UNIVERSITY OF GHANA

OPERATIONALIZING GHANA'S PATIENTS' CHARTER IN PUBLIC HOSPITALS: A CASE STUDY OF KASOA POLYCLINIC IN AWUTU SENYA EAST MUNICIPAL ASSEMBLY

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DECLARATION

I, hereby declare that with the exception of the references to other people's work which have been duly acknowledged, this long essay is entirely my own work under the guidance of my supervisor and that neither the whole of this work, nor any part thereof, has been presented for an award of another degree elsewhere.

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DIANA BAIDOO DATE

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CERTIFICATION

I hereby certify that this long essay was supervised in accordance with the guidelines on supervision laid down by the University of Ghana.

…….. .....

DR. THOMAS BUABENG DATE

(SUPERVISOR)

DEDICATION

This long essay is dedicated to Mr. Stephen Appiah Nyamekye for creating an enabling environment and for supporting me every day.

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LIST OF ABBREVIATIONS

CHRAJ-	Commission for Human Rights And Administrative Justice
GHS-	Ghana Health Service
OPD-	Out Patient Department
PC-	Patients Charter
PRC-	Patients' Rights Charter
ROHEO-	Royal Health Organization
UDHR-	Universal Declaration on Human Rights
UN-	United Nations
WHO-	World Health Organization

ABSTRACT

This study assessed the operationalization of Ghana's Patients' Charter (PC) in Public Hospitals using the experience of Kasoa Polyclinic. The study sought to access the knowledge and awareness of patients and health staff on the Patients Charter as well as document the experiences of health staff. A qualitative and case study method was used to interview participants who were purposively selected. The findings indicate that the staff of Kasoa Polyclinic were aware of the existence of the patients' charter and also know its contents. Patients on the other hand, had no knowledge of the existence and the contents of the Charter. Also experiences of health staff with regards to the operationalization of the patients' charter were grouped into two main factors: inhibiting and promoting factors. The inhibiting factors were human and capital resources to execute the tenants of the Charter. Also, availability of the Patients'' Charter, community sensitization, monitoring as well as training or orientation of staff are the factors that promote the operationalization of the Charter in the facility. To ensure effective implementation of the Charter, the study recommends that the health facility must ensure that patients that visit the facility are well informed about their rights. It is recommended that patients' rights and responsibilities are dramatised and broadcasted on television and radio in major Ghanaian languages to enhance awareness of patients on the Charter. Future research could focus on the role of various levels-national regional and district levels in operationalizing the PC.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

This chapter presents the background of the study, statement of the problems, objectives, research questions, and operational definitions of terms. Also, the scope of the study and relevance of the study are discussed in this chapter.

1.1 Background to the Study

Provision of quality healthcare is very crucial in all countries in the world. This is because governments have realised that the health of every nation is the wealth if its citizens. The World Bank recognised this fact when it stated in the 2002 World Development Indicators report that 'health of a country's adults influences its economic vitality and wellbeing'.The economic benefits of quality healthcare to individual citizens and the nation at large cannot be overemphasised. Studies have established that provision of effective healthcare has a direct correlation to the economic worth of the nation (Starfield, 2004; Dowie, 1970).

Recognising this, the World Health Organization (WHO) has established that healthcare is a fundamental human right (WHO, 1995). Thus, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. It is also evident in Article 25 of the Universal Declaration on Human Rights (UDHR, 1948) that everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, etc.

In Africa and the developing world legislative instruments that are meant to promote patients rights exists. Some of these are: South African Patients' Rights Charter (PRC), launched in 1997 and the Ministry of Health's Service Charter in Nigeria.

In Ghana, Article 30 of the 1992 Republican Constitution stipulates that "a person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs. Thus, governments in developing countries including Ghana have become increasingly aware of the need to ensure quality health care by becoming more committed to the provision of effective and reliable healthcare for their citizens.

In lieu of this, the Ghana Health Service in 2002 enacted the Patient's charter. This comprehensive Charter highlights the patients' rights and responsibilities in the care process irrespective of age, sex, ethnic background and religion. In the charter, health facilities must therefore provide for and respect the rights and responsibilities of patients/clients, families, health workers and other healthcare providers.

The Patients' Charter which is expected to ensure that the dignity of patients, irrespective of their socio-cultural and religious backgrounds, age, gender and other differences are held paramount has been in existence since 2002. The few studies done on the patient charter have focused on the knowledge and implementation of the patient charter in greater Accra and Volta regions of Ghana (Abeka-Nkrumah et. al.(2010); ROHEO (2013). This research sought to assess the experiences of patients and health workers since the implementation of the patients charter in Ghana. Although some research on the implementation of the patients charter have been done in Ghana, the methods employed were mostly quantitative (Abeka-Nkrumah et. al.(2010); ROHEO (2013). This research seeks to delve deeply into the operationalization of the Charter in public hospitals by employing qualitative methods of research. Additionally, the research was carried out in a region where no specific research has been done on the operationalization of the Charter since its inception in 2002.

1.2 **Problem Statement**

Ten Years ago, the Ghana Health Service established the patients' charter as a tool to ensure that patients' rights are protected and that the dignity of every patient is held paramount. However, the Ghana health service report on clinical care quality assurance conference in 2012 highlighted some key challenges confronting the service. They include patient safety, poor staff attitude and long client waiting time. The meeting agreed that to ensure quality of service there is a need to sustain dissemination of the Patient's Charter and the GHS Code of Conduct & Disciplinary Procedures. The report also recommended that conscious efforts should be made to arrest the root cause(s) of conducts that can compromise the provisions in the Patient charter (GHS 2012). By these assertions one may suggest that behaviours that compromise the provisions of the charter still exist ten years after its inception.

Further, a study on the patient charter conducted in four health facilities in Accra by Nkrumah-Abekah et al., (2010) on the implementation of Ghana's Patient Charter, indicated that a significant number of patient respondents complained of impolite treatment from a cross-section of hospital staff. Also, majority of patients studied reported that their consent were not sought before drugs were given to them. The study also reveals that males were less likely to be consulted than females, . The findings of the study also indicated that majority of patients and a good number of providers were ignorant of the existence and contents of the Charter, and that providers had generally not been able to carry out their obligations under the Charter as expected.

Additionally, a baseline study undertaken by the Royal Health Organisation (ROHEO) in partnership with other non-profit organisations established that in Ghana, 'the Patient's Charter, remain largely unheeded to in the discharge of services'. According to the report an overall assessment proved that 90 percent of 376 respondents sampled in the project area have low knowledge about the Patient Charter. The few researches done on the patient charter have

focused on the knowledge and implementation of the patient charter in Greater Accra and Volta regions of Ghana (Abeka-Nkrumah et. al.(2010); ROHEO (2013). This research sought to assess the experiences of patients and health workers since the implementation of the patients charter in Ghana.

As indicated earlier, although some research on the implementation of the patients charter have been done in Ghana, the methods employed were mostly quantitative (Abeka-Nkrumah et. al.(2010); ROHEO (2013). This research sought to delve deeply into the operationalization of the Charter in public hospitals by employing qualitative methods of research. Additionally, the research was carried out in a region where no specific research had been done on the operationalization of the Charter since its inception in 2002. It is therefore hoped that the findings of this study will serve as a source of information to guide future studies and to all stakeholders including policy makers and practitioners.

