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Participatory action approach for client-centered health insurance

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Abstract

This methodological paper systematically describes the steps towards exploring client-perceived barriers to enroll in the National Health Insurance Scheme in Ghana. To respond to the stagnating enrollment rate and to provide evidence-based information for developing policy and practice, the request for this study was made by the insurance authority. We adopted a Participatory Action Approach (PAA) and employed a linked trajectory of qualitative and quantitative methods to inquire deeply into clients' motives and assumptions, and the root causes of these barriers, while transferring learning among multiple stakeholders in the system: the client, the healthcare provider, and the insurer. Data were collected in 2011 and 2012 among clients in their local communities in two regions in Ghana. Clients were participants in the research, expressing and sharing their emic perspectives and commonly shared opinions with the other stakeholders. This paper explores the contribution of the PAA to healthcare and health insurance studies. We claim that the PAA is a necessary approach for the study of a complex situation such as the health insurance context in Ghana as well as for the facilitation of learning and democratic decision-making. Making multidisciplinary stakeholders, including clients, part of the research contributes to finding solutions

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that are acceptable to different stakeholders. Our study contributes to PAA methodology knowledge and provides new insights on combining qualitative and quantitative research methods. We propose this as a model to be used within action research that can also be applied in other contexts outside of Africa.

Keywords

Participatory Action Approach, clients, perceptions, health care, health insurance, policy development, Ghana

Introduction

Data that capture the experiences of people, their perceptions of illness, health seeking, healthcare and health insurance services, their concerns and their expectations, are extremely useful for managers and policymakers in order to design policies and programs and navigate them towards successful implementation. Making optimal use of this information is likely to contribute to building trust and participation (Asenso-Boadi, 2010; Jehu-Appiah et al., 2011a, 2011b). In the rapidly expanding field of health insurance in Africa, where scientific evidence of the effect of such programs is extremely important, the vast majority of research currently presented in the literature focuses on willingness to join and pay for insurance, mainly based on socioeconomic surveys (Blanchet et al., 2012; Brugiavini & Pace, 2010; Jehu-Appiah, et al., 2010; McIntyre et al., 2005; Sarpong et al., 2010).

The context of this study is Ghana, a country located on the west coast of Africa with a population of over 25 million people. Health care is provided by public and private healthcare providers (including church-based). The system has five levels of providers: health posts, which are the first level primary care for rural areas; health centers and clinics; district hospitals; regional hospitals; and tertiary hospitals. Health care is variable throughout the country, with urban areas being served well with an increasing choice of private healthcare facilities, while rural areas have a more limited choice. Services here are mainly offered by public and/or church-based health facilities. Patients in these areas often have to travel longer distances to access health care or else rely on the traditional healers. In total, there are over 5500 healthcare facilities in Ghana. Many qualified health professionals prefer practicing in urban areas.

Ghana is one of the first countries in Africa to have introduced national health insurance. The National Health Insurance Scheme (NHIS) was established by an Act of Parliament (Act 650) in 2003 and aims to secure financial risk protection against the cost of healthcare services for all residents in Ghana. Massive information campaigns were organized for the population and for people working in the health sector. The NHIS contracted close to 4000 accredited healthcare facilities to deliver the healthcare services. Despite major progress in the scheme's implementation and attainment of a cumulative enrollment rate of over 70% (17 million people), the percentage of people actively using the scheme reached a mere 34% of

the population in 2011 (<http://www.nhis.gov.gh>). This reveals that a large portion of the population is not enrolling in the scheme or is dropping out, despite exemption mechanisms for those below 18 and above 70 years of age, pregnant women and indigenous people. Earlier studies revealed a variety of implementation problems, such as insufficient information and communication, low perceived quality of health services delivered by the healthcare facilities, and delays in card production and distribution (Jehu-Appiah et al., 2011a; Ministry of Health and Ghana Health Service, 2010; NHIA, 2010; Sarpong et al., 2010).

This study has been commissioned by the National Health Insurance Authority (NHIA) with the intention to obtain a better understanding of the clients' perceived barriers to enroll in the scheme so that it can improve its services. This study aims to gain a better understanding of clients' perceptions regarding illness, health-seeking, health care and health insurance services, in order to contribute practical solutions to facilitate client-centered health care and health insurance services and increase participation in the scheme. We do not focus on barriers but rather on what motivates people to use health care and health insurance services. The resulting scientific evidence is intended to inform policy and practice.

