

ASSESSING THE QUALITY OF PRIMARY HEALTH CARE PROVIDED BY ACCREDITED SERVICE PROVIDERS IN THE UPPER EAST REGION, GHANA

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Abstract

This study examines the issue of delivery of quality health services in the Bawku Municipality, Ghana. Globally, health quality is increasingly becoming an important aspect of health care.. Patients have become more aware of quality issues and want health care to become safer and of higher quality where the providers have a moral obligation to provide quality and safe care. In many parts of Ghana, studies of patient satisfaction and experiences with health care are carried out regularly, and the results are made available to the public together with other indicators of health care quality but the case in Bawku is different as there is little research regarding the quality of delivery and patient satisfaction rating on the facilities. Hence, this study used a mixed methodology to assess the quality of primary health care provided by Bawku Presbyterian Hospital, Vineyard Hospital & Quality Medical Centre. The findings indicate that Ghana Health Service has put in place Quality Assurance systems and structures. Generally, the facilities in Bawku adhere to those standards and services provided by the target facilities are considered satisfactory. However, the absence of visible quality assurance teams in some facilities is not the best. It has therefore been recommended that quality assurance teams be made more effective and efficient. Besides, conditions of service of staff should be improved as well as the physical structure of some of the facilities to ensure delivery of quality services.

Keywords: Health management, Quality, Patient satisfactions, Hospitals

INTRODUCTION

The concern of financing health care to ensure quality in the delivery process has dominated global healthcare discourse for some time now. The issue of financing healthcare in Ghana has journeyed far from pre-independence to the First Republic under the Convention Peoples Party (CPP) Government, through the 'Cash and Carry' period under the Provisional National Defense Council (PNDC) and the National Democratic Congress (NDC) Government, to the present health insurance regime under the New Patriotic Party (NPP) led Government, and is still being improved upon by the current NDC led Government, for the betterment of Ghanaians.

At the time the CPP Government was overthrown, Ghanaians were enjoying free healthcare in line with the Socialist philosophy of the CPP Administration. After the overthrow of the CPP Administration, there was a sweeping reversal of Healthcare financing in Ghana. Under the National Liberation Council (NLC), Ghanaians were asked to pay for their own healthcare; hence the emergence of the 'cash and carry' system in the country. Under the 'Cash and Carry' system, patients were required to pay for drugs and some medical consumables whenever they visited hospital, while the State bore all other costs including consultation, salaries and emoluments for Doctors, Nurses and other healthcare workers in state hospitals. 'Cash and Carry' also provided for free medical care for the aged above 70 years of age, children under five years and pregnant women for their ante-natal care, all under an exemption programme implemented with that system.

The challenge since 1981 has been how to find the best combination of Government-Peoples-Partnership that would meet each other part of the way and satisfy the needs and pockets of Ghanaians as well as the Government's finances in the healthcare sector. Finding an alternative to 'cash and carry', as a means of healthcare financing in Ghana began in 1996 with pilot projects in the Dangme West District in the Greater Accra Region and Nkoranza District of the Brong Ahafo Region.

In 2001, the conceived new healthcare financing regime of a health insurance scheme was put to fruition with a statutory enactment of the National Health Insurance Act, Act 650 of 2003 and the establishment of a National Health Insurance Scheme (NHIS) in 2004 under a National Health Insurance Authority (NHIA) with a Governing Council. This has been the system of healthcare financing in Ghana for the past ten years. The National Health Insurance Scheme (NHIS) was thus, established to provide financial access to healthcare services that meet basic quality standards.

However, the provision of quality health care has always been a great challenge to any health delivery system, including national health insurance schemes, of which the Ghana National Health Insurance Scheme is no exception.

The introduction of the National Health Insurance Scheme has led to a tremendous increase in out-patient-department attendance with no corresponding changes in the health care infrastructure and number of trained health professionals among others. Nevertheless, there is a great deal of progress in people's understanding of health care quality, and there is growing interest which is supported by growing demands from clients for greater accountability in the delivery of primary healthcare services, all paying attention on making sure the health of the entire citizenry is improved. As Berwick (1989) emphasized, "the health care delivery systems need to include a strong emphasis upon continually improving three specific types of quality indicators: the efficacy of care (knowing what works), appropriateness of care (doing what works) and the execution of care (doing well what works)."

Statement of the Problem

There have been frequent complaints from patients about the poor quality of the services they receive at the primary health care facilities in the country. "Poor quality health care causes loss of lives, loss of revenue, low morale among health workers and poor image of health care providers" (Bannerman et al, 2002). Consequently, quality health care is increasingly becoming an important aspect of health care that is given priority these days. Patients have become more aware of quality issues and want health care to become safer and of higher quality. In many countries, studies of patient satisfaction and experiences with health care are carried out regularly, and the results are made available to the public together with other indicators of health care quality but the case in Ghana is not the same.

The improvement of quality health care is central to the reforms of health systems and service delivery. All countries face some challenges to ensure access, equity, safety and participation of patients, and to develop skills, technology and evidence-based medicine within available resources. Apparently, literature abounds on the assessment of the quality of care provided to various patients especially in the developed countries. The scenario is not quite different in developing countries, Ghana being no exception.

The National Health Insurance Authority in Ghana is concerned about quality of Primary health care, but improvements in quality have been slow partly because quality improvement activities have received inadequate priority amongst some NHIS accredited service providers. There have been efforts to research into quality of primary health care and institutionalisation of quality assurance in Ghanaian health facilities. These were initiated through a project from 1993–1996 and then 1998–1999 in the Upper West Region and some facilities in Eastern and Volta Regions. There continue to be complaints about the quality of care given by health workers or received by clients.

Indeed, the impact of poor quality service delivery is obvious: the loss of patients' lives, revenue, material resources, time, morale, staff, recognition, trust and respect and in individual and communities' apathy towards health services, all of which reduce the effectiveness and efficiency. The Ministry of Health has identified improving the quality of healthcare as one of its five key objectives of health sector reforms in Ghana. It envisages that quality of health care might be improved through paying more attention to the perspectives of clients, improving the competencies and skills of providers and improving working environment by better management, provision of medical equipment and supplies and motivation of staff.

In Ghana, quite scanty attention has been given to research on the quality of primary health care since the inception of the National Health Insurance Scheme in the country as a whole and in the Upper East Region in particular. Yet the implementation of the NHIS has led to significant increases in the number of health care providers as well as attendance by clients without a corresponding improvement in health infrastructure and equipment as well as human resource. This has resulted in extra workload; over-stressed staff, excessive pressure on existing amenities and reduced attention to patients. The situation in the Bawku Municipality is even more serious in view of the fact that facility attendance has increased considerably over the years while the numerical strength of health professionals has remained virtually at a standstill. That situation has necessitated the researcher to conduct a study into "Assessing the Quality of Primary Health Care Provided by Accredited Service Providers under the National Health Insurance Scheme: A Case Study Of some Selected Primary Health Care service Providers in the Bawku Municipality".

Objectives of the Study

1. To evaluate the quality assurance measures being implemented by the selected accredited service providers in the Bawku Municipality of the Upper East Region
2. To evaluate patients satisfaction on the services provided by the health care service providers in the Bawku Municipality of the Upper East Region.

LITERATURE REVIEW

Theoretical Framework of the Study

This study seeks to adopt Beauchamp and Childress' Four Principles of biomedical ethics as the theoretical framework in assessing primary healthcare delivery in the target District. The Four Principles are general guidelines that leave considerable room for judgment in specific health cases. These principles articulate a fundamental commitment on the part of health care professionals to protect their patients from harm.

The Four Principles are general guides that leave considerable room for judgment in specific health cases. These principles are discussed below under the three principles.

The Principle of Respect for Autonomy

Any notion of moral decision making assumes that rational agents are involved in making informed and voluntary decisions. The principle of respect for autonomy entails taking into account and giving consideration to the patient's views on his/ her treatment. In health care decisions, respect for the autonomy of the patient would mean that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would militate against a free and voluntary act. This principle is the basis for the practice of "informed consent" in the physician/patient transaction regarding health care. An autonomous decision does not have to be the 'correct' decision from an objective viewpoint, otherwise individual needs and values would not be respected. However an autonomous decision is one that is informed that is, the patient given enough information, in a manner that she/he can comprehend. Respect for Autonomy is not an all or nothing concept. For instance, the patient may not be fully autonomous and not legally competent to refuse treatment but this does not mean that ethically his/her views should not be considered and respected as far as possible.

However, the principle of respect for patient autonomy acknowledges the right of a patient to have control over his or her own life – and this would include the right to decide who should have access to his/her personal information.

The Principle of Beneficence

The ordinary meaning of this principle is the duty of health care providers to be of a benefit to the patient, as well as to take positive steps to prevent and to remove harm from the patient. These duties are viewed as self-evident and are widely accepted as the proper goals of medicine. These goals are applied both to individual patients, and to the good of society as a whole. For example, the good health of a particular patient is an appropriate goal of medicine, and the prevention of disease through research and the employment of vaccines is the same goal expanded to the population at large.

