Ghana Civil Society Monitoring Campaign

HEALTH MONITORING REPORT, 2008

Alliance for Reproductive Health Rights (ARHR)

August 2010

Acronyms and Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Ante-Natal Care/Clinic
APDO	Afram Plains Development Organisation
ARHR	Alliance for Reproductive Health Rights
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
CHN	Community Health Nurse
CHRAJ	Commission for Human Rights and Administrative Justice
CIP	Capital Investment Plan
CSM	Cerebro-spinal Meningitis
CWC	Child Welfare Centre
DA	District Assembly
DACF	District Assemblies Common Fund
DBO	District Budget Officer
DCO	Disease Control Officer
DDHS	District Director of Health Services
DHMT	District Health Management Team
DHOC	District Health Oversight Committee
DSW	Department of Social Welfare
EBF	Exclusive Breastfeeding
FDB	Food and Drugs Board
FGD	Focus Group Discussion
GDHS	Ghana Demographic and Health Survey
GH¢	Ghana cedi
GHS	Ghana Health Service
GoG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
HIRD	High Impact and Rapid Delivery [programme]
HIV	Human Immune-deficiency Virus
IALC	Inter Agency Leadership Committee
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment [in pregnant women]
ITN	Insecticide-Treated Net
KATH	Komfo Anokye Teaching Hospital
KEEA	Komenda Eguafo Edina Abrem
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NMCG	Nurses and Midwives Council of Ghana
NHIS	National Health Insurance Scheme
OPD	Out-Patient Department
ORS	Oral Rehydration Salt
PHO	Public Health Officer
PLWHA	People Living with HIV/AIDS
PNC	Post-Natal Care
PRA	Participatory Rural Appraisal
RHN	Regenerative Health and Nutrition [programme]
TB	Tuberculosis

TBA	Traditional Birth Attendant
U5	Under-Five
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WIFA	Women in Fertile Age

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Executive Summary

1. Purpose and methodology

The specific purpose of this report is to share the health experiences and perceptions of poor rights holders in five selected districts – Agona East, Bongo, Builsa, KEEA and Kwahu North. By capturing the voices of these stakeholders, the report contributes to interrogating the degree to which Ghana is fulfilling the health agenda it has set for itself, namely, "*to ensure a healthy and productive population that reproduces itself safely*" (Ghana 2009: 11)[1] and the specific medium-term priorities of:

1. Ensuring healthier mothers and children;
2. Promoting good nutrition and food safety;
3. Combating communicable diseases such as HIV/AIDS, malaria and tuberculosis;
4. Improving housing, personal hygiene, environmental sanitation and access to potable water; and
5. Forging equitable and accountable health systems.

In line with these, the fieldwork comprised a three-week period of engagement with health rights holders to elicit information on their experiences and behaviours. The research further entailed interactions with duty bearers and a review of available district-level data. Rights holders were interviewed mainly in focus groups, the majority of which were constituted of women of childbearing age, particularly those with young children. Exit interviews were also held at a small selection of health facilities used by poor citizens, enabling a measure of triangulation of the community-level findings (Section 1.3).

Overall, the evidence from this round of qualitative monitoring suggests that while the first round (in 2007) may have been limited, the opportunity it provided to hold duty bearers to account may indeed be bearing fruit (Section 1.4). Indeed, in the three districts which had participated in the earlier round of monitoring and feedback, health managers were much more generous with data during this round. Nevertheless, several officials in the Assembly secretariats and the health service still fail to appreciate the value of civil society monitoring and continue to question the monitoring team's right to gather citizen feedback on financial and health matters. Such attitudes are entirely inconsistent with the inclusive spirit of the Ministry of Health's *Five-Year Programme of Work* (Ghana, 2007b: 30).

For the sake of simplicity and brevity, recommendations are presented separately in Section 10. Readers are thus encouraged to read that section as a complement to this executive summary. The structure of the summary follows that of the main report to enable details to be followed up easily.

2. Child health

The 2009 Programme of Work (PoW) of the Ministry of Health explicitly articulates an expectation of sustained "*[improvements in] maternal and neonatal health*" following earlier progress. Specific sector programmes – namely the High Impact and Rapid Delivery (HIRD)

[1] Ghana (2009): The Ghana Health Sector 2009 Programme of Work: Change for Better Results – Improving Maternal and Neonatal Health. Accra: Ministry of Health.

and Regenerative Health and Nutrition (RHN) – have been acclaimed for their contribution to this progress (Ghana 2009: 14), particularly in the area of child mortality.

For 2008, the PoW had prioritised "*[improvements in] family planning, maternal health and … emergency obstetric and newborn care*" (Ghana, 2007a: 2)[2] among others. The research did indeed that find most women aimed to feed their babies on exclusive breast-milk for at least the first six months. However, very few actually manage to stay the course. Rising awareness -- through growing Child Welfare Centre (CWC)/PNC[3] attendance rates -is enabling mothers to recognise colostrum's nutritive and immunological value, so that they are increasingly feeding it to their infants. It appears plausible that the integrated nature of the HIRD approach -- including immunisations, Vitamin A supplementation and continuous education on breastfeeding -- is a contributing factor towards the significant drop in child mortality rates. The recent launching, in November 2009, of the Child Health Policy and Strategy is another positive step.

Most mothers know how to prepare reasonably nutritious meals for their children. However, the poorest are often financially challenged to put this knowledge into practice. In the northern districts especially, the inclusion of legumes in infant feeds drops significantly during the cyclic lean season, compromising the long-term development and life outcomes of the savannah's children. Further, the choice of feed regimen is not a decision made by a newborn's mother alone, but is often influenced by the baby's grandmother.

The assessment found mothers to prioritise PNC attendance for as long as their "*children are due injections*" (i.e., vaccinations). The under-appreciation of the vital role of PNC in fostering infant and maternal health gives cause for concern, particularly so because many infants are needlessly missing out on the essential health tracking, diagnostic and preventive services offered at such clinics. However, the gap in awareness is not the only cause accounting for the deficits noted in PNC attendance. Where resources, particularly nursing staff, are stretched, nurses sometimes dissuade mothers from completing PNC in order to make space for those with younger (presumably more vulnerable) infants. The increased workload arising from the free maternal care policy and rising NHIS subscriptions (Garbarino et al, 2007: 18, 24) is likely to be a factor influencing such advice. The study also found that PNC attendance is highest on community "taboo days", suggesting opportunity costs to accessing PNC services – even where these are not charged for. In addition, the overwhelming majority of mothers attending PNC are not systematically asked which of the five danger signs they had observed in their children.

3. Healthcare-seeking behaviour

Across the sites visited, malaria is by far the most consistently reported childhood illness. District-specific illnesses include anal sores in Bongo District, ringworm in KEEA and hydrocephalus (known as "*asram*") in Kwahu North.[4] Curiously, mothers in Bongo District said they had stopped reporting the anal sores – mainly because the nurses insist that there is no such disease in their guidebooks.

Rather disturbingly, women who had lost infants and other young children were neither informed of the medical causes nor counselled. Such deficits in counselling are echoed in the

[2] Aide Memoir -- 2007 Health Summit

[3] In Ghana's public health service, post-natal care (PNC) is delivered through designated Child Welfare Centres (CWCs). In this report, the expressions are used interchangeably -- PNC being the more universal term.

[4] The Kwahu North health directorate had no record of this disease but indicated its intention to follow up on the reported situation.

Child Health Situation Analysis in Ghana (---, 2007a: 3). Under such circumstances, most are left to believe that the causes are purely spiritual. Convulsions are, similarly, widely perceived as having spiritual origins. In the southern sites monitored, children with convulsion are typically sent to "prayer gardens" run by spiritualists rather than to formal healthcare facilities.

Mothers tend to self-prescribe treatments when their infants show signs of ill health – such as high temperatures, lethargy and a loss of appetite. Perceived as a wonder drug, paracetamol (a.k.a. "*para*") is administered as a panacea for all manner of illnesses ranging from diarrhoea to convulsions. As the *Child Health Situation Analysis in Ghana* report notes, "*mismanaged illness in childhood, particularly diarrhoea, may be contributing to malnutrition*" (---, 2007a: 3).

In communities where mobile interventions are well implemented, this has significant potential to improve access for the poorest, such as those who are unable to pay for transport services. And in communities visited regularly by their community health nurses (CHNs), this is manifesting in a corresponding higher level of health awareness among the women. Where the service provider is community-based (for instance, at Goo, in Bongo District), user satisfaction is relatively high. Similarly, where traditional birth attendants (TBAs) were present in a community, they were generally regarded highly because of their relative sociability and respect for the feelings of their clients.

4. Sanitation

Healthful sanitation is a major challenge; the overwhelming majority of poor participants lack access to home-based toilets. Many residents still use the bushes either because there is no public place of convenience or they want to avoid the odour typically associated with communal latrines. As a result of cultural barriers, women and adolescent girls are often compelled to hold their bowels till nightfall, risking snake bites in the process. Mothers seemed oblivious to the risks their barefoot children face when they use the bushes and refuse tips as their places of convenience. Often these heaps contain rusty tins, broken bottles and toxic chemicals.[5]

It is common for people to use only water when washing their hands after coming into contact with faeces. Further, some of those who wash their hands with soap (or ash) do so because they are concerned with the smell on their hands rather than for reasons of hygiene. In general too, participants in our focus groups were not enthusiastic about using soap just before eating, asserting that "*the scent of soap would ruin the flavour of the food*."

5. Immunisation and maternal prophylaxis

While immunisation is, without doubt, a priority for local women across the monitoring sites, vaccination practices do not appear to be consistent and significant numbers of children in poor communities fail to make the full five immunisation visits required to provide comprehensive protection from the key childhood killer diseases.

Significant numbers of expectant mothers continue to drop out of the intermittent preventive treatment (IPT)[6] regimen during the course of their pregnancies. Some of the mothers interviewed justified dropping out of ANC (and by implication IPT) on the grounds that pregnancies feel more secure during the latter stages and thus have less need for professional attention. Further, many poor women begin ANC relatively late because local traditions discourage women from announcing their pregnancies at the initial stages. That many mothers continue to undervalue the role that critical services such as ANC (also PNC) can play in

[5] Poor management of neighbourhood garbage also raises the risk of cholera outbreaks.

[6] Intermittent preventive treatment.

averting and/or reducing both neonatal and maternal morbidity should, thus, be a source of immense worry.

6. Treated bed nets

Nominally, bed nets are the most available form of protection against malaria, suggesting that the attention given to this area in MOH's Five-Year PoW may be achieving some impact. However, the use of ITNs is erratic and, in reality, insecticide coils often dominate households' choices. In some northern communities, bedrooms are smoked by burning pungent herbs for about a half hour before bedtime. To optimise the efficacy of this form of insect control, doors and windows are kept shut all night, risking cross-infection and attendant fatalities when CSM[7] strikes during the warm months after the annual harmattan.

Even where ITNs are now the protection of choice, respondents reported removing them during the warmest hours of the night and abandoning them temporarily during the hot season. Again, most users appear reluctant to retreat their nets or simply pack them in when the insecticide wears out, citing the discomfort and expense as their justification. There also appears to be justifiable criticism of the programme on the grounds that it is overly supply-led, with little evidence of a willingness to address the concerns raised by users.

7. Maternal health

It is instructive that improvements in maternal and neonatal health top the list of priorities identified by the Inter Agency Leadership Committee (IALC) for Year 2009. In the current monitoring round, the team found that the proportion of mothers participating in ante-natal care (ANC) rose sharply in 2007 and that this positive situation has continued since then. However, very few women know all the key danger signs in pregnancy.

Non-medical factors such as transportation challenges constitute major barriers to accessing facility-based healthcare for poor rural dwellers. Particularly influential in determining where a woman chooses to deliver, regardless of proximity,is the attitude of caregivers (see the next subsection for other barriers). A further constraint on access for the poor is the fact that the policy on free maternal care - ostensibly implying the abolition of upfront charges, is interpreted differently by practitioners in different locations. Despite the acknowledgement at the 2008 Partners Health Summit that maternal mortality had acquired the status of a "*national emergency*"[8] and the associated implementation of a "*free maternal care*" package for pregnant women, a Ghana Health Service[9] representative in KEEA insisted that women who did not hold NHIS[10] cards must pay in full for pregnancy testing. This creates financial barriers to accessing ANC services in some localities and is particularly worrying, given that equity and access remain strategic pillars in the Ministry of Health's quest to achieve the relevant MDGs (Ghana 2009: 40; Ghana 2010: 3, 19).[11] Indeed, the Aide Memoir from the 2007 Health Summit specifically identified as a national priority, the improved targeting of indigent households for exemptions from NHIS premiums. This mirrors an expectation in the Five-Year PoW (Ghana,

[7] Cerebro-spinal meningitis.
[8] By the then Minister of Health.
[9] Ghana Health Service.
[10] National Health Insurance Scheme.
[11] In particular, Goal 2 of the Five-Year Programme of Work aimed at "*[reducing] the excess risk and burden of morbidity, disability and mortality especially in the poor and marginalized groups*" while Goal 3 sought to "*reduce inequalities in health services and health outcomes*." The NHIS Card Holder ratio shows the lowest income groups to be least represented in the roll (Ghana 2010: 4).

