PROFILE OF REPRODUCTIVE HEALTH SITUATION IN GHANA

For World Health Organization, Ghana.

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November 2003

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Abbreviations and Acronyms

AYA	-	African Youth Alliance
CECAP	-	Cervical Cancer Prevention
CPF	-	Christian Professional Fellowship
CPR	-	Contraceptive Prevalence Rate
DHS	-	Demographic and Health Survey
FGM	-	Female Genital Mutilation
FHI	-	Family Health International
GHS	-	Ghana Health Service
GSMF	-	Ghana Social Marketing Foundation
HIV	-	Human Immunodeficiency Virus
HMIS	-	Health Management Information System
HTP	-	Harmful Traditional Practices
ICC/CS	-	Interagency Coordinating Committee on Contraceptive Security
ICPD	-	International Conference on Population and Development
IEC	-	Information, Education and Communication
IMCI	-	Integrated Management of Childhood Illness
JHPIEGO	-	An Affiliate of Johns Hopkins University
MCH/FP	-	Maternal and Child Health/ Family Planning
MOH	-	Ministry of Health
MPH	-	Masters in Public Health
NGO	-	Non-Governmental Organisation
PAC	-	Post-Abortion Care
PAP	-	Papanicolaou
PLWHA	-	People Living with HIV/AIDS
PMM	-	Prevention of Maternal Mortality
PMTCT	-	Prevention of Mother-To-Child Transmission
PPAG	-	Planned Parenthood Association of Ghana
RCH	-	Reproductive and Child Health
RH	-	Reproductive Health
RHI	-	Rural Help Integrated
STI	-	Sexually Transmitted Infections
TBA	-	Traditional Birth Attendant
TFR	-	Total Fertility Rate
UN	-	United Nations
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
VIA	-	Visual Inspection with Acetic Acid Wash

WB	-	World Bank
WHA	-	World Health Assembly
WHO	-	World Health Organisation
YWCA	-	Young Women Christian Association

Executive Summary

Ghana demonstrated its commitment to the advancement of population programmes by formulating its first Population Policy in 1969. The Policy was revised in 1994 to incorporate emerging issues such as population and the environment, concerns about the aged, children, the youth, persons with disabilities and HIV/AIDS. Total fertility and mortality rates have been declining and contraceptive prevalence rates have steadily been increasing.

The report begins with a global perspective of Reproductive Health. The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked the watershed for Reproductive Health after which the shift from Maternal and Child Health and Family Planning to the broader Reproductive Health came into effect. This has been described by population experts as the "paradigm shift". The response of the World Health Organisation to ICPD has been reflected in the new Reproductive Health Strategy which is an outcome of resolutions adopted by World Health Assembly and the Regional Committee.

The country background starts with the history of the organisation of Maternal and Child Health (MCH) and Family Planning (FP) services. It continues with the move from MCH/FP to Reproductive Health. This is followed with the demographic changes and the formulation of population policies. There is a brief summary on the development of the national safe motherhood programme, the reproductive health service policy and standards and other policies, guidelines that have a bearing on reproductive health. The work that is being done in other components of reproductive health is briefly touched on.

The progress to date starts with summaries of policies, guidelines and protocols. The policies, guidelines and protocols are made up of the National Population Policy, (Revised Edition) 1994, National Reproductive Health Service Policy and Standards, National HIV/AIDS and STI Policy, Adolescent Reproductive Health Policy, Policy for Children Under-Five, Maternal Health/Death Audit Guidelines and Reproductive Health Service Protocols.

The co-ordination of Reproductive Health programme at the national level of the Ministry of Health/Ghana Health Service is done by the Reproductive and Child Health Unit of the Public Health Division. The national as well as the regional and district health management teams facilitate the implementation, monitoring and supervision of Reproductive Health activities at their respective levels. There is also collaboration with other Ministries, Departments and Agencies as well as the private sector working in Reproductive Health at all levels.

The main activities under the Reproductive Health programme are Safe Motherhood, Post-abortion Care, Family Planning, Female Genital Mutilation, Reproductive Tract Cancers, Prevention of Mother-To-Child transmission of HIV and Adolescent Reproductive Health.

The report continues by outlining the indicators that are currently used to monitor the Reproductive Health (RH) programme. Information from the Ghana Demographic and Health Survey, 1998 edition is used as the baseline and the current RH position in Ghana is reflected by data from the Reproductive and Child Health Annual Report of 2002.

Information on partners and areas of support and sources of funding has been included. The report continues by highlighting research and research findings that have been conducted in various aspects of Reproductive Health.

Future challenges that need to be addressed to move forward the Reproductive Health programme in Ghana have been outlined.

The conclusion calls for more commitment and increased funding in Reproductive Health by Government and Development Partners.

EPIDEMIOLOGY OF REPRODUCTIVE HEALTH

The 1994 Cairo International Conference on Population and Development (ICPD) marked a turning point for reproductive health. For the first time, reproductive rights were internationally recognised by Governments, as contained in the international human rights documents.

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant….." (ICPD Programme of Action, paragraph 7.2)[1].

The Programme of Action adopted at the ICPD established the right of men and women to be informed about their reproductive health choices and to have access to the information and services that make good health possible.

The International community came together to discuss population growth in Bucharest in 1974 for the first time. The main concern was rapid population growth and the undoubted impact on the carrying capacity of countries, regions and indeed, the planet itself.

During the 1960's, the objectives, design and evaluation of family planning programmes were largely driven by this demographic imperative.

In 1978, the Primary Health Care concept was adopted with maternal and child health care activities.

In the 1980's, attention was focused on the child and child survival strategies and programmes were developed with the objective of reducing infant and child mortality. Thus, two components of Reproductive Health were dealt with separately and with great intensity and investment of international and national efforts and resources. The combination of Maternal and Child Health/Family Planning (MCH/FP) represents a first attempt to bring the two components together and to deal in a more comprehensive

manner with aspects of Reproductive Health-Child birth, child health and family planning. MCH/FP served an important mission but it was not enough because it focused almost exclusively on women – usually, married women and their children. Women's own needs were neglected leading to the question posed during the early 1990's - Where is "M" in MCH? [2]

The 1994 ICPD and ICPD +5 constellation of services under Reproductive Health reflect a need to considerably broaden the range of services provided by most of the current MCH/FP programmes (e.g. MCH/FP/STI/HIV). The need is to respond to the needs of the individual, couples and families.[1]

A PARADIGM SHIFT

In Cairo, a new model of RH was exposed. A shift occurred when the old model (MCH/FP) was replaced by the new (RH) model.

MCH/FP	**RH**
▪ MCH/FP services	MCH/FP, RTIs, infertility, sexual Health, female genital mutilation, Gender based violence
• Isolated	Integrated approach
▪ Quantity	Quality of care (client centred
	based Rights based, gender sensitive
▪ Women favoured	Balance on women, men, young People, families, refugees
• Demographic needs	Meeting individual needs
• Independent	Inter-dependent, etc
▪ Clients –as recipients	Clients participate in decision Making
▪ Reproductive age	Free, informed choice, life-cycle approach

WORLD HEALTH ORGANASATION'S RESPONSE TO ICPD

The new reproductive health strategy is an outcome of resolutions adopted by the World Health Assembly (WHA) and the Regional Committees, namely:

- Resolution WHA38.22 of 1985, on adolescent motherhood and promotion of responsible parenthood;
- Resolution WHA48.10 of 1995 on WHO's role in the global strategy on reproductive health;
    - Endorses the role of the Organisation within the global reproductive health strategy;
    - Reaffirms the unique role of the Organisation with respect to advocacy, normative functions, research and technical cooperation in the area of reproductive health.
- Resolution AFR/RC44/R11 of 1994 on accelerated reduction of maternal and neonatal morbidity and mortality in the African Region;
- Resolution AFR/RC/45/R7 on health of young and adolescents: situation report and trend analysis.

In addition, the United Nations General Assembly, by its resolution 49/128, endorsed the ICPD programme of action. Various international conferences on population, the Fourth World Conference on Women held in Beijing in 1995, and other related initiatives such as the population policies formulated and adopted by many Member States have also underscored the need for a more comprehensive approach to reproductive health.