It is sometimes held that non-maleficence is a constant duty, that is, one ought never to harm another individual whereas beneficence is a limited duty. A physician has a duty to seek the benefit of any or all of her patients, however, the physician may also choose whom to admit into his or her practice, and does not have a strict duty to benefit patients not acknowledged in the panel. This duty becomes complex if two patients appeal for treatment at the same moment. Some criteria of urgency of need might be used, or some principle of first come first served, to

decide who should be helped at the moment. This principle considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

The Principle of Non-maleficance

The principle of non-maleficance requires that health providers do not intentionally create a needless harm or injury to the patient, either through acts of commission or omission. In common language, it is considered as negligence if a physician imposes a careless or unreasonable risk of harm upon a patient. Providing a proper standard of care that avoids or minimizes the risk of harm is supported by both moral convictions and the laws of society as well. In a professional model of care a health official may be morally and legally blameworthy if he fails to meet the standards of due care. The legal criteria for determining *negligence* are as follows:

1. the professional must have a duty to the affected party
2. the professional must breach that duty
3. the affected party must experience a harm; and
4. the harm must be caused by the breach of duty.

This principle affirms the need for medical competence. It is clear that medical mistakes occur however; this principle articulates a fundamental commitment on the part of health care professionals to protect their patients from harm. In short, do no harm to the patient.

The Principle of Justice

A theory of justice for health and healthcare raises three central questions. First, is healthcare special? Is it morally important in ways that justify the fact that many societies distribute healthcare more equally than many other social goods? Second, when are health inequalities unjust? After all, many socially controllable factors besides access to healthcare affect the levels of population health and the degree of health inequalities in a population. Third, how can we meet competing healthcare needs fairly under reasonable resource constraints? Universal access to appropriate healthcare, that is a just healthcare, does not break the link between social status and health a point driven home in studies of the effects on health inequality of the British National Health Service (Black et al. 1988; Acheson et al. 1998; Marmot et al. 1998), and confirmed by work in other countries as well (Kawachi, Kennedy, and Wilkinson 1999).

Our health is affected not simply by the ease with which we can see a doctor, though that surely matters, but also by our social position and the underlying inequality of our society. We cannot, of course, infer causation from these correlations between social inequality and

health inequality. Suffice to say that, while the exact processes are not fully understood, the evidence suggests that there are social determinants of health (Marmot 1999).

The principle of justice in health care is usually defined as a form of equity and fairness, or as Aristotle once said, "Giving to each that which is his due." This implies the fair distribution of goods in society and requires that we look at the role of entitlement. The question of distributive justice also seems to hinge on the fact that some goods and services are in short supply, there is not enough to go around, thus some fair means of distributing the scarce resources must be determined.

It is generally held that persons who are equals should qualify for equal treatment. This is borne out in the application of Medicare, which is available to all persons over the age of 65 years. This category of persons is equal with respect to this one factor, their age, but the criteria chosen says nothing about need or other noteworthy factors about the persons in this category. In fact, our society uses a variety of factors as a criterion for distributive justice, including the following:

1. to each person an equal share
2. to each person according to need
3. to each person according to effort
4. to each person according to contribution
5. to each person according to merit
6. to each person according to free-market exchanges

John Rawls and others claim that many of the inequalities we experience are a result of a "natural lottery" or a "social lottery" for which the affected individual is not to blame, therefore, society ought to help even the playing field by providing resources to help overcome the disadvantaged situation. One of the most controversial issues in modern health care is the question pertaining to "who has the right to health care?" Or, stated another way, perhaps as a society we want to be beneficent and fair and provide some decent minimum level of health care for all citizens, regardless of ability to pay.

Quality of Care: the Praxis Dimension

The issue of quality delivery of health services has gained momentum internationally. For instance, the Health Committee of the Council of Europe established a committee of experts on quality way back in 1995. This committee drafted recommendations to ministers of health (adopted in 1997) that the governments of Member States should establish a quality improvement system and should: "create policies and structures, where appropriate, that support the development and implementation of quality improvement systems, i.e., systems for

continuously assuring and improving the quality of health care at all levels” (Dandhi, R. 1997: 25). The resolution was based on the concept that receiving health care of good quality is a fundamental right of every individual and every community, implicit in Article 11 of the European Social Charter on the right to the protection of health, and Article 3 of the Convention on Human Rights and Biomedicine that requires Contracting Parties to provide “equitable access to health care of appropriate quality”. (Dandhi, R. 1997: 25)

National Reviews

In the late 1990s, prompted by mounting evidence of quality failures, public demands and increasing costs, several countries set up task forces to examine the existing national approach to quality and to recommend improvements as were necessary. The general conclusions were that statutory and voluntary quality systems should be coordinated with national or local governments in order to ensure valid standards, reliable assessments, consumer involvement, demonstrable improvement, transparency, and public access to quality criteria, procedures and results.

Improving quality requires commitment at all levels of the health care industry. Health care organizations, professionals, and other participants in the health care system must make quality improvements the driving force of the industry. Many government initiatives to improve quality, especially in developing countries, are part of packages of reform in public health and primary care. Some emerge from efforts to maintain and improve standards of care while controlling costs and encouraging competition, and some are aimed at establishing public accountability and restoring public confidence in the face of emerging evidence of health system failures. The dominant motive is shaped by the public–private division of the funding and delivery of services, by the balance of central or local control, and by public and professional attitudes to regulation in general.

Accreditation Programmes

Many countries have adopted external accreditation of health services as a vehicle for disseminating national standards and for public accountability. Traditionally, in Australia, Canada and the United States these programmes were begun by voluntary collaboration of clinical associations (especially medical) and hospital administrators as a means of organizational development. More recently, they have also been driven by reimbursement schemes, central control, and an emphasis on primary care, health networks and community-based services as opposed to self-management.

In developing countries, many governments support quality values such as access, equity, and effectiveness in general statements of policy, but few have published comprehensive strategies for quality improvement across the board. Proposals and plans tend to be specific responses to current problems rather than proactive, long-term, comprehensive blueprints which may appeal more to academics than to politicians.

The case of Ghana seems somewhat different. The Ghana health Services under the aegis of the Ministry of Health appears to place emphasis on the need for quality health care delivery over the years. Indeed, "The Ghana Health Service has as one of its main objectives, the improvement in quality of care at all service delivery points" (Akosa, as cited in Ofie & Bannerman et al, 2004: iii). The Service places premium on the following as components of health quality delivery: Access to all; Technical competence on the part of service providers; Equity in delivery for all who need the services; Effectiveness by providing care that brings about change; Efficiency in providing high quality service at minimal cost; Continuity as when a patient's records are properly kept and s/he gets services even beyond the provider when need arises; Safety in the reduction of injuries, infections, harmful side effects and other dangers to clients and to staff; and social amenities that can ensure the comfort of patients. (Ofie & Bannerman et al 2004).

However, studies on actual quality of health care in Ghana suggest that all is not well in terms of quality of services provided. A study on quality of healthcare delivery was conducted by Turkson (2009). The study aimed at finding out clients' perceptions of the quality of healthcare delivery at the district level in rural Ghana, using the Komenda-Edina- Eguafo-Abrem District as a case study. The study reports that generally the quality of healthcare delivery was perceived to be high for most of the indicators used. There were, however, some concerns that patients were not told the diagnosis or informed about the management of their illness. Another study by a former Director General of the Ghana Health Services suggested that the quality of primary health care delivery is saddled with many obstacles. "Our ability to provide quality healthcare service delivery depends on quality information available at the right time in the right place to the right person" (Nyonator, Frank as cited in Vibe Ghana 18th Dec.2011) such difficulties stemmed from the health facilities dependence on paper-based systems which often translates into chains of errors in the record, classification, translation, timeliness and accuracy of reports on patients. Changing technology was identified as an obstacle as staff needed to adapt more quickly to and embrace the available technology to better position the providers to deal with emerging diseases. Besides, inadequacies and weaknesses in human resource and institutional capacity for information management was identified in the literature. Yet another research conducted by SEND Foundation Ghana (2010) expanded their focus to examine the impact of

National Health Insurance on quality health care provision in the country. The objective was to assess the rate of subscription to the NHIS in the selected districts, and quality of health care provided to clients of the scheme. The study was conducted in 44 selected districts from four regions, Greater Accra, Northern, Upper West and East Regions. The findings indicate that more than three-quarters of the accredited NHIS health care facilities, representing 76 per cent, said the scheme had negative effects on quality health care delivery. It said accredited health care providers stated that implementation of the NHIS had negatively affected their ability to acquire medicines both in terms of quality and quantity to cope with the increasing attendance. The findings said in the three Northern Regions, the average NHIS clients to a medical doctor ratio rose from 5,845 in 2006 to 21,663 in 2008 while the average NHIS clients to a nurse ratio also swelled from 208 to 743 during the same period. It revealed delays in the issuance of NHIS identity cards to clients resulting in some not accessing health care services adding 27 per cent clients in Northern, 34 per cent in Upper West and 13 per cent in Greater Accra Regions could not access health care services because of the delays in issuing identity cards. The findings said contrary to views of managers of health care facilities, District Mutual Health Insurance Schemes considered the NHIS to be inappropriate for the promotion of scheme sustainability because of the high tariffs service providers charged.

However, little empirical research has been conducted to examine the issue of quality delivery in the Bawku Districts and this is partly because of the protracted nature of the conflict there. The only work done in the area sought to examine the impact of the conflict on development of the area. The study, conducted by Hamidu (2012), suggests that access to quality medical care at the Presbyterian Hospital by most patients from the rural areas was threatened because of insecurity. The study also reveals that the state of insecurity affected the implementation of vital projects such as those meant to combat the menace and stigma of HIV/AIDS and other related projects by national and International aid-agencies. The downside of that study is that it did not delve into the various aspects of quality healthcare delivery and customer satisfaction.