Understanding clients' perceptions implies studying clients in their own sociocultural context and taking account of other stakeholders who are part of that context. The initial stakeholder meeting revealed not only the urgency of the issue but also the great need for solutions to improve the situation. The aforementioned features of *multi-stakeholder involvement in a complex environment* and *need for social change* required a Participatory Action Approach (PAA) combined with the application of a linked trajectory of qualitative and quantitative methods. In this paper, we aim to demonstrate the value of our research design. We argue that the PAA and used methods are instrumental in the inquiry process to generate rich data grounded in practice, which helps to obtain a better understanding of clients' perceptions, behavior and decision-making. Moreover, the process that allows stakeholders to engage in the research as partners is key in facilitating ownership and learning, both important conditions for social change and for the improvement of services. This study, therefore, also contributes to methodology knowledge. We propose this as a model within action research that can be applied in contexts in Africa and beyond.

This paper is organized as follows: The next section describes the study design, including the underlying theories, research approach, and data management. We illustrate this with some examples of data generated through our approach and methods. The last section, Conclusion and recommendations, concludes with a discussion on the scientific contribution of this research.

Research design

Underlying theories

Studying perceptions of clients and identifying what motivates people to use health care and health insurance services requires positioning the client in a broader

sociocultural system, while acknowledging the political dynamics and complex interrelationship between the clients, the healthcare providers and the health insurance provider. A review of the existing literature in this field resulted in a selection of social theories used to develop the deductive conceptual framework and research questions. These theories are the Socio-Anthropological Explanatory model on healthcare systems (Kleinman, 1978); the Social Capital theory (Bourdieu, 1986; Coleman, 1988; Fukuyama, 2000; Grootaert & Bastelaer, 2002; Putnam, 2001; Woolcock & Harper, 2001); the New Institutional Economic theory (North, 1990); and Mechanics Three-Dimensional Trust model (Mechanic, 1998). Anticipating the broader sociocultural system, key concepts from these theories that we expect to influence clients' perceptions and motives to use healthcare and health insurance services are *explanatory models*¹ and *social capital*.² Differences in explanatory models of 'illness', 'the need for care', 'quality of care' and 'role in care' between clients, healthcare providers and the NHIS are believed to lead to miscommunication, resulting in decreased trust in relationships. Social relations within and between (community) groups and the social support that people derive from their social networks do influence perceptions and choice of healthcare. We expect that diverse channels of social capital offer potential opportunities to clients, healthcare providers and health insurance schemes for mobilization, information sharing, collective decision-making and reducing opportunistic behavior. These theories are explored in Fenenga et al. (2013). Based on a review of these theories, *trust* emerges as a pivotal component in clients' perceptions and health-seeking behavior. We are referring to interpersonal trust between clients and their doctor or the insurance officer, but also to the trust clients have in the health facility and insurance organization as institutions (institutional trust). Finally, their behavior and decision-making is influenced by rooted cultural beliefs as well as the views and opinions of family, friends and other people in their community whom they trust. People's need for trust is related to the vulnerability associated with being ill, but also to the asymmetries in information (Calnan & Row, 2006). The complex interrelation between clients, healthcare providers and health insurer, and the NHIS requires not only looking at the perspectives of clients, but also of the other two stakeholders in the tripod (Figure 1). This provides insights from three perspectives and comparison of data. The more specific conceptual framework that guides the design, interviews and analysis of clients' perceptions is presented and explained in detail in Fenenga et al. (2013).

The stakeholders

This methodological paper focuses on the *client perspective*. Our data were collected from NHIS clients and the potential clients of 64 primary healthcare facilities in the Western Region and the Greater Accra Region in Ghana, characterized by a mixed urban and rural population. However, the larger study consists of three sub-studies that were conducted simultaneously. Each of the sub-studies explores the perspectives of one of the stakeholder groups in the tripod (Figure 1). These are: (1) the clients (clients and potential clients) of the NHIS; (2) the healthcare providers

Figure 1. Perspectives of the three stakeholder groups.

(facility managers, nurses, doctors, and laboratory staff) of the 64 selected primary healthcare facilities (public, church-based, and private) in Western Region and Greater Accra Region, with health authorities from district, regional and national levels participating in the stakeholder meetings (SM); and (3) the NHIS staff from the district, regional, and national levels. At various moments in the research, these three stakeholder groups are brought together as part of the PAA. This will be explained in the following paragraphs and is illustrated in Figure 2. This paper should be seen in the context of this larger study. Papers of the other studies are forthcoming (Duku, Kaba-Alhassan, forthcoming).