2007b), which includes an emphatic case for scaling up NHIS coverage for the sake of the nation's poor.

Women who were interviewed in the districts were unanimous in the view that formal healthcare facilities are better equipped to offer infusions, blood transfusions and vital support in the event of obstetric emergencies. Consistent with this observation, there have been reported improvements in health facility delivery rates (GSS 2009; Ghana 2010: 4, 5). Nevertheless, this assessment finds attended delivery rates to be very low when compared with ANC and PNC utilisation rates (see Tables 2.1-2.5 and 7.1-7.2). The huge difference between ANC and PNC rates reflects continuing barriers in women's de facto access to safe delivery services and is consistent with the observation by MoH of a "*very high number of still births [confirming serious challenges] in referral and emergency services throughout the health system* " (Ghana, 2010: 28).

Considering that the majority of infant deaths tend to occur soon after birth (---, 2007a: 1), it is worrying that significant numbers of expectant mothers shy away from facilities when appropriate emergency care may have saved the lives of their babies. Many women said they avoid health facilities largely because of uncaring behaviours among care providers. By opting for community - or home-based deliveries, poor women are effectively subsidising the NHIS. Secondly, it means that expectant mothers are compromising their labour outcomes by exposing themselves to needless risks associated with prematurity, asphyxia (from delayed/obstructed labour) and other delivery/neonatal emergencies. Under these conditions, it is not surprising that the *Child Health Situation Analysis in Ghana* report found over half of neonatal deaths occurring at home (---, 2007a: 1).

Knowledge about contraception options was high among the women and men interviewed. However, birth control per se remains an unpopular choice among rural women generally, and family planning services are not covered under the NHIS (Ghana, 2010: 27). It appears that family planning education continues to focus disproportionately on feeding women with the *technical* options rather than promoting the benefits of smaller families or helping women make more informed decisions regarding when best to become pregnant. Even where women show an interest in birth control, mothers-in-law can be a major barrier to actual practice. The low level of male involvement in family planning counselling is yet another factor undermining the success of campaigns.

For illiterate rural women to opt more routinely for safer care, health personnel will need to align their behaviour more closely with citizen expectations and see patients as partners in the ambitious and challenging agenda of delivering the health MDGs. For now, however, MOH's own assessment concludes that "*the productivity of the health work force … is generally perceived to be low*" and "*the new salary structure … is not translating into increased productivity of the health workforce*" (Ghana 2009: 17).

8. HIV and tuberculosis

In general, the focus groups interviewed appeared to be aware of the main routes by which HIV is transmitted. However, a minority either had no real appreciation of the disease or were simply in denial, refusing to believe that it is transmitted by causes other than spiritual ones. While HIV infection rates appeared to be trending downwards (Ghana 2009: 20), the study nevertheless found infection rates to be rising in KEEA, Kwahu North and Builsa, in all cases by over 100% since 2006. Indeed, a subsequent assessment of prevalence rates by the Ministry suggests a 32% reversal in pre-2008 gains (Ghana 2010: 3). Either way, the findings from this monitoring survey suggest that special attention may be required at specific sites such as those with higher-than-average levels of population movement.

Stigma remains an issue. Even where groups were not overtly prejudiced against PLWHA, fears were routinely expressed about the perceived risk which ART poses to uninfected persons. People are not taking advantage of existing opportunities for HIV testing -- a reflection of weaknesses in existing campaigns -- but also because testing is still perceived to suggest that one already has symptoms of the disease.

Only an insignificant proportion of those interviewed seemed aware of existing opportunities for TB testing, and that both testing and treatment are free.

9. Malaria

Under-five mortality from malaria is highest in the northern districts. The monitoring team found a significant minority of those interviewed lacking adequate awareness of how malaria is caused and/or can be prevented. Of particular concern is the fact that the newer artemisinin-based combination therapy (ACT) is not popular with poor people interviewed and it is common for them to short-dose on it or to take the pills in quantities or at intervals other than what has been prescribed by the manufacturers. Again, prescribers and dispensers are not routinely notifying patients that ACT ought to be taken with relatively fatty foods to enhance its assimilation. Further, poor policing of chemical shops means that it remains incredibly easy to buy chloroquine as a mono-therapy or, for that matter, ACT in unapproved doses.

An increasing source of worry is the issue of counterfeit drugs smuggled into Ghana through the country's porous borders. ACT has been cited as a strong candidate for faking because of its relatively high price. Poor drug storage (at the freight, shop and household levels) is a further source of efficacy loss. Under these combined circumstances, it is only a matter of time before plasmodium parasites develop resistance to ACT as well.

Conclusion

There are some signs of progress in the areas of infant nutrition and participation in ante-natal care, supporting the tentative conclusions documented in the 2009 PoW report of the Ministry. However, achievement continues to lag behind expectation in many respects and is exacerbated by poor and insanitary housing environments and lack of access to safe home toilets (Section 4.1), locational and transportation disadvantages, laboratory fees and other charges (Section 7.2), constraining cultural beliefs and practices (Section 5.2) and the dynamics of power inequality, all of which conspire to sustain ill-health among the poor.

In many cases, the skill to deliver quality healthcare is in place. However, a major ingredient that appears to be missing is the supporting attitudinal change among frontline health workers (Sections 7.2 and 7.3).[12] Closely related to the poor attitude of health workers is the question of political will to ensure that duty bearers are indeed discharging their duties responsibly. While the Ministry of Health's quest to "*ensure adequate numbers … of well motivated health professionals*" (Ghana 2009: 17) is both justifiable and commendable, it is vital that any such effort is accompanied by clear steps to enhance downward accountability and foster greater commitment to the feelings and rights of the poor. To this end, plans by the Ministry of Health to roll out a system of performance contracts (Ghana, 2007b: 31; Ghana 2009: 17) ought to be accelerated and monitored carefully over the coming years. This is an area that could benefit greatly from civil society inputs and collaboration.

[12] Suboptimal attitudes towards patients were confirmed by health workers in a study by Garbarino *et al* (2007: 36).

It is the hope that this report will assist in building bridges between local communities and their service providers, and also between civil society and district managers charged with protecting and promoting the health rights of citizens.

1. Introduction

1.1 Background

At the turn of the millennium, world leaders signed up to accelerate ongoing efforts towards global equity and development. These commitments are represented in a set of ambitious targets encapsulated in the eight Millennium Development Goals (MDGs). The goals offer great promise, by galvanising international will and hope around common targets. Locally, they also represent a historic window of opportunity for rights holders and civil society (i) to press for greater equity in the distribution of health resources and (ii) to demand greater discipline in how health policymakers and care workers discharge their duties.

Over the fifteen years to 2015, the three MDGs related to health aim to:

- reduce child mortality;
- reduce maternal mortality; and
- halt and reverse HIV/AIDS, malaria and other major infectious diseases.

Nationally, these are being addressed partly through the Ministry of Health's Five-Year Programme of Work (PoW) 2007-2011, particularly the following five specific priorities of:

- Ensuring healthier mothers and children;
- Promoting good nutrition and food safety;
- Combating communicable diseases such as HIV/AIDS, malaria and tuberculosis;
- Improving housing, personal hygiene, environmental sanitation and access to potable water; and
- Forging equitable and accountable health systems.

These goals will require huge commitments to discipline and to ensuring that women – especially those living in poverty – have unfettered access to ante-natal care (ANC) and post-natal care (PNC). Their achievement will also require deliveries routinely taking place at facilities where women can be assisted by skilled and caring attendants to give birth to their babies; improvements in public health and nutrition awareness; more sanitary behaviours and a new culture of patron-centeredness and social accountability. Nine years on from the Millennium Declaration, the Alliance for Reproductive Health Rights (ARHR) has undertaken a second round of monitoring aimed at contributing to ongoing civil society efforts demanding further progress on the MDG targets.

1.2 Purpose of the report

The specific purpose of this report is to capture the perceptions and experiences of poor rights holders insofar as these relate to the health goals in five selected districts: Agona East,[13] Bongo, Builsa, Komenda Edina Eguafo Abrem (KEEA) and Kwahu North (see Section 1.3). The report seeks further to complement and to assist in qualifying the

[13] It is important to note that Agona East is a new district with major deficits in social infrastructure and health personnel. As a result, health statistics are not as readily available for that district as they are for the other four. This is particularly so for earlier years -- for which the statistics for Agona East were subsumed under those for the larger Agona West (from which Agona East has been hived off).

findings of larger, more statistical analyses such as the Ghana Demographic and Health Survey (GDHS) and the Multiple Indicator Cluster Survey (MICS) by providing civil society with evidence and illustrations gleaned from participatory micro-assessments in the five monitoring districts. Ultimately, it is expected that the findings will contribute to tracking progress in the health sector and to making health policymakers and workers -- especially those at the district level -- more accountable for their stewardship, leading to greater responsiveness in the delivery of health services. As an Asante proverb aptly notes, "*the fly that has no one to advise it will follow the corpse into the grave*."

1.3 Methodology

This monitoring round, the second by ARHR, was conducted by a team of researchers with backgrounds in the health and social sciences. In all, five districts were visited -- namely Agona East,[14] Bongo, Builsa, Komenda Edina Eguafo Abrem (KEEA) and Kwahu North. Out of these, Bongo, KEEA and Kwahu North had also participated in the earlier round in 2007. To the extent possible, efforts were made to ensure that the monitoring teams were reasonably conversant in the main language of their respective study districts.

The research employed a participative approach, engaging with health rights holders to elicit their health and healthcare experiences and with duty bearers for relevant district-level data with which to interpret the responses of their constituents. The interviews with service providers were mainly one-on-ones whereas those with rights holders mostly took the form of focus group interviews (FGDs). The teams also interacted with District Directors of Health Services (DDHSs) where present and available, nurses at a range of health facilities visited, Disease Control Officers (DCOs), Public Health Officers (PHOs) and District Budget Officers (DBOs).

Taking cognisance of the specific issues which the study had targeted to address, the majority of the focus groups were constituted of women of childbearing age, particularly those with young children. These discussions were complemented with a smaller number of interviews with men in the same communities and with key informants who had direct experiences of especial relevance to the issues under discussion. In each participating district, exit interviews were also conducted at a small selection of health facilities used by poor citizens, enabling a measure of triangulation of information received from the community-level discussions. Where possible, these diverse data sources were supplemented with a review of annual monitoring reports and summary statistics from the respective District Health Management Teams (DHMTs).

In terms of monitoring indicators, the report opts to assess processes and outcomes rather than outputs and impacts. Indeed, measuring short-term changes on indicators such as maternal mortality is rather impractical in a country like Ghana, where the registration of births and deaths is not yet universalised and where significant numbers of pregnant women still deliver outside formal facilities. Again, it is clear that women in our sample have difficulty distinguishing between maternal and other deaths.

It is important to caveat the methodology and findings from the onset. For a start, the methodology employed was rapid and participatory, drawing broadly from the participatory rural appraisal (PRA) research tradition. As a result, the information adduced is largely limited to the experiences and perceptions of participants drawn from

[14] It is important to note that Agona East is a new district with major deficits in social infrastructure and health personnel. As a result, health statistics are not as readily available for that district as they are for the other four. This is particularly so for earlier years -- for which the statistics for Agona East were subsumed under those for the larger Agona West (from which Agona East has been hived off).

poor communities. That notwithstanding, it is important for drawing the attention of duty bearers to the voices of poor rights holders who, for the most part, lack other opportunities to share their opinions of service providers or to contribute to review processes. Secondly, the sample is relatively small (five districts with an average of five communities visited in each). Further, these districts and communities were purposively selected to learn from specific poor districts where partners of the Alliance have a functional presence. The small sample size also reflects the constraints on ARHR's resources, with a budget considerably smaller than is available to the larger survey-based studies which this report seeks to complement.

No doubt, a larger and more random sample has potential advantages of greater representativeness and scientific robustness. However, the qualitative approach adopted in this monitoring study also has its advantages in respect of faster turnaround time[15] and sensitivity for respondents' privacy. Indeed, the opportunistic sample was also informed by the delicate nature of some of the issues being assessed - issues such as contraception, perceptions regarding HIV, sanitation practices, hand-washing behaviours and the gap between health knowledge and practice. It was felt that targeting communities in which ARHR's partners were already well known offered advantages for obtaining reliable information within the very limited time frame for the fieldwork.

A further justification for opting for a qualitative methodology (as a complement to existing work) is that, in many cases, the statistics available at district level are themselves questionable. For example, records from KEEA indicate that there has not been a single under-five (U5) death from malaria, acute respiratory infection[16] (ARI) or diarrhoea for several consecutive years, in spite of some very insanitary environments and access challenges encountered in that district. Some other statistical results supplied to the monitoring teams were simply untenable. For example, both in Bongo District and in KEEA, the statistical records had more infants immunised than there were infants at that level.[17] Then in Builsa District, records for 2008 show over 10% more U5s receiving Vitamin A supplementation capsules than the equivalent U5 population. Bongo District similarly claims to have more pregnant women receiving tetanus toxoid vaccinations in 2007 than there were pregnant women that year. At one facility in Elmina, aggregated records received from the Disease Control Officer differ significantly from those obtained from the Public Health Officer (sometimes by as much as 200%) -- even though both sets were for the same period.