1.3 **Research Objectives**

This study sought to assess the operationalization of the Patients' Charter in Kasoa Polyclinic. To achieve this, the following specific objectives were used to guide the study:

- To assess the awareness and knowledge of the patients' charter among patients and Health staff of Kasoa Polyclinic
- To asses patients experiences in operationalizing the Patients' Charter in Kasoa Polyclinic
- To investigate factors that affect the operationalization of the Patients' Charter in Kasoa Polyclinic

1.4 Research Questions

To achieve its objectives, the study was guided by the question "how has the Charter been observed in Kasoa Polyclinic". Specifically, the study sought to answer three questions namely;

- What is the level of awareness and knowledge of patients and Health staff of the patient's charter at Kasoa Polyclinic?
- What have been the experiences of patients of Kasoa Polyclinic in operationalizing the Patients' Charter?
- What are the factors that affect the operationalization of the patient charter in Kasoa Polyclinic?

1.5 Significance of the Study

This study is significant in many ways. While the Ghana Health Service is focusing on improving access to healthcare, there is a need to also ensure that patients who patronise the facilities are treated in a humane manner. The patients' charter came into being to ensure this. Ten years after its inception, this study examined the operationalization of the charter by drawing experiences of both patients and health staff through a qualitative research approach.

The research provides information to the management of public hospitals as well as policy makers on the implementation of the patients' charter. Also, the research will inform management on any short comings and encourage existing practises that are geared towards the improvement of patients' rights and responsibilities.

The awareness of patients' rights and responsibilities will be heightened among patients, healthcare providers and the general public.

In the area of research, this study adds to the few researches done on patients' rights protection in Ghana. In sum, the study will ensure improved service delivery, inform policy

makers and benefit the patients and personnel of public hospitals in Awutu Senya East District of the Central Region and Ghana as a whole.

1.6 Scope and Limitations of the Study

Conceptually, the scope of the study covers issues on patients' charter and its operationalization in public hospitals. It must also be emphasized that the findings of the study is limited to public health facilities in Awutu Senya East District and cannot be generalized for all health facilities.

1.7 Operational definition of terms

This section has been included here to avoid misconceptions and misinterpretation of all the important concepts that were used in the study:

Health Staff: All staff at the Kasoa polyclinic

Patient: Any person who has some form of ailment and has visited Kasoa Polyclinic at least once.

Patients' charter: A document stating the rights and responsibilities patients

Rights: Patients' expectation of care from health workers as stated in the Patients' charter

Responsibilities: Patients' obligations in the care process as stated in the Patients' charter

1.8 Organization of the study

The study is organized in five chapters. The first chapter presents the introduction which covers a brief background of the study, the statement of the problem, research objectives and questions, significance of the study and the scope and limitation of the study. The second chapter presents a comprehensive review of the theories and existing literature about the implementation of the patients' charter while chapter three describes in details the research methodology used to undertake the study.

The fourth chapter contains a detailed analysis, interpretation and discussion of the findings of the study. Finally, chapter five presents a summary of the major findings, conclusion and the recommendations made based on the findings.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This literature review examines the theoretical underpinnings of patient rights and the essence of rights empirical studies on the Patients' Charter. It further reviews literature on the legal backings to patient's rights in Ghana as well as the content of patient's charter.

The literature search for this study included relevant national policy documents such as Ghana's Patient charter (2002), the National Health Policy (2007), CHRAJ document on state of human rights in Ghana (2009). International documents on human rights, textbooks, journal articles and internet information were also reviewed.

2.1 Theoretical underpinnings of Health Policy Implementation

A policy refers to a broad statement that reflects future goals and aspirations and provides guidelines for carrying out those goals. According to Hill (1993) a policy is 'the product of political influence, determining and setting limits to what the state does'. Thus, when a government takes a decision or chooses a course of action in order to solve a social problem and adopts a specific strategy for its planning and implementation, it is known as public policy (Anderson 1975).

Policy scientists argue that public policy is best conceived in terms of a process (Jenkins, 1978; Rose, 1976; Anderson, 1978). This is because policy decisions are not 'something confined to one level of organization at the top, or at one stage at the outset, but rather something fluid and ever changing (Gilliat, 1984). Similarly, Rose (1969) argued that policy making is best conveyed by describing it as a process, rather than as a single, once-for-all act.

This process involves negotiation, bargaining and accommodation of many different interests, which eventually give it a political flavour. These political interactions happen within the network through which decisions flow, programmes are formulated and implemented and

inter organisational dependencies and interactions take place. Thus 'policy making' is not a simple rather a complex dynamic process involving series of actions and inactions of varieties of groups with varieties of interests at different stages. Thus, it is important to note that public policy making not only involves the public bodies or public officials as policy actors; rather, private or non-official groups also play a very active role in policy making.

Policy Implementation

According to Pressman and Wildavsky (1973), implementation literally means carrying out, accomplishing, fulfilling, producing or completing a given task. Thus; policy implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieve them.

Policy implementation encompasses those actions by public and private individuals or groups that are directed at the achievement of objectives set forth in policy decisions. This includes both one-time efforts to transform decisions into operational terms and continuing efforts to achieve the large and small changes mandated by policy decisions (Meter & Horn, 1975). According to Mazmanian and Sabatier (1983), policy implementation is the carrying out of a basic policy decision, usually incorporated in a statute, but which can also take the form of important executive orders or court decisions. The starting point is the authoritative decision. It implies centrally located actors, such as politicians, top-level bureaucrats and others, who are seen as most relevant to producing the desired effects. In their definition, the authors categorize three types of variables affecting the achievement of legal objectives throughout this entire process. These variables can be broadly categorized as:

- Tractability of the problem(s) being addressed;
- The ability of the statute to favourably structure the implementation process;
- The net effect of a variety of political variables on the balance of support for statutory objectives.

Also, O'Toole (2003) defines policy implementation as what develops between the establishment of an apparent intention on the part of government to do something or stop doing something and the ultimate impact of world of actions. More concisely, he remarks that policy implementation refers to the connection between the expression of governmental intention and actual result (O'Toole et al., 1995). Also, Elmore (1978) identified four main ingredients for effective implementation:

- Cearly specified tasks and objectives that accurately reflect the intent of policy;
- A management plan that allocates asks and performance standards to subunits;
- An objective means of measuring subunit performance;
- A system of management controls and social sanctions sufficient to hold subordinates accountable for their performance.

Failures of implementation are, by definition, lapses of planning, specification and control (Elmore, 1978). Successful implementation, according to Matland(1995), requires compliance with statutes' directives and goals; achievement of specific success indicators; and improvement in the political climate around a program (Hill & Hupe, 2002).

Further, Giacchino and Kakabadse (2003) assess the successful implementation of public policies on decisive factors. According to them, these are the decisions taken to locate political responsibility for initiative; presence of strong project management or team dynamics and level of commitment shown to policy initiatives. Besides this, the success of a policy depends critically on two broad factors: local capacity and will. Questions of motivation and commitment (or will) reflect the implementer's assessment of the value of a policy or the appropriateness of a strategy.

Motivation or will is influenced by factors largely beyond the reach of policy environmental stability; competing centres of authority, contending priorities or pressures and other aspects

of socio-political environment can also profoundly influence an implementer's willingness. This emphasis on individual motivation and internal institutional conditions implies that external policy features have limited influence on outcomes, particularly at lower level in the institution (Matland, 1995).