The long-term vision of the reproductive health strategy for the African Region 1998-2007[3] and beyond is that all the people of the Region should enjoy, within the next 25 years, an improved quality of life through a significant reduction of maternal and neonatal morbidity and mortality, unwanted pregnancies and sexually transmitted infections and through the elimination of harmful practices and sexual violence. The countries of the Region should also promote healthy sexual relationships, responsible parenthood and gender equality.

Resolution WHA55.19, May 2002: member States should "strengthen and expand efforts to meet, in particular, international development goals and targets related to reduction of maternal and child mortality and malnutrition and to improve access to primary health care services, including reproductive health, with special attention to the needs of the poor and underserved populations."

INTERNATIONAL GOALS AND TARGETS

To be achieved by the year 2015:

- All primary health care and family planning facilities offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection;
- Deliveries assisted by skilled birth attendant should reach 90% globally and 60% in countries with high maternal death rates;
- Unmet need for contraception should be eliminated;
- All men and women in the high-risk age group 15 to 24 should have access to voluntary HIV/AIDS testing and counselling, and to the information and means (such as male and female condoms) to prevent its transmission.

UN MILLENNIUM DEVELOPMENT TARGETS TO BE ACHIEVED BY 2015

- Reduce the maternal mortality ratio by three-quarters;
- Reduce by two-thirds the under-five mortality rate;
- Halt and begin to reverse the spread of HIV/AIDS.

COUNTRY BACKGROUND

Organised Maternal and Child Health (MCH) started in Ghana in the 1920s. By the end of 1972, there were 416 institutions comprising government hospitals, health centres, health posts, private midwives clinics and homes, private doctors' clinics and hospitals and mission hospitals and clinics offering services to mothers and children. In the 1960s, the idea of birth spacing was placed in the context of Maternal and Child Health.

In 1970, the Ghana National Family Planning Programme was established under the Ministry of Finance and Economic Planning with the belief that it is a fundamental human right that couples should have the opportunity to decide freely the number and spacing of their children.

Later Maternal and Child Health (MCH) and the Ghana National Family Planning Programme were merged under the Ministry of Health. It became MCH/FP.

The intercensal rate of growth for the country has slightly declined from 2.6 per cent in 1984 to 2.5 per cent in 2000 per annum[4]. Although this is a small change, it indicated a significant demographic trend in fertility in Ghana. It supported earlier findings from the 1993 and 1998 Ghana Demographic and Health Surveys of Total Fertility rates of 5.5 and 4.6 respectively[5]. The fertility rate of the country is still quite high which in simple terms means the family planning component was not achieving the desired results.

Ghana has viewed the rapid population growth and the youthful age structure of the population as two of the several critical main factors which have made the attainment of the country's development goals and objectives a difficult task. During the 1960-1970 and 1970-1984 intercensal periods, the annual growth rate of the population averaged 2.4 and 2.6 per cent respectively. The 2000 population results indicated an increase of 49.7 per cent over the 1984 population, compared with 43.7 per cent recorded by the 1984 census over that of 1970 (14 years). The increase of 49.7 per cent over the 1984 census count meant that during the sixteen –year period, the land area of Ghana has been inhabited by one and a half times the number of people recorded over the fourteen-year period between 1970 and 1984.

The National Population Council was set up by ACT 485 of Parliament as the highest statutory body to advice Government on population and related issues that included reproductive health. In 1969, [6]the First Population Policy was formulated. It was comprehensive and holistic in nature and encompassed key areas such as education, productivity, gainful employment and wider non-domestic roles for women but it was not implemented in full. In 1994, a revised Population Policy was formulated. The policy included emerging issues such as the environment, the aged, persons living with disabilities and STI and HIV/AIDS.

In the same year, 1994, in Cairo, the **International Conference on Population and Development (ICPD) was held.** As an outcome of the conference, Ghana endorsed the Programme of Action of ICPD and adopted the ICPD definition of reproductive health which has the following components: safe motherhood, family planning, prevention and management of unsafe abortion and post abortion care, prevention and management of reproductive tract infections including sexually transmitted diseases (STI) and HIV/AIDS, prevention and management of infertility, prevention and management of cancers of female and male reproductive system, responding to concerns about menopause, discouragement of harmful traditional practices, gender based violence and reproductive health care, sexual health and information, education and communication.

Ghana moved from MCH/FP to the broader coverage of services of **Reproductive Health**.

The objectives of reproductive health in Ghana were targeted to reduce maternal mortality rate from 214/100,000 (DHS 1993)[7] live births to 150/100,000 live births by 2006,[8] to reduce Infant mortality rate from 56.7/1000 (DHS 1998) live births to 50/1000 live births by 2006, to increase contraceptive prevalence rate from 13.1% (DHS 1998) to 28% by 2010[9] and reduce the total fertility rate from 4.6 (DHS 1998) to 4.0 by 2010.[9]

In 1983, the Ministry of Health took over the responsibility for coordinating the information and education aspects of the family planning programme. The personnel of the Ministry and its facilities were used for the design, production and distribution of educational materials, the preparation of materials for the media, outdoor publicity and group discussions.

The Ministry of mobilisation and Social Welfare contributed to the interpersonal communications programme and the recruitment of new family planning clients.

Family planning formed an integral part of the programme of the Department of Social Welfare and Community Department.

The Ministries of Agriculture and Education were to participate in the information and education activities of the programme.

In the private sector, Planned Parenthood Association of Ghana and the Christian Council of Ghana participated actively in the activities of the National Family Planning Programme, and the Catholic Secretariat which emphasised the rhythm /ovulation method. Volunteers from the community were used in some projects for the distribution of contraceptives and private medical practitioners offered family planning services.

The Social Marketing Foundation Programme began in 1986 and introduced the sale of condoms, vaginal foaming tablets and oral contraceptives through retail outlets.

The safe motherhood programme started with operations research in 12 districts in 1987. Another operations research on traditional birth attendants (TBAs) was also started in 1987. In 1988, the Prevention of Maternal Mortality (PMM) network started operating in Ghana conducting research into haemorrhage and obstructed labour as causes of maternal deaths in two districts. In January 1993, the first national consultative meeting on safe motherhood was held. The purpose was to share information and experiences among field researchers, programme planners/managers, academicians, obstetricians, midwives and donor agencies involved in safe motherhood activities.

Recommendations included an urgent need to improve the quality of services provided in health facilities, the development of a comprehensive, well-targeted health education programme to support safe motherhood at the community level. As a result, a National Task Force on safe motherhood was established. Two documents namely: "Safe motherhood Clinical Management Protocols" and "Health Education Guidelines on Safe Motherhood" were developed by the task force. A second consultative meeting was held in November 1994 to outdoor the two documents and plan the training of health providers.

After ICPD, a review of documents on family planning situational analysis, household surveys, and DHS revealed a great variation in service delivery practices and different interpretations about service policies and standards. Medical and other barriers to service provision were revealed. It was also found out that there were an abundance of official circulars, manuals and memoranda, but they tended to be vaguely worded, out-of-date, inconsistent and overlapping. The bits and pieces did not add up to comprehensive guidelines for service directors, managers, supervisors, providers and trainers. In December, 1994, a multi-sectoral, multidisciplinary task force was formed to develop a comprehensive national reproductive health service policy and standards. In 1996, the Reproductive Health Service Policy and Standards were developed. This effort received considerable support from various stakeholders, including NPC, USAID, DFID and UNFPA. The second edition of the Policy and Standards were developed in August 2003 to include other issues such as sexual health and gender based violence.

Other reproductive health policies/guidelines that have been developed and produced include: National HIV/AIDS and STI Policy, Adolescent Reproductive Health Policy, Policy and Strategies for Improving the Health of Children Under-Five in Ghana, Maternal Health/Death Audit Guidelines, and Ghana HIV/AIDS Strategic Framework.

The National AIDS Commission established by Parliament, in 2002, ACT 613 is a supra-ministerial body under the Office of the President. It advises the Government on policy issues relating to HIV/AIDS.