The research team

The researcher is a PhD student, who works in a team with two other PhD students, (two Ghanaians, one Dutch) each responsible for one sub-study as described earlier. The PhD students are supported each by two supervisors. Besides overall responsibility of a sub-study, other tasks were training the research team, managing the data, liaise with the other researchers in the two other sub-projects, moderation of focus group discussions (FGD), and SM. While the Ghanaian researchers had the advantage to be more familiar with the specific sociocultural context and Ghanaian health sector than the Dutch researcher, the diversity of local languages required moderators with specific linguistic skills to support the three researchers.

The disadvantage of being familiar with the local context is that the researcher too easily understands what the participant is talking about, hence this knowledge and experience can block recognizing new or unexpected issues (Hennink, Hutter, & Bailey, 2011). Interviewees who know that the person interviewing has had similar experience might be less explicit in their answers because they suppose that the researchers knows already what they mean. The researchers were aware of this.

They were trained in qualitative and quantitative research methods. The researcher conducting the client sub-study was trained in participatory action

Figure 2. PAA and linked trajectory of methods.

research and was responsible for this approach in the study. All researchers and moderators were made aware of their position in the study and the importance to make the clients, healthcare providers and health insurer active participants in the research.

Participatory Action Approach

To explore clients’ perceived barriers and to search for solutions to reduce these barriers and improve the clients’ position, it is important to understand clients’ health seeking behavior (Verstehen), their underlying sociocultural schemas, and their experiences enrolling in the NHIS (Snape & Spencer, 2003). We studied NHIS clients and potential clients in their own communities, where we obtained inside perspectives and captured the decision-making processes. This approach features the PAA to research, which is context-specific, cyclical and reflective in design and focuses on problem solving (Hardon et al. 1994; Hennink et al., 2011; Koning & Martin, 1996; Maxwell, 2005; McIntyre, 2008). Another important feature of the PAA is the emancipatory aspect of participation of clients, healthcare providers and health insurance staff³ as partners throughout the research process: from initiating the study and identifying the problem to testing the interventions. At various stages in the research process, we created space for dialogue among stakeholders, pooling knowledge and facilitating awareness, interest and commitment to

social change. Democratic processes are expected to ultimately influence policy and practice in health care and health insurance services.

Linked trajectory of methods

To collect the data, we followed a *linked trajectory of methods*, which can be seen as a sequential procedure of methods (Creswell, 2003). However, as described by Bailey and Hutter (2008), the *linked trajectory of methods* is more than a mixed method. In most studies that use mixed methods, the reasoning on how the researchers mixed the methods is not clear. We claim that applying the methods in a specific sequence (Figure 2), interpreting and validating information from the previously used method into the next one, will result in strongly grounded and generalizable evidence. In the following paragraph, we elaborate on the PAA and linked trajectory of methods and illustrate these with examples from our data.

PAA and linked trajectory of methods together

Figure 2 shows the framework of our study approach and data collection methods. The left column indicates the stakeholders involved in the different steps of the research, while the right column depicts the steps taken that involve strong participatory action in the form of dialogue and awareness raising. The middle columns show the trajectory of the methods.

Initiation Meeting. The first step of the study was an Initiation Meeting (IM, Figure 2) with the initiators of the research, the NHIS. Here the problem was presented and the need for exploring clients' perceptions on illness, health-seeking, health care and health insurance services stated. Insights in clients' views and perceptions should help understand their views, behavior and decision-making, and this was expected to contribute to finding solutions for the problems experienced in uptake and retention in the scheme. Scientific evidence would support development of policy and practice.

Stakeholder Design Meeting. A subsequent Stakeholder Design Meeting (SDM, Figure 2), including clients, healthcare providers and NHIS, was held to analyze the current situation and explore and specify problems and priorities. The design meeting allowed the researchers to capture information about other relevant studies in the field of health insurance that had been or were being conducted. Stakeholders jointly emphasized that this client-centered study should focus primarily on the client/provider and client/insurer relations, which would make this study quite unique in Ghana. This consensus created an important basis for building local ownership. The central position of the client was emphasized repeatedly at various SM during the research process. This SDM enabled a relatively quick survey of the situation, resulting in an outline of research questions and study design. While recognizing the limitation of this setting to identify individual opinions, the joint situation analysis facilitated determining the *relevance and appropriateness of the research* questions.