Thus, while there are undoubtedly drawbacks to the approach selected for this study - as indeed with any other methodology,- it is the hope that the voices generated will help fill some gaps in duty bearers' awareness of the experiences of poor constituents and of the reasons behind their opting out of specific services. Ultimately, it is hoped that these voices will contribute to the process of holding health service providers to account for the services they are expected to render to citizens.

Prior to the fieldwork, a series of electronic and face-to-face interactions between the (external) Research Advisor and ARHR's Research Manager helped to clarify the expectations of ARHR and to agree a schedule for the fieldwork. As part of this process, a preliminary set of issues was formulated, based on the MDG monitoring matrix. Embedded in this initial rubric were a quest for greater access to health services and the

[15] The MICS report for 2007/08, for example, was only completed in June 2009 and the GDHS report for 2008 is still preliminary.
[16] Including pneumonia.
[17] The DHMT for Bongo explains this as arising because mothers from other districts come to their district for such services.

removal of barriers preventing poor people from living healthy, productive and dignified lives. The draft set of issues was subsequently adjusted to take account of key concerns from a series of zonal stakeholder meetings recently organised by ARHR. The aggregated set of issues emerging from these discrete steps was subjected to further review during an orientation session with the research team at the start of the fieldwork.

In order to optimise the participation of rights holders, the field process employed simple scoring/ranking techniques. Probing participants' responses further enabled the monitoring teams to elicit the reasoning behind perceptions and choices and to better appreciate the factors contributing to deficits in various health outcomes. The approach was also flexible, permitting the research team some leeway to adapt to circumstances and opportunities on the ground. Thus, the number of interviews conducted varied across the districts. Similarly, additional interviewers had to be found and primed to lead the FGDs in the northern districts when it became apparent that language barriers might undermine the study in that area.

As a key part of the research, each day's fieldwork was followed by a team review to harness the key findings and identify gaps requiring further attention. Two debriefing meetings -- the first at Elmina with the Central Region teams and the second in Accra with all team leaders -- were useful for synthesising the findings from the different sites. The final stage was a series of validation workshops with stakeholders in the participant districts.

1.4 Cooperation from duty bearers

There is evidence that the first round of monitoring in 2007, which provided opportunity to hold duty bearers to account, is already yielding some fruit. This expectation is indeed consistent with the priority of *improved workforce performance* set forth in the 2009 PoW and re-echoed by the Inter Agency Leadership Committee (IALC) of the Ministry of Health (Ghana 2009: 14). At the Elmina Urban Health Centre (EUHC), nurses mentioned having been admonished by the Director of Medical Services soon after a feedback workshop on the findings of the first round of monitoring. The monitoring team also met with a considerably higher level of cooperation from that district than in the previous monitoring round. In the three districts which had participated in the earlier round of monitoring and feedback -- Bongo, KEEA and Kwahu North -- data was much more forthcoming and health managers more receptive to the research team. For now, though, there is not much evidence that this improved transparency is translating into district-wide improvements in the attitudes of frontline health staff in KEEA. However, in each of these second-round districts, senior health managers clearly demonstrated a greater willingness to discuss challenges and adverse citizen experiences dispassionately and to find appropriate answers to such problems. Thus, while there is undoubtedly room for improvement, this degree of openness and responsiveness is encouraging and ought to be commended.

Box 1: Service improvements at Elmina Urban Health Centre (EUHC), KEEA District

Mothers and carers attending PNC at the EUHC mentioned a significant improvement in nurses' attitudes over the past year or so. The monitoring team was told: "*Previously, they often yelled at us*" … "*We were ridiculed if we didn't hear when our names were called out*" … "*Some nurses could be very harsh and inconsiderate during labour; now they are more courteous and treat us more sensitively.*"

However, progress remains patchy and masks some quite serious lapses. Even within the same district, patients still recount horrifying accounts of their mistreatment at some specific facilities. Describing services at the Cape Coast Metro Hospital (known as

"*Central*"), women at Abina noted that "*It is still common to be insulted for the flimsiest reasons*" and to be "*treated as if we are not human*". By contrast, the University Hospital was commended for the warm and compassionate deportment of its staff.

Nevertheless, several public officials (both in the District Assembly secretariats and the Ghana Health Service) still do not appreciate the value of civil society monitoring and questioned the monitoring team's right to gather citizen feedback on financial and health matters. In the absence of a Freedom of Information Act duly ratified by Parliament, others demanded clear evidence that the monitoring mission had been authorised by the relevant institutional head. Such pointless bureaucracy and/or caginess are not only inefficient but also engender needless mistrust and friction between duty bearers and civil society. It demonstrates a lack of understanding of the principles of good governance and reinforces the perception that such domains are too technical to be understood by mere mortals or that citizen feedback has nothing meaningful to contribute to policy. Too often too, senior duty bearers were absent, with no notice to their secretaries regarding where they were or when they were even likely to be back in their offices. This feeds inefficiency, with significant amounts of time spent going to and fro in search of simple information.

As noted in Section 1.2, the intention of the report is not to criticise service providers, but to inspire remedial action and progress by identifying gaps and weaknesses which need to be plugged in the journey towards the health MDGs. Given the limitations of the sample and micro scale of the monitoring exercise, the report adopts a cautious approach to assigning specific roles in its recommendations for making services more responsive to the unique needs and requirements of poor and vulnerable mothers and children in Ghana. Instead, its recommendations are intended to qualify those of state-led reviews and the larger "parallel" studies based on statistical approaches. Only by challenging the *status quo* can we ensure that the huge sums going into health expenditures achieve their objective of building a truly functional health system.

It seems that some public servants continue to question the relevance of the monitoring exercise, and it must be stressed that there can be no higher authority in a democratic Ghana than citizens themselves. The kind of collective citizen feedback that this report presents is thus its primary justification.

1.5 Structure of report

The report is in ten short parts, the first of which is this **introduction**. Next follows a discussion of **child health** issues including nutrition and postnatal care. The discussion then turns, in Section 3, to **healthcare-seeking behaviour** -- home treatments and the factors determining mothers' choices of which healthcare option to take. Section 4 then assesses the **sanitation** conditions in the communities -- particularly access to healthful toilets, environmental hygiene and citizens' hand-washing behaviours. Our findings on **immunisation and preventive maternal health** are shared in Section 5, followed, in Section 6, by a review of the ostensibly preventive **insecticide-treated bed net programme** -- especially the reasons for continuing shortfalls. The next section attempts to deepen this assessment, with a greater focus on **maternal health** -- access to antenatal and other services, why traditional birth attendants (TBAs) remain popular in certain areas and performance of family planning interventions. **HIV/AIDS and tuberculosis** are discussed in Section 8, and **malaria** closes off the main assessment in Section 9. The final part, Section 10, presents a set of **conclusions and recommendations** for action.

2. Child Health

2.1 Infant nutrition

2.1.1 Content of infant feeds

Explicitly recorded in the Ministry of Health's 2009 PoW was an expectation of further "*[improvements in] maternal and neonatal health*." This optimism followed on the heels of progress in the preceding year, for which credit was shared between the HIRD and RHN programmes. The evidence from the civil society monitoring effort suggests that this optimism was not unjustified and that incremental progress has continued to be made in the area of infant nutrition. It appears plausible that the integrated nature of the HIRD approach -- combining immunisations and Vitamin A supplementation with continuous education on breastfeeding and other interventions -- is a major contributor to the significant drop in child mortality rates. The recent launching, in November 2009, of the Child Health Policy and Strategy (CHPS) is another positive step. However, further sustained improvements are needed to make a more lasting impact.

Across the sites visited, feed regimens after the sixth month consist of variable proportions of breast-milk, mono-/multi-cereal porridges constituted of locally available grains (especially corn, millet and rice). In the south, maize-based mono-cereal porridges (*koko*) and mashed *kenkey* are the commonest infant meal. The main difference in the northern sites is that the corn is substituted with millet. While most mothers clearly know how to prepare their own versions of "*Weanimix*", it is households that are more stable financially who are able to put this knowledge into practice. This they do by fortifying the cereals with pulses (especially groundnuts and beans). The poorest households are generally unable to afford this. In the northern districts (Bongo and Builsa) especially, the inclusion of legumes in infant feeds drops further during the cyclic "*lean season*", when food stocks are at their lowest, compromising the long-term development and life outcomes of the savannah's children.[18] As a result, infants in the poorest households are not receiving a sufficiently wide range of micronutrients in their diets, reflecting in some depressing statistics in the preliminary report of the 2008 Ghana Demographic and Health Survey (GDHS). For example, stunting – defined as height-for-age malnutrition – among U5s is a whopping 36% in Upper East and 25% in Upper West.[19] Wasting (weight-for-age malnutrition), is 27% in Upper East and 13% in Upper West. **In order to help minimise the adverse impact of the annual lean season on infants in the poorest households, civil society should advocate for PNC-based nutrition assistance for the most food-insecure districts.**

At most monitoring sites, mothers made the effort to continue feeding their children sick with diarrhoea. The commonest feeds are maize-based meals -- such as mashed kenkey, "*koko*" and "*kafa*"/"*agidi*" (or millet preparations in the north) -- and under-spiced light soup with powdered or mashed fish (or vegetable soup in the northern sites). However, there does not appear to be as much awareness about the need to persist with fluids. **This is an area that could benefit from further education at both ANC and PNC levels**.

[18] Some poor mothers are compelled to feed their children on the same diet as the rest of the family, for lack of choice.

[19] GSS (2009): Ghana Demographic and Health Survey 2008, Preliminary report. Accra: Ghana Statistical Service. Stunting is a reflection of chronic -- as opposed to transitory -- malnutrition. See also http://en.wikipedia.org/wiki/Stunted_growth on the adverse effects of stunting.

2.1.2 Duration of exclusive breastfeeding

Most of the women interviewed appeared to appreciate the value of exclusive breastfeeding (EBF) during the early months of their child's life, and the research found most women aim to feed their babies on exclusive breast-milk for at least the first six months. In practice, however, few are able to stay the exclusive breastfeeding course. These findings are consistent with those in the *Child Health Situation Analysis in Ghana* report (---, 2007a: 2), which cites "*substantial*" improvements and "*early initiation of breastfeeding [and] exclusive breastfeeding in the newborn period*", while lamenting that "*half infants under 6 months still do not receive exclusive breastfeeding*."

At Abina (in KEEA), for example, only one-half of women interviewed fed their babies *exclusively* on breast-milk for the first six months. Mothers at Ponkrom (KEEA) estimate that the EBF rate in their community is only a low three in ten. The others supplement breastfeeding with water and cereal-based feeds either because mothers "*lack adequate volumes of breast-milk*" or because they perceived that their "*babies do not get full on breast-milk alone*." This increases the risk of infection, especially where potable water supplies are deficient or if the porridges are stored carelessly.

Consistent with the public investments which continue to be made under the five-year PoW, knowledge of the protective value of colostrum seems similarly high overall. Women at Abina (KEEA) -- previously oblivious to colostrum's antimicrobial properties and its value in protecting neonates against pathogens -- initially expressed and disposed of it before putting their newborns to the breast. This they did because they considered this yellowish fluid to be "*dirty milk*" and thus inappropriate for feeding delicate neonates. As awareness rises through increasing PNC attendance (see Section 2.2), mothers are recognising colostrum's nutritive and immunological significance and routinely feeding it to their infants.

Another important finding is that the choice of feed regimen is not a decision made by a newborn's mother alone, but is often influenced by the baby's grandmother.[20] This arises because, in many cases, the support of these older relatives is sought in caring for the newborn. Even where this is not actively sought, the fact that poorer households tend to live in compound accommodations makes it much harder for a knowledgeable mother to resist advice from her mother-in-law and/or other older women in her shared compound. While this situation may be most common in the rural savannah, it does also occur -- though to a lesser degree -- even in urban settlements in the south. **A policy implication of this cultural practice is that ongoing nutritional literacy efforts aimed at improving newborn health ought to target older women as well because of the strong influence they have on decisions regarding infant nutrition**. The inclusion of traditional leaders as campaign partners would also be helpful in this regard.

2.2 Post-natal care

Monthly post-natal clinics are held in most of the districts visited. The monitoring exercise revealed that mothers prioritise PNC attendance for as long as their "*children are due injections*" (i.e., vaccinations), which they value highly. During that period, mothers are more likely to attend consistently. Explaining their reluctance to persist with PNC visits, women at Abina clearly perceived the other PNC services, such as weighing and counselling as less valuable to their children. The under-appreciation of the vital role of PNC in fostering infant and maternal health gives cause for concern, particularly so

[20] In some communities, informants stated that they had been advised during ANC to combine breast-milk with fluid foods right from birth.

because many infants are needlessly missing out on the essential health tracking, diagnostic and preventive services offered at such clinics.