The Criminal Code, 1960, ACT 29 contains Sections that affect the implementation of reproductive health. The Code was amended in 1994 to include the offence of female circumcision. The Code also contains a Section on abortion. Abortion is illegal in Ghana but is permitted under circumstances such as rape and incest.

In 2001, a Multidisciplinary Collaborating Group was established to promote interventions on the elimination of female genital mutilation (FGM).

Other reproductive health programmes that have been given attention of late include adolescent health, cervical screening and mother-to child transmission of HIV/AIDS. Infertility, menopause /andropause, gender based violence and sexual dysfunctions are areas that need attention in the future.

To achieve these objectives of reproductive health, the programme relies on the principles of primary health care (PHC), including outreach and community based activities, health education, promotion of appropriate technology and collaboration.

The major Development Partners in reproductive health include USAID and UNFPA.

PROGRESS TO DATE

A. EXISTING POLICIES/ GUIDELINES

1. National Population Policy (Revised Edition, 1994).[9]

- Developed twenty five years after the 1969 Population Policy was promulgated.
- The rationale was that:
    i. Ghana's population growth rate still remained unacceptably high;
    ii. The population factor was a serious impediment to the country's economy, sustainable development and eradication of poverty;
    iii. Of the emergence of new concerns such as HIV/AIDS, population and the environment, children, the aged, the youth, and persons with disabilities.

- The Policy therefore is a commitment to the principle that a well managed population resource is a fundamental requirement for sustainable development.

2. National Reproductive Health Service Policy and Standards.[10]

- The First Edition of the Policy was published in 1996.
- The Second Edition (draft) was in June 2003. This became necessary because other issues such as gender based violence and sexual health including male sexual dysfunctions needed to be addressed.
- **The rationale was:**
    - To provide an explicit direction and focus, as well as streamline the training and service provision of reproductive health.
    - To provide the framework for guiding reform and development in the reproductive health service.
    - To make reproductive health service accessible and affordable to the majority of the target groups.
    - To clarify the roles of various agencies involved in the provision and financing of reproductive health services.
- **The Service Policy Spells out:**
    - The general rules and regulations governing reproductive health services and training.
    - Components of reproductive health services, targets and priority groups for services.
    - Those eligible for services, the providers of the services, and how training, logistics, supervision and evaluation activities shall be planned and implemented.
- **The Service Standards set out:**
    - The minimum acceptable level of performance and expectations for each component of the reproductive health services.
    - The expected functions of service providers at the various level of service delivery.
    - The basic training content required for the performance of these functions.

- The Policy took into account the current national goals and priorities of the Ministry of Health/Ghana Health Service within the framework of the National Population Policy and recommendations made at International Conferences such as the ICPD.

3. National Reproductive Health Service Protocols.[11]

- The protocols specify logical and chronological phases of the technical gestures necessary to deliver the service.
- The protocols cover all the components of reproductive health.

4. National HIV/AIDS and STI Policy.[12]

- The Policy seeks to:
  - Create the necessary conducive environment, through advocacy, to ensure sustained political commitment and support for effective action against HIV/AIDS/STI.
  - Create conditions for behavioural change in all areas of sexual and reproductive health.
  - Ensure that there is a consistent programme of information and education about HIV/AIDS/STI among the general population, especially among women and youth.
  - Ensure that the basic human rights of every person especially persons infected with HIV and persons with AIDS, are protected and upheld.
  - Ensure that adequate resources are mobilised for implementation, research, monitoring and evaluation of HIV/AIDS/STI intervention programmes and projects.

5. Adolescent Reproductive Health Policy.[13]

- **The Policy aims:**
  - At adolescents
  - All categories of people who influence the attitudes and behaviour of or provide services to adolescents.

- **The Policy among other things seeks to:**
    - Strengthen linkages among Government Ministries, Departments and Agencies as well as NGOs involved in the formulation and implementation of sexual and reproductive health programmes for adolescents and young people.
    - Inculcate in the youth the idea of responsible sexual behaviour, the small family size norm, pursuit of career, values of responsible adulthood and mutual respect for people of the opposite sex.
    - Provide adolescents and young people with skills that will make it possible for them to be involved in the formulation, implementation and monitoring of programmes designed to meet their needs.

6. Maternal Health/Death Audit Guidelines.[14]

The goal of the guidelines is to assist health workers with a tool to monitor the standards of client care. The guidelines describe the steps involved in conducting a clinical or death audit.

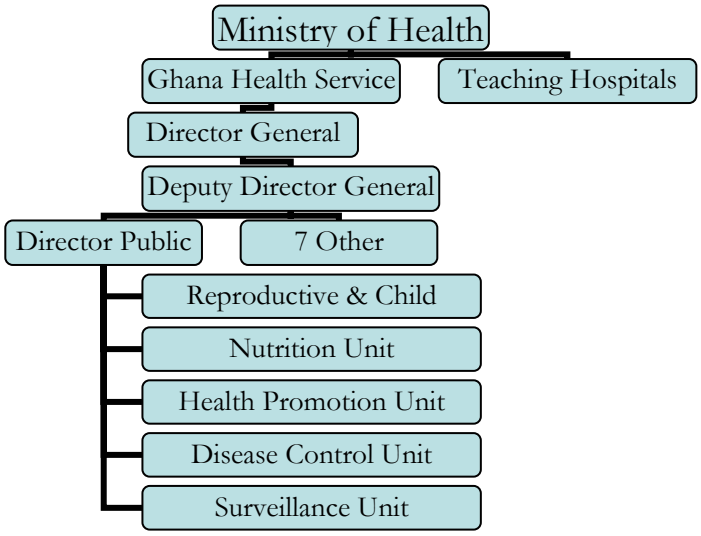
7. Policy and Strategies for Improving the Health of Children Under-Five.[15]

In terms of morbidity and mortality, the under fives are a particularly vulnerable age group and contribute to more than half of deaths in all age groups in Ghana. Although programmes targeted at this age group exist and are on-going, the desired impact has not been achieved. There was therefore the need to develop and implement a more comprehensive and integrated approach to child health including policy formulation and development of protocols.

- The priority interventions to improve child health are:
    - Neonatal health care
    - Prevention and control of growth and nutritional problems.
    - Prevention and control of infectious diseases and injuries.
    - Clinical care of the sick and injured child.
    - Health related interventions.

- Other guidelines and policies that have been produced for children under five include: Breastfeeding Promotion Regulation, 2000, National Breastfeeding Policy, School Health Education Policy, Vitamin A Supplementation Guidelines in Ghana.

B. INSTITUTIONAL FRAMEWORK FOR COORDINATION AT NATIONAL LEVEL



The Ghana Health Service (GHS) is a Public Service body established under Act 525 of 1996 as required by the 1992 constitution. It is an autonomous Executive Agency responsible for implementation of national policies under the control of the Minister of Health through its governing Council, "The Ghana Health Service Council".

The GHS has eight directorates. The Reproductive and Child Health (RCH) Unit is one of five units under the public health directorate. The RCH unit is responsible for co-ordinating the implementation of reproductive and child health activities at the national level. The unit is headed by a Deputy Director of Public Health in charge of Family Health. The unit has programme officers for child health, adolescent health, family planning and safe motherhood respectively. The programme officers are assisted by other health personnel. The unit works with the regional health directorates which are headed by Regional Directors of Health Services. Each regional directorate has a public health unit which sees to the implementation of reproductive health activities. The district directorates have similar structures as that of the regions. The districts report

to the regions and the regions send reports to the national level. At the national level, the RCH unit works with other units under the Public Health Directorate and with other Directorates of the GHS. The RCH Unit also collaborates with other Ministries, Departments, Agencies, Non-Governmental Organisations and the Private sector working in reproductive health area.

The National Population Council (NPC) is to coordinate all population activities. Periodically, the Secretariat of the Council organises meetings of all implementing partners in RH to share information and discuss challenges. The NPC currently receives funding from UNFPA for its activities. It does not receive funding from Development Partners such as USAID and DFID. Because of that, NPC is only able to co-ordinate organisations that benefit from UNFPA funds.

