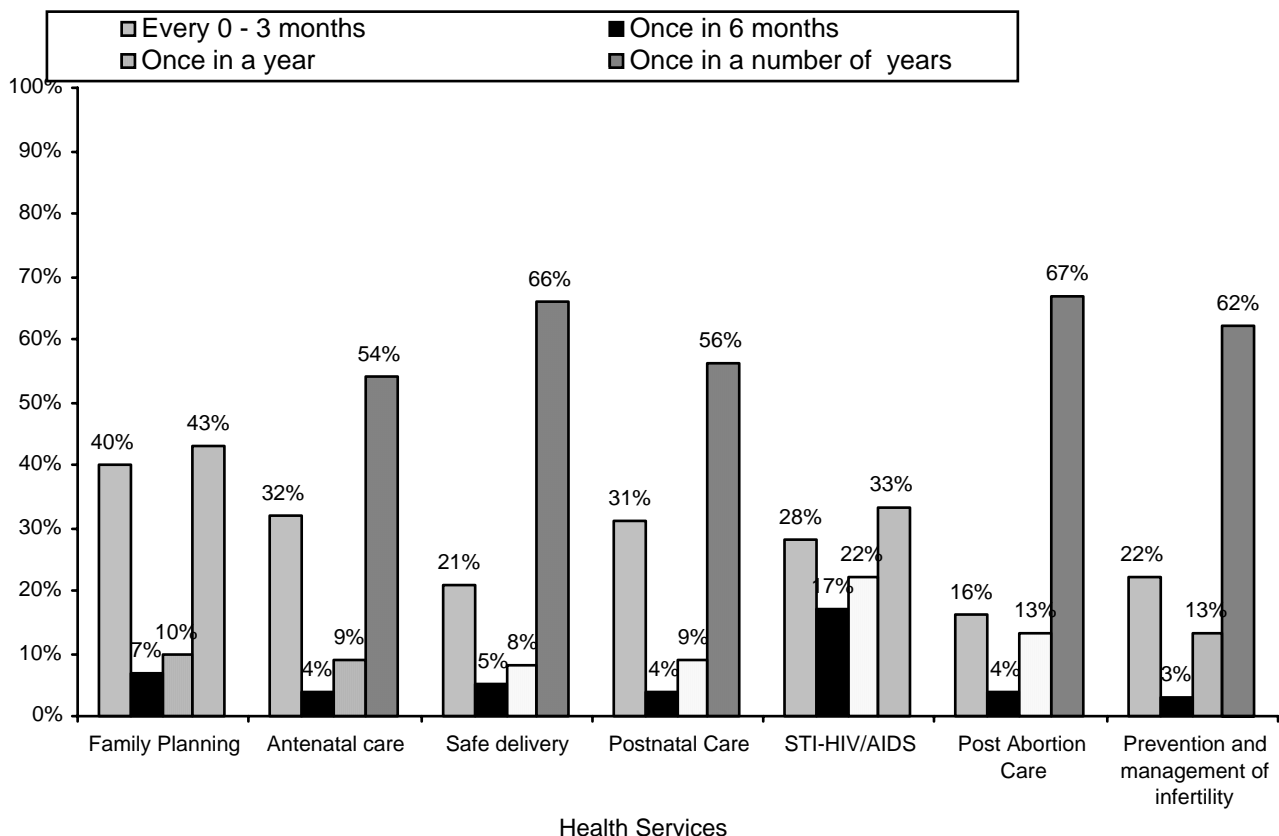
### 3.10 Frequency of Usage of Reproductive and Child Health Services

Most female participants in the FGDs mentioned utilizing antenatal services when they became pregnant, though the frequency of use depended on the health status and duration of the pregnancy. Deliveries were undertaken at maternity homes, clinics, or hospitals. Frequency of accessing delivery services largely depended on how couples practiced birth spacing. The majority of female participants mentioned going for post natal care on a monthly basis after delivery until the child was about a year old.

The frequency of accessing family planning was dependent on the birth control methods individuals had chosen. Some respondents mentioned using daily pills while others said they used injectables monthly or quarterly.

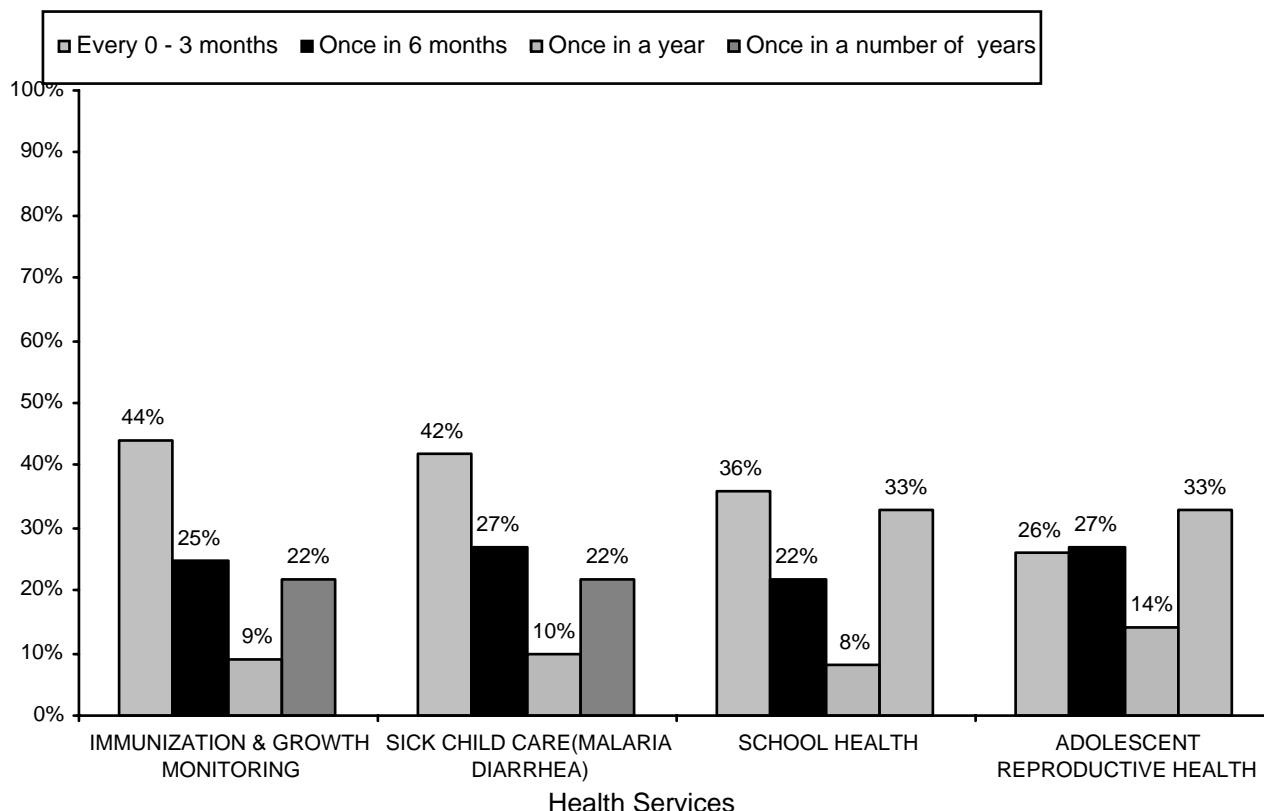
Quantification of the frequency of usage of RCH services showed the majority of the 227 respondents rarely used RH services (once in a number of years). However a number of respondents used family planning (23%), antenatal (21%), and postnatal services (20%) more regularly, at least once or twice in a month. Most respondents mentioned that the least regularly used RH services by them (meaning once in a number of years) were safe delivery (66%) and post abortion care (67%).