Quality Assurance: Structures and Processes

The necessity for quality assurance initiatives permeates health care systems the world over. According to the Institute of Medicine (IOM) report, *To Err Is Human*, the majority of medical errors result from faulty systems and processes, not individuals. Processes that are inefficient and variable, changing case mix of patients, health insurance, differences in provider education and experience, and numerous other factors contribute to the complexity of health care quality assurance.

In most Western countries, quality assurance (QA) became the common term during the 1980s and served well with the Donabedian concepts of examining health care quality as an element of structure, process and outcome. Quality assurance refers to all activities that contribute to defining, designing, assessing, monitoring, and improving the quality of health care. Quality assurance means “to assure quality in a product so that a customer can buy it with confidence and use it – with confidence and satisfaction” (Kaoru Ishikawa).

Quality assurance has been always the primary concern of quality initiatives, but the vehicle has evolved from “quality by conformance” towards “quality by design” and “quality by management”. Because errors are often caused by system or process failures, it is important to adopt various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. Each of these techniques involves assessing performance and using findings to inform change.

The complexity of health care systems and delivery of services, the unpredictable nature of health care, and the occupational differentiation and interdependence among clinicians and systems make quality assurance difficult. One of the challenges in using measures in health care is the attribution variability associated with high-level cognitive reasoning, discretionary decision making, problem-solving, and experiential knowledge. Another measurement challenge is whether a near miss could have resulted in harm or whether an adverse event was a rare aberration or likely to recur.

Consequently, Total quality management (TQM) came to Western countries as the antidote to quality assurance projects that were viewed as fragmented and insufficiently integrated into the process of management. Total quality management is based on participation of all members of an organization and aimed at long-term success through customer satisfaction and benefits to all members of the organization and to society itself. It implies a comprehensive system linking all processes in departments at all levels and also a concerted effort of leadership and staff. Total quality management allows management to intervene in quality of care, which has been considered a sanctuary of the medical professions; where it has been adopted as a tool for control or regulation, it scarcely appeals to clinicians, who stoutly defend their professional independence.

Elements of total quality management include standardization, routine management, policy management, continuous quality improvement, quality design and quality assurance systems. The core values of total quality management have recently been incorporated in various government's policies on quality in health care, particularly in Europe and South-East Asia. Examples of documents put in place to ensure total quality assurance are: the National Programme for quality assurance: safety and continuous quality improvement projects in public

hospitals by France since 1995; The Ministry of Health Quality Assurance programme: national indicators, internal quality assurance, and Training by Malaysia since 1984 and many more.

In Ghana, the Institutional Care Division (ICD) of Ghana Health Service (GHS) has direct responsibility of ensuring health care quality. The development of the “Healthcare Quality Assurance Manual for Sub-Districts” by the Ghana health Service suggests the institutionalization of total quality assurance in the country. That document outlines five key principles that underpin Quality Assurance in the health sector in Ghana, namely:

1. Client-centeredness thus Quality Assurance measures are oriented towards meeting the needs and expectations of clients;
2. Quality Assurance focuses on systems and processes;
3. Quality Assurance uses data to analyze service delivery;
4. Quality Assurance encourages the use of teams in problem solving and quality improvement, and;
5. Quality Assurance to use effective communication to improve service delivery.

The Ghana Health Service believes that “to implement quality assurance successfully, there should be appropriate structures at all levels. The roles, responsibilities and linkages of the structures within the organization must be clearly defined” (Ofie & Bannerman et al 2004). This would go a long way to strengthen monitoring and supervision in the health service delivery processes. In this wise, the Service has put in place teams at the national, regional and District levels as part of the quality assurance strategies.

Governance Structures

Governance in the Municipality is manifest in both modern and traditional forms. The former is represented by the Municipal Assembly created by LI 1738 of 2004 within the framework of the Local Government Act of 1993 (Act 462), while the later is by Chiefs (Traditional rulers)

The General Houses of the Municipal Assembly and the Garu Tempane District are the highest administrative and legislative bodies in the area. Membership is drawn from the elected and government appointees. Other mandatory members are the members of parliament from the area. The two Houses are headed by a presiding member who works part time. They meet at least three times a year to deliberate on issues concerning the area. Among their activities, the Houses; pass by-laws, approve development plans, projects, programmes and approves the budget for the Municipality. Another role played by the houses is the confirmation of the president’s nominees for MCE.

The Executive Committees of the tow houses are made up of sixteen members (that is third of the general house) chaired by the Chief Executives. They each have nine (9) sub-committees, the first five (5) being statutory and the rest created by the Assembly. These include; Works, Development Planning, Social Services ,Justice and Security ,Education ,Food and Agriculture, Environment, Health and Sanitation ,Disaster Relief and Bush fires. Some of the other committees of the house include: Complaints Committees (headed by the presiding members); Tender Committees; Tender Review Committees Board; Security Committees and the Credit disbursement committees.

On the other hand, traditional authority is represented by the Bawku Traditional Council under the presidency of the Zugraana, Bawku Naaba, the Paramount Chief of the Bawku Traditional Area. The membership is made up of the Chiefs of the 24 main divisional chiefdoms who together have 238 sub-divisions. Matters concerning chieftaincy, culture and tradition are handled by the traditional council individual chiefs. In addition, the traditional council is represented in the Municipal Assembly to also voice out their views concerning pertinent development issues. Local level political governance is based on traditional sets of micro-states or chiefdoms. The society is generally patrilineal and patrilocal based upon hierarchies of clans and lineages that control access to land and exercise authority in marriages, funerals, religious and social ceremonies.

METHODOLOGY

Methodological considerations

Research works on healthcare abound in the world today, but little attention seem to be given to the methodologies appropriate for the conduct of such in the target Districts. The depth of research into such healthcare delivery in the area poses a lot of challenge to potential researchers who want to venture into such fields. However, it is not uncommon to find a number of health research works employing various traditional social research methodologies in health research (McCandless & Bangura et al, 2007).

The choice of a particular research methodology is often dictated by a number of factors and most importantly, the specific philosophy, goal, objective, scope, nature of the problem under investigation, the processes of data analysis, interpretation and the presentation type that a researcher wants to undertake. Besides, research work of all types and kinds, similarly have as their bedrock their paradigms, ontology, epistemology that are employed to make the research what it is (McCandless & Bangura et al , 2007, citing Denzin and Lincoln 1994:12).

The philosophical assumptions underpinning this research emanate more from the mixed paradigm tradition. This is a subjective, naturalistic epistemology and the ontological

belief that homocentric reality is both a natural and a social construct which has contextual verities. By extension, this is an endorsement of practical theory (theory that informs effective praxis), eclecticism and pluralism (that even though different, even conflicting, theories and perspectives can be useful; observation, experience, and experiments are all useful ways to gain an understanding of people and the world). Thus, at the ontological level, reality here is assumed to be perceived within historical, political and cultural settings. At epistemological level, value is placed on developing trusting and equitable relationships between researcher and research participants. At methodological level, mixed methods are seen as an appropriate way to address research problems relating to diverse groups.

Study Approach

This project, though based more on the tradition, used a mixed paradigm in data collection and analysis. A lot of academic literature on methodologies seems to concur that there are only two distinctive approaches – quantitative and qualitative to research work (Twumasi, 2001; Brown, 1996). Traditionally, researchers who opt for the measuring of variables and verifying existing theories or hypotheses or questioning them and who use a lot of statistical figures are classified as doing quantitative research (McCandless et al, 2007, Bacho 2001). Alternatively, ‘an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting’ (Creswell, 1994) is said to be the qualitative research paradigm. However, a third genre, the mixed mode paradigm is also discernable in the literature (Patton, 2002).

In the light of the above debate, Brown (1996) opines that a quantitative approach is suitable in a situation where the investigative issue is unambiguously clear and definitive answers are required. Conversely, where the questions are discursive and the answers required are just as complex then it is more convenient to apply a qualitative paradigm. Even the two schools of puritanical thoughts palpably embrace the incompatibility theory which argues that the two paradigms and their associated approaches and methods should be kept sanctimoniously apart (Howe, 1998). But one wonders whether there are ideal situations wherein either of those two research paradigms can be employed solely since ‘All qualitative data can be coded quantitatively...All quantitative data is based on qualitative judgment’ (Trochim, 2006:4). Thus it remains to question whether there are actual pure forms of the two paradigms beyond their philosophies. This is even so because one may use quantitative data to clarify qualitative issues to enrich research findings and the vice versa. Examples of health research conducted in the quantitative research mold include Outcomes research which examines the effects of medical care interventions and policies on the health outcomes of

individuals and society. Investigators conducting outcomes research seek to inform the development of clinical practice guidelines, to evaluate the quality of medical care, and to foster effective interventions to improve the quality of care. Outcomes research has traditionally used quantitative sciences to examine the utilization, cost, and clinical effectiveness of medical care through randomized and nonrandomized experimental designs. But quantitative methods are not as well suited to measure other complex aspects of the healthcare delivery system, such as organizational change, clinical leadership in implementing evidence-based guidelines, and patient perceptions of quality of care, which are also critical issues in outcomes research. Such “more nuanced aspects of healthcare delivery may be most appropriately examined with qualitative research methods” (Mays & Pope, 1995). Qualitative approaches are becoming more common in clinical medicine and health services research (Malterud, 2001). It is further argued that qualitative methods as providing unique and critical contributions to outcomes research.