The National AIDS Commission co-ordinates the national HIV/AIDS/STI response, monitors and evaluates all on-going HIV/AIDS activities, identifies and mobilises various resources for programmes.

C. ONGOING ACTIVITIES

1. SAFE-MOTHERHOOD

The maternal mortality rate was estimated to be 214/100,000 live births (DHS 1993)[7] and infant mortality stood at 57/1000 live births in 1998 (DHS).[5]

The Ghana Safe-motherhood Programme was started in 1987 soon after the International Conference on safe-Motherhood Initiative held in Nairobi, Kenya in the same year. It started with 12 selected districts on operations research basis. It also included training of traditional birth attendants (TBA's) as a back–up to support community maternity care.

Objectives:

- To make childbearing safe for all women;
- To contribute to the improvement of infant health

Strategies:

Provision of integrated services at all levels of service delivery:

- Training of service providers in life saving skills and the use of the safe motherhood protocols and health education guidelines on safe motherhood
- Operations research
- Provision of appropriate equipment and supplies
- Provision of support to partner organisations

- Dissemination and monitoring the use of the National Reproductive Health Service Policy and Standards and Protocols
- Involvement of relevant people, ministries, agencies and organisations on maternal morbidity and mortality issues

Activities:

A. Prevention of Maternal Mortality (PMM) network.

- In 1988, the PMM work was started in Ghana as part of a West African Regional network.
- Two districts were involved in the pilot programme.
- The project established the fact that well established and sustainable structures in maternity care can reduce the unacceptable high maternal morbidity and mortality rates.

B. Life Saving Skills (LSS) Programme.

- In 1990, the LSS programme was started for midwives.
- Midwives were trained to acquire skills that enable them to provide support to mothers in times of emergency.
- The skills taught included; setting up of intravenous line, resuscitation of mother and baby, manual removal of placenta and manual vacuum aspiration using the manual vacuum aspiration (MVA) apparatus.

C. First National Consultative Meeting.

- In 1993, a meeting of researchers, planners, programme managers and key service providers on safe-motherhood was held.
- The meeting identified poor maternal health, inadequate use of health facilities and poor quality of services as factors contributing to the high maternal morbidity and mortality.
- As a result, a national task force was formed and charged with the responsibility of developing the safe-motherhood clinical protocols and health education guidelines.

D. Second National Consultative Meeting.

- In 1994, the second national consultative meeting on safe motherhood was held.
- The meeting recommended the following:
    - Training of regional resource teams for the ten regions.

- The incorporation of the life saving skills into the safe-motherhood programme and
- The components of the safe-motherhood were outlined as:
  - health education,
  - antenatal care,
  - supervised delivery,
  - postnatal care,
  - Family planning and
  - Prevention and management of unsafe abortion.

E. Safe-Motherhood Training.

- In 1995, the safe-motherhood training was decentralised.
- The regional training teams started training service providers in safe-motherhood skills including life saving skills.
- The regional training skills started conducting operations research in the communities.
- Monitoring and supervisory visits by master trainers also begun.

F. Baseline Assessment of Safe-Motherhood Activities:

- In 1997, a baseline assessment of safe-motherhood activities was conducted in three regions (Brong Ahafo, Ashanti and Eastern).
  Areas of focus were:
  - Activities of the regional resource teams for safe motherhood clinical skills and health education.
  - Activities of service providers (doctors, midwives, public health practitioners), and supervisors.
  - Availability of resource materials.

- **Key findings included:**
  - There were evidence of enhanced knowledge and skills in the delivery of maternity services and in carrying out community surveys by trained health workers.
  - District based data on maternal mortality were available in districts that had benefited from the safe-motherhood health education training.
  - Communities involved had benefited from dissemination of findings at various meetings such as durbars and social gatherings.

- **Gaps identified that needed improvement were related to:**

    - The management of infection prevention,
    - The management of Progress of labour.
    - The management of pregnancy induced hypertension.
    - The management of premature rupture of membranes.
    - The management of anaemia.
    - The provision of post-abortion care.
    - Teaching methodologies.
    - Communication skills.
    - Supervision and
    - Inventory of equipment.

G. A Countrywide Rapid Appraisal:

- In 1999, a countrywide rapid appraisal of the safe motherhood training programme was carried out. The programme was found to be progressing.

H. Performance Improvement Approach:

- In 2000, a Performance Improvement Approach (PIA) was conducted in the three northern regions. This approach concentrates on Performance of health workers.
- The aim of PIA was to determine the gap between the desired and actual performance of health workers.
  The parameters used included:
    - Job expectation.
    - Performance feedback.
    - Motivation and incentives.
    - Environment and tools.
    - Organisational support.
    - Knowledge and skills.

- **Interventions after the PIA assessment included:**

    - Re-training and updating of the regional resource teams.
    - Training of clinical instructors for safe motherhood.
    - Provision of equipment and medical supplies including models.
    - Refurbishing and renovations of health infrastructure.

- Conducting facilitative supervision.

Since 2002, seven other regions were introduced to the concept of performance improvement approach.

I. Re-focusing of Antenatal Care:

The "risk approach" to antenatal care has not resulted in significant improvement in maternal survival. Life-threatening complications of pregnancy are difficult to predict with any degree of certainty. Health care providers must, therefore, consider the possibility of complications in every pregnancy and prepare clients accordingly.

- The re-focusing of antenatal care was initiated in 2002 with emphasis on:
  - Individualised care.
  - Enhancing the development of a birth preparedness and complication readiness plan.
  - Partner involvement in maternity care.

J. Safe-Motherhood Campaign:

- In October 2002, the Ghana Health Service/Ministry of Health in collaboration with other implementing partners and development partners launched the first ever Safe Motherhood Campaign.
- The President of the Republic of Ghana launched the campaign in the Central region because of the region's high maternal and infant mortality rates.
- The theme for the campaign was "Death in Pregnancy and Childbirth is Preventable: Act Now!"
- The Ministry of Women and Children's Affairs was a key player. The Ministry organised a forum for women during the campaign period to discuss ways of bringing down maternal mortality.
- Other organisations involved in the campaign included:
  - National Population Council.
  - Ghana Registered Midwives Association.
  - Centre for Development and Population Activities.

    - Religious Organisations.
    - Women and Juvenile Unit of the Police.
    - Development partners (WHO, UNFPA, UNICEF, USAID)

- The Ghana Health Service calendar of events has institutionalised the month of September as the safe motherhood month.

THE NATIONAL SAFE MOTHERHOOD LOGO

The logo was developed and accepted by all implementing partners

K. Exemption Policy:

- Since 1996, the government of Ghana has been implementing an exemption policy for antenatal care clients. The policy does not cover clients who attend tertiary institutions. The implementation of the policy has faced a lot of problems because of the failure of Government to reimburse health facilities. As a result, some health facilities have stopped implementing the policy whilst others are just implementing some aspects of the policy.

- In June 2003, the Government provided funds to cover delivery services for pregnant women in the four most vulnerable regions (Upper East, Upper West, Northern and Central).

2. POST ABORTION CARE (PAC)

In Ghana, many facility maternal mortality data indicate that abortion complications account for about 25% these preventable deaths. (Deganus-Amorin, S. 1993).[16]

In Ghana, abortion is illegal (Criminal Code, 1960. Act 29 Section 58). Abortion is however permitted:

- Where the pregnancy is the result of rape, defilement of a female idiot or incest.

- Where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical and mental health and such a woman consent to it;

- Where there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.

Objectives of PAC:

- To prevent unwanted pregnancies through family planning counselling and services.
- To provide safe abortion services where permitted by law.
- To manage and/or refer abortion complications.
- To link post abortion care to other related health care services.
- To create public awareness on the dangers of unsafe abortion.
- To educate clients on the complications of abortion.

Training:

- The training of doctors and midwives (as specified in the RH policy) in post abortion care (PAC) started in 1996.

- The training includes

    - The use of manual vacuum aspirator (MVA) apparatus.
    - Pain management.
    - Stabilisation and referral.
    - Infection prevention.
    - Patient counselling.
    - Post abortion family planning services.
    - Follow-up and community education.