**Figure 23: Frequency of utilization of reproductive health services**



Of the CH services shown in the figure below, immunization and growth monitoring (25%) and sick child care (27%) were used fairly regularly (i.e. once in every six months) by the 214 respondents. School health and adolescent RH were rarely used (once per year or even less frequently).

**Figure 24: Frequency of utilization of child health services**



### 3.11 Availability of Reproductive and Child Health Services

Safe motherhood services like antenatal care, safe delivery, and post natal care were available in the maternity homes and clinics in participants’ communities. Also available were family planning services such as pills, condoms, and injectables. Patronage largely depended on one’s preference and needs. Long-term family planning methods such as Intrauterine Devices (IUDs) and Norplant were only available in bigger health facilities that were not necessarily located in respondents’ communities.

Although some maternity homes/clinics offered STI prevention and management services in respondents’ residential communities, the majority of respondents preferred to either go to bigger health facilities or to pharmacy shops. Some women also mentioned using unorthodox means for STI prevention and management, such as douching with warm water and salt and the use of antiseptic products such as TCP, Dettol, etc.

***“Most of the time if we are infected by “white” (candidiasis), we do not take it seriously. So we go to the pharmacies to ask for advice, and they sometimes suggest that we go for lab test. If it’s serious, you are then advised to go to the hospital.”***  
*Younger female group, Takoradi*

***“As for me I use dettol and something called TCP, which is mild, and is also very good for the treatment of such things”.***  
*Younger female group, Takoradi*

### **3.12 Charges for Reproductive and Child Health Services**

#### Antenatal Care

Most female participants in the Takoradi and Kumasi FGDs had not attended antenatal care in the past year so their views on the charges of services they received were not current. The few who had received treatment in the last year mentioned paying a maximum of ₵50,000 (USD \$ 5.5) on their first visit to an antenatal clinic. This amount consisted of consultation fees and a number of laboratory tests. The quantitative results, shown in Figure 25, show a somewhat lesser price of about 38,626 ₵ (USD \$4.2) for this service, on the average.

#### Delivery

Depending on the type of facility, respondents in the FGDs mentioned paying between ₵200,000 (USD \$22) and ₵300,000 (USD \$33) for normal/uncomplicated deliveries. Respondents in the quantitative section reported a lesser price, about ₵94,585 (USD \$10.4), for delivery, as shown in Figure 25. A few respondents mentioned delivering their babies at a healthcare facility (government hospital or private maternity home) free of charge, as a recently introduced service by the Ministry of Health. This category of clients only spent money on medication.

#### Postnatal Care

Participants were not charged fees for postnatal care in any of the health facilities mentioned above. Postnatal care was ideally given to mothers up to six weeks after delivery, or until the mother was deemed to have sufficiently recovered from the delivery. However, in most instances, fees were charged if the mother needed and was given extra care. Charges respondents paid for this service during the FGDs was between ₵10,000 - ₵20,000 (USD \$1.0 - \$2.0). Respondents in the quantitative study claimed to have paid more, about ₵43,333 (US \$ 4.8).

#### Family Planning

The few respondents in the FGDs who mentioned using family planning services in the public/government hospitals said they paid between ₵2,000 and ₵5,000 (USD \$0.2 – USD \$0.5) for injectables, irrespective of the duration of action of the contraceptive. Those on IUDs paid about ₵15,000 (USD \$1.6). The quantitative study showed that respondents paid about ₵31,210 (USD \$3.4) for these services, irrespective of private or public facilities.

#### STIs

The few respondents in the FGDs who accessed services for the management and treatment of reproductive tract infections (vaginal discharges) said they spent about ₵200,000 (USD \$22) at private doctor-run clinics. Respondents in the quantitative section indicated paying about ₵93,333 (USD \$10.25) for this service.

#### Prevention and Management of Infertility

Respondents in the quantitative section of this study paid about ₵71,600 (US \$7.9) for the prevention and management of infertility.

**Figure 25: Mean charges for reproductive and child health services**

Service	# of Respondents	ASHANTI (Cedis)	GREATER ACCRA (Cedis)	WESTERN (Cedis)	Average (Cedis)	Average (USD)
<b>Reproductive Health</b>						
Antenatal care	131	30,233	40,533	55,385	38,626	4.2
Safe delivery	96	108,372	81,220	90,833	94,583	10.4
Post natal care	120	45,349	38,971	66,667	43,333	4.8
STI & HIV/AIDS	36	102,963	35,000	88,000	93,333	10.3
Post abortion care	21	75,000	73,750	72,000	73,810	8.1
Infertility treatment	25	100,000	64,000	15,000	71,600	7.9
<b>Child Health</b>						
Immun. & growth	67	8,261	14,717	14,000	12,874	1.4
Sick child care	179	78,689	75,050	83,529	77,095	8.5
School health	43	5,000	7,333	22,000	8,605	0.9
Adolescent RH	18	40,000	46,923	None	45,000	4.9

