ARHR advocates for

1

The Ghana Government, development partners and civil society to develop mechanisms that ensure equitable access to sexual and reproductive health.

2

Increased efforts to target the poorest and most disadvantaged populations with appropriate health services to avoid preventable deaths and injuries such as maternal deaths.

3

Government to commit to making structural changes in every area by ensuring quality and equitable access to basic essential services (including education and health care), increased incomes for the poor, in particular, in addition to decentralised planning and democratisation to ensure that the voice of those of the marginal is heard in processes that affect their well-being.

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Art and Production
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Funding provided by EKN Cordaid

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Reproductive Health Watch

ALLIANCE FOR REPRODUCTIVE HEALTH RIGHTS

First Edition Volume 1

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To Alter or Not To Alter

The Role of Traditional Birth Attendants In Childbearing

Once upon a time, traditional birth attendants were counted in supervised deliveries. **NOT ANYMORE.**

World Health Organisation (WHO) and other bodies say Traditional Birth Attendants (TBAs) must be excluded from assisting childbirth.

What does this mean for Ghana's rural and poor areas that lack access to medical professionals?

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From the Executive Director's Desk

Reproductive rights are human rights, and human rights are protected by Ghana's constitution. Yet many people are denied their reproductive rights on a daily basis. For poor women and rural populations, denial of their reproductive rights often leads to losing their life in childbirth, unsafe abortion, or AIDS.

Despite Government health policies and commitments, progress in sexual and reproductive health in Ghana has been rather mixed: good in areas such as antenatal care, deplorable in the rest of maternal health, poor in the level of contraceptive use. As a result, Ghana still has high rates of preventable deaths and injuries related to pregnancy, childbirth, and AIDS.

Further, there are glaring inequities in the health sector. More than half the population do not have access to services that are proven to reduce maternal deaths, such as access to deliveries by medical personnel, well-functioning health facilities, and emergency obstetric care.

What is disturbing is that the trend in access to reproductive health services and indicators shows negligible increases in the last two decades.

True, the health sector is underfunded.
But combining it with inequalities and inefficiencies has produced devastating health outcomes, especially for poor and rural people.

True, Ghana has scarce resources, and the health sector has been underfunded, but combining this with inefficiencies and inequalities in the health system has produced devastating health outcomes. That is why sexual and reproductive health rights, particularly for poor and rural populations, cannot be realised without challenging the systems and structural inequalities that sustain poor reproductive health outcomes.

It is to address these long-standing inequities and challenges — not only in the health system, but also the wider processes that determine access to services, utilisation of those services and their outcomes — that a number of national and local organisations came together as the Alliance for Reproductive Health Rights.

ARHR partners work in 29 underserved districts in nine regions.

The Alliance seeks a more just health system in which the Government takes action to improve the health outcomes for all its citizens, regardless of income, education, or residence in Ghana.

ARHR's newsletter, Reproductive Health Watch, seeks to draw attention to gaps between the policies and actual practices in sexual and reproductive health. In future issues, Reproductive Health Watch will feature real life stories to highlight such gaps.

signature
Vicky T. Okine
Executive Director

About ARHR

Alliance for Reproductive Health Rights

The Alliance for Reproductive Health Rights exists to ensure that every Ghanaian — poor and rich, young and elderly, female and male, in rural and in urban areas — has access to the best reproductive health care.

This is achieved by challenging systemic and structural inequalities in the health system and other basic services necessary to avoid preventable deaths, mistimed pregnancies and HIV infections through advocacy, promotion of responsive service delivery, good governance and accountability.

ARHR is represented in nine of the ten regions in Ghana, and its implementing partners serve in 29 districts, reaching about 150 communities. ARHR is coordinated by three national NGOs: Integrated Social Development Centre (ISODEC) in northern Ghana, Centre for the Development of People (CEDEP) in the central belt, and Centre for Community Studies, Action and Development (CENCOSAD) in the south. The ARHR Secretariat, based in Accra, leads the national advocacy effort.

ARHR Programmes
Current ARHR programmes include
The Alliance Reproductive Health Programme (ARHP), focusing on increasing access to sexual and reproductive health (SRH) services and building capacity to claim RH rights.