Strategic plan on abortion:

The Ghana Health Service has developed a strategic plan (August, 2003) to combat the high levels of unsafe abortion in the country. The strategy includes:

- Dissemination of the law on abortion to health workers, general public and partners.
- Training of doctors on how to perform safe abortion (under the law).
- Continued training of doctors and midwives in PAC.
- Nationwide research on abortion.
- Development of appropriate information, education and communication (IEC) materials.

- Promotion of family planning.

3. FAMILY PLANNING

The contraceptive prevalence rate (CPR) for modern methods stood at 5% in 1988 with a total fertility rate (TFR) of 6.4. In 1993, the CPR was 10.1% with a TFR of 5.5%. In 1998, the CPR was 13.1% with a TFR of 4.6%. The decline in total fertility rate in 1998 far exceeds the increase in contraceptive prevalence and is inconsistent with international experience on the relationship between fertility and contraceptive prevalence. [5, 7]

Goal:

- To assist couples and individuals of all ages to achieve their reproductive goals and improve their general reproductive health through information and counselling on contraception and other reproductive health services.

Objectives:

- To provide information, education and counselling to individuals and couples to enable them decide freely and responsibly the number and spacing of their children;
- To provide affordable contraceptive services and make available a full range of safe and effective methods;
- To provide information on child bearing;
- To assist couples to achieve pregnancy and have babies;
- To prevent and manage RTIs including STI/HIV/AIDS.

Policies:

- Adolescents- Sexually active adolescents who seek contraceptive services shall be counselled and served. Information and counselling shall be provided to adolescents. For adolescents, in general, emphasis will be on abstinence. [10]
- Spousal consent- For married couples, spousal consent for contraceptive use is not required. [10]
- Mental disability- In case of mental disability or serious psychiatric disease where the nature of the disease does not allow for informed choice, contraceptives shall be provided in consultation with all parties including persons in *loco parentis* and trained service providers.[10]

Contraceptive Methods:

Ghana provides a constellation of family planning commodities:

- Short-term methods.
- Long-term methods.
- Permanent methods.

Activities:

- Training of service providers including:
    - Counselling.
    - Insertion and removal of IUD.
    - Insertion and removal of implant.
    - Minilaparatomy for Tubal ligation.
    - Syndromic management of STI.
- IEC including material development.
- Operations research.
- Monitoring and supervision.
- Forecasting and pricing of commodities.
- Advocacy.

IEC Campaigns

In 1990, there was the social marketing strategy- The "I Care "campaign to boost the image of service providers.

In 1998, there was the campaign for long term methods.

In 2001, there was the launching of the "Life Choices" campaign.

Male Involvement

- The Planned Parenthood Association of Ghana (PPAG) and other NGOs such as the Ghana Social Marketing Foundation (GSMF), Rural Help Integrated (RHI), Muslim Family Counselling Services, Young Women Christian Association

(YWCA) and Young Men Christian Association (YMCA) have family planning activities for men. These include workplace activities, community activities, and workshops.

- PPAG has facilities that provide men only reproductive health services.
- Ghana Health Service is also developing facilities to provide men only services.
- The Ghana Health Service is also actively involved in finding innovative ways to reach men with family planning including providing services at the workplace.
- RHI and GSMF organise workshops for Long Distant Drivers in STI/HIV/AIDS and condom negotiation skills.
- RHI and GSFM use entertainment – education like soccer matches, bicycle race to reach the out-of-school youth.
- RHI and GSMF/PPAG/ Ghana Health Service organise workshops in schools and colleges and peer counselling sessions to reach in-school youth.
    - The Ministry of Education through the Ghana Education Service offers Family Life Education in the schools.

Contraceptive Security

In the context of an uncertain funding environment, Ghana's demand for contraceptives is growing. To meet this growing demand and avoid contraceptive shortages, the MOH/GHS and its partners committed to the development of a comprehensive strategy to help ensure contraceptive security, held in May, 2002 a conference titled, "Meeting the Commodity Challenge: Securing Contraceptives and Condoms for Ghana." Participants included donors, MOH/GHS, NGOs and technical partners. A consensus was achieved on the major contraceptive issues facing the country. Mechanisms were also discussed to address these issues, and the importance of securing short and long term financing for contraceptives was highlighted. To help move the contraceptive security agenda forward and begin to develop national strategies to address the issues, the MOH established the Interagency Coordinating Committee on Contraceptive Security (ICC/CS).

4. FEMALE GENITAL MUTILATION

In Ghana female genital mutilation (FGM) is practised by various tribes in the three northern regions. Due to migration the people have carried along their customs and practices. The practice is said to be widely found in communities where there are large concentrations of people from the above mentioned regions as well as migrants from West African countries.

Researches conducted indicate that the prevalence rate of FGM in the country is between 8% and 9%.[17]

The 1992 Constitution Article 26 (2) calls for the prohibition of all customary practices which dehumanise or are injurious to the physical and mental well-being of persons. Hence, in 1994, the Criminal Code 1960 (Act 29) [18] was amended to include the offence of female genital mutilation. Despite the law against FGM, the practice still continues.

FGM1 (excision of the prepuce with or without excision of part or the entire clitoris) and FGM2 (excision of the prepuce and clitoris together with partial or total excision of labia minora) are the predominant types seen in Ghana. FGM1 accounts for 37% to 42% of all cases and FGM2 accounts for 57% to 61% of cases. [17, 18]

In 2001, a Multidisciplinary Collaborating Group was established by WHO to assist in data collection and promotion of interventions on the elimination of FGM. The Group is chaired by the Deputy Director of Public Health in charge of Family health of the GHS.

Desk review

A data collection and desk review on FGM was conducted by the Multidisciplinary Group in 2002.

The review included:

- Policy adopted or in preparation,
- Research done and findings available,
- NGOs/Institutions most active in FGM/HTP,
- Socio-cultural practices that promote prevention and elimination of FGM and harmful traditional practices (HTP) and evidence of attitudes, practices, and behavioural change, both positive and negative.

Workshops:

- A workshop was organised for nurses and midwifery tutors so as to include issues on FGM in their respective curricula.
- Another workshop was held to disseminate the findings of the desk review.

Planned future activities by the Multi-disciplinary Collaborating Group:

- Sensitisation of traditional authorities, district assemblies and parliamentarians,
- Facilitating the enforcement of the law on FGM,
- Sensitisation of all other stakeholders in the field,
- Research into the effectiveness of the implementation of the legislation outlawing the practice of FGM,
- Inter-sectoral collaboration among agencies in the implementation of intervention programmes,
- Mobilisation of funds at international, national, local and community levels to fight against FGM,
- Education on FGM should be incorporated into the curricula of schools and training colleges,
- FGM must be an integral part of the primary health care programme which is community based,
- Research to come out with national statistics on FGM to guide and monitor the progress of intervention programmes.

Activities of NGOs:

- The Ghana Association for Women's Welfare (GAWW) is in the lead in the fight against FGM. It is also leading in the amendment of the law on FGM to include other perpetrators apart from the circumcisers. GAWW periodically conducts educational workshops on FGM.

- Rural Help Integrated (RHI) conducts workshops for women, men, chiefs and other stakeholders who are the custodians of the numerous cultural practices in the project area (Bolgatanga and Bongo, Upper East Region) to re-examine the practices in order to abolish the harmful ones. It also conducts studies in FGM in the project area. RHI had a sub-contract with UNFPA to conduct activities in FGM. This continued in the third and fourth UNPFA/GOG country programmes. WHO Ghana, in 2001 provided support to RHI to set up advocacy and behavioural change towards FGM in the Builsa District of Upper East Region. WHO in Geneva is also working on the obstetric sequelae of FGM which was started in December 2001.

- Navrongo Health Research Centre which is also based in Upper East Region has conducted studies in FGM.

Other harmful traditional practices being addressed include:

- Pregnancy related taboos,
- The use of harmful vaginal herbal preparations,
- The use of herbal uterine stimulants for hastening labour and termination of pregnancy, and
- Ritual servitude

5. REPRODUCTIVE TRACT CANCERS

These include in women cancers of the cervix and breast and in men cancers of the prostate and testes.