The four moderators who were to carry out the qualitative data collection were trained in a four-day workshop focusing on participative action approach and moderation techniques. Topic guides were pre-tested and refined together with the moderators. For the selection of the participants, we liaised with the regional health authorities and chose facilities in different areas so that we would collect a rich variety of responses. Participants were selected in consultation with the local community worker, using a snowball approach. The interviews were conducted at a neutral location, such as at clients' homes or community buildings. All qualitative data were recorded, transcribed, coded and analyzed using N-Vivo 9.

Individual Health Histories. To acquire insight into the communities' perspectives, we employed Individual Health Histories (IHH, Figure 2) to gather in-depth individual views and interpretations from literate and (semi) illiterate individuals. In individual interviews, clients shared their experiences and views on an illness episode that had taken place within the last six months. Recalling the experiences step by step gave insight into their beliefs and interpretations of their health problem, the support structures and subsequent perceived barriers they encountered when accessing healthcare and insurance services. The following quote from a participant in the Western Region reflects a view commonly found among clients:

...It seems that here in the western region we really face problems. When I was in Kumasi, my wife was sick, she was bleeding and admitted at the hospital. She was holding her insurance card and they took care of her very well without asking "kaple" (extra money). They gave her medicines until she got well.....But when we came here, they told me the insurance did not cover this [health problem]. So next time she is ill we will not go here. (Male, IHH, Western Region)

The quote provides insight into the participant's beliefs about illness, which led to the decision that his wife required professional care from a hospital. It also reveals perceived experience with the healthcare services as an NHIS enrollee, which apparently varies per healthcare provider. The finding points to discrepancies between what the NHIS promises to clients and what clients actually experience in practice. We subsequently used other methods to explore and validate this information.

Key Informant Interviews. Key Informant Interviews (KII, Figure 2) were held with specific knowledgeable community members such as a chief, a fetish priest or spiritual healer. These key informants helped to comprehend information and contextualize data. In certain areas, for example, we found traditional beliefs to be strong. Here, herbalists or fetish priests were common or sometimes the preferred providers to seek care from.

Sometimes one has stomach problems and has visited the hospital three or four times without improvement. When this happens, I use some herbal medicines to cure them. Sometimes they bring children with convulsions, unconscious. If I find that he/she "has breath in him" I take some herbal medicine. I squeeze juice out of it and put this in their

nose, making them sneeze or go to toilet. After finishing the herbal treatment I refer them to the hospital. (Spiritual healer, KII, Western Region)

This quote demonstrates the common practice of using informal and formal services when patients do not find immediate relief. It also indicates the widely used herbal therapy. The fact that traditional practitioners are not affiliated with the NHIS may influence the demand for health insurance. Traditional practitioners, however, do refer patients to western hospitals. Collaboration between traditional and healthcare authorities varied from area to area and was generally considered important by the key informants.

Focus group discussions. Focus Group Discussions (FGD, Figure 2) were used to pursue the question of how individual beliefs and emic concepts identified in the IHH and KII were shared between community members as common opinions. The groups of on average nine participants were of various compositions: female insured; male insured, female uninsured; male uninsured; and mixed groups. Topics included views and interpretations on health and illness; common support structures; and experiences with health care and health insurance services, with specific attention to accessibility, quality, and trust. The FGD generated a broad range of opinions on the issues mentioned above, facilitated through interaction in the group.

*R1 ‘... there are **different schemes** in [name district] and this brings a lot of variations; even in [name primary hospital], services such as scans and other operations are all covered by the scheme but here in [other primary hospital], the situation is very different.’*

*R2 ‘ah Yes, and if you do not have insurance, they give you **better and more medicines** than someone who has the insurance card. With the insurance, you’ll get some para and maybe some other medicine. Then they will say for this and that you should pay 2 cedis; you have to **pay, in addition to your insurance.**’ (FGD, female insured)*

The first quote suggests that observed variations in treatment are rooted in the differences in decision-making between different district offices of the NHIS. The second quote suggests differences in treatment are based on the insurance status of the client: those not insured are treated better than those insured. In another FGD in the same area, we obtained yet more new information:

*R1 ‘On the TV they announced health insurance and we heard that it is good for our health. But the health insurance does not cover a lot of drugs nowadays, **unlike at first.** Some blood tonics and other drugs, which used to be under the scheme, **are no longer covered.** These days you have to pay for those.’ (FGD female and male insured)*

This quote suggests not only differences per location, but also changes in services over time by the same healthcare provider: insurance benefits are gradually

reducing. This was supported by the next quotes:

R1 'There are so many differences. I went to hospital and instead of two drugs I was given one. I asked them and they told me to go and buy the other. I brought my money and paid. Just imagine. You can compare "health" [health insurance] to cash and carry.'