### 3.13 Composition of an Ideal Reproductive and Child Health Care Package

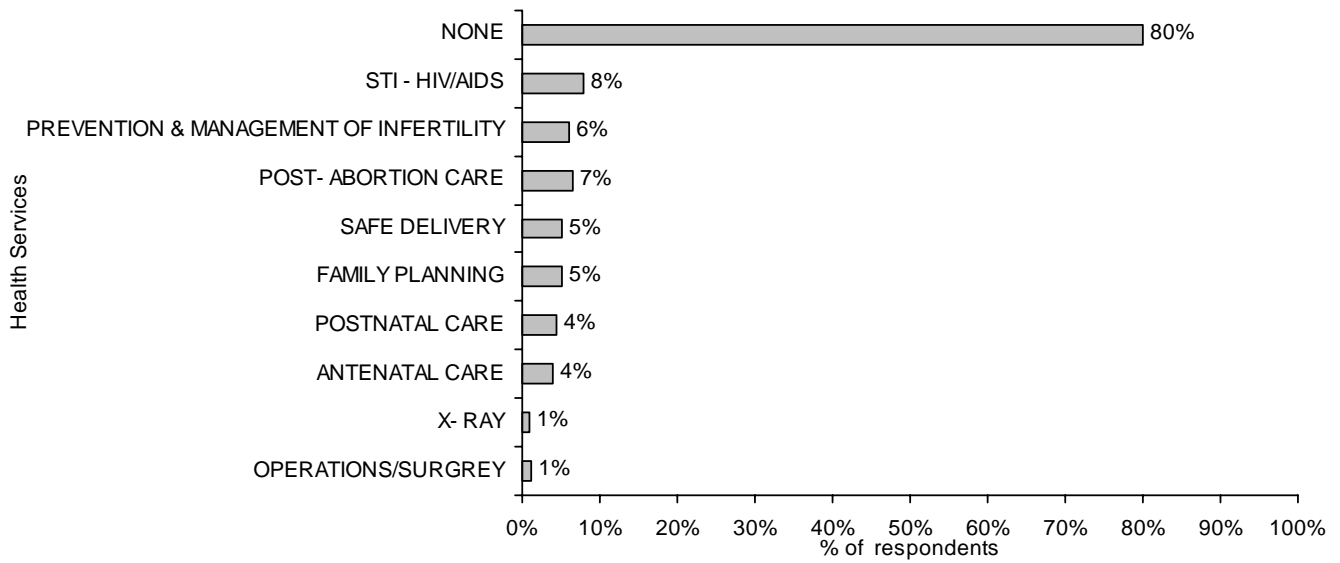
Participants had difficulty defining an ideal RCH service package because their awareness and knowledge of available RCH services was low - limited mainly to safe motherhood, immunisations, and family planning. Rather, participants made suggestions for the improvement of available services. Some of the suggestions were as follows:

- Increase public education on RCH services
- Spouses should be encouraged to get involved in safe motherhood services
- RCH services should be made affordable
- Train more health professionals to handle RCH services
- Health workers in the public sector should be more friendly

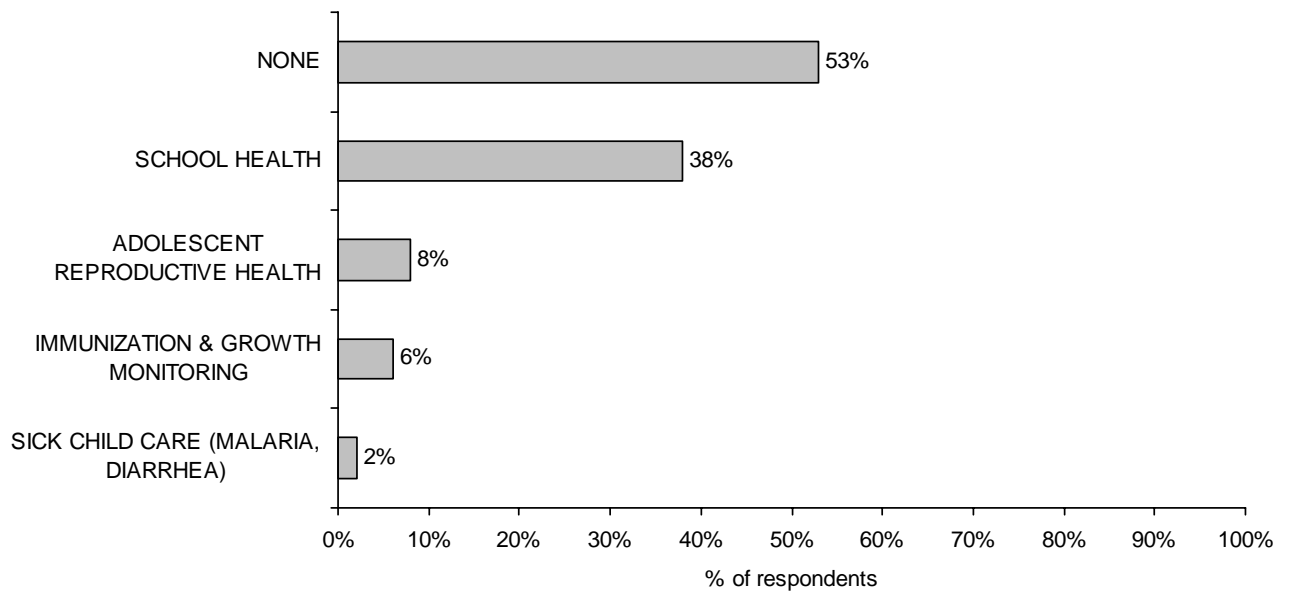
### 3.14 Gaps in the Provision of Reproductive and Child Health Services

Given the low awareness and knowledge of RCH services, potential clients could not identify any significant gaps in service provision. As shown in the figures below, the great majority of the 300 respondents were unable to identify desired RCH services that were unavailable at their usual health facility.