In view of the deficiencies inherent in the monolithic paradigms and the fact that either type of research typology and methods could be used to enrich a particular research findings, a mixed paradigm was adopted in this particular project. This approach has both currency and relevance in healthcare research since mixed methods “are increasingly recognized as valuable, because they can capitalize on the respective strengths of each approach” (Jick, T, 1979). *McCandless et al (2007)* in advocating for this type of approach to research in Africa, encourage African researchers to combine quantitative and qualitative methodologies in analyzing the multifarious problems of the continent.

In this study, the mixed paradigm which is variously termed ‘the third wave’ or ‘third research movement’ or even the ‘pragmatic paradigm’ (Creswell 2003:11) is defined as ‘ the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study.’ Data collection in this perspective combines qualitative and quantitative traditions in either simultaneous or sequential order with a view to answering the research questions in the best possible way (Creswell 2003).

The merits in the use of this paradigm lie in the possibility to use the strengths of an additional method to overcome the weaknesses in another method by using both in this project. It is also hoped that this project will benefit from the logic of triangulation and generate more complete knowledge necessary to inform both theory and praxis.

There have been a few attempts to bring together different approaches to the study of healthcare. For instance, Sambanis (2004) argues for the use of qualitative studies after model estimation to identify measurement error, explore exogeneity, endogeneity, omitted variable bias and causal mechanisms to allow revision and improvement of the model in a given

analysis. Others argue for using large quantitative study as a stepping stone to more in-depth case studies, identifying most and least likely cases, highlighting variables that provide direction when conducting the study and allowing the researcher to enter a case study with some degree of general knowledge about the health quality. Others still focus on using qualitative methods, in particular case studies, for the purpose of theory building and then the application of quantitative methods for the purpose of theory testing (Kalyvas, 2006). Those attempts at mixed methods have been embedded mainly within Lieberman's concept of nested analysis. Yet, nested analysis is criticized on grounds of being rather shallow since it glosses over the core issues relating to ontology and epistemology and focuses instead on how different research methods can be complementary. Besides, such analysis tilts in favour of only one particular type of 'science', the traditional positivist discourse, thus neglecting the sticky issues that have appeared so incommensurable within the discipline, in particular the ontological and epistemological divides that have separated the 'positivists' and the 'post-positivists'.

The Research Process

The procedure for this research began with the identification of the conundrum associated with quality of healthcare delivery in the Bawku Municipality. Thus, the research questions, objectives and hypothesis are anchored on the quality of healthcare in the light of the introduction of the NHIS. Appropriate documentation regarding theoretical as well as conceptual discourse on quality delivery, quality assurance and NHIS in primary healthcare were carefully reviewed in the light of the research questions. It was then discovered that an innovative and appropriately insightful approach to carry out the study would be a mixed method approach – combining aspects of both qualitative and quantitative research tools, methods and techniques. This is what informed the research design. Hence, data collection was conducted sequentially as follows; survey, exit interviews and focus group discussions. The collected data were then analysed, conclusions based on the findings were made and finally recommendations touching on policy advocacy with regards to the improvement of quality healthcare delivery in the target facilities are made. Possible areas for future research are highlighted in the end.

The Research Design

Research design is regarded here as 'the plan of action that links the philosophical assumptions of the project to specific methods' (Creswell, 2003; Crotty, 1998). As an action plan, usually, the choice of a design guides the inquirer in his investigation just as the compass does for the pilot en route to the appropriate destination. This research adopted a mixed method approach which is variously seen as a research methodology (Tashakkori & Teddlie, 1998), a method (Elliot,

2005; Creswell et al., 2003; Greene, Caraceli, & Graham, 1989; Onwuegbuzie & Teddlie, 2003), and a research design as well (Creswell 2006).

Thus in this study, a mixed method design refers specifically to the practice of collecting and analyzing qualitative and or quantitative data in a single study in which the data is collected either sequentially or synchronously wherein only the data is integrated at single or multiple stages of the research process (Tashakkori & Teddlie, 2003). In spite of the diversity of permutations that abound for data integration in a mixed method design a sequential transformative one in which a more highly resourced qualitative research follows lesser resourced quantitative work was adopted.

This design was used to facilitate generalization of the dominant qualitative findings about the quality of healthcare delivery to different samples, determine the quality assurance mechanisms in target facilities whilst the quantitative data facilitated the development and testing of other instruments that led to a better conduct of the qualitative data collection (Katsulis 2003, citing Creswell 2003). A case study approach was adopted for this study. The limitations of the research as well as the scope of the study were taken into account in choosing the case study approach.

Data Sources

This study has used mixed methods, collecting both quantitative and qualitative data from the two main sources of data gathering in social research; primary and secondary. It is noteworthy that the choice of any particular source of data collection is often dictated by a number of factors including; the research problem, goal of the study, the design type, the demographic peculiarities and the repertoire of skills at the command of the researcher. According to Grady (1998), it is important for researchers to consider the nature of the phenomenon under study, the kind of respondents to be involved including their psychology and the general environment of the study.

In the light of the above, primary source of data for the study included respondents to the exit survey, key informants and interviewees. Study of the social dynamics between the regulatory bodies and healthcare providers relied mostly on secondary literature. Broadly, this comprised of publicly available material in book, journal and article form, consisting of historical, political, and clinical records.

Sampling and Sampling Techniques

Sampling, may be described as the act, process, or technique of selecting and studying characteristics of only some segments of people, situations, or items within a given group for

the purpose of determining parameters of the whole population (Kane, 1999) and is crucial to this research project because it helped to inform the quality of inferences made by the researcher that stem from the underlying findings. The preference for samples over using entire populations in research has been highlighted by many scholars. For instance, Millar (1999) opines that a study of representative samples is often better than basing studies on entire populations who may be providing similar responses to particular interview questions. However, there is no guarantee that any sample will be precisely representative of the population from which it comes. Consequently, a sample is expected to be neither excessively large nor too small but optimal. Such a sample should fulfill the requirements of efficiency, representativeness, flexibility and reliability (Creswell 2006). This study therefore takes into consideration the above requirements including parameters of the population to be studied, its size, distribution and the cost of study (Twumasi, 2001; Kane, 1999).

This study used the sequential mixed method sampling strategies embodying the two main sampling techniques; probability and non-probability sampling. Even though 'most frequently used mixed-method designs start with a qualitative pilot study followed by quantitative research' (Morgan, 1998:5), this research project reversed that order; the quantitative survey preceded the interpretive data gathering processes. Sequential mixed methods sampling entails 'the selection of units of analysis for an MM study through the sequential use of probability and purposive sampling strategies...' (Johnson & Onwuegbuzie 2006:4). According to Kemper et al (2003:11), in this type of sampling, information from the first sample (typically derived from a probability sampling procedure) is often required to draw the second sample (typically derived from a purposive sampling procedure).

Random sampling involves 'selecting a relatively large number of units from a population, or from specific subgroups (strata) of a population, in a random manner where the probability of inclusion for every member of the population is determinable' (Tashakkori & Teddlie, 2003). This study used the simple random sampling, the 'lottery box' to select the three main facilities, namely; Bawku Presbyterian Hospital, Vineyard Hospital and Quality Medical centre in the Municipality. The merit for this choice is based on the law of statistical regularity which states that, 'if on an average the sample chosen is a random one, the sample will have the same composition and characteristics as the universe' (Yin, 1993). Also, a simple random sampling was applied to the quantitative explorative exit survey phase of the project. Besides, a parallel relation exists between the survey and in-depth data collected.

The survey helped identify areas that should be prioritized in the interpretive data gathering process which formed the second phase of the data collection process. Interpretive methods, offer a number of strengths over survey-based methods for examining healthcare

delivery and quality controls systems. While survey methods are essential for quantifying impacts on key indicators targeted by the project, they have a number of limitations. These include the necessary brevity of questions and the use of proxies that are often blunt measures; respondents' limited ability to express what they mean in selecting among categorical or continuous variables; the limited ability of enumerators to follow up when more information or clarification is needed; and the difficulty of establishing the rapport and trust needed to maximize truthfulness in replies. Qualitative research on the other hand enables the exploration of social issues and impacts requiring open-ended rather than closed responses; improves our understanding of people's perceptions, as expressed in their own words; raises underlying and less obvious issues, including those that the researcher may not have anticipated; allows us to probe responses (including internal contradictions and conflicting responses between respondents) and explore relationships between topics and responses; and finally, enables solicitation of respondents' solutions for the problems they identify.

Questionnaire Administration

The questionnaire was administered on a sample of 300 respondents comprising an equal number of men and women in all the three Bawku hospitals (50 male, 50 female in each). Sickneses attack both sexes without discrimination is the main reason why equal distribution of the questionnaire was given to both sexes. The main objective of the study is as mentioned earlier to assess the quality of primary health care delivery by accredited service providers under the National Health Insurance Scheme in the Bawku Municipality.

Thus from those selected strata or sections, the survey questions were then administered to a sample of 300 respondents comprising 150 male and 150 female through quota sampling. Indeed, for Nichols, it is quite important to choose the group of people that the researcher is most interested in (Nichols 2000). This state of affair however, depends on the research objectives and the kinds of research questions that the researcher intends to solve. Based on these, the quota targeted mainly patients who were leaving the hospitals and were between ages 18 and 69. In addition, health workers, including management and staff were also contacted. By choosing people in this category it is thought that these are people who bear the brunt of sicknesses and or take care of the sick and can answer for themselves. Also, the choice has been influenced by an understanding that people within that group would bring variety of opinions to enrich the studies.