Objectives:

- To prevent cancers of the reproductive system;
- To detect early cancers of the reproductive system;
- To treat cancers of the reproductive system;
- To manage terminally ill patients.

Cervical cancer

The GHS/MOH is committed to the prevention of cervical cancer and all other gynaecological cancers in Ghana. This has always reflected in the past and present RH policies. PAP smear was the encouraged primary prevention strategy for cervical cancer. The cost involved in setting up a national screening programme based on PAP smear was the one factor that limited the setting up of such a programme.

Visual inspection of the cervix with acetic acid and cryotherapy (VIA) for cervical cancer prevention has become available. This is a more cost effective technique and the GHS has decided to set up a national screening programme with this method.

The RH Service Policy and Standards have been revised to include the following:

- VIA/ Cryotherapy as the primary method of screening for and treatment of pre-cancerous cervical lesions;
- The health centre facility is the lowest level at which screening for cervical cancer can be undertaken;
- Nurses (Midwives, Community health Nurses and Medical Assistants) will be the primary service providers for cervical cancer screening;
- Management of cervical cancer patients has been spelt out to include curative and palliative care.

A pilot screening programme:

- It involves one urban health facility and one rural health centre,
- It was commenced in March 2000 and 2002 respectively,
- It is a JHPIEGO Cervical Cancer Prevention (CECAP) project,
- The pilot programme ends in September 2003,
- Preliminary results for pre-cancerous lesions for the urban and rural health facilities are 11.1% and 6.6% respectively (unpublished).

Strategy for scaling up:

- The country will be divided into three zones.

- These three zones will become the focus for the expansion down to the sub-district levels.
- Master trainers will be developed for each zone.
- The master trainers will undertake the training of clinical trainers who will in turn train the service providers.
- If this strategy is implemented, service provision will be available at the sub-district within five years.

6. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Goal:
The goal of the project is to reduce mother-to-child transmission of HIV and improve health service provision and psychosocial support for mothers and children.

Objectives:
- Introduce HIV voluntary counselling and testing (VCT) for pregnant women;
- Administer Nevirapine to mothers and babies during and after delivery respectively;
- Specifically advise HIV infected mothers on appropriate alternatives to breastfeeding;
- To educate health workers and Para-medicals on MTCT of HIV;
- To train health workers and Para-medicals on PMTCT of HIV;
- To facilitate the integration of PMTCT of HIV into formal health delivery services;
- To enable documentation of data and experiences on PMTCT of HIV;
- To encourage community mobilisation and support for PMTCT of HIV activities;
- Assess the effectiveness of the intervention and derive lessons for scaling up.

A Pilot Programme:

- The prevention of mother-to-child transmission (PMTCT) of HIV was started as a pilot programme in two facilities in a district in Eastern region.
- The programme was started in December 2001 to cover a three year period.
- It was a collaborative effort between the GHS and partners especially Noguchi Institute, UNICEF, WHO AND UNAIDS.

The pilot sites were chosen because the district had one of the highest HIV sero-prevalence in the country.

Programme Management and Coordination:

- There is adequate national commitment to reduce MTCT of HIV in Ghana.
- There exist key documents such as,
    - The National HIV Strategic Framework,
    - MTCT manual for training Health workers.
- A multi-sectoral task-force oversees the programme implementation,
- The anchoring of PMTCT within the RCH Unit of GHS augurs well for its integration into existing health interventions,
- There is a conducive environment for implementation of the infant feeding strategy:
    - The policy on breastfeeding is in place as well as implementation guidelines,
    - The Code on Marketing of Breast Milk Substitutes Regulations (passed in May 2000 by Parliament) is being implemented,
- Nevirapine is the drug being administered to women in labour and infants after birth,
- All infants born to HIV positive mothers receive Cotrimoxazole for prevention of Pneumocystis Carinii Pneumonia (PCP) from 6 weeks until 12 months of age,
- Noguchi provides polymerase chain reaction testing of infants at 2 weeks, 3months, 6, 9, 12 and 15 months as part of an ongoing research into the transmission and the health outcomes of infants born to HIV infected mothers,

- The Queen Mothers Association provide communities with education on STI/HIV/AIDS. The Association with its 371 members provides girls' education, vocational training of young girls in tie and dye batik, soap making, care of orphans and vulnerable children including socio-economic support. The activities of the Queen Mothers are supported by USAID, WB and the UN gender programme.
- Other NGOs such as The Christian Professional Fellowship (CPF) provides adults and young people general education and counselling as well as STI treatment in an adolescent friendly environment through mobile clinics.
- There is an ongoing programme on Integrated management of Childhood Illness (IMCI),
- PMTCT is part of the Global Fund programme for HIV/AIDS.

Voluntary Counselling and Testing:

- The cumulative VCT uptake for the 2 sites as at July 2003 is about 53%, and
- HIV positive rate is 12%.

Care and Support:

- Care and support services for PLWHA are integrated into other services at the 2 health facilities.
- The activities include:
    - Clinical care including anti-retroviral treatment
    - Management of opportunistic infections
    - Psychosocial support,
    - Nutritional advice,
    - STI syndromic management,
    - Socio-economic support.
- The services are supported by Family Health International (FHI) START project.

Scaling up:

- A strategic plan for scaling up has been drawn,
- Sixteen more sites throughout the country have had training to start implementing PMTCT of HIV,
- Twenty sites would be implementing PMTCT by the end of 2003.

Challenges:

- Access and quality of PMTCT services are constrained by user fees for delivery and STI management.
- Shortage of staff.
- Weak communication strategy.
- Fear of stigmatisation.
- Lack of transport for home visits by counsellors.
- Fifty percent (50%) of HIV positive mothers deliver outside the health facilities.
- Monitoring and evaluation system is not fully developed.
- The capacity of health workers to utilise data for planning and advocacy at the district and facility levels is not well developed.
- There is no comprehensive multi-year cost plan for PMTCT of HIV.

7. ADOLESCENT REPRODUCTIVE HEALTH

The Ghana Health Service's adolescent health programme (ADH) started in 1996. This was in response to a number of factors:

- In country studies carried out by individuals and organisations revealed that adolescents in Ghana suffered poor health due to health damaging behaviours. The problems were mostly reproductive health related;
- Recommendations from ICPD and the 1995 Women's Conference held in Beijing;
- The need to preserve gains made in the implementation of health interventions in early childhood;
- All components of RH have a bearing on adolescent health;

- The Ministry's objectives for the 1997-2001 Medium Term Health Strategy favoured the adolescent health programme.

Goal:

The goal of the programme is to contribute to improved adolescent health through the provision of cost-effective health services in Ghana.

Objectives:

The long term objectives are:

- To contribute to increased utilisation of quality health services by adolescents;
- To provide adolescents with information and knowledge on health to ensure positive behavioural practices.

The short term objectives include:

- To facilitate the commitment of community leaders and other key stakeholders to ADH programme;
- To strengthen the capacity of the RCH Unit to provide support to ADH in the regions;
- To strengthen capacity of health workers in data collection and analysis concerning adolescents;
- To enhance the capacity of adolescents to utilise health services;
- To equip adolescents with knowledge and skills for positive behavioural practices;
- To provide parents with knowledge and skills for effective parental guidance and support.

Strategies:

The strategies adopted included:

- The programme to begin with sexual and reproductive health;
- Expansion to cover other health areas;
- Formation of adolescent health task forces;
- Training in adolescent health programme for regional/district health teams, community groups;
- Operations research.

Activities:

- In 1996, the RCH Unit of the GHS carried out organisational analysis on strengths, weaknesses, opportunities and threats of the Ministry to enable it develop a cost-effective adolescent health programme.
- In 1998, a baseline study to assess adolescent health was conducted in the regions.
- The health management information system (HMIS) of the MOH was reviewed to include disaggregating data on adolescents.
- Three task forces were formed on service delivery, training and IEC/advocacy.
- The Service Delivery Manual, Manual for Training Health Workers and Facilitators Manual had been developed.
- In 2000, a stakeholder analysis study was carried out by the IEC & Advocacy task force with technical support from Population Impact Project PIP), University of Ghana, Legon.
- Adolescent Health Primers for Primary Schools had been developed in collaboration with the Health Research Unit of the Ghana Health Service.
- A National Adolescent Health Steering Committee had been put in place.
- As at the end on October 2003, nine regions had regional/district health teams trained as trainer of trainers in adolescent health.