**Figure 26: Desired but unavailable reproductive health services**



**Figure 27: Desired but unavailable child health services**

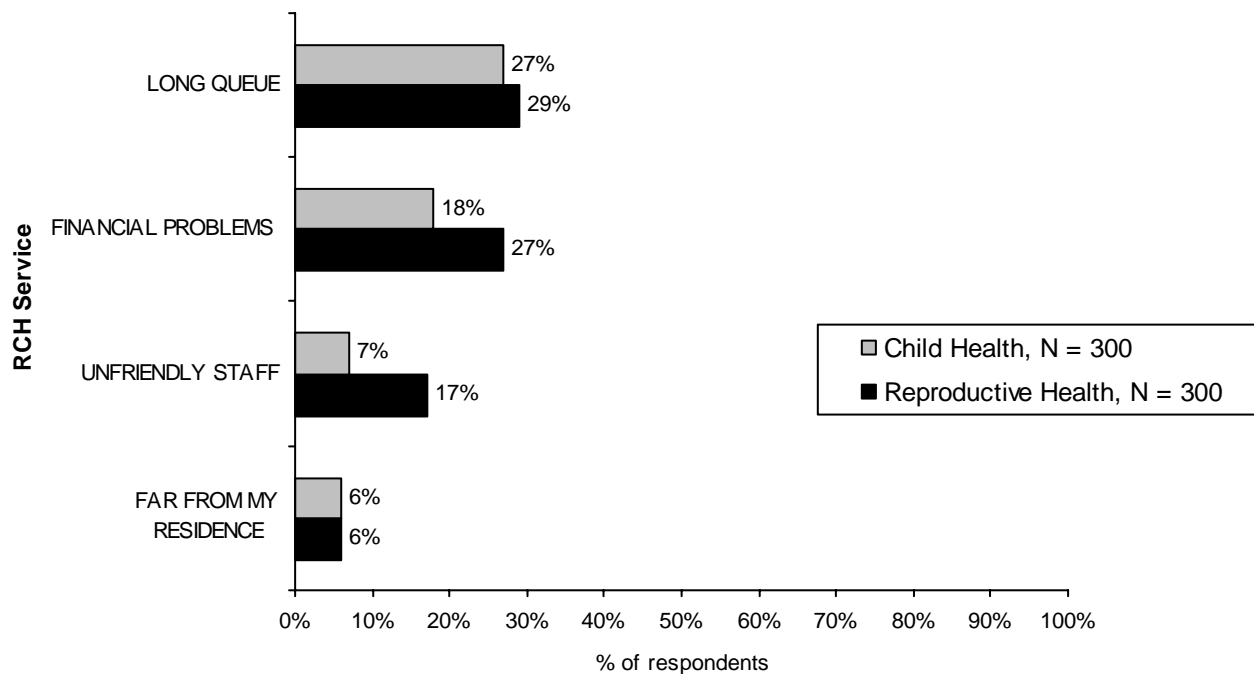


### 3.15 Barriers to Utilizing Reproductive and Child Health Services

Charges for health care in general and RCH services in particular were perceived to be high because of the cash and carry system (direct out-of-pocket cash payment for health services). Respondents said this affects their access to general health care services in the country (irrespective of whether from a private or government health facility).

The quantitative study found that the most important barrier or problem with RCH services was long queues at their regular health facilities. This was followed by relatively high charges for services, unfriendly staff, and the locations of health facilities that were rather distant from the homes.

**Figure 28: Barriers to utilizing reproductive and child health services**



## 4. FINDINGS ON SOCIAL FRANCHISING

Awareness of social or commercial franchising was very low among participants, irrespective of gender and location. The very few (who were most often males) who had heard of the term “franchising” defined it in political terms.

***“When I was in school I heard the word “franchising” in terms of government, and in government it means the right a person has to vote, but I don’t know in terms of health ” Male group, Accra***

### 4.1 Views About Franchising

The proposal to introduce franchising into the delivery of RCH services in Ghana was perceived by most participants, irrespective of gender and location, to be a good and timely idea. For some participants, franchising of RCH care services was seen as possibly leading to an increase in specialisation among health care providers, thereby diversifying specific skills and reducing the stress on specific health care facilities. Some participants thought that franchising RCH services was more appropriate for public health care facilities because these facilities, and especially those in the hinterlands or rural areas, do not have adequate equipment to run basic tests nor do they have doctors to run the facilities. Another point was the need to franchise the whole health care delivery system in Ghana because the health care system needs to be improved to enhance the quality of service delivered in all types of facilities. Yet another group of participants expressed the fear that franchising the private health facilities would result in those facilities being used exclusively by the few rich people in Ghana. Finally, the franchising idea was perceived by some as a good way to ensure uniformity in the delivery of health services in both private and public/government health care facilities.

### 4.2 Benefits of Franchising

The perceived benefits of a franchised program to participants were:

- Reduction in the existing gap between the quality of service provided by private and public health facilities
- Improved health delivery system because: 1) the workload of health care providers would reduce and therefore reduce stress; 2) better facilities/equipment would be available; and 3) trained health personnel might be provided for the facility by the franchisor
- Increased confidence in the quality of service received, irrespective of service type or where received
- Need to travel shorter distances to access RCH services
- Access to more moderately-priced drugs
- More moderate cost of accessing RCH services throughout Ghana

In general, respondents felt the current health system did not offer adequate services in all health facilities (both private and public), even considering that some provide better quality service than others. Respondents thought those who provided quality services have capitalised on the situation to charge high prices, making it unaffordable for most Ghanaians. They felt that a franchised program for RCH services would increase the number of quality RCH service providers who would offer their services at a moderate, standard cost, thus making quality RCH services more affordable for most Ghanaians.

Potential clients surmised that the benefits of franchising RCH services for health care providers would be:

- Gaining knowledge to build upon one's experience
- Building clients' confidence in the services they provide their customers
- Increased patronage and productivity of small health care facilities
- Increased returns therefore increased remuneration for service providers

***“I think..... it will solve the issue of monopoly whereby service providers in the system have been monopolizing or taking advantage of it. It will create a uniform situation because standards have been established and they have to be kept. Everywhere you go you are going to be treated in a particular way and this is what you have to pay for such services” Male group, Accra***

***“It will help because the services are going to be the same. Not like the private and public hospitals where the services are not the same. I think it will also prevent people from travelling long distances before going to the government hospitals for care. They can go to the private hospitals.” Older female group, Kumasi***

***“I also think it will help us immensely because both private and government hospitals will meet the same standards and you would have to pay the same amount for the services you receive everywhere” Younger female group, Takoradi***

### 4.3 Barriers to Franchising

Perceived disadvantages/disincentives to franchising are the possibilities that:

- Conditions of the contract or the mode of operations will not favour private health care facilities
- New standards of operations will be lower than the present system, leading to loss of patients and mistrust among clients
- The good name that entrepreneurs have built for themselves over the period of practice may be soured

Based on the opinions of participants, the probability of participants switching from their current sources of RCH services to a franchised source of RCH services largely depended on the following:

- The cost of accessing the franchised RCH service in a given health care facility: It is generally expected that eventually health care facilities operating under the National Health Insurance Scheme will not collect money from their clients for health care services so respondents reasoned that the cost of health care in a franchised facility cannot be high.
- The quality of service delivered to their clientele: They were likely not to patronise the franchised RCH services if they perceived their current quality of health care to be of a better/higher quality than that of the franchised facility.

## 5. CONCLUSIONS

### 5.1 Potential Franchisees of Reproductive and Child Health Services

All potential franchisees interviewed in this study believed they were currently providing quality health services to their clients. They cited measures such as regular supervision of medical staff and assistants and adherence to regulations and guidelines as examples of their dedication to quality. Nonetheless, the majority of potential franchisees (and especially midwives) were interested in improving upon the quality of their health services and welcomed initiatives that would help them do so.

Awareness and understanding of social franchising and other forms of franchising programs were low amongst both private medical doctors and midwives. After the social franchising concept had been explained to respondents, a majority stated their interest and willingness to join a franchised program for RCH services. However, the level of enthusiasm/interest and willingness to join the program expressed by doctors was much lower than that of midwives. This is because most doctors, while supporting the franchising of RCH services as a good concept, were more skeptical about joining such a program, mainly because of the unknown term/conditions that could be attached to such an arrangement. Most midwives, on the other hand, readily stated their preferences to join a franchised RCH program.