The sample selected in this regard will have to meet the study's needs. The advantages of this sampling method are that the researcher is able to access targeted respondents with the requisite traits by staying within the frame. Right choices of individuals with the needed

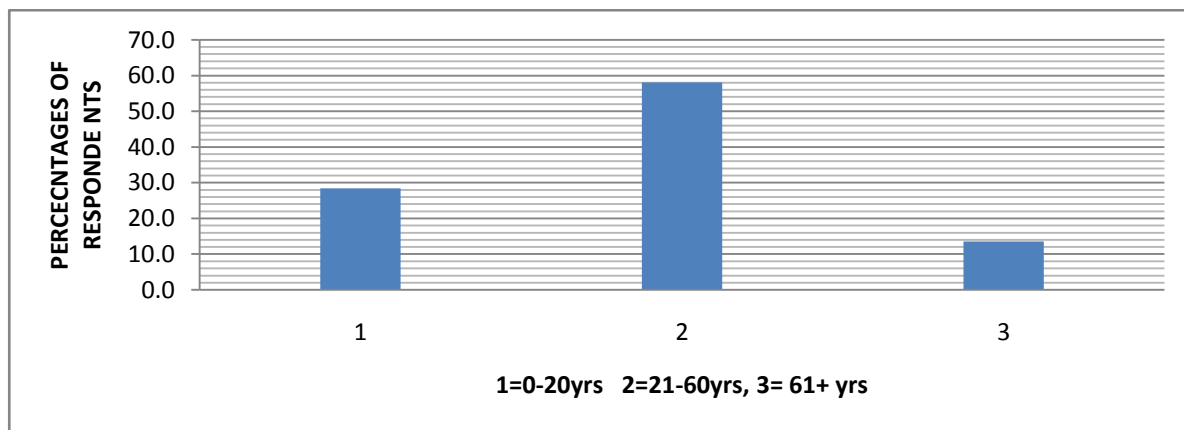
information about the situation under study are gotten whilst the researcher is able to assess the respondents chosen for the study.

All respondents approached agreed to take part in the exercise except 13 people comprising of 9 women and 4 men who refused. Most of those women who refused argued that they needed permission from their absent husbands before they could answer the questions. It could also be attributed to the fact that some of the patients were frail and needed to get home quickly and relax. Indeed, most excuses given were that they were busy; others were not motivated at all to talk to us. Respondents who refused to take part in the study were substituted by others who were willing enough to part-take in the exercise.

ANALYSIS & FINDINGS

Socio-Demographic Characteristics of Respondents A total of 300 hundred respondents were interviewed during the survey. In all 101 male representing 37% and 199 females representing 63% took part in the survey. Some details of those respondents are presented diagrammatically as follows:

Figure 1. Age Distribution of Respondents



The ages of the respondents are as shown above in bar chart. About 28% of respondents were under 20 years. There were also 56% of respondents above 20 years but below 60 years. The less percentage of the respondents were in the age bracket of 61 plus, which made up 16%. This is an indication that fewer aged people seek medical attention as compared to those under age 60.

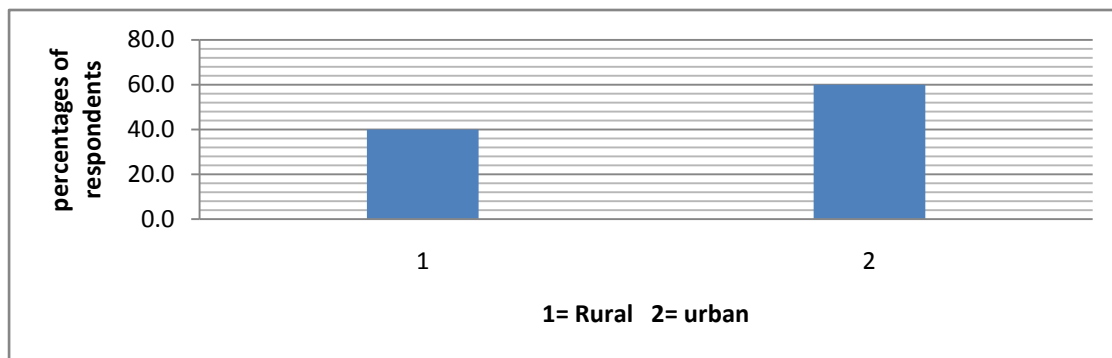
Figure 2 marital statuses of Respondents



Out of the respondents interviewed, 36% are unmarried which is the second highest with 54% as those married being the highest in the population and less than 3% are divorced and there was response on separation.

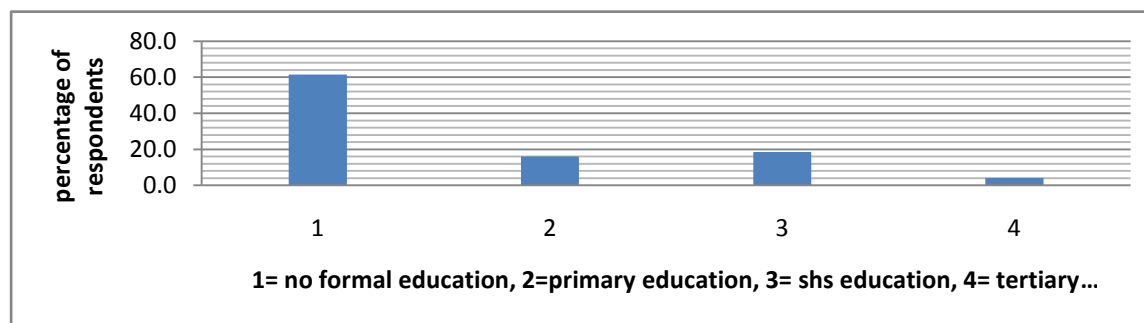
The higher percentage of married and single respondents is because in most traditional African society and more particularly the study area where social cohesion is strong, few cases of divorces are experienced and those that occurred, remarriages are common. Therefore, you may have higher percentage of marriage and single/no marriage category of people but not divorced as shown above.

Figure 3 Where Respondents live



The records of data gathered show that less number of respondents live in the rural areas with many living in the urban areas as about 40% of respondents are said to be rural inhabitants and 60% from urban areas. This may suggest either those from rural areas attend the community clinics or coming to these major hospitals in the town may be on serious cases or on referral basis. This made the number of users of the health facilities to be more of urban dwellers.

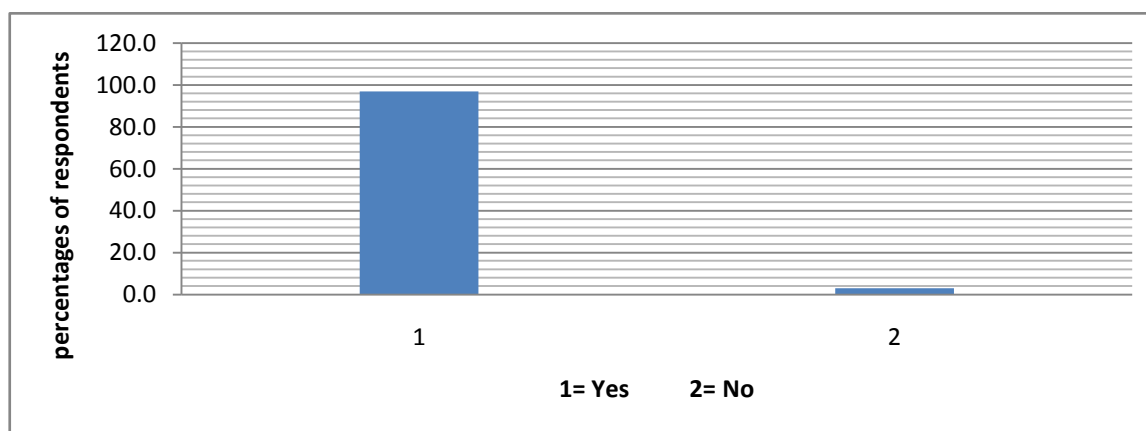
Figure 4. Educational Levels of Respondents



The questionnaire also captured the socio-demographic characteristics of respondents in terms of their educational level. Above in figure 4 are the percentages. The graph shows that higher number of the respondents representing a little above 60% had not obtained formal education with a percentage of less than 40% obtaining primary, secondary and tertiary education levels of which tertiary education registered a lower percentage.

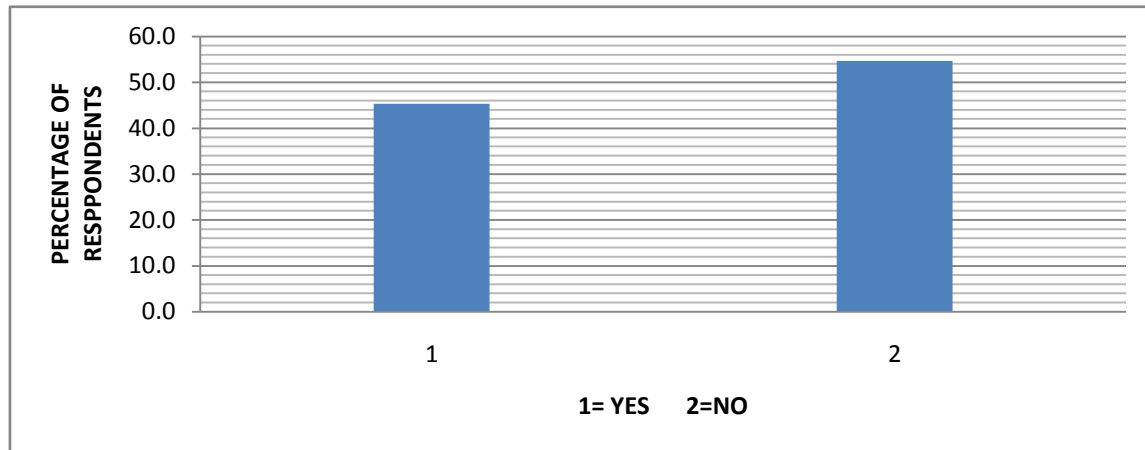
The fact that 62% of the respondents cannot read and write does not imply that they are incapable of giving an independent and personal assessment of the service delivery at these hospitals.