However, the gap in awareness is not the only cause accounting for the deficits noted in PNC attendance. In Bongo District, for example, women interviewed reported attending PNC an average of about six times and not necessarily in an unbroken stretch. Postpartum mothers tended to drop out of PNC from around the ninth month. Those who returned after this mostly did so because their children were ill. In some of the focus group discussions, participants reported that they were sometimes dissuaded by the nurses from continuing PNC beyond nine months. The standard reason given was to make space for mothers with younger (and, thus, presumably more vulnerable) infants. The increased workload arising from the free maternal care policy is likely to be a factor influencing such advice.[21] In the savannah districts, where Weanimix rations are distributed at PNC clinics, there is even greater pressure on mothers to stop attending PNC if their infants appear reasonably healthy.

Exit interviews at the facility level also revealed that a surprisingly high proportion of infants are brought to the clinics by carers other than their own mothers. As a result, many carers are unable to provide adequate information to the nurses.

The IMCI[22] record book at the Elmina Urban Health Centre shows attendance peaking on the local "*taboo day*", Tuesday. Indeed, attendance on such days can be up to twice the average for typical days, suggesting that there are opportunity costs to accessing PNC services, even where these are not charged for. Indeed, the community-level interviews suggest that farm work does compete for poor people's attention. However, PNC participation rates are highest in Kwahu North, where clinics are held on market days. This strategy is succeeding in capturing women who would have slipped through the service net, such as those who would prioritise their farm work or weekly shopping above PNC.[23] A further advantage of holding post-natal/well-baby clinics on market days is that transport services are much more accessible on those days, especially for residents of remote parts of the district. As Tables 2.1-2.5 demonstrate, the impact can be seen in consistent and significantly higher PNC attendance rates of around 90% in Kwahu North. **Health authorities in other districts may wish to revisit their PNC (and other outreach) schedules based on the lessons from Kwahu North's superior performance in the utilisation of PNC services. In particular, consideration should be given to hosting such services on market days in order to facilitate access for poor women confronted with the tough choice of deciding between attending PNC, prioritising their livelihoods and fulfilling their other important reproductive roles**.

[21] Garbarino *et al* (2007: 18, 24) similarly links increased workloads with the NHIS.
[22] Integrated Management of Childhood Illness.
[23] While KEEA does not follow the market day strategy, mobile services are reportedly extensive in that district. This may explain the district's relatively strong (though somewhat erratic) performance in Table 2.4.

Table 2.1: Utilisation of post-natal care services, Agona East District

	2006	2007	2008
No. of women attending PNC	NA	NA	1,901
Women attending PNC as % of all pregnancies[24]	NA	NA	62%
Total pregnancies	NA	NA	3,036
District Population	NA	NA	75,890

Source: DHMT and District Assembly, Agona East District

Note: See footnote 13 on the relative lack of health data for Agona East.

Table 2.2: Utilisation of post-natal care services, Bongo District

	2006	2007	2008
No. of women attending PNC	3,010	2,698	2,873
Women attending PNC as % of all pregnancies	61%	64%	82%
Total pregnancies*	4,956	4,210	3,512
District Population	83,169	84,084	85,008

Source: DHMT and District Assembly, Bongo District

* *The cause of the 29 percentage point drop in fertility in Bongo District between 2006 and 2008 is unexplained*. However, the Ghana Maternal Health Survey 2007 does report a considerably lower fertility rate for Upper East than for the other savannah regions.[25]

Table 2.3: Utilisation of post-natal care services, Builsa District

	2006	2007	2008
No. of women attending PNC	1,848	1,974	1,850
Women attending PNC as % of all pregnancies	57%	61%	56%
Total pregnancies	3,220	3,255	3,291
District Population	80,489	81,375	82,269

Source: DHMT and District Assembly, Builsa District

Table 2.4: Utilisation of post-natal care services, KEEA District

	2006	2007	2008
No. of women attending PNC	3,735	2,886	4,139
Women attending PNC as % of all pregnancies	87%	58%	82%
Total pregnancies	4,271	4,918	5,061
District Population	127,369	130,044	132,774

Source: DHMT and District Assembly, KEEA District

[24] Data on deliveries outside formal facilities is not available in most districts, making it impossible to compute PNC attendance as a proportion of total deliveries. The report therefore substitutes total pregnancies as a proxy denominator in the assessment of this access indicator.

[25] The relevant statistics are: Northern 6.8, Upper West 5.0, Upper East 4.3, national 4.6.

Table 2.5: Utilisation of post-natal care services, Kwahu North District

	2006	2007	2008
No. of women attending PNC	3,245	4,090	5,055
Women attending PNC as % of all pregnancies	86%	85%	92%
Total pregnancies	3,752	4,808	5,519
District Population	147,533	151,920	154,046

Source: DHMT and District Assembly, Kwahu North District

Facility-based exit interviews with mothers attending PNC indicate that the overwhelming majority are not systematically asked which of the five danger signs they had observed in their children. Most mothers were either asked just a couple of these or were not even asked at all. **This is a critical area which needs improving upon**.

3. Care-seeking behaviour

In each district for which the monitoring team has relevant data, efforts have been made to increase capacity in the integrated management of childhood illnesses (IMCI). Table 3.1, below, presents a summary for the monitoring districts.

Table 3.1: Number of prescribers trained in IMCI

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	10	0	2
Builsa	9	12	15
KEEA	10	15	15
Kwahu North	10	12	14

Source: DHMTs

3.1 Main childhood illnesses

By far the most consistent childhood illness reported during the assessment was malaria. This finding tallies with the data in the various health sector reports over the past few years. Other common illnesses include convulsions, diarrhoeas and coughs. District-specific variations include anal sores (probably an upshot of persistent diarrhoeas) in several of the FGDs in Bongo District, ringworm in KEEA and hydrocephalus (known locally as "*asram*") in Kwahu North. However, mothers at Apatanga said they had stopped reporting the anal sores because the nurses had told them that there is no sickness called "sore anus". **The fact that anal sores appear to be exclusive to communities of Bongo District raises concerns and ought to be taken seriously and investigated by the district and regional health directorates**.

The research drew a blank on the main causes of child death in most of the monitoring communities. This is because women who had lost infants and other young children were neither informed of the medical cause nor counselled. Under the circumstances, most are left to believe that the causes are purely spiritual. Here again, **proactive counselling services would be helpful in removing beliefs that could hamper their health and in promoting better hygiene and health in poor communities.**

3.2 Home treatments for childhood illnesses

When infants show signs of ill health like high temperatures, lethargy and a loss of appetite, it is common for mothers to self-prescribe treatments. While oral rehydration salt (ORS) is common in the home management of diarrhoeas, fevers are generally addressed at that level by sponging or dousing the sick child with water and by administering "*para*" (i.e., paracetamol).[26] Indeed, at Abina (KEEA), a child with a fever or diarrhoea would be given just a single-dose tablet of "*para*" -- widely perceived as a wonder drug, a panacea for all manner of illnesses ranging from diarrhoeas to convulsions. Needless to say, such **abuse of medications has high costs not only in terms of immediate treatment failure but even more importantly, its potential to spawn drug resistance in the case of antibiotics**.

[26] In parts of Bongo District, sick children are also smeared in an unspecified herbal brew. The efficacy of this treatment was not ascertained, however.

3.3 Choice of external care

In the case of fevers, facility-based care is generally considered if children do not appear to be responding to the home treatment after about three days. In practice, however, there are various barriers which may prevent this desire from being actualised (see Sections 7.2 and 7.3). Convulsions are widely perceived as having spiritual origins and, in the southern communities visited, are typically referred to so-called "*gardens*" run by spiritualists rather than to formal healthcare facilities. These are discussed further under Maternal Health (Section 7). Again, despite clear improvements in IMCI capacity (Table 3.1), unfriendly health staff attitudes were cited in several interviews as undermining the wider utilisation of facility-based services (see Sections 7.2-7.3 and Box 3 for fuller accounts). This rather unflattering observation concurs with what Oxford Policy Management found in their independent study of health workers in Ghana (Garbarino *et al*, 2007: 14).

It appears that negative attitudes among frontline health workers may be due, in part, to the continuing centralisation of certain management powers. In practice, district-level managers have relatively little influence over postings, deployment and salaries of the staff they are expected to supervise. Under such conditions, they simply lack real authority to take disciplinary measures against offending staff.

3.3.1. Mobile Healthcare

From the community-level interviews, mobile healthcare services appear to be quite extensive in KEEA as well as in Kwahu North. In the latter, outreach services are extended to marketplaces, making it easier to reach larger numbers of women traders and shoppers. Where mobile interventions are well implemented, this has significant potential to improve access for the poorest -- such as those who are unable to pay for transport services -- and other high risk groups (such as pregnant women, disabled people and others with impaired or limited mobility). However, at Apatanga (Bongo), holding these mobile services outdoors means that services tend to be disrupted in the rainy season. Participants at a validation workshop held in Agona East also observed that these clinics are sometimes scheduled without prior information to the women.

In communities visited regularly by their respective community health nurses (CHNs), this is manifesting in a corresponding higher level of health awareness among the women. Thus, women interviewed at Abina (KEEA) generally had a sound knowledge of how long to administer EBF for, what kind of foods to wean their infants with, the value of vaccinations for their children and the relevance of preventive care for themselves during pregnancy. The regular visits by CHNs have also resulted in a higher level of access to PNC services than one finds in comparable communities in most of the other districts. Based on the field observations, **mobile interventions ought to be promoted and supported as a pro-poor approach**.

3.3.2 Community- and faith-based care

Where the service provider is community-based (e.g., at Goo, in Bongo District), user satisfaction is especially high. In the words of the women's focus at that site, this is because "*the nurse lives with us*." Satisfaction is also higher at facilities owned by faith-based missions.[27] Downward accountability is particularly impressive at the Donkorkrom Presbyterian Hospital (Kwahu North), where the results of patient satisfaction surveys are now posted at the facility's out-patient department (OPD). While the results do show a

[27] Garbarino *et al* (2007: 15) find similarly -- that "*dedication is higher in … the faith-based hospitals … because monitoring and sanctions are in place and because the health workers have the 'fear of God'*" -- and that performance is also evaluated more rigorously than it is in the public sector.

few areas with low client scores, this **self-monitoring effort is both proactive and to be commended to the public sector**.

4. Sanitation

4.1 Access to household latrines

Sanitation is a major issue in most of the communities sampled – from Apatanga in Bongo District to KEEA, where the coastline is littered with human excreta all the way from Elmina to Komenda.[28] Unexpectedly, children interviewed at Komenda did not see their poor sanitation condition as a problem, but merely a logical response to the human metabolic process. Similarly, residents of Ponkrom (KEEA) had declined subsidies for the construction of home latrines. A notable exception to this situation was found in Kwahu North, where APDO[29] has invested quality animation efforts and subsidies to promote sanitary behaviours. But even in that district, open defecation is still the dominant mode of sanitation in some communities, such as Abotanso and Apeabra. Unsurprisingly, the national statistic for healthful sanitation coverage was only a low 13% for 2008, well below the MDG target of 54
%.

It is not surprising that the overwhelming majority of participants in the sample sites lacked access to home-based toilets. It was not uncommon to find only the chief's house with one toilet, and even so, this was often of the most rudimentary form. Most communities could only boast a traditional pit latrine, infested with flies and maggots, and reeking of the foulest odours. Indeed, at many sites, residents deliberately opt for the bushes in order to avoid the odour of the communal latrine. However, for women and adolescent girls, cultural barriers mean that they are often compelled to delay this basic metabolic function till after nightfall, risking snake bites in the process. Women at Namewura (Agona East) are compelled to share the same communal latrine with men, a situation which does little to encourage them to use the facility habitually. At Ponkrom (KEEA), those unable to hold their bowels till daybreak use so-called "*night bags*" which they dump into the bushes at dawn. Local dogs reportedly drag these out of the bushes and litter the community with the contents. A further challenge with the lack of home latrines is that routinely delaying defecation may induce constipation and compromise health in the long term. All told, the monitoring team found very little evidence that the brown agenda and its consequences are a major priority of policy-makers.

Mothers in all five districts[30] seemed oblivious to the huge risks their children – many barefoot – are exposed to when they use the bushes and local refuse tips (especially in KEEA) as places of convenience. It is disturbing that mothers remain unperturbed that these rubbish heaps often contain rusty tins, broken bottles and toxic chemicals. Yet, some of these children are only four years old. Clearly, many poor citizens lack sufficient knowledge and the will to adopt or pay for healthful sanitation choices. What makes this particularly worrying is that individual indiscretion in this area can have major impacts on the health of entire communities, with particularly adverse consequences for pregnant women and little children. **As these consequences are generally of a public rather than merely private nature, responsibility for resolving the risks should not be left in the**

[28] The area around Coconut Grove Hotel and the small stretch between Brenu and Ampenyi are notable exceptions, having recently been reclaimed through private commercial/NGO interventions.

[29] Afram Plains Development Organisation.

[30] The reported incidence is lower in Kwahu North, however.

hands of individual residents but addressed through a comprehensive public health strategy combining education with enforcement.[31] **It would also seem appropriate to engage traditional authorities more fully as part of such a strategy**.

4.2 Handling of infant stool

Typically infant stool is rinsed out into nearby bushes. Others allow their children to defecate on the bare ground, after which they cover it cosmetically with sand. In the northern communities, it is more common to bury the fresh excreta. Altogether, communities did not appear to realise the serious public health implications of these practices. Other related issues are discussed below, in the next section, on residents' hand-washing practices.