Various factors and barriers were identified by both doctors and midwives as capable of affecting their decision to join a franchised program. These were:

- The terms and conditions of the franchising program agreement - this was mainly associated with what profits and benefits could be gained, rather than the services involved in the program
- Strength of the franchisors' brand (image) should be more than what franchisees themselves have developed
- The benefits that franchisees and clients would derive from the franchised package
- Origin (country) of the franchising organization: Franchisors from Western Europe and North America were named as more respected than those from Eastern Europe
- The group to which the franchising organization is affiliated or represents
- Respondent's age: A few doctors were old and not interested in managing any new health service scheme or program.
- Governmental influence/involvement: Specifically, the potential that government's influence or involvement might make such a program unattractive because of previous delays in the implementation of similar such programs by the government (for example the National Health Insurance Scheme)

Barriers were cited as:

- Unwillingness of well-established private health facilities to share decision-making with a franchising organization or allow regular supervision
- Unwillingness of Ghanaian institutions to contribute/pay royalties to organizations other than their own
- Perception of the franchising concept as having a commercial motive
- Feeling of self sufficiency/sustainability already established
- The possibility of being cheated by the franchising organization
- The inability to pay back loans/royalties to franchisor should there be a reduction in patient volumes

Most health facilities visited offered the following RCH services:

- Family planning

- Antenatal and postnatal care
- Delivery
- Prevention and management of HIV/AIDS and STIs
- Immunization and growth monitoring
- Sick child care

Generally, respondents indicated that client volumes had decreased over year preceding the study. Sick child care was most utilized and family planning services were least utilized. Doctors attributed this decline to the poor economic situation in the country, which has resulted in the inability of most Ghanaians to afford services from private health care facilities. Midwives, on the other hand, attributed the decline to the increased number of health facilities in their operational locations. Some doctors were confident that the introduction of both private and public health insurance schemes would enable people to afford the services of private health facilities.

At both private doctor-run clinics and midwife-run maternity homes, charges for delivery services were the highest of all RCH services. Family planning services had the lowest charges. Low family planning charges were likely due to the fact that most family planning services demanded by patients were short-term contraceptives such as condoms, pills, and injectables.

The majority of respondents believed they were providing all necessary RCH services, though a few doctors and midwives were interested in, and strongly wanted to add, services not currently available at their facilities, such as:

- Safe delivery
- Oxygen for newborn babies
- Laboratory services
- Pharmacies
- Ultra sound scanning services
- Immunization services

## **5.2 Potential Clients of Reproductive and Child Health Services**

Potential clients of franchised RCH services, though all of whom had very limited knowledge about franchising of health services before explanation was provided as part of this study, expressed interested in receiving services from franchised RCH health facilities. They believed it would enable both the rich and poor in society to access quality RCH services at moderate, standard prices at private clinics and maternity homes throughout the country.

The majority of potential clients were unable to identify desired RCH services currently unavailable at their regular health facilities. This can be attributed to the fact that many of them were unaware of services that constitute an RCH package. Most potential clients thought only of family planning, antenatal care, and immunization services.

Medical charges emerged as the main driver in the choice of facility, though not choice of service. Clients expressed preference for accessing services from government clinics/hospitals where fees and charges were relatively lower than at private clinics and maternities. In general, charges for RCH services mentioned by potential clients were lower than those given by potential franchisees. This disparity is likely due to the fact that responses about service charges were rough estimates by both parties.

On the whole, respondents used services such as family planning and antenatal and postnatal services more frequently (about twice in a month) than other services. Sick child

care and immunization and growth monitoring services were used about once every six months.

Finally, most potential clients preferred to access RCH services from government hospitals because of affordability, and the availability of highly-trained professionals and better equipment at the government hospitals. On the other hand, the majority of potential clients who preferred private health facilities did so because of the good human relations they experienced there and the shorter waits for service.

## 6. RECOMMENDATIONS

There is a place in the market for the introduction of franchised RCH services. Any interested stakeholder who has the intention of improving access to these services in Ghana should implement a franchising system for RCH services in the target regions. This recommendation is primarily based on the fact that most respondents in this study were interested in joining or receiving services from a franchising program if the conditions involved were favourable to them.

Given the factors and barriers mentioned as capable of affecting potential franchisees decision to join a franchised program, it is recommended that the franchisor ensure that the terms and conditions attached to the franchising agreement are attractive, meaning the franchisor should choose terms/conditions that will ensure benefits such as the provision of quality and moderately-priced drugs, affordable royalties, and provision of financial assistance at low interest rates (about 2% per annum) for facility expansion. Potential franchisees stated that these were important factors that they would weigh when deciding whether to join a franchised program.

Based on potential franchisees' and clients' low levels of awareness of the social franchising concept, the concept should be considered new to the country's health system. Therefore it is recommended that, prior to the implementation of a franchised program for RCH services in Ghana, a marketing program be developed to educate potential franchisees and clients about the franchised RCH services concept and how it works in health service delivery. This will facilitate better understanding and increase acceptance of the concept, and thus ease implementation. In addition, potential clients should be educated on the exact composition of franchised RCH services and the facilities where they can use these services.

It is also recommended that the franchisor use media (television, radio and print) and medical professionals to create awareness about franchised RCH services to achieve maximum impact, as these media were mentioned as the most accessible and trusted by potential clients.

Given that the majority of potential franchisees made little or no mention of providing RCH services listed in the Ghana Health Policy guidelines, it is recommended that these unmentioned services (herein referred to as "gaps") be included in an ideal franchised RCH package. As referred to above, potential clients should be educated about these services because potential franchisees might not have mentioned the gaps because there is lack of demand for such services by their clients. These RCH service gaps are:

- Prevention and management of unsafe abortions and post-abortion care
- Prevention and management of infertility
- Prevention and management of cancers of the female and male reproductive system, including breast cancer
- Responding to concerns about menopause and andropause
- Discouraging harmful traditional practices and gender-based violence that affect the reproductive health of women and men
- Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conception care and sexual health.
- School health
- Adolescent RH

Having considered the issues of service charges, client volumes, identified RCH service gaps, and the desired addition of certain services to their current range of services, it is recommended that, in order to ensure effective RCH service provision, cost recovery, and

profitability by potential franchisees, franchisors should consider the following ideal RCH packages for different service providers.