Figure 5. Information on NHIS card holders



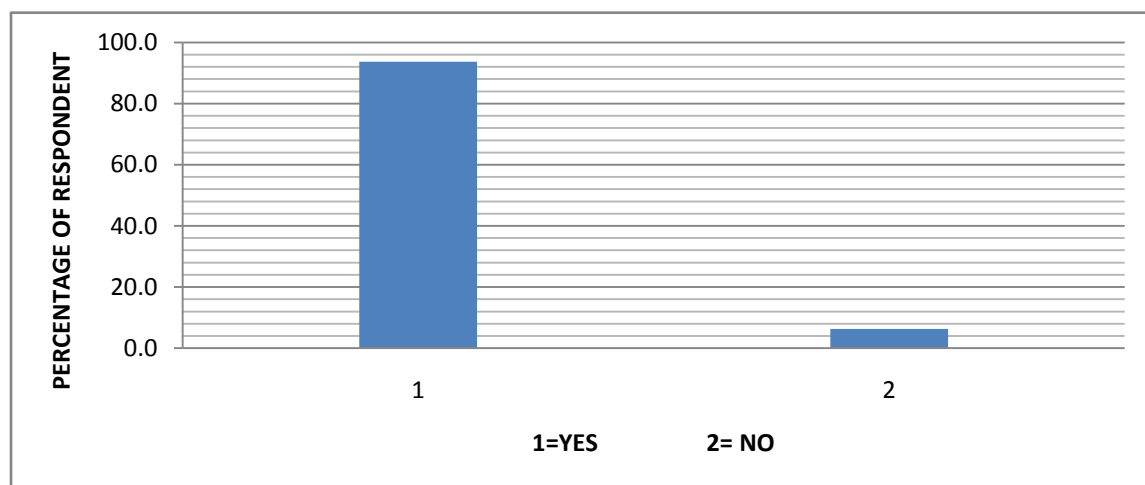
The information as gathered from the respondents showed that 294 respondents are NHIS card holders indicating 98% level of patronage which may be as a result of either good health delivery by the health providers or effective education given out to the general public about the scheme. It could also mean that NHIS card holders go to hospital most often as compared to their counterparts who may be sick but cannot afford the bills; as such they do not go to the health facilities often.

Figure 6. Unnecessary Delays



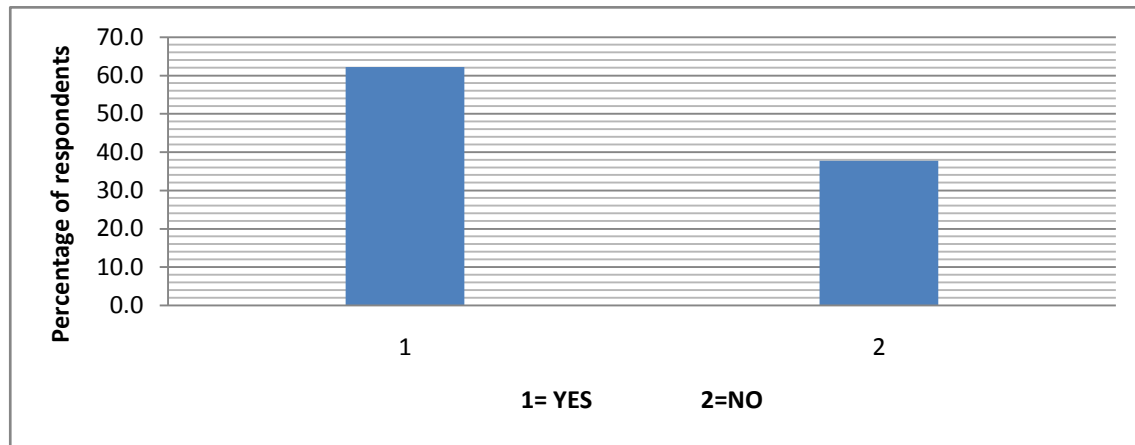
Respondents were to state whether there were unnecessary delays any time they visited these health facilities. About 44% percentage answered in the affirmative and gave the following as reasons for the delays during visits to the hospitals. They complained that it took a longer time to process NHIS cards of outpatients and inadequate number of Doctors and Nurses, long and cumbersome procedures at the facilities, low output of Doctors and Nurses, favoritism and discrimination and the slow manner in which the dispensary serves patients. The rest of the respondents interviewed (56%) were of the view that there are no delays. They said patients who come to the facilities late will have to wait until they get their turn to see the doctor/nurse and that is not a delay according to them.

Figure 7. Doctors Examination of Respondents.



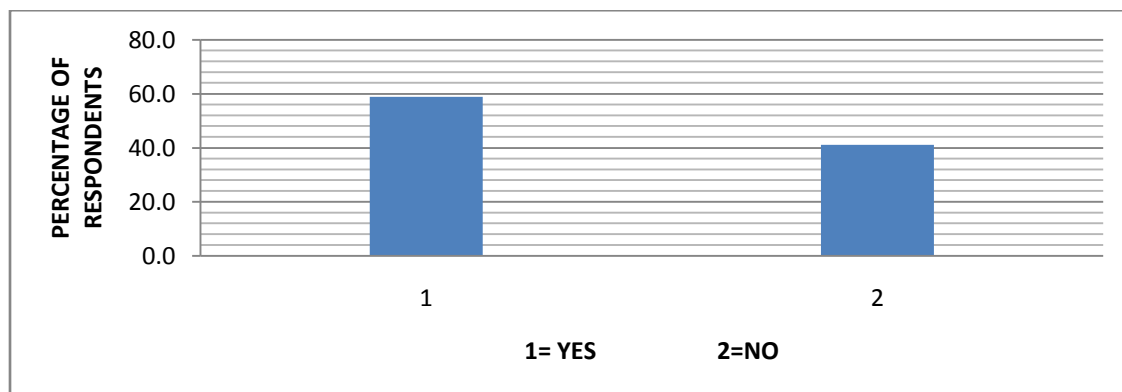
Nearly 90% of the respondents answered in the affirmative when they were asked if Doctors/Nurses had time to examine them well before commencing treatment. They said among other things that Doctors/Nurses were friendly and treated them with the dignity that they deserved. However, less than 10 % of respondents said otherwise as they complained of nurses harassing them and not giving them adequate attention during examination

Figure 8. Communication with Doctors



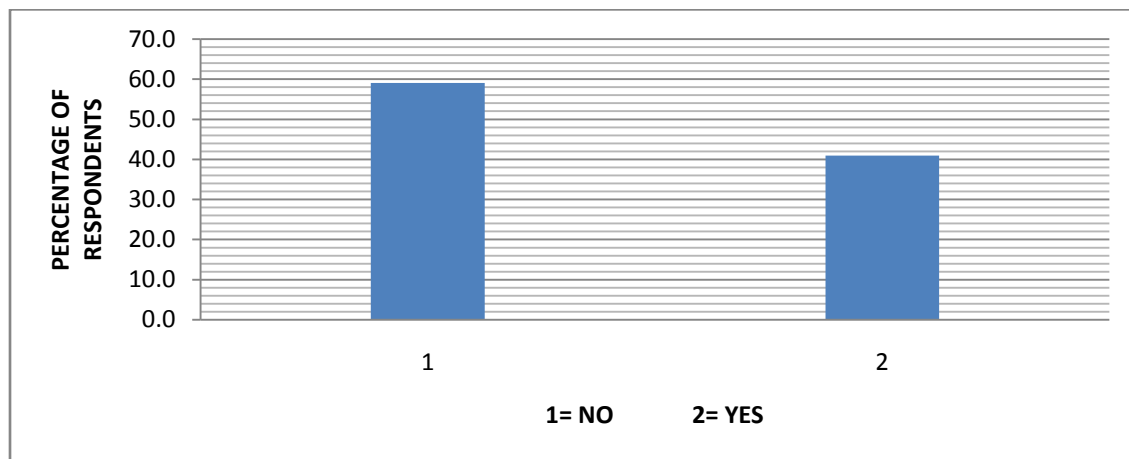
In assessing Doctors communication skills, 63% respondents said they understand the instructions given to them by Doctors/Nurses on their medication. On the contrary, 37% said they did not understand most times what Doctors/Nurses told them. This is an indication that Doctors/Nurses should do more to communicate effectively to their patients. The information basically shows how respondents indicated their satisfaction or dissatisfaction with the way Doctors/nurses take their time to explain issues to their understanding.