4.3 Hand-washing behaviours

Of those interviewed at the various monitoring sites, the majority do not wash their hands after using the toilet and after performing cleaning chores. Most routinely wash their hands with water alone. At Apatanga (Bongo District), for example, only two out of the eight women interviewed said they washed their hands regularly with soap after handling their children's stools. All seven women interviewed at Domoki (Agona East) confessed to not washing their hands with soap after coming into contact with faeces, attributing this shortcoming to "*stressful living*" (a euphemism for "not having the time") and to "*lack of soap*". Virtually all groups interviewed in Kwahu North admitted ignoring hand-washing advice, even though they had the knowledge.[32] This is absolutely surprising, given the presence of APDO and the reportedly good work they have been doing in the area of health and environmental hygiene.

In some cases, people who washed their hands with soap (or ash) said they did so because they were concerned about the lingering foul smell on their hands rather than for reasons of hygiene. Only in rare instances -- e.g., at Bando (KEEA) -- did the public latrine have soap and water to encourage hand-washing.[33] Generally too, participants in our focus groups were entirely unenthusiastic about using soap just before eating, asserting that "*the scent of soap would ruin the flavour of the food*." Further, poverty appears to be a factor determining deficient hand-washing behaviours. In some of the poorest communities of the north (for instance, Goo and Kadare), the inability to afford soap for routine households use came up repeatedly as a very real challenge in their lives.

Together, these findings suggest a continuing and yawning gap on the preventive side of the health agenda. **Efforts must be stepped up to foster safer practices (of excreta management, hand-washing, and others, without which it will be impossible to make real progress in human health. Further, health education in poor communities should also include the conditions under which ash is a safe alternative to soap**. For now, the emphasis on health insurance appears to be drawing attention away from preventive actions towards the clinical care.

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[31] Recall that environmental hygiene was considerably better when Town Council inspectors (a.k.a. "*tankass*") were functional.

[32] Hand-washing with soap was the norm at Odumase but not at the other four communities in that district -- Abotanso, Apeabra, Bebuso and Somsei.

[33] In Builsa and Bongo Districts, ash is often substituted for soap. Oddly, women at Abil-Yeri (in Builsa) "wash" their hands by rubbing them with soil, itself likely to be contaminated with all manner of microorganisms, especially so in a community where open defecation is the norm!

5. Immunisation and preventive healthcare

5.1 Perceived relevance of vaccinations

Immunisation is a priority both for local women across the monitoring sites and for Ghana's health ministry. A group of women at Abina (KEEA) opined, "*vaccinations will make our children fit and strong*." This statement was echoed across the focus groups interviewed. However, going by records inspected at the Elmina Urban Health Centre (EUHC) and other health facilities, vaccination practices do not appear to be consistent. While some one-year-olds have received their measles and yellow fever vaccinations, others who have attended PNC consistently (judging by their cards) have not had these. At Apowongo (Bongo District), several mothers alleged that "*the nurses do not always tell us the type of vaccination they are giving our children; … sometimes, they also fail to record it on the weighing cards*." While they do know that vaccinations are generally helpful, it is important to address this concern as it can dissuade women from participating in further immunisation sessions if left unresolved.

Immunisation rates appear higher in communities where community health nurses (CHNs) routinely make outreach visits to augment the facility-based PNCs. Generally, however, significant numbers of children in poor communities fail to make the full five immunisation visits required to provide comprehensive protection from the key childhood killer diseases.

5.2 Maternal prophylaxis

Data on the dispensing of intermittent preventive treatment (IPT) (Table 5.1) generally suggest a rise in participation rates since 2006. This improvement has been attributed, in part, to the introduction of the free maternal care policy. Curiously, however, significant numbers of expectant mothers continue to drop out of the IPT regimen during the course of their pregnancies. Thus, for all districts for which data are available, the records show well under one-half of pregnant women completing the course in any particular year. Indeed, the 2007 records for KEEA show only a paltry 35% of mothers who reported for the first dose completing the programme.[34] Nursing mothers at Abina justified dropping out of ANC (and by implication IPT) on the grounds that pregnancies feel more secure during the latter stages and thus have less need for professional attention. Indeed, only two out of eleven nursing mothers interviewed in that community had received the full three-dose course during their last pregnancy. Further, women often reported that they were simply handed the tablets and ordered to take them in the presence of the dispensing nurse, with no explanation whatsoever.

*Table 5.1: Participation in intermittent preventive treatment (IPT) (%)**

District	2006	2007	2008
Agona East	NA	NA	59%**
Bongo	NA	70%	69%
Builsa	48%	71%	52%
KEEA	47%	44%	72%
Kwahu North	30%	54%	61%

Source: DHMTs

* *The results presented indicate the proportion of pregnant women participating in IPT, regardless of whether they actually complete the course.*

[34] The Kwahu North statistic for 2006 is an even lower 22%.

** *The record for Agona East is only available for IPT2.*

Box 2: Women are not keen to disclose their pregnancies early

A major reason why poor women tend to begin ANC relatively late is that local traditions generally discourage women from announcing their pregnancies at the initial stages. This is attributable, in part, to superstitions which ascribe miscarriages to the work of rivals and other enemies. As a result, many women are reluctant to disclose their pregnancy status until it is visible. This is particularly common in Bongo District,[35] but also occurs in the other four districts. The research further revealed that a minority do not realise they are pregnant till they are well into the first trimester. Women interviewed at Bando (KEEA) said that delays also arise when pregnancies are either unexpected or unwanted, leaving them embarrassed and not eager to disclose their status.

By avoiding or failing to complete the IPT course, pregnant mothers are exposing themselves to malarial morbidity, with the attendant risks of miscarriage, stillbirth and low birth weight. This adverse situation arises because of the hormonal and immunological changes that occur during pregnancy, making malaria not only more common but also more atypical and significantly more severe than it is in the rest of the population.[36] That many mothers continue to undervalue the role that critical services such as ANC (also PNC) can play in averting and/or reducing both neonatal and maternal morbidity should, thus, be a source of immense worry.

Education needs to be stepped up to counter the constraining beliefs shrouding the experience of pregnancy. In recognition of the continuing role of communal beliefs, a case can be made for engaging with potentially influential traditional partners -- such as chiefs and traditional birth attendants (TBAs) -- in a more strategic role. Efforts should be made both by GHS and civil society to involve these groups in relevant campaigns as well as in sector review processes and in MDG monitoring. In northern communities with *magazias* (women's leaders), actively soliciting their participation can go a long way to reassure local women and encourage them to be less secretive about their pregnancies.

[35] According to women at Apowongo, "*we wait till the seventh month so that we are certain that it is indeed a pregnancy*."

[36] http://www.malariasite.com/MALARIA/Pregnancy.htm

6. Treated bed nets

6.1 Choice of protection from mosquito bites

In terms of methods for preventing mosquito bites, insecticide coils, bed nets (treated as well as untreated) and aerosols are used to varying degrees. In nominal terms, bed nets appear to be the most common; however, their use is entirely erratic (see Section 6.2) and, in reality, insecticide coils are the most routinely used form of protection. In some northern communities (especially in Bongo District), bedrooms are smoked by burning pungent herbs for about a half hour before bedtime. To optimise the efficacy of this form of insect control, doors and windows are kept shut all night long, risking cross-infection and attendant fatalities when CSM[37] strikes during the warm months after the annual harmattan season.

Table 6.1: Access to insecticide treated nets (ITNs) among U5s (%)

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	NA	76%	NA
Builsa	70%	36%	84%
KEEA	NA	NA	NA
Kwahu North	46%	19%	10%

Source: DHMTs

The community interviews suggest that insecticide-treated nets (ITNs) are used most regularly in Builsa District, ostensibly because of sustained promotional work by UNICEF and other agencies. Even then, the data for that district (Table 6.1) show that performance has not been consistent on this indicator -- a situation attributable, in part, to occasional supply shortages. Poor women interviewed at Apowongo and Kadare (both in Bongo District), Duabone, Namewura and Otabilkwa (all in Agona East), Odumase (in Kwahu North) and several other communities even found the unit price of GH¢2-3 difficult to afford.[38] Elsewhere -- and despite their acclaimed potential to cut malarial mortality significantly in children and their renewed promotion under the HIRD strategy -- ITNs were nevertheless criticised as being "*unsuitable in warm weather*". Groups interviewed complained routinely that "*the treated nets make [them] sweat and cause itching*" as well. Others mentioned a "*burning sensation*" and "*skin rash*", especially when the net is damp, or immediately after retreatment, and also in stormy weather.[39] It appears that users are not really aware that the nets are supposed to be dried in the shade for six hours before use. As a result, many are not adhering to this, leading to the effects reported. **Further community education is required to ensure that nets are dried properly in order to minimise adverse side effects**.

6.2 De facto utilisation of ITNs

As a result of the above concerns, eight out of nine women interviewed at Bando (KEEA) said they could only use their nets during the relatively cold months -- ostensibly in the harmattan and around August. These adverse side effects are presumably associated with

[37] Cerebro-spinal meningitis.

[38] The nets are sold in the northern sites for GH¢2 and between GH¢2.50 and GH¢3 in the south. It is also the case in Builsa District that pregnant women are made to pay GH¢0.50 for supposedly free ITNs.

[39] This may explain, in part at least, the rather poor national utilisation rate of 45% for U5s.

Pyrethrum,[40] the main chemical recommended by WHO[41] for the impregnation of bed nets. Even where the ITNs are now clearly preferred (for instance, in the Builsa communities), they are often used in ways that deprive the owners of maximum impact. Many respondents reported removing the ITNs during the warmest hours of the night and/or abandoning them temporarily during the hot season. This obviously limits the effectiveness of the nets, considering that the windows and ceiling areas of their swish compounds offer little or no protection against mosquito intrusion. Again, most users appear reluctant to retreat their nets (or simply pack them in) when the insecticide wears out, citing the discomforts and expense as their justification.

6.3 Further challenges with the ITN programme

The ITN programme has strong backing from the international development community. While this support is delivering vast supplies of bed nets (the reported shortages notwithstanding), there appears to be justifiable criticism of the programme on grounds that it is overly supply-led, with little evidence of a willingness to address the concerns raised by users. Rather, health professionals often see the concerns raised as signs of ignorance, hence the predictable effect. **Greater citizen consultation is required -- especially with poor and vulnerable stakeholders -- as a way of addressing demand-side concerns related to the design of anti-malarial interventions** (see also Section 9.2 on artemisinin combination therapies).

Once again, it makes sense to consider investing more energy in supplementary public health/environmental hygiene approaches. In this regard, **while the ongoing trials to produce a malaria vaccine under the Malaria Clinical Trials Alliance (MCTA) project may be welcome news for MDG monitors, there is also a risk that their success could make communities even less proactive where issues of environmental hygiene are concerned. Precisely for that uncomfortable reason, it is important to intensify the campaign to rid communities of filth**.

[40] http://www.anapsid.org/pyrethrin2.html
[41] World Health Organisation.

7. Maternal health

7.1 Ante-natal care

In the districts with relevant data, the proportion of mothers participating effectively in ante-natal care (ANC) rose sharply in 2007 and continues to do so, if more gradually now (Table 7.1). This finding is consistent with the Ministry of Health's report on the same indicator (Ghana 2010: 4, 28). Presumably, the fusion of rising NHIS coverage and the free maternal care policy has been influential in this positive development.

Table 7.1*: Proportion of pregnant women making at least 4 ANC visits (%)*

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	51%	75%	80%
Builsa	23%	73%	79%
KEEA	45%	55%	76%
Kwahu North	NA	NA	NA

Source: DHMTs

In line with the free maternal care policy, women are generally not charged for services rendered during ANC (and also PNC) visits. However, some pregnant women were required to pay GH¢2 for pregnancy tests at the Komenda Health Centre because they did not have NHIS subscriptions. Others reported that some nurses at the Cape Coast Metro Hospital (known as "*Central*") do demand payment for delivery services. This is discussed separately in Section 7.3, below.

Very few women know all the key danger signs in pregnancy. Exit interviews conducted by the monitoring team suggest that this may be due, in part, to the fact that many women still delay the start of their ANC visits, thereby missing out on some vital education. Indeed, the data in Table 7.1 show that while increasing numbers of pregnant women are taking up ANC services, the shortfall is significant. The report on *Child Health Situation Analysis in Ghana* observes similarly that "*intervention coverage for antenatal … remains relatively low [and] antenatal visits tend to be made late and many women do not make four visits*" (---, 2007a: 3).

7.2 Access to maternal services

Despite the fact that successive PoWs for the health sector have prioritised improvements in maternal health and related obstetric care, there remain significant non-medical factors such as transportation challenges, including motorability and sheer lack of vehicles, undermining access to facility-based healthcare for rural dwellers. At the peak of the rainy season, pregnant women in the Siniensi area (Builsa District) have to wade through a seasonal river to access services at the Siniensi Community Clinic.[42] Their counterparts at Ponkrom (KEEA) often travel over ten kilometres each way on foot just to access services at Agona. During the rainy season, this can be a significant barrier and can exacerbate complications of pregnancy and childbirth.