**Figure 29: Ideal franchised reproductive and child health service packages**

<b>Package 1: Ideal RCH package for private doctor-run clinics</b>	
1.	Family planning services
2.	Delivery services
3.	Antenatal and postnatal services
4.	Prevention and management of unsafe abortions
5.	Sick child care
6.	Prevention and management of cancers of the female and male reproductive systems including breast cancer
7.	STI – HIV/AIDS management
8.	Responding to concerns about menopause and andropause
9.	Prevention and management of infertility
11.	Circumcision
12.	School health
13.	Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conception care, and sexual health
14.	Discouragement of harmful traditional practices and gender-based violence that affect the reproductive health of women and men
<b>Package 2: Ideal RCH package for private midwife-run clinics</b>	
1.	Family planning services
2.	Delivery services
3.	Antenatal and postnatal services
4.	Prevention and management of unsafe abortions
5.	Sick child care
6.	Adolescent reproductive health
7.	STI – HIV/AIDS management
8.	Responding to concerns about menopause and andropause
9.	Breastfeeding (education/counselling)
10.	Immunization and growth monitoring
11.	Circumcision
12.	School health
13.	Information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conception care, and sexual health
14.	Discouragement of harmful traditional practices and gender-based violence that affect the reproductive health of women and men

Given that medical charges emerged as potential clients' main driver in the selection of a health facility (resulting in more patronage of public health facilities), it is suggested that the franchisor conducts market research to determine the optimum prices potential clients will pay for franchised RCH services. This will allow the franchise to appeal to potential clients from both private and public health facilities.

## APPENDICES

## Appendix 1: Potential Franchisees by Region

Name of health facility	Qualification of interviewee	Role in health facility	Source of income
<b>Accra/Tema Region</b>			
<b>Private doctors</b>			
North Ridge Clinic	MBA/Post Grad in Obstetrics/Gynaecology	Gynaecologist/obstetrician in charge of facility	Real estate/Medical practice
Vicoms Specialist Clinic	Post grad studies in Obstetrics/Gynaecology	Gynaecologist/obstetrician in charge of facility	Medical practice
Trinity Clinic	Medical Doctor	General practitioner in charge	Medical practice
Jubail Clinic	Postgraduate	Gynaecologist/obstetrician in charge of facility	Medical practice
Odorna Clinic	Postgraduate	Administrator	Medical practice
Baeta Memorial Clinic	Postgraduate, Accident surgery	General practitioner in charge of facility	Medical practice
Tudu Clinic	No data obtained	General practitioner in charge of facility	Medical practice
Dansoman Central Clinic	No data obtained	General practitioner in charge of facility	Medical practice
Karikari Brobbey Hospital	Postgraduate Obstetrics/Gynaecology	Gynaecologist in charge of facility	Medical practice
Philips Clinic	Postgraduate	General practitioner in charge of facility	Medical practice
St Andrew's Clinic	General Practitioner	Director of Operations/Doctor in charge	Medical practice
<b>Private Midwives</b>			
Amanda Maternity Home	Midwife/Senior nursing officer	Midwife/Senior nursing officer in charge of facility	Proceeds from maternity home
Cyndan Maternity Home	Midwife	Data not obtained	Proceeds from maternity home
North Kaneshie Maternity Home	SRN	Midwife	Proceeds from maternity home and private school
St. Maurice Maternity Home	SRN	Midwife	Proceeds from maternity home
Gloria Family Health Centre	SRN	Director /Midwife	Proceeds from maternity home
Mother Love Maternity Home	Data not obtained	Midwife	Proceeds from maternity home
Hannah Larbi Maternity Home	Data not obtained	Midwife	Proceeds from maternity home
Mayfair Clinic & Maternity Home	Data not obtained	Midwife	Proceeds from maternity home
Henrietta Maternity Home	SRN	Senior nursing officer/ Midwife	Proceeds from maternity home

Name of health facility	Qualification of interviewee	Role in health facility	Source of income
<b>Kumasi Region</b>			
<b>Private doctors</b>			
Oforikrom Clinic	Obstetrician /Gynaecologist	Doctor in charge	Medical practice
Kuffour Clinic	Obstetrician/ Public Health	Senior medical officer & decision maker	Medical practice and other sources
Bomso Clinic	Obstetrician	Main decision maker	Medical practice
Asafo Adjei Clinic	MBCHB with specialization in Piles	Main decision maker	Medical practice
<b>Private midwives</b>			
Queen Victoria Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Comfort Maternity	Enrolled Nurse/ Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Holy Rosary Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Vibro Maternity	Nursing officer	Midwife in charge & main decision maker	Proceeds from maternity home
Queen of Peace Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Majero Maternity	Enrolled Nurse/ Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Baby Pearl Maternity Clinic	SRN/midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Sophia Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Victory Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Mama Rose Danquah Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home and remittances from children
Charlotte Maladaga Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
<b>Takoradi Region</b>			
<b>Private doctors</b>			
Our Lady's Clinic	Gynaecologist/ obstetrician	Doctor in charge/ main decision maker	Medical practice and other sources
West End Clinic	Medical Practitioner	Doctor in charge/ main decision maker	Medical practice
<b>Private midwives</b>			
Stratsford Maternity and Clinic	Midwifery / neonatal care	Midwife in charge & main decision maker	Proceeds from maternity home
Jemima's Maternity Home	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Abayie-By His Grace Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Mrs Akoto Maternity	Midwifery	Midwife in charge & main decision maker	Proceeds from maternity home
Twin City Maternity	Community health nursing	Midwife in charge & main decision maker	Proceeds from maternity home
Cudjoe Maternity	Data unavailable	Main decision maker	Data unavailable