Figure 9. Doctors advice to Patients (Respondents0



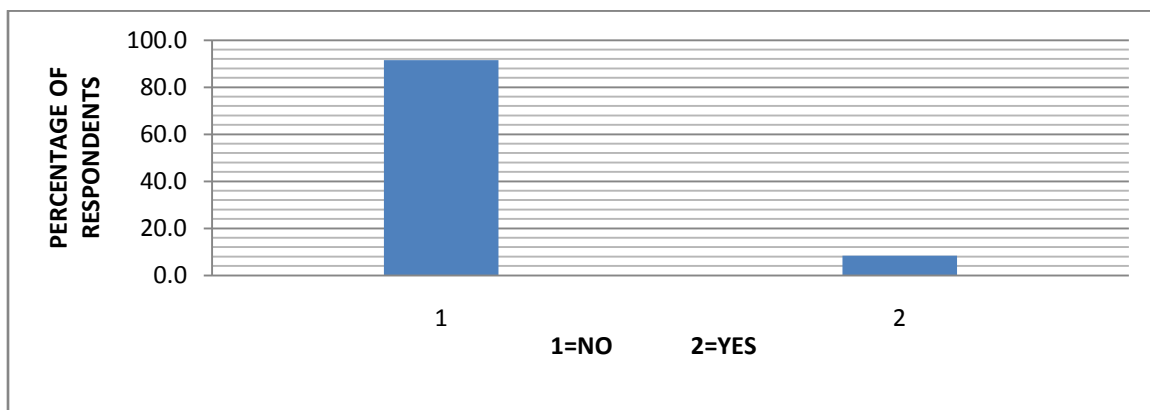
Respondents were to state if they are given any medical advice after being examined by Doctors/Nurses. Nearly 60% said Doctors/Nurses took their time and explained matters concerning their health to them and the rest of the respondents said no Doctors/Nurses gave them any medical advice with regard to their health status. This percentage is a bit on the high side which should be avoided by the health facilities as much as possible since many patients' illnesses could be as a result of the life style that they live. This kind of situation can only be avoided through patients counseling by qualified medical professionals.

Figure 10. Information on Repeat Visits/Reviews to Hospital by Respondents



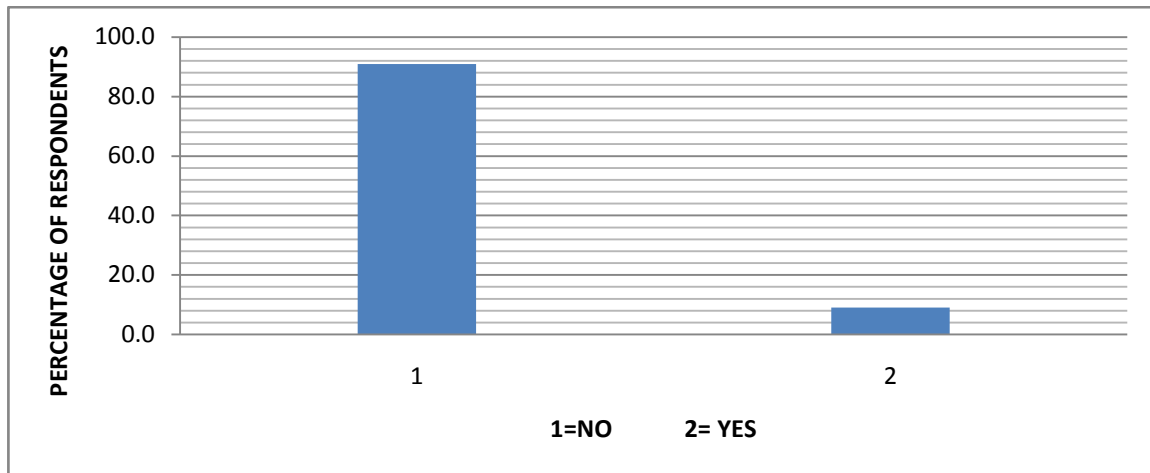
Out of 100% respondents, 40% said there was no information on their review visits which could mean that their illness was managed at their first visit to the hospitals. On the contrary 60% of the subjects said Doctors/Nurses asked them to come to the health facilities in one, two weeks or a month for a review. They added that they are willing to repeat visit to the same facility when they are sick and not only the review visits.

Figure 11. Privacy of Respondents during consultation



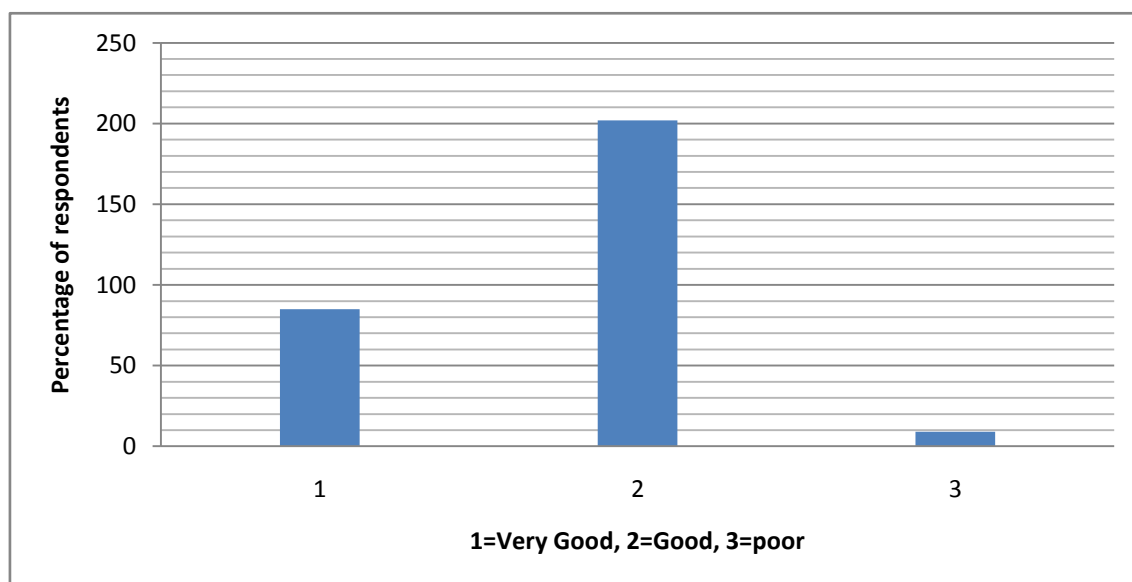
Respondents were also required to indicate whether they had privacy or not during consultations. About 8% responded in the negative. But the majority (92%) said they were given adequate privacy during consultation.

Figure 12. Issuance of Prescribed Drugs



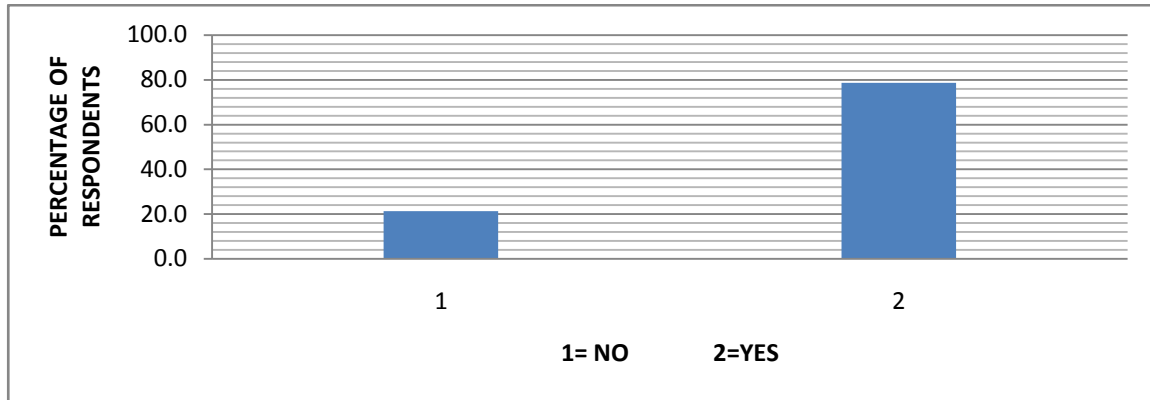
Respondents were again asked if they got all the prescribed drugs by the Doctors/Nurses from the dispensary and the responses are that, 9 % said they could not get all the drugs from the health facilities but 91% said they received all the recommended drugs. This is an indication that NHIS coverage is good and patients are receiving the prescribed medicines. Even higher was the percentage of respondents who felt the medication was adequately explained to them to comprehend and use (95%).

Figure 13. Attitudes of health providers



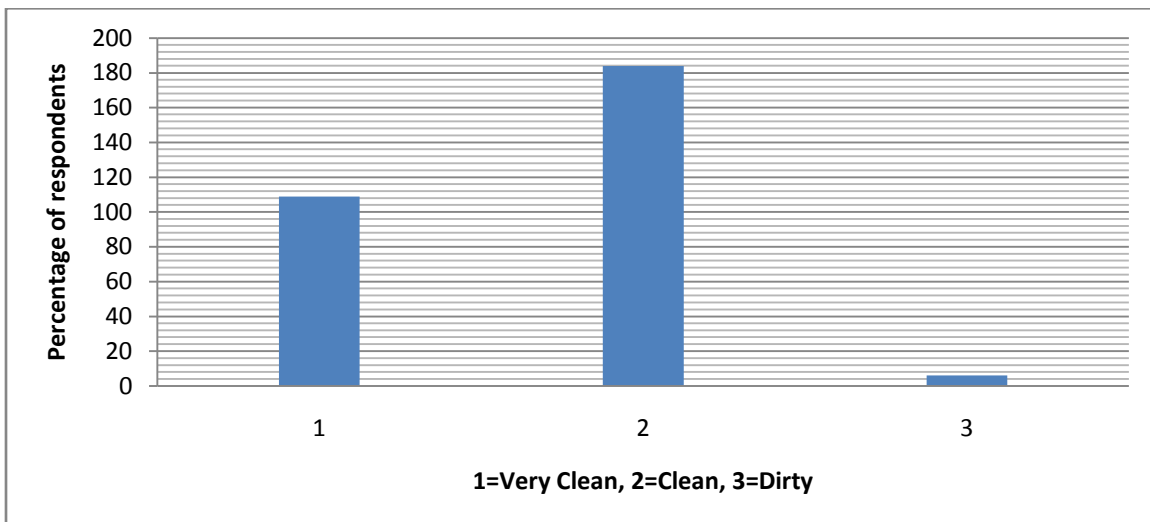
The overall assessment of health providers' attitude towards respondents was generally satisfactory as over 98% said they were satisfied with their attitude toward them with only 2% expressing disapproval in some few health workers in those facilities.