[42] The health directorate for Builsa also asserts that roads leading to the Wiaga catchment area become impassable during the raining season rendering communities in that area inaccessible to healthcare providers.

Women at Abreshia, Atabadze, Bando and Ponkrom (all in KEEA) consistently described highly unprofessional attitudes among care givers at their facilities.[43] Indeed, in terms of inappropriate attitudes of frontline healthcare workers, the district came second only to Builsa District.

For poor households, mandatory laboratory tests (in KEEA, for example) represent a financial barrier to accessing ANC services. This is because, at GH¢7, the initial lab test is not covered by the NHIS and remains prohibitive for many poor women.[44] Without going through this initial test, women are not permitted to access subsequent ANC services. In such cases, they may well lose the opportunity to participate in vital preventive interventions such as HIV screening, tetanus toxoid vaccinations and IPT. In the process, they and their unborn babies are left exposed to needless preventable risks, thereby violating the rights of the unborn child.

7.3 Intended place of delivery

Preference for facility-based delivery is higher in urban localities (e.g. Elmina). In all districts, women interviewed were virtually unanimous in the view that the formal health facilities are better equipped to offer "*water*" (i.e. infusions), blood transfusions and vital support in the event of obstetric emergencies. In the northern sites, women frequently noted that "*the hospital cuts the umbilical cord properly*." Where fathers were interviewed, they expressed similarly positive opinions about formal delivery services. Though sketchy, the data from the field work (Table 7.2) does indeed show skilled deliveries to be increasing overall, a finding consistent with the 17% rise reported in by MoH (Ghana, 2010: 27). Notwithstanding this improvement, utilisation rates for skilled attendance (Table 7.2) are considerably lower than ANC and PNC utilisation rates (Tables 2.1-2.5 and 7.1) in each of the sample districts for which relevant data are available, suggesting barriers in women's de facto access to skilled delivery services.[45] It is not surprising then that the ministry's own report acknowledges the "*[persistence of] high maternal mortality, neonatal mortality and infant mortality [rates]*" (Ghana 2009: 20) in spite of the renewed focus on these areas. The *Child Health Situation Analysis in Ghana* report echoes this observation, noting that "*half of all deliveries are attended by an unskilled attendant [and] visits are rarely made in the first 24-48 hours*" (---, 2007a: 3).

Even in Builsa District, where many women said they preferred facility-based deliveries, the utilisation rate for 2008 is only a poor 36%. This is not particularly surprising if one takes account of the finding reported in Section 7.2, that of the five districts sampled, care workers in Builsa came across as being the least sensitive to the needs of care seekers. It is equally revealing that in spite of the acknowledgement that formal facilities are better resourced, participants did not necessarily perceive overall health outcomes to be significantly higher than where services were provided by ostensibly less skilled operators such as the traditional birth attendants (TBAs), where these were present, or the ubiquitous neighbourhood drugstores. Thus, for example, while six participants in a

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[43] Yet, according to Garbarino *et al* (2007: 14), health workers as a whole opine that "*dedication is a necessary condition to [working in] the health sector*."

[44] While GH¢7 may seem like a pittance to many, there are many poor households in the hinterland whose average monthly income is less that GH¢30. For such a household, the GH¢7 lab fee is not such an easy amount to pay as a lump-sum, particularly where rural income streams are seasonal. Bongo District reports, however, that no charges are made for such services in that district. The scale of the problem becomes clearer when one takes account of the under-representation of the poorest sections of the population among NHIS card holders (Ghana 2010: 4).

[45] On the positive side, attended delivery rates exceeded the 2008 national statistic of 39 per cent in as many as three of the five of the monitoring districts.

seven-woman focus group at Abreshia (in KEEA) said they would use ANC services, only one of the seven said she would opt to have her baby at a formal health facility!

Table 7.2: Skilled deliveries as proportion of pregnancies (%)

District	2006	2007	2008
Agona East	NA	NA	54%
Bongo*	32%	39%	53%
Builsa	32%	31%	36%
KEEA	39%	31%	35%
Kwahu North	38%	46%	51%

Source: DHMTs

The interviews revealed physical, financial and social challenges that influence women's decision to avoid facility-based deliveries.

1. Previous care-seeking experiences inform subsequent decisions as do recommendations from relatives and friends, particularly those residing in the same community. Friends who have had unpleasant experiences at facilities often dissuade their peers from seeking facility-based care or, at least, from delivering there. Similarly, a successful first labour outcome facilitated by a TBA is likely to be followed by return visits.

2. The policy on free maternal care, ostensibly implying the abolition of upfront charges, is interpreted differentially by practitioners in different locations. Outreach nurses interviewed from EUHC in KEEA indicated that, without an NHIS subscription, a mother may be required to pay for various delivery services (e.g. theatre fees where a caesarean section is required).[46] This hurdle limits poor women's access to skilled deliveries at such facilities. In Kwahu North, where the health authority interprets the policy more liberally, it reflects in a more respectable (though still inadequate) rate of service utilisation (Table 7.2), despite the adverse transport situation associated with the district's many rivers.[47] **Clearly, there is a case for further education -- both of care workers and the public -- on the content of the NHIS policy, its associated exemptions and what precisely the expression "maternal care" embraces**.

3. Peculiar to KEEA, costs are higher for skilled deliveries because mothers are required to provide a string of items including disinfectant, bleach, cloths, new bath towels, sanitary towels, cotton wool, new cot sheets, bath soap and petroleum jelly. These quickly add up to levels that poor rural couples find difficult to meet. On occasion, nurses were reported to insist on particular product brands[48] or to reject used sheets and old cloths intended as nappies. The list of prescribed essentials is considerably shorter in Builsa. However, significantly higher levels of poverty in the Upper East

[46] In KEEA, women may be charged for pregnancy testing if they do not have an NHIS subscription.

[47] Even there, women at Abotanso and Bebuso expressed a clear preference for TBA deliveries, citing cost as the determining factor. In the view of the health directorate, the high level of confidence expressed in the district's TBAs is due, in part, to the training these TBAs have received.

[48] It is important to state that there are indeed many health workers who are offering selfless services and sacrificing much to bring relief to their patients. However, unaccountable behaviours are also reportedly common across the country, including at major facilities such as Komfo Anokye Teaching Hospital (KATH). According to a nurse interviewed in KEEA, the prescribed disinfectant is Dettol, bleach has to be Parazone, regarding toilet soap, the prescribed brand is Geisha and Vaseline is the specified skin cream.

Region[49] mean that this still poses a problem for pregnant women, particularly in rural parts of the region.

4. The proximity of a care provider is another key criterion in the decision on where to deliver. In hinterland settlements where motorised transport can be quite scarce, access costs can be a major determinant in deciding which delivery option to choose. Women in such remote settlements tend to opt for home- or community-based deliveries, especially if labour commences at night. At Ponkrom (KEEA), for example, the nearest health facility at Agona township is a good 15 km away, with unreliable transport services. Under such conditions, it is not hard to see how poor road infrastructure and a lack of motor transport easily conspire to keep rural women from accessing essential maternal services.

5. The attitude of caregivers towards patients (see Box 3) is also influential in determining where a woman chooses to deliver, regardless of proximity. MoH's Programme of Work for the period 2007-2011 appears to appreciate the importance of healthy patron-provider relations and seeks explicitly to forge closer ties with local communities (Ghana, 2007b: 30). In focus group discussions, the Agona health facility (KEEA) and several in Builsa came across as being particularly notorious in the way that expectant mothers are treated. Professional medical staff of all grades came under sharp criticism by women at Bando and Ponkrom for their perceived insensitivity at the Agona facility. Service users reported that staff at that facility exhibit little sense of urgency or concern, even in obvious emergencies.

Such inhospitable attitudes repel rural women, moving them to avoid health facilities and opt for alternative care. Oxford Policy Management confirms such attitudes and their impact, citing health workers themselves admitting to variously being "*impatient with users, … tell[ing] them off, get[ting] angry …, shout[ing] …, los[ing] their temper and insult[ing]*" their patients (Garbarino et al, 2007: 36). Closely mirroring this finding, the draft independent sector review also concludes that "*some of the main obstacles of the Ghana health sector … are in the broad domain of governance*" (Ghana 2010: 1). In KEEA communities especially, women are thus compelled to risk their lives and those of their newborns at the hands of local TBAs and healing "*gardens*" run by "*spiritual churches*"/self-appointed "*prophetesses*". Considering that the majority of infant deaths tend to occur soon after birth, it is worrying that significant numbers of expectant mothers shy away from facilities when appropriate emergency care may have saved the lives of their babies -- all because of such uncaring behaviours among care providers.[50] By contrast, women reporting with labour are courteously addressed as "*madame*" at Zorko (in Bongo), a situation which has reportedly helped with improving relations between care workers and clients at that facility.

Box 3: Abusive attitudes at care facilities

Neglect, abuse and other unprofessional behaviours among frontline health workers were cited in women's focus groups and exit interviews as turning mothers off facility-based care. Specific examples of abuse and negativity include nurses shouting at mothers seeking care and making threatening remarks -- either to pregnant women or to their

[49] The poverty statistic for Upper East is a whopping 70%; extreme poverty is 60%. Source: GSS, 2007: Pattern and Trends of Poverty in Ghana: 1991-2006. Accra: Ghana Statistical Service, pp. 40, 41.

[50] Such attitudes thus contribute to the spiral of "*high … neonatal deaths*" reported by MoH (Ghana 2010: 26).

visiting relatives.[51] A mother attending PNC at the Elmina Urban Health Centre noted: "*I am not pleased with the attitude of some of the nurses. Some of them lack the patience to explain things … and get angry very easily*." Another attending the Donkorkrom Child Welfare Clinic (Kwahu North) had this to say: "*I am satisfied with the expertise but not with the attitude of the nurses. When you make a little mistake, they shout at you*." Yet another recalled during an exit interview at the Atengua Community Clinic (Bongo): "*There used to be a nurse here who was rude and abusive, but she has been transferred*."

A focus group of mothers at Adaboya (also in Bongo) told of how "*the nurses sometimes beat us when we are … wailing in labour*." Similar experiences were recounted at Kadare: "*They beat us when we are unable to push during delivery*." Others described how they were ignored on the delivery ward when they drew the nurses' attention to the fact that their babies were literally due, only for the babies to arrive unaided while the nurses were away. At Goo, a group of women described how "*we are shouted at when we take seriously sick children for treatment*" and "*they should treat us before blaming us*." Another focus group at Somsei mentioned insulting behaviour by local nurses. Others at Abil-Yeri (Builsa) told of being "*insulted by nurses because more mothers are reporting sick as a result of the health insurance*" (presumably increasing stress levels among nurses). At Alaba-Yeri (also in Builsa District), people complained that "*The nurses do not regard us as their fellow human beings*." A focus group of women at Bando noted: "*We prefer to use TBAs because they are … more patient by comparison with the nurses [at Agona], who tend to be harsh even when we are in pain*."

Given the rather deferential and hierarchical structure of rural/traditional Ghanaian society, poor citizens encountered during the monitoring exercise had neither the willingness nor capacity to complain or to hold duty bearers accountable for their behaviour.[52] As is clear from above, it is not uncommon for care givers to blatantly refuse assistance to (or even hit) defenceless women at the peak of labour. Surprisingly, some nurses interviewed tried to justify their impatience and the use of harsh techniques to get illiterate women to comply with their wishes.[53] This is altogether reprehensible and patronising, particularly so for health caregivers, who have pledged their dedicated service to the health needs of the communities they have been assigned to serve. These inappropriate behaviours coalesce to feed the status quo, causing poor women to hold back from participating regularly in prescribed clinics, with often tragic consequences.

Where TBAs are present in a community, they are generally regarded highly because of their relative sociability and respect for the feelings of their clients. For a start, TBAs are generally better known to residents (being community-based). As reported above, social proximity is influential in poor women's care-seeking choices. Typically, TBAs were said to show a personal interest in each case brought to them. A group of mothers at Abina (KEEA) noted that TBAs "*tend to be older and more caring*". Delivering at a TBA's or elsewhere in the community also provides greater assurance of support from friends and family. To women used to a communal lifestyle, this can be at least as influential as the quality of medical care. Yet, the avoidance of formal facilities has several adverse implications for the poor.

[51] Anecdotal evidence -- including personal experiences of some members of the monitoring team -- suggests that this practice does occur in public health facilities.
[52] Garbarino *et al* (2007: 38) report similarly on the issue of patient voice.
[53] The words of one nurse from the EUHC are so telling: "*Sometimes, you have to shout at them so that they stop wasting your time*." She elaborated further: "*It teaches them not to be obtuse. Some wait till the last moment before reporting with all manner of complications that need not have arisen if they had come in promptly*."