## Appendix 2: Estimated Charges for Reproductive and Child Health Services

PRIVATE DOCTORS					
CLINIC NAME	LOCATION	SERVICES	CONSULTATION FEES (FIRST TIME CLIENT) IN CEDIS	CONSULTATION FEES (REGULAR CLIENT) IN CEDIS	OTHER FEES CHARGED
Tudu Clinic	Accra	Family Planning	100,000	20,000-30,000	No Data
		Antenatal	100,000	20,000-30,000	No Data
		Delivery	100,000	20,000-30,000	No Data
		Postnatal	100,000	20,000-30,000	No Data
		Sick Child Care	100,000	20,000-30,000	No Data
		STI Management	100,000	20,000-30,000	No Data
Philip Clinic	Accra	Family Planning	40,000-95,000	40,000-95,000	No Data
		Antenatal	40,000-95,000	40,000-95,000	No Data
		Delivery	40,000-95,000	40,000-95,000	No Data
		Postnatal	40,000-95,000	40,000-95,000	No Data
		Sick Child Care	40,000-95,000	40,000-95,000	No Data
		STI Management	40,000-95,000	40,000-95,000	No Data
St Andrew's Clinic	Accra	Family Planning	50,000(Monthly)	No fees charged within a month of first visit	No data
		Antenatal	50,000(Monthly)	Same as above	No data
		Delivery	50,000(Monthly)	Same as above	No data
		Postnatal	50,000(Monthly)	Same as above	No data
		Sick Child Care	50,000(Monthly)	Same as above	150,000-170,000
		STI Management	50,000(Monthly)	Same as above	200,000
North Ridge Clinic	Accra	Family Planning	270,000	240,000	Guess estimates could not be given
		Antenatal	270,000	240,000	Same as above
		Delivery	270,000	240,000	Same as above
		Postnatal	270,000	240,000	Same as above
		Sick Child Care	270,000	240,000	Same as above
		STI Management	270,000	240,000	Same as above
Trinity Clinic	Accra	Family Planning	30,000	No extra charge within a week of first visit	No Data
		Antenatal	30,000	Same as above	30,000-140,000
		Delivery	30,000	Same as above	No Data
		Postnatal	30,000	Same as above	No Data
		Sick Child Care	30,000	Same as above	No Data
		STI Management	30,000	Same as above	No Data
Bomso Clinic	Kumasi	Family planning	120,000-150,000	No Data	No Data
		Antenatal	120,000-150,000	No Data	110,000
		Delivery	120,000-150,000	No Data	600,000
		Postnatal	120,000-150,000	No Data	110,000
		Sick Childcare	120,000-150,000	No Data	250,000
		STI Management	120,000-150,000	No Data	350,000
Oforikrom Clinic	Kumasi	Family planning	100,000	No Data	No Data
		Antenatal	100,000	No Data	30,000-80,000

		Delivery	100,000	No Data	No Data
		Postnatal	100,000	No Data	No charge
		Sick Childcare	100,000	No Data	40,000-60,000
		STI Management	100,000	No Data	30,000-50,000
Asafo Adjei Hosp.	Kumasi	Family planning	No fees charged	No fees charged	No data
		Antenatal	No fees charged	No fees charged	No data
		Delivery	No fees charged	No fees charged	350,000-400,000
		Postnatal	No fees charged	No fees charged	60,000-100,000
		Sick Childcare	No fees charged	No fees charged	40,000-150,000
		STI Management	No fees charged	No fees charged	No data
West End Clinic	Takoradi	Family planning	20,000(monthly)	No fees charged within a month of first visit	No data
		Antenatal	20,000(monthly)	Same as above	50,000
		Delivery	20,000(monthly)	Same as above	No data
		Postnatal	20,000(monthly)	Same as above	80,000
		Sick Childcare	20,000(monthly)	Same as above	40,000-150,000
		STI Management	20,000(monthly)	Same as above	No data
Our Lady's Clinic	Takoradi	Family planning	Service not offered	Service not offered	Service not offered
		Antenatal	16,000	10,000	30,000 -150,000
		Delivery	No charge	No charge	200,000-1,800,000
		Postnatal	No charge	No charge	10,000
		Sick Childcare	14000	14000	120,000
		STI Management	14000	14000	60,000
<b>Private Midwives</b>					
<b>Maternity</b>	<b>Location</b>	<b>Service</b>	<b>Consultation first time client in Cedis (¢)</b>	<b>Consultation regular client in Cedis (¢)</b>	<b>Overall Charge in cedis (¢)</b>
Henrietta Maternity	Accra	Family planning	20,000	No charge	10,000-40,000
		Antenatal	20,000	No charge	40,000-up
		Delivery	20,000	No charge	350,000-up
		Postnatal	20,000	No charge	No Data
		Sick Childcare	20,000	No charge	50,000-up
		STI Management	20,000	No charge	No Data
Hannah Larbi Maternity	Accra	Family planning	No Data	No Data	5,000
		Antenatal	No Data	No Data	30,000-40,000
		Delivery	No Data	No Data	350000-400,000
		Postnatal	No Data	No Data	10,000
		Sick Childcare	No Data	No Data	35,000-40,000
		STI Management	No Data	No Data	45,000
Gloria Family Health Centre	Accra	Family planning	15,000(Card charge)	No charge	No Data
		Antenatal	15,000(Card charge)	No charge	Depends on mother's condition
		Delivery	15,000(Card charge)	No charge	400,000-500,000
		Postnatal	15,000(Card charge)	No charge	No Data

		Sick Childcare	15,000(Card charge)	No charge	No Data
		STI Management	15,000(Card charge)	No charge	No Data
Baby Pearl Maternity	Kumasi	Family Planning	10,000	No charge	6,000
		Antenatal	10,000	No charge	15,000
		Delivery	No charge	No charge	130,000-150,000
		Postnatal	No charge	No charge	No Charge
		Sick Childcare	10,000	No charge	No Data
		STI management	10,000	No charge	No Data
Comfort Maternity	Kumasi	Family Planning	No charge	No charge	10,000
		Antenatal	No charge	No charge	15,000
		Delivery	No charge	No charge	130,000
		Postnatal	No charge	No charge	5,000
		Sick Childcare	No charge	No charge	21,000-40,000
		STI management	No charge	No charge	No Data
Queen Victoria Maternity	Kumasi	Family Planning	No charge	No charge	5,000
		Antenatal	No charge	20,000-60,000	No Data
		Delivery	No charge	No charge	130,000-250,000
		Postnatal	No charge	No charge	No Data
		Sick Childcare	No charge	No charge	75,000-150,000
		STI management	No charge	No charge	45,000-85,000
Majero maternity	Kumasi	Family Planning	No charge	No charge	5,000-15,000
		Antenatal	No charge	No charge	25,000-35,000
		Delivery	No charge	No charge	130,000-200,000
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No charge	No charge	55,000-60,000
		STI management	No charge	No charge	No Data
Queen of Peace Maternity	Kumasi	Family Planning	25,000	8,000	No Data
		Antenatal	No charge	No charge	10,000-20,000
		Delivery	No charge	No charge	130,000-150,000
		Postnatal	No charge	No charge	No Data
		Sick Childcare	50,000	No Data	10,000-up
		STI management	10,000	No Data	No Data
Shalom Maternity	Kumasi	Family Planning	5,000	10,000	No Data
		Antenatal	15,000	No charge	5,000-10,000
		Delivery	No charge	No charge	150,000
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No Data	No Data	7,000-40,000
		STI management	No Data	No Data	15,000
Vibro Maternity	Kumasi	Family Planning	10,000-25,000	8,000	No data
		Antenatal	25,000	10,000	No data
		Delivery	No data		120,000-220,000
		Postnatal	Free	Free	Free
		Sick Childcare	No data	No data	10,000-25,000