From the above discussion, implementation can be conceptualized as a process, output and outcome. It is a process of a series of decisions and actions directed towards putting a prior authoritative decision into effect. The essential characteristic of implementation process is the timely and satisfactory performance of certain necessary tasks related to carrying out of the intent of the law.

Other perspectives on Policy Implementation:

Two schools of thought have been developed for studying and describing implementation of policies. These are: top-down and bottom-up approach.

The Top-down perspective:

The top-down perspective assumes that policy goals can be specified by policymakers and that implementation can be carried out successfully by setting up certain mechanisms (Palumbo & Calista, 1990). This perspective is policy-centered and represents the policymaker's views. A vital point is the policymaker's capability to exercise control over the environment and implementers (Younis and Davidson, 1990). Other scholars see implementation as concerned with the degree to which the actions of implementing officials and target groups coincide with the goals embodied in an authoritative decision (Meter & Horn (1975); Mazmanian & Sabatier (1978). Further, the extent to which successful implementation depends upon linkages between different organizations and departments at local level (Pressman & Wildavsky (1973). The top-down perspective exhibits a strong desire for 'generalizing' policy advice. This requires finding consistent and recognizable patterns in behaviour across different policy areas (Matland, 1995). The top-town perspective emphasizes

formal steering of problems and factors, which are easy to manipulate and lead to centralization and control. Interest will be directed towards things such as funding formulas, formal organization structures and authority relationships between administrative units, regulations and administrative controls like budget, planning and evaluation requirements (Elmore, 1978).

The bottom-up perspective:

The bottom-up perspective directs attention at the formal and informal relationships constituting the policy subsystems involved in making and implementing policies (Howllet and Ramesh, 2003). This perspective has as its starting point a problem in society. The focus is on individuals and their behavior, and in this respect street-level bureaucrats are made central in the political process. The street-level bureaucrats are considered to have a better understanding of what clients need as it is they who have direct contact with the public. Lipsky, (1980) propounds a theory of 'street-level bureaucracy'. Lipsky's theory focuses on the discretionary decisions that each field worker or 'street-level bureaucrat'- -as he prefers to call them--makes in relation to individual citizens when they are delivering policies to them. This discretionary role in delivering services or enforcing regulations makes street level bureaucrats essential actors in implementing public policies. However, implementation failure is connected with discretion and routine, together with personal malfunctions, and one has to identify where the discretion is congregated and which organization's repertoire of routines needs changing (Elmore, 1978).

Conclusion:

In conclusion, both top-down and bottom-up perspectives draw attention to the implementation process. However, there is a conflict between the two perspectives because each tends to ignore the portion of the implementation reality explained by the other.

Therefore policy designers should choose policy instruments based on the incentive structure of target groups, stating precise policy objectives, elaborating detailed ways of achieving these objectives and specifying explicit outcome criteria by which to judge policy at each stage of the implementation process

2.2 Legal backings to Patients rights

The Universal Declaration of Human Rights (UDHR: 1948) is a universal document developed by the United Nations (UN: 1948) to spell out the fundamental human rights of people of all nations in the world. This document of rights was developed as a result of the atrocities that were perpetrated during the Second World War. The declaration encompasses the social, cultural, civic, economic as well as political rights. The UDHR holds the idea that all human beings are born free and equal in dignity and rights, including the right to health. The UDHR is an important document that is used as a universal reference regarding human rights. Several authors maintain that this historical and landmark document continues to inform and to influence our current thinking and practices about human rights (Duchscher, 2004 ; Easley, 2007; London 2005; Reilly & Niens 2000).

All member countries of the United Nations (UN) that have ratified the UDHR are bound by its prescripts as the law of each particular country, and thus the prescripts are translated into national and international law (Leonard, 2006; London, 2005). The laws include human rights in health care, where health is defined by the World Health Organization (WHO) as a state of complete physical, mental and social well-being. The other declaration that supports this view is the Alma Ata Declaration of 1978 which presupposes that health is a fundamental right (Haigh, 2002).

In Ghana, the supreme law which is the Constitution provides for general fundamental freedoms in article 21. Apart from that, other relevant articles are article 15 on the inviolable

dignity of a person, article 16 on the prohibition of slavery, servitude and false labour, article 17 on non-discrimination and article 19 on fair trial. Others are article 26 on cultural rights and practices, article 28 on children's rights and article 29 on the rights of the disabled. The articles in on the non-justifiable Directive Principles of State Policy also provide social objectives for the Government. These can be found in article 37 (2) (b) that details the requirement for protectionist legislation to protect and promote the rights of the disabled and children amongst others. (1992 Constitution of Ghana)

According to the 2009 CHRAJ report Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Additionally, article 34(2) of the 1992 constitution of Ghana recognizes health as a human right and mandates a sitting President to ensure the realization of basic human rights; the right to good health care of every citizen. In recognition of this, the Commission continue its monitoring exercise on awareness of Health as a human right issue state of maternal and infant mortality ,NHIS and Patient's Charter.

The right to health as explained by the 2009 state of human rights in Ghana is based on the premise that people will, and can only demand their rights when they are aware of what the said right, entails. The report (CHRAJ 2009) also published a study on the patient charter and concluded that that many Ghanaians are still ignorant of the existence of the charter though majority still claims they know their rights as patients. On the part of health authorities, about 95.1% of them also responded that the charter allows patients to access high quality service in any part of the country. In assessing the perception of hospital authorities about the impact of the charter, 88.2% of them felt the charter really measures fairness and transparency within the health sector. More effort should therefore be exerted in educating patients about the charter and hence their rights and responsibilities.

2.3 Operationalizing Health Policies: The role of healthcare professionals

In 2007, the Special Rapporteur on Health reporting to the Human Rights Council recognised the pivotal role that health professionals can potentially have in promoting health within a human rights framework (Human Rights Council, 2007). The report stressed that the realisation of the right to the highest attainable standard of health depends upon health professionals enhancing public health, delivering medical care, developing equitable health policies and programs and making key decisions about priorities and resources within government and nongovernment health sectors. In sum, there is no chance of operationalizing the right to health without the active engagement of many health professionals.

The Rapporteur also found that most health professionals were unaware of human rights frameworks or felt uncomfortable about them, believing that it would put them at risk or place unreasonable demands on them. This then is a key challenge in using a human rights framework in healthcare services.

Patients Charter in the Context of Human Rights

Patients' charters are guidelines that target the relationship between health professionals and users of health services, providing information on standards of care that patients can expect to receive and demand as a basic human right (London 2006).

Discussions on patient rights in the literature reviewed is understood and developed within a human rights context. Developed countries such as New Zealand, United Kingdom, Australia, the United States and Norway have seen the introduction of patient bills of rights and responsibilities, or patient charters. These documents recognised patients' rights, defined healthcare objectives, and emphasised the complementary nature of rights and responsibilities between patients and healthcare providers.

In some of these nations, patients' rights have the force of law; in others, they are statements of health policy. Regardless of the form they take, these initiatives have two goals: to

empower patients by providing them with certain rights and entitlements as they interact with healthcare providers and institutions; and to place the patient-healthcare provider relationship on a more equal footing. By outlining what is expected of healthcare providers, institutions and patients, they also serve as important guidelines for the delivery of healthcare services (Smith, 2002).