First, by opting for community-based deliveries, the poor are effectively subsidising the NHIS. Secondly, it means that expectant mothers are compromising their labour outcomes by exposing themselves to risks associated with prematurity, asphyxia (from delayed/obstructed labour) and other delivery/neonatal emergencies. These risks arise because TBAs and "*spiritual churches*" lack the relevant resources to provide the highly specialised care that such situations require. Unhygienic delivery environments and poor care of the umbilical cord -- all too common in community-based deliveries -- further expose neonates to a range of avoidable infections (among them neonatal tetanus, newborn septicaemia and pneumonia). It is hardly surprising that the majority of neonate deaths occur at home and due largely to preventable and/or easily treatable causes (---, 2007a: 1). Birth registration is also less likely when births take place outside formal health facilities. Furthermore, when the health of nursing mothers is compromised through such unsafe delivery services, it can adversely affect the survival prospects of their babies, especially when mothers die from such complications. This is important, considering the widely acknowledged potential of skilled attendance in averting (or at least minimising) pregnancy-related deaths. In view of these barriers, care of mothers and newborns cannot, in practice, be said to be either truly integrative or continuous.

For illiterate rural women to opt more routinely for safer care, health personnel will need to align their behaviour more closely with citizen expectations and see patients as partners (neither as adversaries nor as a burden) in the ambitious and challenging agenda of delivering the health MDGs. **Health workers will need training to better appreciate the feelings, fears and rights of illiterate and rural populations, and to aim for a more patient-centred approach to service delivery. From our limited observations and findings, the content of such training could usefully include inter-personal and counselling skills as well as genuine respect for the rights of other citizens, regardless of their social status or differences**. The training would be delivered with the express aim of equipping health workers to respond more respectfully and sensitively to the needs and fears of vulnerable populations. Only then can we have both the supply- and demand-side players pulling in the same direction in combating morbidity and mortality in poor and hinterland areas. The decision of the Nurses and Midwives Council of Ghana (NMCG) to deploy "*a code of conduct for midwifery practice with a view of improving quality of care*" and to "*conduct supervisory visits with the view to enforcing standards of professional practice*" (Ghana 2009: 29, 30) are especially relevant, given the findings of this monitoring survey. **At the district level too, managers ought to be handed greater powers over deployment decisions and disciplinary remedies**.

Systems also need to be put in place to monitor progress more routinely through exit interviews and participatory research techniques. Supervision also needs improving, but this can only take place if senior managers are themselves trained to be responsive and sensitive to the feelings and rights of the vulnerable.

Citizens, likewise, need support to better appreciate their rights and identify effective ways of asserting these consistently. Most pregnant and nursing mothers interviewed in the research were clearly willing to participate in focus group discussions and exit interviews designed to elicit their personal experiences. This offers prospects for civil society action to -- for example/among other things -- educate women, advocate the health rights of poor citizens and work towards disseminating the contents of provider charters. **Civil society could further explore innovative ways of ensuring compliance (e.g. through developing effective interfaces for negotiating social justice for poor rights holders and facilitating complaints arrangements)**. The fact that poor women often attach considerable weight to recommendations from friends and relatives means

that when pregnant women are treated inhumanely at public health facilities, the impact on service uptake is much more diffused than practitioners think.

7.4 Family planning

There appears to be reasonably high knowledge about contraception *options* among women and men interviewed. However, birth control per se is not a popular choice among rural women generally. This adverse situation is reinforced by the fact that family planning services are excluded from the NHIS package (Ghana, 2010: 27), despite its being a priority concern of the Ministry of Health. District-based records show consistently low levels of adoption among women in the fertile age (WIFA) range -- under 30% in Builsa, under 35% in Bongo, under 40% in Kwahu North and just over 10% in Agona East (Table 7.3). Unfortunately, reported shortages of condoms and other short-term birth control options (Ghana, 2010: 28) do little to help this situation.

Of nine women interviewed at Bando (KEEA), none was interested in contraception! At Abina (KEEA), only one out of eleven mothers interviewed had ever practised family planning, though all were aware of the options and knew where services could be accessed. By contrast, efforts at fertility stimulation (typically through herbal preparations) are common. Even in this third millennium, women in that community still have a high regard for local enema applications, even if this carries a risk of infection and damage to various internal organs.

The research further revealed how -- in close-knit traditional communities -- a single bad experience (like a mismanaged tubal tie) can seriously deter an entire community from participating in any form of family planning. Without doubt, dissatisfied clients came across as very powerful agents in dissuading others from patronising specific services. Various focus groups alluded to certain birth control methods "*causing waist pains … and palpitations*", resulting in "*unhealthy appearances*" or even "*creating lifelong disability*."[54] Others spoke of "*excessive bleeding … or irregular menstrual cycles*" and other undesirable side effects after they had come off the programme. A woman at Goo described how "*my friend practised contraception for five years and was always ill; soon after she removed it, she regained her health fully and did not fall ill again*."

Men likewise complained that contraception sometimes "*creates fertility problems later on in life*" or makes their "*women become too fat … or too lean*." Then again, poor men unable to finance the cost of farm labour sometimes prefer to have large households as a source of free labour. This is common among those of northern origin. Often, such men refuse to cooperate with their wives, compelling women to practice contraception without their husbands' knowledge. In Builsa District, the fear of marital infidelity was reported as a significant factor undermining men's willingness to cooperate with their spouses wishing to practice family planning. Such instances of mistrust and non-cooperation were reported as engendering marital rifts particularly in the northern communities.

While these do need looking into, it also appears that family planning education rituals focus disproportionately on feeding women with the *technical* options rather than enthusing them about the benefits of smaller families or helping them make more informed decisions regarding when best to become pregnant. In the process, myths and misconceptions persist, leaving a predictable wedge between knowledge and practice. That is not to suggest, however, that women's fears are unjustified. In other cases (e.g. Agona East), inappropriate prescriptions have been blamed on incomplete histories presented by women attending the family planning clinics.

[54] Presumably, the issue of disablement arises when surgical options go badly wrong.

Table 7.3: Contraceptive usage among women of fertile age (WIFA) (%)

District	2006	2007	2008
Agona East	NA	NA	11%
Bongo	32%	35%	34%
Builsa	27%	29%	28%
KEEA	35%	46%	82%*
Kwahu North	26%	37%	39%

Source: DHMTs

** This picture contrasts sharply with data from the FGDs with women in KEEA and seems highly unlikely in the considered view of the research team. For Ghana as a whole, the couple year protection statistic for 2008 was 34% (Ghana 2010: 3).*

Even where women show an interest in birth control, mothers-in-law can be a major barrier to pursuing their intention to its logical conclusion. The power of the extended family (and relatively high incidence of young spouses living with their in-laws) means that many young couples lack the freedom to make their family planning decisions without interference. Not uncommonly, mothers-in-law came across as being averse to their daughters-in-law delaying childbirth. Unsurprisingly, it is in the Islamic northern districts -- where women tend to have least voice in reproductive and other household-level decisions -- that fertility rates are highest, and significantly so (Table 7.3). In Bongo District, for example, health workers noted how they are sometimes "*attacked*" by husbands of women to whom they have dispensed family planning services. The low level of male involvement in family planning counselling is yet another factor undermining the success of campaigns. In a small proportion of interviews, typically in Kwahu North, the cost of services was mentioned as a disincentive. **For family planning to be more effective than it has been thus far, the strategy will have to include widening the sensitisation net to rope in potentially influential stakeholders such as husbands and mothers in-laws**.

8. HIV/AIDS and Tuberculosis

8.1 HIV knowledge, attitudes and practice

In general, the focus groups interviewed appeared to be aware of the main routes by which HIV is transmitted. Participants indicated that they obtain this knowledge mainly through radio and posters. However, a minority either had no real appreciation of the disease or were simply in denial, refusing to believe that it is transmitted by causes other than spiritual ones.[55] The large number of teenage mothers in the focus groups is further suggestive that these girls practised unsafe sex, despite having the requisite knowledge. Others are in denial of their own vulnerability to the disease. Some focus groups identified ongoing high rates of temporary migration to Cote d'Ivoire for sex work as a causal factor in the HIV equation. **While the mass media do appear to be raising awareness of the pandemic, there is no room for complacency as significant numbers still doubt that the causes are largely sexual/physical**.

Among young pregnant women aged 15-24, Table 8.1 shows HIV infection rates to be rising in KEEA, Kwahu North and Builsa, in all cases by over 100% since 2006. While the rate of increase seems much higher than would be inferred from the national statistics reported by MoH (Ghana 2010),[56] both sets of research are united in the finding that infection rates have indeed gone up among pregnant women. The records for Bongo are erratic and are not much more comforting, particularly when one takes account of its small population. Kwahu North appears to fare particularly poorly in comparison with the other districts. However, this anomaly is attributed by the DDHS to an increase in the proportion of women being tested.[57] Notwithstanding this explanation, **the steep rise in HIV infection statistics in some districts does call for further investigation and attention, in light of the significance of the disease**.

Table 8.1: HIV-positive pregnant women aged 15-24

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	5	13	5
Builsa	0	6	9
KEEA	0	2	5
Kwahu North	12	29	34

Source: DHMTs

Stigma remains an issue. While some men at Apatanga (Bongo) explicitly frowned on any form of prejudice against people living with HIV/AIDS (PLWHA),[58] others opined that infected persons had brought the tragedy upon themselves and were fully deserving of the consequences. Some unashamedly confessed to being altogether unwelcoming

[55] Both at Abreshia and Atabadze (KEEA), some participants still believe HIV is an airborne disease.

[56] The MoH report notes, on page 12 of its annex, that "*the decline in median HIV prevalence among pregnant women … could not be sustained in 2009*."

[57] Further, large numbers of people flock into Kwahu North from neighbouring districts each market day to take advantage of its cheap agricultural produce. This is perceived by their health directorate as another factor contributing to the higher-than-expected infection rate reported.

[58] They asserted that those with the disease rather needed love and comfort.

towards people perceived to be infected with the virus. Women at Abina, for example, were not keen on PLWHA socialising with their children, fearing that such socialisation could facilitate sexual intercourse and the resulting infection of their children. Even more pathetically, women at Apatanga and Apowongo even felt that anti-retroviral therapy (ART) should be discontinued so that infected persons would be easier to identify by their (unhealthy) countenance and not live long enough to infect others. Even where groups were not overtly prejudiced against PLWHA, fears were routinely expressed about the perceived risk which ART poses to uninfected persons. **Ongoing sensitisation campaigns ought to take account of this concern and address it in the content of education messages**.

In Ghana, it is mainly pregnant women who get tested for HIV. Otherwise, people are not taking advantage of existing opportunities for HIV testing. For example, only one woman out of eleven interviewed at Abina showed any interest in testing. This finding is consistent with the fact that people interviewed generally did not feel particularly at risk of contracting the disease. Some also shy away from testing for fear of stigmatisation (in the sense that the mere fact that you are known to have gone for testing could suggest you already had the disease). But the low rate of testing is also a reflection of the ineffectiveness of existing campaigns in that direction. **Here again, there is a clear case for revisiting both the content and strategy of existing HIV education**.

8.2 Tuberculosis

Knowledge about the causes and management of tuberculosis (TB) appears higher in the southern monitoring sites than in the north. Further, only an insignificant proportion of those interviewed seemed aware of existing opportunities for TB testing, let alone that both testing and treatment are free. For those who had reasonable knowledge about TB, however, they had acquired this knowledge either through radio or through the education campaigns facilitated by the community health nurses.

The number of new TB infections in KEEA seems very high (Table 8.3). Indeed, in comparison with Kwahu North -- which has a similar population (Tables 2.4, 2.5) -- KEEA's infection rate is about five times higher. This huge difference is, according to KEEA's Focal Person for TB, attributable to the presence in that district of a "*communicable disease prison located at Ankaful*," which alone accounts for two-thirds of TB infections in the entire district. **While the proportion successfully completing treatment is rising among those reporting the disease (Table 8.2), this is no cause for complacency, in the light of continuing deficits in awareness regarding testing. It is clear that the community education effort on tuberculosis needs stepping up**.

Table 8.2: Tuberculosis treatment, completions with negative smears

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	13	11	13
Builsa*	9	23	19
KEEA	20%	62%	82%
Kwahu North	22	14	19

Source: DHMTs

* *A second set of figures submitted by the district differs significantly from the initial set*.

Table 8.3: Tuberculosis new smear positive registrations

District	2006	2007	2008
Agona East	NA	NA	NA
Bongo	13	12	20
Builsa	10	23	21
KEEA	103	100?	115
Kwahu North	16	13	26

Source: DHMTs

9. Malaria

Under-five mortality from malaria is highest in the northern districts. Bongo and Builsa each have only half the population of Kwahu North (Tables 2.2, 2.3 and 2.5), yet have three to six times as many counts on that indicator. This equates to about six to twelve times the relative incidence. So, **while aggregate indicators may suggest positive trends nationally for malaria (Ghana 2009: 20), there nevertheless are poor districts and pockets needing especial attention**.

9.1 Causes and prevention

A significant minority of those interviewed lacked adequate awareness of how malaria is caused and/or can be prevented. At Abina, the view was expressed that "*malaria can be contracted by eating low-grade food such as gari*" and that it can, similarly, be prevented by enriching one's gari with palm oil.

It seems surprising that, in relative terms, vector control measures through environmental sanitation approaches continue to receive little attention in the quest to rid the country of malaria (see Section 4.1).

9.2 Treatment

In the northern districts, common herb-based therapies include brews of neem leaves and acacia, both of which are known to be efficacious under certain conditions.[59] Neem brews are also widely used in each of the Kwahu North communities visited by the monitoring team.