The Way Forward:

- Finalisation of all resource documents on adolescent health;
- Youth specific IEC and advocacy materials to be developed;
- Training of health workers in the districts;
- Operations research on adolescent health;
- Provision of quality and friendly adolescent health services;
- Monitoring and evaluation of the programme.

Funding:

- The ADH programme of the Ghana Health Service which started with funding from UNFPA is now being funded under the African Youth Alliance (AYA) Project.

NGOs in Adolescent Programme:

A number of NGOs are also participating in youth programmes in Ghana. Notable among them are:

- Planned Parenthood Association of Ghana (PPAG) which has youth friendly centres (Young and Wise Centres). These centres are used as field sites by GHS for its adolescent training programme.
- Ghana Social Marketing Foundation (GSMF) has a lot of programmes including entertainment –education activities for adolescents and youth.
- Rural Help Integrated (RHI) uses entertainment –education to reach the out-of school youth and organises workshops in schools and colleges and peer counselling sessions to reach in-school youth.

D. PROGRAMME INDICATORS

The RH Programme is being monitored using indicators which include the following:

- Antenatal care coverage – 87.5% (DHS 1998) [7],90% (GHS, RCH 2002)[20]
- Average number of visits -4.6 (DHS1998), 2.9 (GHS, RCH 2002)
- Adolescent pregnancy- 14.1% (DHS 1998), 14.1% (GHS, RCH 2002)
- Haemoglobin level at registration & 36 weeks- 63.7% (>10g/dl, 1st visit, RCH, 2002)
- Tetanus immunisation coverage – 51.6 (DHS 1998), 101.4%* (GHS,RCH 2002)
- Low birth weight rate – 13.0% (DHS1998), 10% (GHS, RCH 2002)
- Still birth rate - 2% (DHS 1998), 2% (GHS, RCH 2002)
- Supervised delivery – 68.5%**(DHS 1998), 74.7%** (GHS, RCH 2002)

- Maternal mortality ratio (institutional) 2.14/1000(DHS 1993), 2.04/1000 (RCH 2002)
- Infant mortality rate- 56.7/1000live births, DHS 1998
- Under Five mortality rate-107.6/1000 live births, DHS 1998.
- Postnatal care coverage – 49.3% (DHS 1998), 76.1% (GHS, RCH 2002)
- Total fertility rate- 4.6 DHS 1998.
- Contraceptive prevalence rate -13.1% (modern methods, DHS 1998)
- Couple Years of Protection – 642,520 and 354,671 for short and long term methods (GHS, RCH 2002)
- EPI coverage-62% (DHS 1998), DPT-Hep.B-HiB 111.1% (GHS, RCH 2002)
- Exclusive breastfeeding rate- the rate at 4 months increased from 2% in 1988 to 37% in 1998 and at 6 months from 0% in 1988 to 17% in 1998 (DHS, 1988and 1998).
- Number of Baby Friendly Health Facilities- From 1 in 1995 to 62 in 2002 (GHS, RCH 2002)
- Number of Adolescent Friendly Health Facilities – 4 in 2002 (GHS, RCH 2002)

*The 2000 census report came out with lower population figures than those projected from the 1984 census. The RCH Annual Report was compiled using the 2000 census data; hence some indicators recorded higher figures than expected.

** The figures included the contribution of trained traditional birth attendants. They contributed 24.2% and 29.6% of the deliveries respectively.

The RH programme is yet to compile complete information on all basic and comprehensive essential obstetric care facilities in the country in relation to the Primary Health Care Strategy. However, the programme has already started collecting information on caesarean section, vacuum extraction and forceps delivery.

E. PARTNERS AND AREAS OF SUPPORT/ SOURCES OF FUNDING

UNFPA: UNFPA assistance to the Ministry of Health/ Ghana Health Service started in 1986. The assistance has moved from support of Maternal and Child Health to the broader Reproductive Health. The current 4th Country Programme has two projects with

the Ministry/Ghana Health Service. The first project covers the three Northern Regions and the other covers the Southern Sector of the country. The activities include training of health workers in RH activities- safe motherhood, STI/HIV/AIDS, family planning, etc. UNFPA procures equipment and supplies for RH activities in the country. Equipment includes medical supplies, vehicles, tractor ambulance, motorcycles, computers, etc. UNFPA assists the Ministry with capacity building by providing fellowship training abroad and in-country. For example, UNFPA supports the Masters in Public Health training at The School of Public Health, University of Ghana, Legon. UNFPA also provides technical assistance through its Country support Team and procures some of the contraceptives for the country.

UNFPA funds some of the NGOs (PPAG, RHI) and Society of Private Medical Practitioners in implementing RH activities. National Population Council and Ghana Education Service also receive funds for implementing population and family life education programme activities respectively.

USAID: USAID has supported the Government of Ghana since 1957. USAID assists in the procurement of contraceptives for the country. Through its Corporative Agencies, the Ministry/Ghana Health Service has received a lot of technical assistance especially in the area of logistics management for family planning, training and development of Reproductive Health Service Policy and Standards and Protocols. USAID also provides equipment (including vehicles, medical supplies, computers, training models, etc) to the programme. USAID assists a lot in capacity building by providing fellowship training abroad and in-country training of health workers. In the area of infrastructure, USAID has assisted in the construction a Resource Centre and Public Health Reference Laboratories. Most of the family planning campaigns were assisted by USAID. USAID/Ghana Country Strategic Plan (2004-2010) includes Reproductive health, Child Health and STI/HIV/AIDS.

USAID also funds some NGOs in the RH area- PPAG, GRMA, GSMF. It provides funding to the National Population Council and Ghana Education Service.

WHO: WHO assists the Ministry/Ghana Health Service in Reproductive Health especially in the area of Safe Motherhood, HIV/AIDS, and IMCI/RBM. WHO assists in the procurement of some equipment and supplies (tractor ambulance, computers, and medical supplies). WHO assists in training health workers in safe motherhood activities, HIV/AIDS, IMCI/RBM. WHO also provides funding for training of health workers outside the country.

UNICEF: UNICEF assists the Ministry/Ghana Health Service in Safe Motherhood, Child health especially breastfeeding, IMCI/RBM, HIV/AIDS. UNICEF provides a lot of

medical equipment and supplies (vehicles, vaccines, computers, stationery etc). UNICEF also assists in capacity building by providing fellowships for training abroad and in country.

UNICEF provides funds for some NGOs working in the RH area, e.g. CPF

WORLD BANK: World Bank has assisted in the procurement of contraceptives.

DFID: DFID provides funds for contraceptives. DFID also assists NGOs like Save the Children Fund in implementing reproductive health activities. To improve contraceptive security, DFID will be providing funds for the procurement of male condoms for the next five years.

GOVERNMENT OF GHANA: The government reimburses all health facilities through its policies on exemption of fees for antenatal for the whole country and for deliveries for the four most vulnerable regions. The government also procures equipment and medical supplies for the implementation of the reproductive health programme. The government has provided funds twice for procurement of contraceptives.

F. RESEARCH FINDINGS

A NUMBER OF RESEARCHES HAVE BEEN CONDUCTED IN RH AREA. THESE INCLUDE:

1. ADOLESCENT REPRODUCTIVE HEALTH STUDY [21]

The study was carried out in 1998/9 by the Health Research Unit of the Ministry of Health.

Key Findings:

- **Adolescents and Community Members:**
    - Teenage pregnancy and unsafe abortion are perceived health problems amongst adolescents,
    - Inadequate parental care embedded fundamentally in parents low financial status,
    - Low RH knowledge amongst adolescents e.g. menstrual period, contraceptive methods, STIs, HIV/AIDS,
    - Lack of special services for adolescents,

- Low patronage of health services in government health institutions,
- Peer pressure,
- Lack of role models in the communities,
- High school-drop out rate and unemployment.