In the US for instance, a report revealed that the effectiveness of the patient charter was largely due to state legislation that oversees the process (Silver, 1997). This indicates a strong limitation of patient charters in other countries that are not legislated, including Australia. Margaret Smith, (2002) conducted an overview of different patient bills of rights and affirmed that the potential of patient charters to strengthen the position of the patient in the patient–healthcare provider relationship. However, therein also lies a significant limitation of patient charters. Thus, Patient rights and charters only deal with the aspect of health in relation to healthcare services and do not necessarily address the broader, complex underlying determinants of health.

2.4 **Empirical studies on Patients Charter**

In a comparative analysis of patients' rights across five countries, Rider and Makela (2003) explained that irrespective of the comprehensiveness of a country's statement of rights, Patients' awareness and familiarity with the rights are crucial to quality in and effectiveness of the health care system. Patients need to know their rights and responsibilities to ensure that they take actions and ask questions relevant to their care and delivery.

However, in a study by Changole *et al*. (2010), it was reported that half of the patients who participated had never heard of patients rights. This finding indicates how the health care system has neglected such an important legal issue. It was also discovered that no single

poster on patients rights was available on the walls of the unit and no lessons were given to patients concerning their rights.

Also, Zu¨lfikar and Ulusoy(2011), interviewed 128 patients in a large hospital in Turkey using questionnaires that included items on patients' rights. They reported that only 23% of the patients were aware of patients' rights. In addition, 38% of the patients did not know their own diagnosis, and 63% of those undergoing surgery did not know the reason for their operation. Zu¨lfikar and Ulusoy concluded that the two factors contributed to these results wereThe patients' low socioeconomic status and the low educational level of the women participants (about half of those taking part in this study).

The authors also noted that, although the nurses in the hospital where this research took place were aware of the Turkish Patients' Rights Regulations, they believed they could not influence the system in order to achieve implementation of those rights.

Similarly, Abeka-Nkrumah et al.(2010) qualitatively assessed the implementation of Ghana's Patients' Charter and came out with the following findings: majority of patients (53.4 per cent) are not aware of the existence of the Charter of those that know about it, a sizeable minority (33.7 per cent) are not knowledgeable about its contents. Relative to patients, providers exhibit better awareness (61.8 per cent) and content knowledge (61.8 per cent) of the Patients' Charter, but on the whole are not yet carrying out their responsibilities under it.

In 2000, Merakou et al. conducted a survey in Greece to study the way in which patients' rights are being exercised in everyday hospital practice. A total of 600 patients were questioned and interviewed and the results showed that over 97% were not aware, or were only vaguely aware, of Greek law on patients' rights. Nevertheless, their level of

understanding of the information received was high, as was their level of satisfaction that their questions were answered by the doctors.

Similarly, Joolaee et al. (2003) conducted a qualitative study in a Tehran hospital by using semi structured interviews to discover what patients and their families understood about their rights. Although not being able to verbalize patients' rights as they appeared in an act on patients' rights, these respondents thought that 'something was wrong'. They believed that their right to care included patient-centered care and 'caring attendance', which they did not receive. These patients concluded that this was partly due to the extreme nurse shortage, resulting in nurses having increased workloads with very little reward.

Woogara (2001), studied qualitatively the work culture and ward environment in a general hospital in England by using ethno-methodological observation accompanied by unstructured and semi structured interviews. This concerned aspects of protecting the dignity and privacy of patients. This author found that many doctors and nurses were not aware of the 1998 Human Rights Act (especially the older nurses) and thus they did not implement these rights to the same degree as the younger, more knowledgeable nurses.

Similarly, a qualitative research study was conducted in Israel by Steinmetz and Tabenkin(2001), concerning physicians' opinions about the Patient's Rights Law. Their conclusions were that, although the law was very important, the work conditions of physicians in Israel (time and place limitations) made it difficult to implement it. They were also concerned that the law could be abused by patients, and that medical care would come to be practised defensively.

According to Büken & Büken (2004), establishing patients' rights is a step towards protecting patients' rights, but they report that violation of these rights is common in healthcare institutions in Turkey. This is because of systemic and institutional obstacles, such as

insufficient healthcare staff and inadequate purchase and maintenance of technological equipment, also play an important part in rights violations.

Albishi (2004) also studied the concept of patients rights in a multidimensional way in Saudi Arabia, by exploring the patients', physicians' and nurses' lived experiences with patients' rights. He found out that meeting the patients' needs must be the core concept for the meaning of patients' rights in Saudi Arabia. He also found the lack of knowledge about the rights, lack of standard of practice among the hospitals and the impact of service pressure and subsequent lack of holistic care, as some of the barriers to patients' rights practice in Saudi Arabia.

Although the operationalization of the Patients' Charter seem to be very difficult as depicted in the above literature, the journal on Human Rights Education suggest that, information and opportunities to learn about issues such as the definition and reinforcement of patients 'rights should be available to every- one, not just health- care professionals or patients (Human Rights Education Associates, 2000). Mass communication media, educational institutions, medical companies, political parties and religious groups should all have an important role to play in the reinforcement of patients' rights.

2.5 **Conclusion**

This literature review firstly discussed the theoretical underpinnings of health policy making and implementation. From the discussion it was discovered that policymaking and for that matter health policy making is best conveyed by describing it as a process, rather than as a single, once-for-all activity. Also, The top-down and bottom-up perspectives as well as other theoretical underpinnings of policy implementation was discussed.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses the methods and procedures that were used in realising the objectives of the research. A detailed discussion on the rationale for selecting a qualitative case study approach is also presented. Additionally, ethical issues with reference to consent and confidentiality are discussed. Also, sampling processes and data collection techniques, as well as instruments are discussed in this chapter.

3.1 Research Approach

This study employed a qualitative research approach. This approach, according to Burns et al., (2009) is the blueprint for conducting a study; it guides the researcher in the planning and implementation in such a way that it most likely to achieve the intended goals. This research approach will allow for a deeper understanding about the operationalization of the Patients' Charter in public hospitals in Ghana. Although Ghana's patients' charter has been in existence since 2012, there has not been much research into this subject. This study will therefore apply qualitative approach in an attempt to understand the experiences of patients and health management regarding the operationalization of the Patients' Charter.

3.2 Research Design

A case study design was employed in this study to ascertain the patients and health staffs knowledge on the patients' charter as well as their experiences since the operationalization of the charter in Kasoa Polyclinic. The case study design offers a holistic form of inquiry (Gangeness and Yurkovich, 2006) and Topping (2006) asserts that case studies have wide application in nursing research. DeVaus (2001) considers that a case study which develops a causal account and can indicate how the causal factors interrelate, for example how the

environment and staff behaviour together impact on the observance of the provisions in the patients' charter, rather than as individual and separate influencing factors. The case study design is seen as appropriate since the researcher is interested in a particular setting and how the rights and responsibilities of patients is being operationalised. This design also gave the researcher the opportunity to do an in-depth assessment and analysis of each of the objectives with a view not to generalize the findings of the study but to portray what specifically pertains in Kasoa Polyclinic since the operationalization of the patients' charter.