*R2 'Yes... you see, because there is no money attached to the insurance card, doctors don't want to attend to you fast... After you have shown your card they will tell you the medicine you want they don't have... But that same medicine will be given to the one that has the money. So those having money **will be attended faster and better** than those having the insurance card.'* (FGD male insured)

During the same discussion, another man added information regarding the type of facility and the behavior of certain providers.

*R3 'Mostly these are the government hospitals... when you go there and you are holding your "health insurance", it is like **they would not get any benefit from you to put in their own pocket**... With the health insurance they are not interested to attend to you at all.'*

The specific sequence and complementarities of the qualitative methods were intended to show the convergence and dissonances of information. For example, the FGD in our linked trajectory confirmed and validated the perspectives found in the IHH on services in the healthcare facilities. We determined common aspects in the opinions of clients. Informing each subsequent method by the previous step allows for validation and optimizes the quality of the collected data.

Regional Validation Meeting. Two Regional Validation Meetings (RVM, Figure 2) were organized to validate and assess the generalizability of findings to a regional level. Here the three stakeholder groups were invited for a full day. During the first part of the day, stakeholders were organized into separate groups to validate the data gathered through qualitative methods. In each RVM, 20 purposively selected clients, who had taken part in the earlier methods, were invited. By discussing the findings, we allowed for interaction and trust building within the group of clients (see Appendix 1, Case description). This prepared the clients for the plenary Stakeholder Meeting (SM) in the afternoon.

Stakeholder Meeting. In the subsequent SM (see Appendix 1, Case description), in which on average 55 people participated, stakeholder-specific interests and needs became more apparent, such as the eminent differences in perceptions between clients and providers on what constitutes quality health care. The sociocultural dimension of power relations confirmed the assumptions expressed by the generally weak voice of clients. When clients have queries about the healthcare services and benefits of the NHIS, they are rarely passed on to the managers of the healthcare facility or insurance office. Likewise, feedback from clients that could help providers and insurer to improve procedures or correct any misconduct by staff was only occasionally given.

This was either due to lack of information about where to file complaints or, more commonly, due to lack of trust and to fear of negative repercussions.

The openness of discussions (or lack of openness) demonstrated the contextual differences between the two regions. In Greater Accra, the capital region, the flow of communication between the stakeholders was much easier than in the predominantly rural Western Region. This reflected the limited level of empowerment found in the latter. The timely sharing of the preliminary findings of our study (and the other two sub-studies), among managers and policymakers who were also participating, facilitated important first steps in awareness as well as action for change. Table 1 shows the areas defined in the SM to achieve improved, client-centered services.

The three researchers who moderated the meeting and also made observations and notes. These were compared, analyzed, and compiled in a report. The reports were shared with participants and used for development of the intervention.

The SM also demonstrated the complex interdependency in the client-healthcare provider-health insurance tripod: an insurance membership card has no value if the NHIS-affiliated healthcare provider offers poor services. The healthcare provider cannot run his services if claims are not reimbursed in time.

The more open dialogue in the Greater Accra stakeholder meeting resulted in a response to a client's question from one of the NHIS directors. The client's dissatisfaction and limited confidence could likely be the result of insufficient information provision regarding the policy changes introduced by the NHIS. The authority's communications had focused on healthcare providers rather than their clients, while these changes directly influenced services and benefits for clients.

Household Survey Figure 2. To obtain knowledge that is generalizable for a larger population and relevant for policy advice, the qualitative data were subsequently used to inform the household survey (HHS, Figure 2): the rich qualitative data ensured survey questions were well grounded in the local context. To illustrate, in Ghana assembly men play an important role in community activities and communication. This information was integrated into the survey section on community trust and solidarity. For the data collection, 40 surveyors were trained in four-day workshops. Topic guides and the questionnaire were pretested and refined together with the research team. For the quantitative data, respondents were sampled through a multi-stage sampling strategy. First, 64 clusters of healthcare facilities were selected on the basis of their ownership (public/private), location (rural/urban), and NHIS accreditation quality scores. Subsequently, 30 households were randomly sampled from within a radius of 10 km around each selected healthcare facility. Using a semi-structured questionnaire, we collected information on sociodemographics, sociocultural beliefs regarding health and illness, support structures, employment status, health status, and healthcare utilization, NHIS enrollment, perceived quality of healthcare and health insurance services and consumption expenditure patterns and dwelling characteristics. Quantitative data were cleaned and analyzed using SPSS-20. All data were validated, triangulated and compared with data of the other sub-studies of respectively healthcare provider and health insurer. This

Table 1. Areas for improvement.