		STI management	No data	No data	25,000-35,000
Mama Rose Danquah Maternity	Kumasi	Family Planning	All inclusive	All inclusive	2,000-25,000
		Antenatal	15,000	15,000	20,000
		Delivery	No data	No Data	200,000
		Postnatal	No charge	No charge	No charge
		Sick Childcare	All inclusive	All inclusive	25,000-35,000
		STI management	No charge	No charge	No charge
Mary Dabanka Maternity	Kumasi	Family Planning	No data	No data	No data
		Antenatal	No data	No data	10,000-30,000
		Delivery	No data	No data	Free delivery exemption
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No data	No data	20,000-25,000
		STI management	No data	No data	No data
Abiye God's Grace Maternity	Takoradi	Family planning	No charge	No charge	5,000
		Antenatal	No charge	No charge	10,000-33,000
		Delivery	Free delivery exemption	Free delivery exemption	Free delivery exemption
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No charge	No charge	20,000-30,000
		STI Management	No charge	No charge	No data
Kudjoe Maternity	Takoradi	Family planning	No Data	No Data	No Data
		Antenatal	No Data	No Data	40,000
		Delivery	No Data	No Data	250,000
		Postnatal	No Data	No data	No data
		Sick Childcare	No data	No data	No data
		STI Management	No data	No data	10,000-20,000
Mrs. Akoto's Maternity	Takoradi	Family Planning	No charge	No charge	10,000-20,000
		Antenatal	No charge	No charge	20,000
		Delivery	No charge	No charge	150,000-250,000
		Postnatal	No charge	No charge	5,000 (payment for drugs)
		Sick Childcare	No charge	No charge	15,000-25,000
		STI Management	No charge	No charge	No data
Jemima Maternity	Takoradi	Family planning	No charge	No charge	No data
		Antenatal	No charge	No charge	30,000-54000
		Delivery	No charge	No charge	200,000-300,000
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No charge	No charge	46,000-70,000
		STI Management	No charge	No charge	50,000

Stratford Maternity	Takoradi	Family Planning	No data	No data	No data
		Antenatal	30,000	20,000	No data
		Delivery	No charge	No charge	120,000 – 210,000
		Postnatal	No charge	No charge	No charge
		Sick Childcare	No charge	No charge	40,000 – 90,000
		STI Management	20,000	20,000	60,000 – 80,000
Twin City mat. Home	Takoradi	Family planning	55,000	30,000	No data
		Antenatal	55,000	No data	No data
		Delivery	Service not offered	Service not offered	Service not offered
		Postnatal	55,000	30,000	No data
		Sick Childcare	55,000	30,000	35,000-55,000
		STI Management	55,000	30,000	80,000-180,000

### Appendix 3: Contribution of RCH Services to Facility Income

Figure: Approximate percentage contribution of RCH services to total income of health facility (private doctors)

No.	Facility	Percentage contribution
<b>Private Doctors</b>		
1.	Dansoman Central Clinic	25%-33.3%
2.	Trinity Clinic	Unable to estimate percentage contribution
3.	Karikari Brobbey Hospital	Unable to estimate percentage contribution
4.	Beata Memorial Clinic	No data
5.	North Ridge Clinic	Unable to estimate percentage contribution
6.	Tudu Clinic	No data
7.	Philip Clinic	30%
8.	St. Andrews Clinic	Unable to estimate percentage contribution
9.	Bomso Clinic	Unable to estimate percentage contribution
10.	Oforikrom Clinic	80%
11.	Asafo Adjei Clinic	No data
12.	Our Lady's clinic	Unable to estimate percentage contribution
13.	West End Clinic	30%
<b>Private Midwives</b>		
1.	Charlotte Maledaga Maternity	No data
2.	Doreen Ashiavor Maternity	Unable to estimate percentage contribution
3.	Gloria Abbey Maternity	50%
4.	Henrietta Maternity	Unable to estimate percentage contribution
5.	Hannah Larbi Maternity	Unable to estimate percentage contribution
6.	Baby Pearl Maternity	Unable to estimate percentage contribution
7.	Comfort Maternity	60%
8.	Victoria Maternity - Angloga	100%
9.	Majero Maternity	100%
10.	Mama Rose Danquah Maternity	33%
11.	Queen of Peace Maternity	No data
12.	Mary Dabanka Maternity	Unable to estimate percentage contribution
13.	Shalom Maternity	50%
14.	Vibro Maternity	90%
15.	Victoria Maternity - Anyija	25%
16.	Abayie Maternity	70%
17.	Jemiama Maternity	60%
18.	Kudjoe Maternity	20%
19.	Mrs Akoto Maternity	90%
20.	Stratsford Maternity	No data
21.	Twin City Maternity	30%

## Appendix 4: Source of Reproductive and Child Health Clients

	Percentage Referrals from Government Hospitals	Percentage Walk- ins	Percentage Referrals from Commercial/ Industrial Institutions	Other
<b>Private Doctors</b>				
Asafo Adjei Clinic	No data	No data	No data	No data
Baeta Memorial Clinic	No data	No data	No data	No data
North Ridge	None	40	60	None
Philips Clinic	None	20	80	None
Bomso Clinic	Unwilling to estimate	Unwilling to estimate	Unwilling to estimate	Unwilling to estimate
Dansoman Central Clinic	No data	No data	No data	No data
Twin City Clinic	5	60	35	None
Karikari Brobbey Hospital	No data	No data	No data	No data
Tudu Clinic	No data	No data	No data	No data
Trinity Clinic	No data	No data	No data	No data
Our Lady's Hospitals	No data	No data	No data	No data
Oforikrom Clinic	None	90	None	None
St. Andrews Clinic	No data	No data	No data	No data
<b>Private Midwives</b>				
Baby Pearl Maternity	None	45	15 - 25	None
Comfort Maternity	No data	No data	No data	No data
Gloria Abbey Maternity	10	80	10	None
Kudjoe Maternity	No data	No data	No data	No data
Mary Dabanka Maternity	No data	No data	No data	No data
St. Mary's Maternity	No data	No data	No data	No data
Vibro Maternity	10	50	None	40
North Kaneshi Maternity	No data	No data	No data	No data
Hannah Larbi Maternity	No data	No data	No data	No data
Queen Victoria Maternity	10	94	None	None
Majero Maternity	None	100	None	None
Mother Love Maternity	No data	No data	No data	No data
Queen Of Peace Maternity	None	90	None	10
Victoria Maternity	No data	No data	No data	No data
Charlotte Maledaga Maternity	No data	No data	No data	No data
Henrietta Maternity	No data	No data	No data	No data
Mama Rose Danquah	No data	No data	No data	No data
Mrs. Akoto Maternity	None	95	None	5
Shalom Maternity	None	10	90	None