3.3 **The Study Area**

The study was conducted in Kasoa Polyclinic in Awutu Senya East Municipal Assembly. The Polyclinic is one of the three Government health facilities in the Municipality. The others are Ofaakor CHPS Compound and Opeikuma CHPS Compound.

Kasoa Polyclinic was established in 1983 and was a health centre until December, 2012 when it was elevated to the status of a Polyclinic. There are six main units in the polyclinic. They are the Reproductive and Child Health Unit, Disease Control Unit, Laboratory Unit, Maternity Unit, Children's Unit as well as the general Out Patients' Department. Below is the Health Personnel Inventory (Kasoa Health Centre).

Table 1: Health Personnel inventory of Kasoa Health Centre

NO.	Staff Category	No. At Post	No. Required	Gap
1	Medical officer(s)	1		
2	Technical Officer (Disease	3		
3	Control)	0		
4	Technical Officer (Leprosy)	0		
5	Technical Officer (Nutrition)	0		
6	Public Health Nurse	28		
7	Staff Nurse	20		
8	Community Nurses	14		
9	Ward Assistants	0	1	1
10	Physician Assistant	0	2	2
11	Revenue Collectors	0	4	4
12	Midwives	1	3	2
13	Biostatistics	17		
	Total	**89**		

Source: Directorate of Health-Awutu Senya East Municipal, September 2012

The Nurse/Patient ratio at the Kasoa Health Centre in 2009 was 1:868 which was reduce to 1:859 in 2010. In the year 2011 it increased to 1:933 and this further drop during the half year of 2012 to 1:464. Due to the high attendance at the Health Centre there is the need for more nurses should be transfer to the Kasoa Health Centre to assist health care delivery.

Doctor/Patient ratio in Kasoa Polyclinic is very poor due to the fact that there is only one (1) Medical Doctor at the Kasoa Health Centre taking care of all OPD attendants. In the year 2009, the Doctor/Patient ratio was 1:46,859 and reduce in 2010 to 1:46,365. In the year 2011 the Doctor/Patient ratio increased from 1:46,365 to 1: 50,380 and this further drop in 2012 as June to 1: 25,039. From the above, one may suggest that the Human Resource state of the Polyclinic needs urgent attention because it forms the basis for quality health care delivery.

3.4 Sources of Data

Data collection is a process of collecting information from the identified participants in a systematic manner to answer the research question and is relevant to the objectives of the study (Burns et al., 2009).

In this study data was collected by means of interviews, observations and field notes. Additionally, the researcher has already had an informal discussion with health authorities at the Kasoa Polyclinic to ascertain the possibility of conducting the research in that facility and also to gain a fair idea about the research area. A formal letter from the school requesting for the study to be conducted in the facility was also sought. At the District Health Directorate, an approval letter for the study was granted after the proposal and interview guide had been thoroughly examined.

In addition to the primary data, secondary sources were used to obtain additional information to buttress the responses gathered from the interview. A number of secondary sources, both published and unpublished materials from annual reports and journals, articles from data bases such as Ebschost, print media, internet were also utilised.

3.5 Study Population

According to Polit et.al (2006) a population is the entire set of elements, that is, individuals, objects and events that have common characteristics as determined by the researcher. The population in this study comprises staff and patients of Kasoa polyclinic.

3.6 Sampling Technique

A purposive sampling technique was used to select 5 frontline health workers who had worked for more than two years in Kasoa Polyclinic. These included four staff nurses and the Administrator of Kasoa Polyclinic. This criteria is justified by the fact that the researcher wanted to gather experiences of the frontline health staff with regards to the operationalization of the patients' charter. To this end, only those who have been working for more than two years were purposively selected to respond appropriately to the questions asked.

Currently, Kasoa Polyclinic has six main units; comprising the Reproductive and Child Health Unit, Disease Control Unit, Laboratory Unit as well as maternity, out patient, children's unit.

The researcher selected the out patients' unit and the maternity unit with the support of the Administrator of the facility. It was agreed that based on the objectives of the research, the selected units were better placed to have respondents who meet the selection criteria.

During the data collection these wards were visited on a regular basis. On each occasion, the Administrator supported in identifying the appropriate respondent who met the selection criteria in the study.

In addition to the health staff, twenty (20) patients were selected for the study. Convenience sampling technique was used. This technique was employed because it was only the most readily accessible persons who met the sampling criteria and are willing to participate in the study were approached and interviewed. Of the twenty patients, ten were selected from the maternity ward and ten from the outpatients unit.

3.7 **Sample size**

In qualitative research, the size of the sample is controlled by the nature of data required. In this study, 20 patients who were willing to participate will be included in the sample. Ten patients in the out patients unit and ten inpatients from the maternity unit participated in the study. Also, 5 health staff were selected to participate in the study. The Administrator as well as 2 clinical staff nurses were selected from the maternity and out patients units to be interviewed. The Health staff were purposively selected based on the sampling criteria. Patients were selected and interviewed until the point of saturation when responses became repetitive.

Also, the criteria used in selecting patients were that:

- Respondent must be an adult patients (18) years and older.
- Must have visited the facility at least once
- Has the ability to respond to questions

3.8 Data Collection Tool

An in-depth interview guide with probing questions was used. Each interview was tape recorded and transcribed verbatim. Informal observation and writing of field notes as well as other sources – secondary data were used in the analysis.

In addition to the primary data, secondary sources will be used to obtain additional information to buttress the responses gathered from the interview. A number of secondary sources, both published and unpublished materials from annual reports and journals, articles from data bases such as Ebschost, print media, internet were also utilised.

3.9 Data Management and Analysis

Data in the form of voice recordings was transcribed. Additionally, the transcribed data and field notes were reviewed and categorized based on themes, patterns and relationships that were determined. The theses were: resources to execute the Patient's charter, Availability of tool/Community sensitization, Monitoring and Training/ orientation. Data was further organized and categorized according to the patterns identified. A final categorized data was presented for discussion. In the discussion, relevant statements in the study were quoted verbatim to support the research findings.

3.10 Ethical considerations

A qualitative research requires a methodological soundness and adequacy, therefore; Guba's Model of Trustworthiness as described by Lincoln et al., (1985) was used to ensure this. The four strategies that were used to ensure trustworthiness included credibility, and confirmability.

Credibility requires sufficient submersion of the researcher in the research setting to enable the recurrent patterns to be identified and verified. This was addressed by listening to the audio recordings repeatedly after which a verbatim transcription of the recordings are made. The transcripts were typed by the researcher and read them many times during data analysis.

The strategy of confirmability also guarantees that the findings, conclusions and recommendations are supported by the data and that there is correlation or congruence in the researcher's interpretation and the actual evidence (Brink 2006; Wolf 2003).

In this study, objectivity was maintained throughout the research process. The actual evidence in this study includes the transcribed interviews, field notes of observations and participation with the respondents.

Permission to undertake the study was sought from the Department of Public Administration and Health Administration of the University of Ghana Business School. Additionally, a letter from the Municipal Directorate of Health Services was also sought before the study was conducted in Kasoa Polyclinic. All the participants who took part in the study were required to give an informed consent. Confidentiality, privacy, protection from harm and the respect for the human rights and dignity of the participants was maintained in this study.