Stakeholder level	Identified areas for improvement in Stakeholder Meeting
Clients	<ul style="list-style-type: none"> • Involve community groups, clients, and community leaders in communication, dissemination, and monitoring of health services and health insurance services • Clients to respect healthcare providers and insurance and understand limitations • The NHIA to consider accreditation of qualifying traditional practitioners
Healthcare Provider	<ul style="list-style-type: none"> • Health staff to improve attitude • No discrimination in treatment and waiting time (insured versus non-insured) • Fair and transparent queue system • Reliable availability of drugs
NHIS	<ul style="list-style-type: none"> • Reliable enrollment and renewal system and timely provision of NHIS-ID cards • Information service package • Regular enforcement NHIS services/regulations and clinical audits

quantitative data enhanced further insight into the extent of perceived barriers, while surveys among the healthcare providers (a different sub-study) provided insight into the technical quality levels of these facilities. As an example, we take the information from the SM, which reveals that many clients are not happy with the quality of services provided by the healthcare providers.

Table 2 illustrates that clients' satisfaction with the quality of services of the healthcare provider is significantly positively associated with enrollment.

Stakeholder Meeting. The findings of the survey were presented and discussed in two regional SM (Figure 2), in which stakeholders were invited to respond. Stakeholders elaborated on the convergences and divergences between the qualitative and quantitative findings. The qualitative findings generally revealed a more critical, negative perception of clients regarding service quality than the quantitative data showed. Discussion generated possible answers to these questions and facilitated learning.

Intervention MyCare. The suggestions for improvement in Table 1 form the basis of the Intervention MyCare (IMC, Figure 2), which is part of the PAA. By involving clients in the monitoring services of the healthcare provider and the NHIS, we anticipate a number of effects such as enhanced inter-stakeholder communication, empowerment of clients, improved client-centered services, and trust-building. The development and results of the intervention are presented in two forthcoming papers ('*Engaging clients in monitoring healthcare and health insurance services*' and '*Health service quality improvement through systematic client engagement – evidence from Ghana*').

Table 2. Results from household survey.

Perceptions of quality of services at nearest accredited health facility			
Perceptions	Proportion of household heads (agree/are satisfied)		
	<i>Insured</i> (%)	<i>Uninsured</i> (%)	<i>P-value</i>
Respectful treatment from doctor, medical assistant, nurse	85.5	78.7	0.000
Organized and fair queuing system at health facility	84.7	74.6	0.000
Availability of all prescribed drugs at health facility	68.5	57.4	0.000
Equal treatment for insured and uninsured patients	62.1	51.0	0.000

Note: $N = 1803$ households.

Source: Project Survey, 2012.

Conclusion and recommendations

The rapidly growing interest in health insurance in Africa, where Ghana has pioneered the introduction of National Health Insurance for the entire population, has attracted interest in the scientific world. Most studies, however, are socioeconomic studies, using quantitative methods, sometimes complemented with few individual interviews. This study introduced a different model. We aimed to obtain a better understanding of clients' perceptions regarding illness, health seeking, health care, and health insurance services in their own sociocultural context. The features of *multi-stakeholder involvement in a complex environment* and *need for social change* required the use of a PAA combined with the application of a linked trajectory of qualitative and quantitative methods. In this paper, we aim to demonstrate the value of our research design. We argue that the PAA with the linked trajectory of methods is an essential approach for researching a complex situation such as the health insurance context in Ghana, where various stakeholder groups are involved, with different views, experiences and expectations. Providing evidence for policy and practice that would contribute to client-centered services requires a deep understanding of the perspectives of the community regarding illness, health care, and health insurance services. Using qualitative methods enables this research process. The PAA in our study is instrumental to the facilitation of learning and support for democratic decision-making in the process of developing client-oriented care. Making clients, together with other stakeholders, part of the research has helped to foster relationships and find practical solutions that are acceptable and supported by clients and all stakeholders. Such an approach is not only suitable for the support of policy changes in Africa, but also in other parts of the world.