Figure 14. Emergency health provision in the health facilities



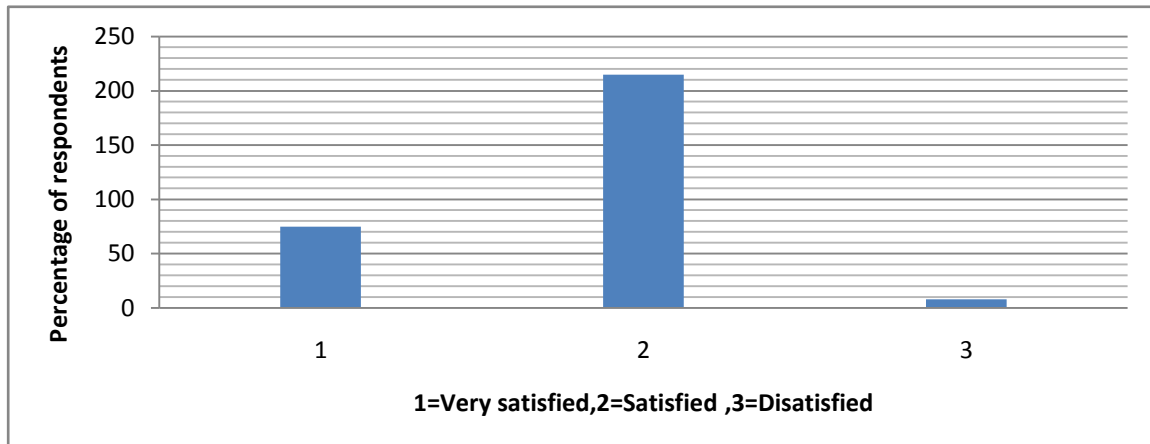
About 21% of the respondents said that they had come to those facilities on an emergency issue and 79% said they did not. 31% of those who had visited in emergency situations said they were attended to as promptly as they ought to have been treated. The remaining 69% however expressed dissatisfaction with the delay in attending to them.

Figure 15. Sanitation information on the health facilities



Furthermore, respondents were asked to describe the tidiness of the facilities. Only 2% said the hospitals were dirty. However, 61% described the facilities as being clean while 37% described the facilities as being very clean.

Figure 16. General Satisfaction during day of survey



When asked about their general perception of treatment during the day of their visit, only 2% said they were not generally satisfied that day. In contrast, 62% said they were satisfied while 36% of them said they were very satisfied with both the visit and treatment they received that day.

Insured and uninsured respondents were to enumerate what they liked and disliked about the three hospitals in the municipality. In the case of the likes, 95% respondents enumerated their heightened interest in the use of the facilities as being: the proximity of the hospitals to the larger population, the friendly nature of staff and care to ensure proper treatment, the good human relation of doctors/nurses, the hard working attitude of doctors/nurses and the cleanliness of the facilities and their surroundings.

However, about 5% percentage thought otherwise as they complained about doctors/nurses treating without Lab exam, the lack of certain modern equipment in the hospitals, the inadequate number of Doctors, the delays associated with attending to some patients, the appalling attitude of some staff towards work, the mistreatment of pregnant & expectant mothers.

CONCLUSION

In the first place, it was realized that Ghana Health Service has put in place Quality Assurance systems and structures. These systems and structures are supposed to guide the work of every accredited facility in Ghana, Bawku being no exception. Secondly, it was again realized that, even though some of the facilities in Bawku adhered to those standards put in place by the Ghana Health Service, others do not have visible quality assurance teams in place.

Thirdly, it was observed also that the quality of customer care and service delivery in the Bawku Municipality is generally high albeit the fact that each facility had more potential to improve upon

their services. Fourth and finally the services provided by the target facilities were considered generally satisfactory by clients/ patients. Outpatient's satisfaction of services by these hospitals was dependent on Nurses and Physician human relations and how they explained issues to the understanding of the patients. It is also dependant on the waiting time that customers experienced when they visited the hospitals for treatment. The cleanliness of the immediate environment and public toilet and urinal also played a key role on customer satisfaction.

However, the absence of visible quality assurance teams in some facilities was also observed. Some other issues raised by respondents bordered on: poor communication by some Doctors/Nurses regarding lack of feedback to patients, non-invitation of patients for reviews; the lack of adequate privacy; inadequate drugs; delays in attending to patients during emergencies; Doctors/Nurses treating without Laboratory examination; the lack of certain modern equipment in the hospitals, the inadequate number of Doctors, and the appalling attitude of a few staff towards work. These concerns raised must be addressed seriously to improve the delivery of quality health care in the Bawku Municipality.

RECOMMENDATIONS

In the light of the empirical findings, the following have been recommended by the researchers for the improvement in the delivery of quality health care services in the target facilities.

Revamping Quality Assurance Teams

Generally, it has been suggested that the very systems/structures that ensure quality assurance in the delivery of health care in the target hospitals have to be both efficient and effective. In this wise, it has been suggested that both the regional and municipal health management teams have to intensify their monitoring and supervisory roles and ensure that each facility has a vibrant quality assurance team in place. Regular meetings have to be organized and proper minutes and action points both kept and followed by the facility teams.

Besides, best practices in specific facilities should be lauded and espoused by the Municipal and Regional health quality monitoring teams. This will go a long way to encourage facilities to prioritize quality systems and process in their work.

Furthermore, it is suggested that management of each of the facilities also ensure that regular meetings/ durbars are institutionalized and effective.

Other structural areas requiring attention include improvement: in staff working conditions; hospital facilities: seats for patients at OPD; number of doctors for the hospitals and an increase in number of dispensary staff to accommodate large crowd at each facility's dispensary.

Improving Privacy of Patients

The need for privacy of patients is paramount. The patient's charter extols it. Thus, facility managers have to ensure there are cubicles to handle patients during consultation. Also, patients should be handled one after the other no matter the length of the queues.

The issuance of drugs

It is important that all bottle- necks regarding the release of drugs to patients are plugged. Prescriptions for drugs should be strictly followed and explanations for the use of such drugs must be made explicit to patients. The practice whereby patients are asked to go and buy prescribed drugs covered by the NHIS at private shops is unlawful and staff found culpable should be sanctioned to serve as a deterrent to others.

Minimizing Delays at the facilities

The huge percentage (almost 70%) respondents' expressing dissatisfaction with delays in attending to them during emergencies should not be glossed over by management of the facilities. When viewed against the backdrop of complaints expressed by other respondents that: it took a longer time to process NHIS cards of outpatients; the number of Doctors and Nurses was inadequate and; there were long and cumbersome procedures at the facilities coupled with favoritism and discrimination, those delays must be seen as an indictment that should be addressed strategically and pragmatically by facilities' managements. There is the need for improvement of the emergency side of service provision since that is a key component of the health delivery process. Also, the call system of staff at the facilities must be succinctly defined and sanctimoniously followed. Where inadequate numbers of staff is the cause of delay, it is further suggested that hardworking, selfless and dedicated staff with the appropriate mix of skills should be employed, equipped and motivated to work. When equipped with the appropriate computer hardware and software, dedicated staff teams would seamlessly work for speedy - quality services whether at peak times or during emergency cases.

Improving Cleanliness

When viewed as a dynamic process, hygiene in the hospitals should be approached systemically. Cleaning the environs must not be left in the hands of only the hired cleaners; all staff, whether medical, administrative or auxiliary should be psyched up to continuously maintain hygiene. Besides, the invasion of bats, doves and mosquitoes at the Presbyterian Hospital in Bawku should be tackled head on. It is believed that if the above recommendations are operationalized, the quality of health delivery in the Bawku Municipality will improve greatly.

LIMITATIONS OF THE STUDY & SCOPE OF FUTURE RESEARCH

The study was limited to Bawku Municipality of the Upper East Region due to financial and material resources constraints to conduct a national research study. This obviously affected the sample size used in the generalization arising from the findings of the study which may not reflect the real circumstances in other locations in Ghana. In some cases, some respondents might provide misleading responses which obviously might affect the scientific underpinnings for the study. Despite all these, very intensive processes were applied to obtain as valid data as possible which were carefully analysed to reach acceptable findings and conclusions. The study was delimited to the Bawku Municipality of the Upper East Region. Future research studies should involve a broader and wider scope to provide a basis for a more scientific output. The conceptual and theoretical framework should also be broadened to cover other areas of the National Health Insurance Programme.

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