3.11 **Field Experience**

My interactions with Officials at the Municipal health Directorate was quite difficult. It took over two weeks for an introductory letter from the Directorate to Kasoa Polyclinic. At the polyclinic, I introduced myself as a staff of the Ghana Health Service and was in uniform throughout the days of my interview. This enhanced accessibility to the hospital and the wards. Most of the nurses were willing to grant me audience for the interview despite their busy schedule. In fact everyone was supportive.

However, interviewing in-patients was a bit problematic and had to spend more that a day with the patient in order to complete the interview. This was because I did not want to interrupt with the care process; hence, the interviews were conducted at a slow pace and at convenient times.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents the findings of the study. It also discusses the findings in light of appropriate available theories and literature. The findings and discussions are presented in three main thematic areas. These are: Knowledge and Awareness among patients and Health staff, factors that inhibit the operationalization of the patients' rights, and responsibilities, factors that promote the operationalization of the patients' charter.

4.1 Health Workers' Awareness and Knowledge

An analysis of the findings of this study indicates that heath workers in Kasoa Polyclinic are aware that every patient in the facility has rights which must be respected. This is exhibited in the various responses received during the interview. All the Health workers interviewed promptly agreed that patients, like all human beings have rights which need to be respected. The studies findings show that, all Health workers interviewed expressed their awareness of a document containing a list of rights and responsibilities. This buttresses the findings of Abekah-Nkrumah et al. (2010), who also quantitatively assessed the implementation of Ghana's patients' Charter and found out that;

'providers exhibit better awareness and content knowledge of the Patients' Charter, but on the whole are not yet carrying out their responsibilities under it'.

However, when it comes to knowledge of the content of the Charter, the findings of this research is quite contrary to the findings of Abekah-Nkrumah et al. (2010). Additionally, Health workers were quiet knowledgeable with regards to the contents of the patients' charter as indicated in this extract. This indicates that health Workers are aware of the existences of

the Charter know its contents. Below are the responses gathered when health workers were asked to explain what they know about the patients' charter:

"As a Health Worker I know that the patients' charter is a document I work with every now and then. In a summary the patients' charter tells me what the patients rights and responsibilities are. It is a very important document as most often patients rights are trampled upon. But if they know their rights and responsibilities these things are either minimised or completely eradicated"

In the opinion of another respondent, the Patients' Charter

"is a document that spells out things like the right to healthcare, right to privacy, not being discriminated against. In a nutshell it is a document that tells me about the does and don'ts when it comes to handling of the patients in this facility. Personally I have not seen the document but I know that the charter is to guide health worker in their daily interactions with patients"

These responses demonstrate the fact that Health Workers are fairly aware of the need to respect patient's rights. They are also aware of the existence of the patients charter, have some level of knowledge about the contents of the Charter. When asked to mention at least three rights and three responsibilities of patients in the facility, only two out of the five respondents were able to provide some answers. One of the said:

"The right to be treated well, respected and have some privacy. Patients also have the responsibility to be respectful, corporative in the care process and

Patients must be treated fairly and equally. They need to also do their part by following all the instructions we give them"

4.2 **Patients Awareness and Knowledge**

Contrary to the above, an analysis of patients' knowledge and awareness of their rights and responsibilities on the other hand revealed a stark reality. This supports the findings by Changole *et al*. (2010), who reported that half of the patients who participated had never heard of patients rights. Not only were patients unaware of their rights they seemed not to care about them. Their sole aim was to get well as soon as possible and back to their economic activities. When asked to mention their rights as patients of the facility, one female patient said:

"I'm not aware of any rights as a patient. All I know is to comply with the doctor's instructions so that I can get well soon"

Other responses gathered were *"right to ask questions concerning my health and obey what the nurses tell me to do" and*

"To give the midwife something as a form of appreciation for all her efforts"

Of the 20 interviewed, 7 respondents were not able to express any knowledge of their rights and responsibilities. The remaining 13 said they know something. However, a probe revealed that the knowledge of the ten were wrong and no where near the contents of the Charter. For instance, they mentioned that some of their rights as patients in the facility were:

"To give something to the midwife when I am discharged", "*To be honest about my condition"* and *"to respect the nurses who take care of me"*

The final three respondents interviewed expressed their knowledge about patients rights and responsibilities as follows:

'*I know that everyone should be accepted in this facility and every patient should be treated equally. Also, it is my responsibility to tell the truth about my condition, to be honest about my condition and to respect the nurses who take care of me"*

Another patient expressed his right as:

"To be attended to and treated as a patient, to have access to all available facilities when the need arise and to have my information kept private and confidential. It is my responsibility to make myself available and to make available every information required to enable decision making"

Awareness and knowledge of the content of both patients and health staff of the patients' charter are two crucial elements in operationalizing the patients' charter. In fact, Rider and Makela (2003), conducted a comprehensive analysis of patients' rights across five countries and concluded that irrespective of the comprehensiveness of a country's statement of rights, Patients' awareness and familiarity with the rights are crucial to quality in and effectiveness of the health care system. Patients need to know their rights and responsibilities to ensure that they take actions and ask questions relevant to their care and delivery. Therefore an effective and efficient operationalization can be realised when aggressive measures are put in place to ensure that both patients and health staff are adequately informed about their rights and responsibilities.

4.3 **Promoting Factors**

Respondents in the Health Staff category were asked to narrate their experience with the operationalization of the patients' charter and to provide factors that affect the operationalization of the Charter. The responses arecategorised into three main themes namely; resources to execute the Patient's charter, Availability of tool/Community sensitization, Monitoring and Training/ orientation.

Resources to execute the Charter

Health workers expressed the usefulness of the patients' charter in the care process. The patients' charter according to one respondent;

"*.....when patients know about the patient's charter it helps, it helps...It guides us to be more cautious in handling the patients. I think beside the patients' charter we have the code of conduct for nurses and midwives.*"'

This assertion is also supported by anther respondent who feels that the patient's charter has improved patient- health worker relationships when she said:

"I think it's a very good tool. It makes us aware of what the patients' rights are. It makes the patients aware of what his or rights and responsibilities are. It helps me as a healthcare worker to improve my service. This means we are able to ensure that patients are treated well in the facility"

Another response was that;

"*I have witnessed one or two occasions where a patient who knows her rights confronted the nurse. The patient felt the nurse was not polite to her because the nurse shouted and*

sneered when she was asked where the lavatory is located in the facility. You see most of the time nurses feel as if they know it all. But immediately you make them know that you know your rights, they recoil and behave civilly towards you. Sometimes they even request to be transferred because of the embarrassment they face and this was what happened in this case"

Thus, the availability of the tool is necessary to ensure adherence to respecting Patients' rights and responsibilities. Rider and Makela (2003) also back this assertion and suggests that to ensure a successful operationalization there is the need to embark on an aggressive educational campaign for all stakeholders. Margaret Smith (2002), also adds that the patients charter is set to empower patients by providing them with certain rights and entitlements as they interact with healthcare providers and institutions; and to place the patient-healthcare provider relationship on a more equal footing. By outlining what is expected of healthcare providers, institutions and patients, they also serve as important guidelines for the delivery of healthcare services.

Availability of tool/Community sensitization

Health worker respondents were asked to explain how they are ensuring that the Patient's charter is operationalised in the facility. The general view or response was that the patients' charter was pasted in all the units of the facility; however because of the ongoing renovations, the posters had been removed and will be pasted after the painting. Also health workers in the facility are constantly reminded to adhere to this charter during monthly and annual review meetings. Management also do spot checks occasionally to ensure that the patients are being treated well.