In Ghana, as in many other African countries, clients are at the bottom of the pyramid. They are in a receiving position, with little attention being paid to their

voice. The used approach shows how participatory action can contribute to social change, empowering clients by letting them be part of the discussions and solutions. As such, they obtain a role in making healthcare providers and the NHIS accountable for their services. This interaction can contribute to an improved power balance and more trust within the client–provider–insurer tripod.

The choice of approach and of the specific methods used in the linked trajectory has suitably informed the research to design the well-founded questions in the survey. A summary of the value of the methods is provided in Table 3. The left column shows the participatory methods in which the three stakeholder groups participated. The second column indicates the methods used to obtain data from the separate stakeholder groups, while the third and fourth columns present the findings and learning outcomes.

When looking at our position and actions as researchers, the participatory approach has continuously required reflection and reaction, in particular during the SM. This to anticipate on the stakeholders, but also on our own functioning. While streamlining the three sub-studies was sometimes challenging, also because the researchers had different approaches of planning activities, the interaction between the researchers and moderators provided a valuable way to compare and verify information and provide feedback to each other. The Dutch researcher had a wide experience in health care in Africa. She did not have the closeness with the Ghanaian system as the Ghanaian researchers; however, this facilitated an alertness for new information which the Ghanaian research found sometimes difficult.

While in the client sub-study most interviews were conducted by the moderator, the researcher drew discussion diagrams, made notes and reflected upon these together with the moderator after the interview. This was a useful learning process and offered a rich exchange of observations. The way people employed space for dialogue, their voice, the intensity of their discussion and expressions reveal a lot about relationships.

The researcher sincerely appreciated the openness and enthusiasm of clients and other stakeholders during this study, making it a rich experience. Stakeholders were appreciative to be part of this participatory process and responded at various occasions with positive remarks. ‘Through their research we realized the importance of our client’s complaints reaching us so we can meet their expectations and clarify issues of their concern’ (District Health Insurance Scheme manager, Western Region). ‘We are glad we could say what really happens. This process has given us a voice’ (Lady client, Greater Accra).

We have demonstrated that the PAA with a linked trajectory of qualitative and quantitative research methods is an effective approach both to research a complex situation such as the position of clients in the health insurance context in Ghana and to facilitate learning and support for democratic decision-making. While clients have played a key role in informing and shaping this study, the meetings with other stakeholders were important to enable collaborative learning and to prepare practical, acceptable solutions. With the enthusiasm of clients and other stakeholders during the research process, we co-created new knowledge and a willingness for social change. We claim that our PAA with a linked trajectory of qualitative and quantitative methods has contributed to new scientific

Table 3. Value and conclusion of approach and linked methods.

PAA	Method	Main findings	Learning outcomes
Stakeholder meetings (IM, SDM, SM 7 & 9): <ul style="list-style-type: none">• Platforms for dialogue and sharing of opinions and experiences.• Awareness raising and learning.• Empowerment of clients• Co-creation of new knowledge and that lead to social action for change (changes in practice and potentially in policy)	Qualitative methods Individual health histories and key informant interviews: (individual) <ul style="list-style-type: none">• Experiences, views• Emic perspectives• Beliefs• High response, incl. from illiterate Focus Group Discussions, Regional Validation Meetings: <ul style="list-style-type: none">• Sharing common views, beliefs and experiences in community by larger group• Detection trends• Generalizing findings (views/opinions) for regional level	Observed power relations and strong position of healthcare providers; regional differences; difference in perception (e.g. what does quality of care mean?); information gaps, sensitivities Strong appreciation by stakeholders for dialogue Insight in social structures of support; traditional beliefs still strong; People often use a combination of various health care (traditional/professional/popular). Multiple barriers to access healthcare and insurance Differences in context Reflection on individual findings of IHH and KII, defining commonalities and incidental issues; Action–reaction evoking new insights; RVM revealed that we captured correct information; participation from different districts. Defined key messages for SM Survey questions well founded. Analysis identified trends and revealed differences when comparing with our qualitative findings, which were again discussed and clarified in SMs	First SM created platform for info sharing, dialogue and stakeholder input Created ownership, trust and support for democratic problem solving Safe environment crucial for multi stakeholder dialogues SM discussion on differences qualitative/quantitative findings informative Generated first insight and enabled checking of appropriateness of topic guides. Emic insight of perceptions and processes. Review of topics Determined common key issues. Triangulation and validation of findings; Insight of situation at regional level; Learning and awareness raising among participants. Empowerment of present client voice at SM
	Quantitative Survey: <ul style="list-style-type: none">• Quantifying information• Generalizing findings for larger population		Essential for generalizing findings and conclusions for the NHIS

methodology knowledge and practice. We propose this as a model within action research that can be applied in contexts in Africa and around the world.