The Citizen's Action and Health project (CAH—MDGs) promotes participation of civil society and poor rural communities in tracking Ghana's performance in meeting the health Millennium Development Goals.

Mobilizing for RH/HIV Integration in Ghana, which is a Global AIDS Alliance initiative.

ARHR strongly urges the Government and the Ghana Health Service to consider these recommendations:

Urgent

1. Link the poorest and most vulnerable to childbirth services
The Ghana Health Service must ensure that no mother is left completely without access to care in pregnancy and childbirth. To prevent deaths and injuries, GHS must immediately activate a plan to link the poorest and most vulnerable communities with childbirth services by providing inputs such as ambulance and communications services.

2. Identify the greatest needs for maternal services
GHS must follow through its strategy to map out where the most critical needs are and identify who is farthest from health facilities.

Short-Term

Low-cost high-impact options
3. Increase access to health facilities by addressing underutilisation of existing facilities
For various reasons, many women choose to deliver at home attended by a TBA or go to so-called prayer gardens. One district in Central Region has shown that TBAs could be effective in bringing mothers into the health facility for delivery. The district instituted an incentive scheme that rewards TBAs with a fee for accompanying pregnant women to a health facility for delivery.

4. GHS should partner with TBAs and NGOs to reduce the 3 Delays
The notorious "3 Delays" contribute to maternal deaths. The first two delays involve the decision to send a pregnant woman to a health facility and getting her there. TBAs and NGOs that are well integrated into communities possess the cultural sensitivity to help achieve behaviour changes that reduce the first two delays.

Long-Term

5. Provide universal access to skilled care
The GHS Strategic Plan (2007–2011) suggests that it intends to train a cadre of health providers made up of community health officers and workers (CHOs and CHWs) to make up the shortfall in doctors/nurses/midwives. Do CHOs and CHWs (who are often volunteers) have the capacity to acquire midwifery skills? Why not focus on the GHS strategy to expand capacity of nursing and midwifery schools? This approach was used by Indonesia in the 1990s in a program to provide "a midwife for every village." With resolute commitment, Indonesia achieved the target in less than 10 years.

What THEY Are Saying About NHIS

Ghana's National Health Insurance Scheme is "the best insurance system in the world," according to the CEO of the National Health Insurance Authority (NHIA). But what do Ghana's rural and poor people say to that?

The CEO may be shocked to learn that thousands of people are prevented from benefiting from NHIS because they know little or nothing about the scheme, are put off by inefficient processes or simply cannot afford it.

NHIS has enabled countless people gain access to health care since its launch three years ago. But the Government cannot achieve its policy goal of reaching the poor unless NHIA addresses specific barriers that hinder poor and rural communities. ford it, or are put off by inefficient processes.

The Gap Between Policy and Practice

Government Policy
In 2005 the Ghana Government established the National Health Insurance Scheme to improve access to health care for the poor and to eliminate the system of user fees ("cash and carry") that made health services too costly for too many people.

In Practice
A 2007 study reveals that many poor and rural people don't benefit from NHIS because of

- *Lack of information about the scheme*
- *Inefficient processes*
- *Inability to pay*

Bridging the Gap

Here, ARHR offers recommendations based on in-depth knowledge of underserved communities and what people told us in our 2007 health survey in 29 districts in nine regions.

I didn't know. About one fourth of people interviewed by ARHR lacked relevant information to register. Even in Greater Accra Region, 28 percent of respondents in Dangbe West and 26 percent in Ashiedu-Keteke sub-metro said they had not registered with NHIS because of ignorance of the scheme.

ARHR recommends: NHIA must target messages directly to the rural, urban poor, and marginalised groups (like street children), not just the general public. Less endowed districts need logistics like motorbikes to spread the word.

I still haven't got a card. The lengthy period for issuing ID cards discourages registration. In eight districts in Ashanti and Brong-Ahafo Regions, the majority of people surveyed received a card in six months or later. This hints at inefficient processes.

ARHR recommends: Reducing the processing time for issuing cards to one or two months. NHIA must provide district mutual offices with the technical assistance needed to achieve this.

I can't pay. Inability to pay the registration fee was by far the most common reason survey respondents gave for not participating in the scheme — 85 percent of non-registrants in eight districts surveyed in Ashanti and Brong-Ahafo, and 69 percent in Hohoe District in Volta Region cited cost as a barrier.