It was gathered from the interview with health workers that although awareness and knowledge is relatively high, the tool was not visible at the wards of the facility.

The availability of the tool serves as a constant reminder to both health workers and patients about the need to respect the provisions in the Charter. As Albishi (2004), asserts, meeting the patients' needs must be the core concept for the meaning of patients' rights. He reports that the lack of knowledge about the rights, lack of standard of practice among the hospitals and the impact of service pressure and subsequent lack of holistic care, as some of the barriers to patients' rights practice.

Operationalizing the Patients' Charter requires a deliberate education among the general public and especially among patients. The journal on Human Rights Education therefore suggest that, information and opportunities to learn about issues such as the definition and reinforcement of patients 'rights should be available to every- one, not just health- care professionals or patients (Human Rights Education Associates, 2000). Mass communication media, educational institutions, medical companies, political parties and religious groups should all have an important role to play in the reinforcement of patients' rights.

Monitoring and Training

A proper managerial policy, monitoring systems, and a responsive managerial system is another promoting factor in operationalizing the patients charter according to respondents in the health worker category. While health worker respondents explained that patients do not complain because

"*they know the conditions in this facility and cannot complain about something like privacy".*

Patients' respondents also explained that they rarely complained because of the fear of being tagged 'difficult'. Although a patient agreed that her last complain was well addressed she was afraid to complain again because of what she witnessed when a patient tagged as difficult was neglected most of the time. Information gathered from the health worker respondents

indicated that although there are standards for health professionals' conduct, or, most of the tenants are flouted, and yet there are no sanctions.

With regards to training, it was made evident from the interview with respondents in the health worker category that there has not been any official training specifically on the Patients Charter. They explained that training is done in a holistic manner and is mostly incorporated into customer care trainings. A respondent observed that

> *".....The last time we had a staff meeting I mentioned the patients charter because many at times our nurses go out of line and the charter helps them to come back. So this is what I know about the patients' charter"*

4.4 **Inhibiting Factors**

There were several factors that were found to be inhibiting the effective operationalization of the Patients' Charter. These may be grouped into: institutional implementation priceedures and low knowledge among patients.

Although all respondents (Health Staff) agreed that the patients charter is an important tool to improve the care process, all respondents were quick to add that operationalizing the Charter requires some resources which when not available makes operationalization unrealistic. To these health workers, certain institutional inadequacies such as lack of supervision, heavy work load because of staff shortage, and lack of facilities as well as basic logistics to ensure that the tenants of the Charter are adhered to are simply on available. This finding is in line with the assertion by Matland (1995), who theorised that a the success of a policy depends critically on two broad factors: local capacity and will. He further emphasised that the will to implement a task is influenced by factors largely beyond the reach of policy environmental stability. And that competing centres of authority, contending priorities or pressures and other aspects of socio-political environment can also profoundly influence an implementer's

willingness. This emphasis on individual motivation and internal institutional conditions implies that external policy features have limited influence on outcomes, particularly at lower level in the institution (Matland, 1995).

Respondents lamented that the facility is too small hence; the respect for one's privacy is a challenge. All respondents noted that staff shortages and heavy workload and inadequate facilities are inhibiting the operationalization of patients' charter. Extracts from the interview are summarised below:

".....we're committed to observing patients' rights but in order to ensure things like confidentiality, privacy and autonomy, there are certain basic prerequisites such as expanded space, enough tools and equipment that will enhance our work.....as you can see this room is supposed to take two patients but there are currently six people. How do you ensure privacy in this situation? We are trying our best".

Another respondent explained that:

"*The staffs here are not enough. There is only one doctor serving about 500 patients a day and it is even worse on market days. How can I know all patients in the ward? I know that I am supposed to introduce myself to each patient but it becomes impossible. I have to execute my work as quickly as possible in order to attend to the next patient"*

Another respondent openly admitted that

"*sometimes I grow so tired and forget to be courteous as a health worker....it is not easy to observe all the provisions of the charter with this workload. Our shifts are long and the patients are many*".

It is evident from the above that human and capital resources are very essential in executing the tenants of the Charter. Similar studies also attest to this fact. In a qualitative research study

conducted in Israel by Steinmetz and Tabenkin(2001), concerning physicians' opinions about the Patient's Rights Law. Their conclusions were that, although the law was very important, the work conditions of physicians in Israel (time and place limitations) made it difficult to implement it. They were also concerned that the law could be abused by patients, and that medical care would come to be practised defensively.

According to Büken & Büken (2004), establishing patients' rights is a step towards protecting patients' rights, but they report that violation of these rights is common in healthcare institutions in Turkey. This is because of systemic and institutional obstacles, such as insufficient healthcare staff and inadequate purchase and maintenance of technological equipment, also play an important part in rights violations.

Complaint Procedure

Findings of the research indicate that there are no systematic complaint procedures in the facility. All the Health Workers interviewed could not readily explain how complaints are handled in the facility. The researcher however, chanced on a complaint box in an obscure place closer to the office of the Administrator of the facility which has rusted. It is evident that that facility has not been used for years. One health Staff examined that patients' rarely complain to her. Another respondent mentioned that:

"*Last January during the municipal's end of year performance review, one of our media partners, a lady from PINK FM insinuated that the nurses of this facility are impolite with patients. But I explained that the patients charter and other codes enshrines in us to be polite. The patients have every right to report any misconduct to the senior nurse in charge or the Administrator but most of the time we do not get these complain".*

As analysis of patients' responses on complaint procedure revealed that most of the patients have had issues with the care process at one point in time. However, most of them did not

know the process to follow. The few who ventured to complain once feel reluctant to repeat because she may be tagged at a '*difficult patient'.* This is evident in the following responses of one of the respondents:

"*The last time I complained to the nurse about my bed which was not very comfortable. The administrator came over and my bed was changed. I do not want to complain again about the mosquitoes because I am sure the nurses will think I complain too much and may not be friendly with me".*

Low knowledge among Patients

The adage, 'Knowledge is power' and 'doctor knows best' is perhaps most appropriate in trying to describe what is inhibiting the operationalization of the Charter in Kasoa Polyclinic. As stated earlier, patients respondents had no knowledge of their rights; hence, do not complain when their rights are violated. Patients' respondents were asked to narrate their experiences with regards to how they were handled during their last visit to the facility. Respondents were asked to explain whether they know to the identity of the health staff handling them, about their health condition as well as Policies and regulations in the facility.

An analysis of the responses indicate that all the respondents did not know the identity of the staff handling them. The researcher probed by asking how respondents will be able to identify the health worker that is handling them and the general response was that they will describe him or her physical features:

> *"None of the nurses handling me introduced herself to me I only know them as aunty nurse and the doctor as chief"*

When it comes to policies and regulations, responses centred on the need to patiently queue for services and to pay all medical expenses when one is not on the National Health Insurance

Scheme. One respondent who gave an indication that he knew what the regulation responded that:

" I saw a paper pasted in the OPD – no smoking. I also know that I have to patiently wait in the queue turn".