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Notes

1. Explanatory Models are defined as notions about an episode of sickness and its treatment that are employed by those engaged in the clinical processes (Kleinman, 1978, p. 88).
2. Social capital is defined as 'networks of community relationships that facilitate trust and motivate action' (Coleman, 1988 p.105).
3. The perspectives of Healthcare providers and NHIS staff were studied by two other researches, while at stakeholder meetings the three groups were brought together.

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Appendix I. Case description (Figure 2, 6.RVM and 7.SM)

To validate the qualitative data from clients, healthcare providers and the health insurer, two regional meetings were organized in Takoradi and Accra. From each interviewed stakeholder group, representatives were invited, using a purposively selection process. This allowed a good mix of representatives (age, gender) and people who were willingly and vocal to share their views in a larger group.

The validation process (RVM) was conducted in three groups (clients, healthcare providers and health insurance staff). Here participants reflected on the analyzed data from their respective groups. The session was facilitated by the researcher and moderators who were known by the participants and cultural-sensitive, understanding, and inviting participants' views. The data had been anonymized and was presented through oral presentation, supported by posted quotes and pictures of villages on the wall. Findings were organized by codes defined by the researcher and moderators during the analysis of the data. The validation process in both Western Region as Greater Accra evoked lively interaction. People liked to re-confirm the presented findings with their own experience. On the question whether any views were missing, participants confirmed that their perceptions had been covered satisfactory. The atmosphere was relaxed and positive. We argue that these validation meetings facilitated a process of familiarization and trust building within the group. Following the validation, the researcher prepared the group for the stakeholder meeting (SM) that would follow that same

afternoon. In the SM, we would combine the three stakeholder groups and present in plenary the findings of respective groups. We argue that a strong message should involve the voice of clients themselves, using their own words, their own language. Hence, the researcher asked participants during the validation meeting their preparedness to participate in the presentation. While the researcher presented the main findings, clients would add and share some of their experiences during this plenary presentation. Several clients enthusiastically expressed their willingness to present their story. The group decided which stories to present.

During the SM (7.SM Figure 2), the three presentations reflected the key findings of the three stakeholders groups. Here, respective groups could listen and learn what transpired from respective groups on topics such as illness, health seeking, service quality of healthcare providers and health insurance scheme offices. In the presentation of clients, the 'life stories' in Greater Accra were presented without any reluctance. In the Western Region, one client found it difficult to talk freely, likely feeling intimidated by the size and composition of the group. Another client anticipated on this by encouraging her to present her story as she did during the validation meeting. Other stakeholders sympathized and patiently waited for the client to complete her story. Most clients, however, did not feel constrained. This reveals that we were able to create a safe environment for all people to talk. We argue that the RVM contributed to build confidence among the group members. In addition, the careful moderation of the meeting contributed to the success of these interactions.

Following the presentation, participants were asked to respond and pose questions. We found people doing so without hesitation, i.e. clients questioned directors of the NHIS, and NHIS staff questioned healthcare providers. Everyone responded in pleasant way. In both regions, the atmosphere was good. In the Western Region, there was a slight tension between some healthcare providers and a participant from a District Health Insurance Scheme when discussing a certain incident, but this was solved and the good atmosphere restored.

Thereafter, the plenary group was asked to form three mixed groups to discuss the findings with each other and come up with suggestions to respond to the challenges found. The researchers did not join the groups but walked around for any question while making observations on the group dynamics and discussions. We found generally all stakeholders participating in the discussion. We argue that this was due to mixed composition of the groups and the trust developed during the course of the day.

The group assignment resulted in three posters, each being presented by a group representative. The assignment guided the participants to explore challenges and possible solutions at various levels: i.e. client level, healthcare provider level, and health insurance level. This triggered all participants to think how to stimulate change in procedures or behavior in each of the stakeholder groups. Results showed that although the composition of each groups might have differed slightly, results were quite similar. Striking was the suggestions for more involvement of clients in the health care services (see Table 1).