ARHR recommends: NHIA should consider allowing people in deprived areas to pay by installments. In addition, NHIA needs to verify that the initial criteria for "indigents" remain valid.

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The Role of Traditional Birth Attendants in Childbearing

It all boils down to how to make childbearing safe. And who should assist women in childbirth to prevent illness, injury or death. Abundant experience has shown that having a skilled health worker at delivery reduces maternal deaths. Skilled health workers are defined as doctors, midwives, nurses, but not traditional birth attendants (TBAs).

The problem is that in developing countries, less than half the mothers have access to skilled health workers. In Ghana, only 35% of deliveries in rural areas were attended by a medical professional in 2006. So traditional birth attendants have been delivering babies in developing countries for decades, and still do.

In the 1960s, the World Health Organisation (WHO) favoured giving TBAs training, and later advocated integrating them into the health system to assist in pregnancy and delivery in areas that lacked access to medical personnel. It was expected that with training, TBAs could provide first aid, improve their deliveries, and refer complications to health centres and ultimately help reduce maternal deaths. In Ghana, training for TBAs was embraced by the health sector. TBAs were to be equipped with skills and tools to provide quality pregnancy and delivery services to mothers, according to the 2003 Ghana Reproductive Health Policy Standards.

Should Ghana Kick TBAs Out of Deliveries?

WHO has revised its position on TBAs. In 2004, WHO issued a joint statement with international associations for midwives and for obstetricians, calling for all mothers to be given access to a doctor, nurse or midwife. Now, Ghana Health Service data excludes TBAs from the definition of "supervised delivery", and GHS plans to "scale down training for new TBAs" in its 2007 strategy.

WHO makes compelling arguments for excluding TBAs from the childbirth process. It points to research that using TBAs (trained and untrained) has ***not*** contributed to reducing maternal deaths in communities they served. In addition, TBAs may lack the capacity to play some of their expected roles. For instance, training for TBAs emphasise how to recognise early signs of pregnancy complications and refer women to a health facility. Now experts say that even with training, TBAs and lay people such as family members, cannot accurately identify early signs of complications, until it is often too late.

But the strongest argument against using TBAs may be found in the gap between developed and developing countries:

In developed countries, nearly all deliveries are attended by skilled health workers — only 1 percent of the world's total maternal deaths occur.

In developing countries, barely half the deliveries are attended by skilled health workers — 99 percent of worldwide maternal deaths occur.

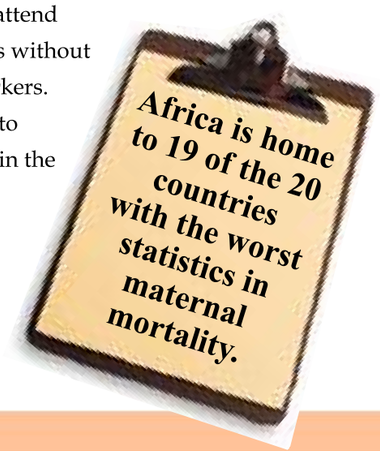
Compare a woman's lifetime risk of dying from pregnancy-related causes:
1 in 17 in Senegal
1 in 8,200 in the U.K.

Who will Attend Deliveries in Rural and Poor Areas?

Clearly, doctors, midwives, and nurses at deliveries save lives. But Ghana does not have enough medical personnel available, particularly, in deprived areas. The conditions that made WHO recommend use of TBAs a few decades ago have not changed much in most of Africa. African countries have barely increased access to skilled delivery in the past 15 to 20 years, particularly for poor and rural areas. In Ghana, access to medical workers at delivery is rather declining: from 47 percent in 2003 to 32 percent in 2007.

Perhaps it is the evidence that TBAs are not the best answer to safe deliveries that led the Ghana Health Service to decide to "scale down training for new TBAs" (according to the "Reproductive Health Strategic Plan, 2007–2011"). What is not clear is how GHS intends to meet the need of the 68 percent of mothers in Ghana who lack access to medical personnel? (And who will soon lack access to trained TBAs.)

ARHR (Alliance for Reproductive Health Rights) is concerned about who will attend deliveries in deprived areas without access to skilled health workers. Where are the ambulances to transport emergency cases in the rural areas? Where are the blood banks?



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