The findings revealed that because of the low knowledge on their rights as patients in the facility, they did not insist and comply with whatever the health worker instructs them to do the 'doctor knows best'. This also confirms the assertion in 2007, by the Special Rapporteur on Health reporting to the Human Rights Council. He recognised the pivotal role that health professionals can potentially have in promoting health within a human rights framework (Human Rights Council, 2007). The stressed that the realisation of the right to the highest attainable standard of health depends upon health professionals enhancing public health, delivering medical care, developing equitable health policies and programs and making key decisions about priorities and resources within government and nongovernment health sectors. However, health professionals are unaware of human rights frameworks or felt uncomfortable about them, believing that it would put them at risk or place unreasonable demands on them. Thus, making operationalization of the charter almost impossible at the facility. When patients are empowered with the knowledge of the tenants of the Charter, they will insist on them and health workers will also be alerted and work in conformity of the tenants of the Charter.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter gives a summary of the study. It also presents the conclusions drawn from the results and recommends strategies towards enhancing the operationalization of the Patients' Charter in Kasoa Polyclinic and other related health facilities.

5.1 Summary

This study assessed the operationalization of Ghana's Patients' Charter in public Hospitals by using Kasoa Polyclinic as a case study. Specifically, the study examined the awareness and knowledge of the content of the patient's charter among patients and health staff, as well as factors that affect the operationalization though the experiences of health staff of Kasoa Polyclinic.

To achieve the above, the study employed the case study design with the qualitative paradigm. In all 20 patients and 5 health staff were selected and interviewed, using the in-depth interview technique. The purposive and convenient sampling techniques were used for health staff and patients respectively.

Although the research focused specifically on Kasoa Polyclinic and the sample size was limited, the findings of this study offer valuable insights into the operationalization of the patients charter in public hospitals and serve as a platform for further study into this very important subject.

The Key findings are summarised below:

Knowledge and Awareness of Patients and Health Staff

Heath workers in Kasoa Polyclinic are aware and know the contents of the patients' charter. An analysis of patients' knowledge and awareness of their rights and responsibilities on the

other hand revealed a stark reality. Not only were patients unaware of their rights they seemed not to care about them. Their sole aim was to get well as soon as possible and back to their economic activities.

Factors affecting the Operationalization of the Patients' Charter

Health workers expressed the usefulness of the patients' charter in the care process and that the patient's charter has improved patient- health worker relationships. The study gathered that the availability of the tool, according to respondents is necessary to ensure adherence to respecting Patients' rights and responsibilities

An effective monitoring system, as well as a responsive managerial system is another promoting factor in operationalizing the patients charter according to respondents in the health worker category. There are no systematic systems in place to address complaints. Although a patient agreed that her last complain was well addressed she was afraid to complain again because of what she witnessed when a patient tagged as difficult was neglected most of the time. Information gathered from the health worker respondents indicated that although there are standards for health professionals' conduct, or, most of the tenants are flouted, and yet there are no sanctions.

With regards to training, it was made evident from the interview with respondents in the health worker category that there has not been any official training specifically on the Patients Charter. Training is done in a holistic manner and is mostly incorporated into customer care trainings.

Institutional inadequacies such as lack of supervision, heavy work load because of staff shortage, and lack of facilities as well as basic logistics to ensure that the tenants of the Charter are adhered to are simply on available. Thus, human and capital resources are very essential in executing the tenants of the Charter.

5.2 Conclusions

Health workers in Kasoa Polyclinic are aware and knowledgeable on the tenants of the patients' charter. However, patients have no knowledge about their rights; hence, do not insist on them. This affects a successful implementation of the Patients Charter. This study gathered that making the patients charter operational in the facility is marred by institutional inadequacies as well as low knowledge among patients. However, from the interview, it was evident that there are opportunities for Management of the facility to ensure that the operationalization the patients' charter is realised. These include making the tool available, sensitizing community members, training as well as monitoring activities of frontline health workers to ensure a successful operationalization of the Charter in Kasoa Polyclinic.

5.3 Recommendations

The findings of qualitative studies are not expected to be generalized and their findings and should only be applied with caution and after adjusting them to each specific context. However, recommendations may serve as a guide to understanding similar situation. Based on the conclusions drawn from the above, the study recommends that future research could focus on the role of various levels-national regional and district- in ensuring the operationalizing Ghana's Patients' Charter.

Management at Kasoa Polyclinic are encouraged to increase awareness of patients rights and responsibilities though other means such as awareness campaigns on local radio stations. Besides, constant monitoring and surveys will reveal a lot about the effectiveness of the campaigns conducted to raise awareness of patients' rights and responsibilities.

Finally, the Municipal Health Directorate should urgently provide enough human and capital resources in order to ensure that patients' rights are respected in the facility.

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APPENDICES

University of Ghana Business School

Department of Public Administration and Health Services Management

Interview guide for Health Staff

I am a student of the University of Ghana Business School and would like to find out how the patients' Charter is being operationalized in this health facility. Be assured that your identity/name will not be referred to anywhere in the final research report. The information you give will be used purely for academic purposes.

Please respond to the following questions:

Gender___ Current Designation_____

Professional qualification: _____

Experience____ (yrs)

Objective One: Awareness and knowledge about the patients' Charter

1. Briefly tell me what you know about the Patients' Charter
2. Please tell me three rights and three responsibilities of patients in this facility
3. Have you been trained on the Patient's Charter?
4. Mention three specific ways by which you are educating the public about the Charter?
5. Do you think these ways are effective? Give reasons

Objective Two: Health Manager/Staff's experiences in operationalizing the Patients Charter

1. Mention three things you have done to ensure that patients rights and responsibilities are operationalised in this facility?
2. Have you had any support from the national or regional level in operationalizing the patients Charter in this facility?
3. Mention at least three challenges you have encountered in the operationalization of the Charter in this facility
4. Does this facility have an elaborate complaint procedure?
5. Please take me through a process whereby a complaint is made and handled step by step.
6. Please share with me an example of a recent complain you were able to resolve

Objective Three: Factors that affect the operationalization of the patients' Charter

7. What Strengths/weaknesses have you identified in the Charter
8. Please mention three or more factors that has helped in making the Charter operational in this facility
9. Mention the factors that has inhibited the operationalization of the Charter in this facility
10. Mention three specific things that must be done to ensure that patients' rights and responsibilities are respected in public health institutions

Thank you

University of Ghana Business School

Department of Public Administration and Health Services Management

Interview guide for patients

I am a student of the University of Ghana Business School and would like to find out how your rights and responsibilities are being operationalised in this health facility. Be assured that your identity/name will not be referred to anywhere in the final research report. The information you give will be used purely for academic purposes.

Please respond to the following questions:

Gender___ Age___

Inpatient/ Outpatient_____

Knowledge and Awareness:

1. Do you know your rights and responsibilities as a patient in this hospital?
2. Has any health staff informed you about your rights and responsibilities?
3. Please tell me at least your three rights as a patient of this facility
4. Please tell me at least your three responsibilities as a patient of this facility
5. Narrate briefly your experience(s) when you last visited this health facility in terms of information about:
    - The identity of the health staff handling you
    - About your health condition

- Policies and regulations in this facilities
- Procedure for complaint
- Privacy
- Confidentiality
- Safety

6. How could the interaction have been made more satisfactory?
7. Please tell me about how your last complain(s) was resolved
8. Were you satisfied with how it was resolved?
9. Tell me at least three things you think should be done in order to ensure that patients rights and responsibilities are respected in this facility

Thank you