By contrast, the newer artemisinin-based combination therapy (ACT)[60] is not popular with poor people interviewed. It is common for them to short-dose on it or to take the pills in quantities or at intervals other than what has been prescribed by the manufacturers. A major factor working against a wider adoption of ACT is that these therapies are up to twenty times more expensive than the aminoquinoline-based mono-therapies (especially chloroquine) which had been in use since just after the Second World War. Many people therefore buy a few tablets at a time and stop treatment as soon as they have some relief. However, cost is not the only reason why ACT use is not as high as had been expected by the Ghana Health Service (GHS). Indeed, in the northern sites, a common complaint was that the combination therapy makes patients feel faint and "*worsens [their] health*". Women at Apowongo and Goo routinely reported "*unpleasant side effects such as dizziness and vomiting*." Together, these discourage patients either from completing the course or from switching from the older mono-therapy.

Routinely too, prescribers and dispensers fail to notify patients that ACT ought to be taken with fatty foods in order to be effectively assimilated. Under these circumstances, it is only a matter of time before plasmodium parasites develop resistance to ACT as well.

Then too, on the regulation side of the equation, the Food and Drugs Board (FDB) has not been particularly successful in obstructing the continued marketing of mono-therapy

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[59] See http://www.interscience.wiley.com/journal/64000109/abstract?CRETRY=1&SRETRY=0 and http://www.malariajournal.com/content/6/1/63, for example.

[60] These are essentially derived from wormwood (*artemisia annua*).

options. FDB has been further criticised for failing to control the blizzard of other herbal preparations (many of unproven efficacy and/or safety) which the Ghanaian public continues to be suffused with at transport terminals, marketplaces and in other public locations. With the poor policing of chemical shops, it remains extremely easy to buy chloroquine as a mono-therapy (or, for that matter, ACT in unapproved doses). Closely related is the quite widespread practice of relying on Artesunate pills as a single therapy. Owing to a combination of transport costs, other accessibility challenges and the poor attitudes of health workers (discussed in Sections 3.3, 7.2 and 7.3), these chemical shops continue to be the first port of call for many with a fever.

Indeed, the efficacy of combination therapies has come under the spotlight recently. An increasing source of worry in this regard – both to health practitioners and the consuming public – is the issue of counterfeit drugs produced by international criminals and smuggled into Ghana through the country's porous borders. Owing to their relatively high cost (some twenty or so times more than chloroquine), artemisinin-based therapies are especially attractive for faking. Some of these fakes actually contain small amounts of artemisinin, which are deliberately included in order to fool certification authorities, but which are insufficient to kill the plasmodium parasite. In addition, even among the well educated and non-poor, it is common for patients to suspend treatment once they begin to feel better. The net effect is that these practices will eventually lead to increased drug resistance, causing ACT to suffer the same fate experienced by chloroquine. Indeed, the malaria-causing plasmodium parasite is already known to be developing resistance to artemisinin in parts of Southeast Asia.[61] **Clearly, regulators such as the Food and Drugs Board ought to sit up just as our security and law enforcement agencies will have to become more vigilant in order to avert the looming catastrophe**. Similarly, organisations such as the mPedigree[62] -- which are proactively involved in championing solutions to counter the trade in fake medicines -- ought to be supported by the state.

Poor drug storage (at the freight, shop and household levels) is a further source of efficacy loss. It is common to find medicines being transported in unventilated vans with internal temperatures around 40^{o}C or being sold in metal containers or kept in kitchens and sunny verandas when the manufacturer has specifically prescribed refrigerated or cool storage. In all of these, it is the poor who have the fewest options and who are compelled to buy from the least reliable sources or to store their medicines at unsafe temperatures.

9.3 Financing healthcare

District Assembly support to the health sector is still difficult to quantify owing to the continuing reluctance of relevant officials to divulge financial information. Even where they eventually obliged offer information, it was either incomplete (Bongo) or presented in a form other than that requested (KEEA), making comparison and tracking impossible and thus diluting its relevance. As such, it is not possible to comment cogently on this indicator. However, what patchy records are available suggest that health spending is not highly prioritised in the finances of the Assemblies. For example, in Kwahu North, the only district for which complete data were available, records indicate a 30% drop in Assembly support for malaria and HIV respectively between 2007 and 2008. In KEEA, the share of the 2008 development budget allocated to health was 3.8%.[63]

[61] http://www.medicalnewstoday.com/articles/159319.php
[62] www.mpedigree.net
[63] Support for HIV activities fell in Bongo District by a whopping 89% between 2006 and 2008.

10. Conclusions and Recommendations

While improvements have been noted in certain aspects of healthcare delivery, progress remains uneven and there is much catching up to do by managers in various districts and facilities. That such poor environmental health behaviours and weaknesses in care services persist in this millennium must be disturbing. Contrary to the opinion of some care providers, these failings cannot be blamed solely on the economy -- not with the impressive rate of GDP growth (between six and seven per cent in recent years) and the halving in extreme poverty from 1990 levels.[64] However, a more pro-poor distribution of national and district resources would be helpful.

The policy of free maternal care has made it easier for more women to access health services but has certainly not been as successful as one might have expected. Indeed, the evidence from the monitoring exercise demonstrates that removing user fees will not, by itself, lead to real improvements in the utilisation of healthcare services without a commensurate improvement in the behaviour of care providers. While many health workers do provide excellent services under trying conditions, the discourteous and unsympathetic attitudes of other colleagues do not encourage maximum uptake of institutional services. This is, perhaps, the single most striking finding of the monitoring exercise.

While we recognise that perceptions elicited through "*quick and dirty*" modes of research are not always accurate, it is nevertheless vital that health professionals do hear the accounts that their patrons have shared of their unique experiences and feelings. Such would be consistent with the inclusive spirit of the MOH's Five-Year Programme of Work (Ghana, 2007b: 30). Insofar as even perceptions have a huge influence on health-seeking behaviour, birth outcomes and other aspects of maternal and child health in vulnerable communities, significant improvements will not be possible unless providers improve on their relationships with patients. Achieving this change will require more than a "band-aid therapy" or superficial approach; it will require real change in underlying condescending attitudes towards the poor. Imaginative ways thus need to be found to assist health professionals to become more responsive to the feelings, perceptions and health rights of patients, particularly the poor.[65] This leaves a vital role for civil society as campaigners, educators on health rights and dialogue partners, but also as watchdogs holding providers to account. Other obvious partners in this effort are the relevant District Assembly sub-committees (for instance, Social Services and Justice), local CHRAJ[66] and DSW[67] offices and the District Health Oversight Committees (DHOCs). Indeed, for Ghana to live up to the ambitious targets in the health MDGs will require harnessing the energies of all potential champions.

For convenience, more specific recommendations recapped from the main report are itemised below:

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[64] GSS (2007): Pattern and Trends of Poverty in Ghana: 1991-2006. Accra: Ghana Statistical Service.

[65] In fairness, it must be noted that some serious attempts by health providers (e.g. in Bongo District) to create interactive platforms whereby rights holders can input to local health agendas have been thwarted by inappropriate demands from the same rights holders for "*refreshments*" as a condition of participation.

[66] Commission for Human Rights and Administrative Justice.

[67] Department of Social Welfare.

Recommendations

Child health
In order to help minimise the adverse impact of the annual lean season on infants in the poorest households, civil society should advocate for PNC-based nutrition assistance for the most food-insecure districts.

At both ANC and PNC levels, more persistent education is required to increase carers' awareness of the importance of providing sick children with fluids.

Ongoing nutritional literacy efforts aimed at improving newborn health ought to target older women as well. This is because of evidence showing their influential role in making decisions around infant nutrition.

In light of the fact that very few women were able to mention all five key danger signs of serious childhood illness, it is recommended that education be strengthened at the delivery and PNC levels in this area.

The local and regional health directorates responsible for Bongo District ought to take the disproportionate incidence of anal sores in that district more seriously and investigate it properly.

Mobile healthcare interventions are proving to be helpful and ought to be promoted further and supported as a pro-poor approach.

Sanitation
Given the serious public health consequences of deficient sanitation behaviours, it is important to step up interventions through, among others, intensified public education coupled with enforcement. It would also seem appropriate to engage traditional authorities, as trusted local leaders, more fully in such a strategy.

Health education should also aim to foster safer hand-washing practices -- including, for example, cheap alternatives to soap such as ash.

Maternal health
Education also needs cranking up to counter constraining beliefs shrouding the experience of pregnancy. Strategic consultation and engagement with potentially influential traditional partners -- such as chiefs and TBAs -- is further recommended. As a first step, efforts could be made both by Ghana Health Service and civil society to involve these groups in sector review processes and in MDG monitoring. In northern communities with *magazias*, actively soliciting their participation can go a long way to reassure local women and encourage them to be less secretive about their pregnancies.

Considering that most women who had lost infants and other young children did not know the medical causes, proactive counselling services are recommended as a way of removing obstructive beliefs and promoting better hygiene and health in poor communities. Without such services, women are left to believe that the causes are purely spiritual.

In order to minimise conflicting interpretations of the NHIS policy, there is a case for further elaboration of, and publicity on, its associated exemptions and what precisely the expression "maternal care" entails.

For family planning to be adopted more widely than it has been thus far, the strategy will have to include widening the sensitisation net to rope in potentially influential stakeholders such as husbands and mothers in-laws.

HIV and tuberculosis
While the mass media do appear to be raising awareness of the HIV pandemic, there is no room for complacency as significant numbers still doubt that the causes are basically physical.

The relatively high rate of new HIV infections in Kwahu North calls for further investigation and attention.

Ongoing sensitisation campaigns ought to take account of the perceived risk which ART poses to uninfected persons (i.e. that infected persons can more easily get away with unsafe sex) and upgrade the content of relevant education messages.

The low rate of testing makes a case for revisiting both the content and strategy of existing HIV education.

While the proportion successfully completing tuberculosis treatment is rising among those reporting the disease, this is no cause for complacency, in the light of continuing deficits in awareness regarding testing. It is clear that the community education effort on tuberculosis needs stepping up.

ITNs and Malaria
In the area of anti-malarial initiatives, greater citizen consultation is required -- especially with poor and vulnerable stakeholders -- as a way of addressing demand-side concerns.

The Food and Drugs Board as well as the security and law enforcement agencies will have to become more vigilant in order to prevent the importation of fake ACT (and other counterfeit drugs) from getting out of hand.

General
Health workers will need training to better appreciate the feelings, fears and rights of illiterate populations, and to aim for a more patient-centred approach to service delivery. The content of such training could usefully include inter-personal and counselling skills as well as genuine respect for the rights of other citizens, regardless of their social status or other difference. The training would be delivered with the express aim of equipping health workers to respond more respectfully and sensitively to the needs and fears of illiterate/semi literate and vulnerable populations. Only then can we have both the supply- and demand-side players pulling in the same direction in combating morbidity and mortality in poor and hinterland areas.

Systems also need to be put in place to monitor progress more routinely through exit interviews and participatory research techniques. Supervision also needs improving, but this can only take place if senior managers are themselves trained to be responsive and sensitive to the feelings and rights of the vulnerable and real authority over deployment decisions and disciplinary remedies devolved to them from the centre. In this regard, the self-monitoring initiative at the Donkorkrom Presbyterian Hospital -- whereby patient satisfaction surveys are posted publicly -- is recommended to the state sector.

Citizens, likewise, need support to better appreciate their rights and identify effective ways of asserting these consistently. In this regard, civil society could further explore

innovative ways of ensuring compliance (e.g. through developing effective interfaces for negotiating social justice for poor rights holders and facilitating complaints arrangements).

Unfortunately, there is, as yet, a lack of both political will and citizen activism to hold health professionals to account. As long as this tolerance for unaccountable behaviour persists, there is little chance that the nation can consign the kind of abhorrent behaviours described in Section 7 to history. That would only make it harder to attain the health MDG targets.

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Annex 1
Summary Profile of Sampled Sites

Region/Community	District	Main livelihoods	Approx. Population
Central Region			
Abina	KEEA	Farming	1,606
Ponkrom	KEEA	Farming	358
Bando Abreshia	KEEA	Farming	487
Atabadze	KEEA	Farming	1,594
Domoki	Agona East	Farming	420
Namewura	Agona East	Farming	302
Duabone	Agona East	Farming	315
Otabilkwa	Agona East	Farming	158
Brahabebume	Agona East	Farming	1,700
Eastern Region			
Somsei	Kwahu North	Farming	587
Odumase	Kwahu North	Farming	563
Abotanso	Kwahu North	Farming	690
Apeabra	Kwahu North	Farming	214
Bebuso	Kwahu North	Farming	721
Upper East Region			
Adaboya	Bongo	Farming	N/A
Apatanga	Bongo	Farming	N/A
Apowongo	Bongo	Farming	N/A
Goo	Bongo	Farming	N/A
Kadare	Bongo	Farming	N/A
Abil-Yeri	Builsa	Crop Farming	1100
Alaba-Yeri	Builsa	Crop Farming	900
Kalijiisah	Builsa	Crop Farming	1800
Chuchuliga Namonsa	Builsa	Crop Farming	2000
Kori-Guuta	Builsa	Crop Farming	700