- **Health Workers:**
  - Inadequate ADH communication skills,
  - Lack of IEC materials on ADH,
  - Inability to provide special services for adolescents.
- **Key Recommendations:**
  - Provide more information on adolescence for adolescents, parents, communities and health workers,
  - Equip health workers with knowledge and skills in handling adolescents,
  - Provide youth-friendly services,
  - Support young people to obtain entrepreneurial skills to limit their vulnerability to sexual activities for financial and other material gains.

2. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN GHANA: A STAKEHOLDER ANALYSIS STUDY. [22]

The study was carried out in 2000 by PIP in collaboration with RCH Unit of the GHS.

Key Findings:

1. **Adolescents:**
   - Mentioned teenage pregnancy, school drop out and lack of parental care as problems facing them.
   - Adolescents perceived HIV/AIDS, abortion and other sexually transmitted diseases as specific RH problems they face.
   - The radio and adolescent peers were stated as the first source of RH information.
   - The most preferred source of information was mother for the female adolescent and the reverse for the male adolescent.
2. **Parents:**
   - Ten percent (10%) of parents reported knowledge of some specific adolescent RH programmes.

- Major problems facing adolescents as indicated by parents in order of magnitude include teenage pregnancy, school drop out, unemployment and lack of parental care.
- Parents attributed these problems to poverty and disobedience of adolescents to parents.
- Parents suggested increased parental care, modern education and counselling on adolescent reproductive health issues.

3. **Policy Makers:**
    - Attributed the causes of poor parent-child communication in respect to RH to cultural and traditional beliefs and inadequate time spent with children at home by most parents.
    - Policy makers accepted the need to educate adolescents on RH issues and provision of a full range of services including family planning for sexually active adolescents.
    - Majority of policy makers cited mothers followed by health personnel and teachers as better placed people to provide information on RH issues.

4. **Opinion Leaders:**
    - Overwhelmingly supported the use of RH services by adolescents.
    - Indicated that sexually active adolescents be given education and counselling, subsidised condoms and parents must be encouraged to take their children to health workers.
    - However, some opinion leaders responded negatively to adolescents being provided with family planning services.

5. **Recommendations:**
    - The Ministry of Youth and Sports should evolve a policy that will make it mandatory for all youth associations and clubs to incorporate ADH into their programmes.
    - Special units should be set up within health facilities to cater solely ADH issues to make it more comfortable for many adolescent clients.
    - Counselling and education on appropriate contraceptive use by sexually active adolescents must be given a priority in service delivery.

- Harmful traditional practices with emphasis on FGM must be the focus of adolescent health IEC/Advocacy.
- Addressing adolescent health problems need a multi-sectoral action.

3. CONCEPTIONS AND MISCONCEPTIONS: COMMUNITY VIEWS ON FAMILY PLANNING. [23]

- In 1991, the Maternal and Child and Family Planning Division of the Ministry of Health requested the Health Research Unit to investigate reasons for low use of contraceptives in rural areas, and to appraise community potential to support family planning services. Three studies were conducted- one in Dangbe West district, one in Berekum district and the third one in Bolgatanga district representing the southern, middle and northern zones of the country. Recommendations from these studies had contributed to improvement in the provision of family planning services in Ghana. The studies revealed various constraints to family planning service provision including a lack of adequate and appropriate information, limited service provision and a number of socio-cultural constraints.

- **Four key constraints to be addressed were:**
    - Lack of a culturally appropriate information,
    - Education and communication,
    - A limited range of clinical contraceptive methods at sub-district level,
    - Lack of privacy in some of the government health facilities and a preference of the people for curative and preventive services in the community as opposed to family planning services.
- **Four strategies developed to address the constraints were:**
    - Development of appropriate IEC messages,
    - Ensure a full range of clinical FP methods at health centre level,
    - Ensure privacy at all service delivery points,
    - Introduce and support comprehensive services at 12 outreach points per health centre.

4. A COMMUNITY BASED STUDY OF RISK FACTORS IN MATERNAL MORTALITY IN THE KASSENA NANKANA DISTRICT OF THE NORTHERN REGION. [24]

This study was carried out by N.Dollimore, et al, 1991. The report was prepared for the Safe Motherhood Initiative of WHO, March 1993, contract number HQ/91/903839.

The study identified the leading causes of death in maternal mortality in the rural areas of the Kassena Nankana district and a wide range of factors which are associated with the risk of dying from maternal mortality.

Key findings:

- Thirty three (33%) of all maternal deaths occurred in health facilities,
- Seventy (70%) of all pregnant women attended antenatal clinic at least once.
- Inadequate IEC programmes to address harmful dietary taboos and other beliefs affecting pregnancy and children.
- Poor quality of services at the antenatal clinics.
- Delays of treatment at health facilities.
- Poor staff attitudes towards women attending antenatal clinics and health facilities.

Recommendations:

- The need to improve services at health facilities before embarking on community programmes.
- The need for IEC programmes at community level to address harmful dietary taboos and other beliefs affecting pregnancy and childbirth.
- Maternal mortality needed to become a "political" issue in northern Ghana.

5. WIDOWHOOD RITES, FOOD TABOOS, FACIAL AND BODY TRIBAL MARKS AND FORCED INFANT FEEDING.

The RHI is conducting the above study in the project area in the Upper East region. The aim is to provide accurate information on these practices for advocacy and behavioural change activities.

6. MALE INFERTILITY.

Male infertility has been observed as an emerging problem in the Upper East region.

RHI is conducting an action research to determine the causes of this problem and offer appropriate management.

7. FEMALE GENITAL MUTILATION – THE CROSS CUTTING ISSUES OF EDUCATION, RELIGION, URBANISATION AND REPRODUCTIVE HEALTH IN BOLGATANGA DISTRICT.25

Findings:

- The overall FGM prevalence in second cycle school girls was 6.3%.
- Education has been found to influence religion, conversion from traditional ancestral worship to Christianity and Islam.
- Girls not in school run almost four times the risk of being cut than their counterparts in school.

Recommendations:

1. Education for all, especially the girl-child, poverty alleviation, modernising traditional ancestral worship and providing basic infrastructure at the community level to transform rural communities to urban communities are medium and long term issues that should be tackled at the government level.
2. Community-based workers such as community based distributors, village health workers, community health animators etc, should be recruited, retrained, motivated and redirected to include gender issues, violence and harmful traditional practices in their communities in their day-to-day activity.
3. International cross-border campaigns should be encouraged especially between Ghana and Burkina Faso.
4. Research work needs to be strengthened to understand specific and crucial socio-cultural factors underlying the main traditional reasons why dangerous and morally indefensible practices still persist.

FUTURE CHALLENGES

1. **Development and Deployment of Human Resources:**

    a. The country is facing a severe brain drain. Although the government is tackling the problem by providing additional duty allowance and vehicles to health workers, the problem is far from being solved. Still doctors, nurses and other health professionals are leaving the country in droves. In addition, most of the remaining health personnel especially doctors and nurses are in the urban areas. This leaves the rural areas poorly resourced. Unless the brain drain is addressed, the provision of health services including reproductive health will be in jeopardy.

    b. The Ministry's/Ghana Health Service Community-based Health Planning and Services is one of the strategies to get health services close to the communities. These services are presently only in a few communities and more resources including funds are needed to expand the process.

    c. Increased intake of personnel for pre-service training is being intensified at the health institutions to address the shortage of health workers. However, the learning facilities available (classrooms, libraries, etc) do not match the increased intake. This has led to a lot of frustration by faculty, tutors and students of these institutions. What is needed is more funding to upgrade and develop more facilities to match the increased intake of health personnel.

    d. In-service training of health personnel needs to be continued in order to improve access and quality.

2. **Establishment of Places of Excellence:**

    With the establishment of the Post-graduate College for Physicians and Surgeons in Ghana, places of excellence for family Health need to be established throughout the country. Such facilities may help in the distribution of doctors. Funding for the development of such facilities is what is needed most.

3. **Strengthen the Environment and Capacities within the Health Sector:**

    a. There must be a constant supply of basic essential drugs as well as equipment. Maintenance and replacement schedules need to be followed.

b. Job descriptions and job aids should be made available to health all health professionals.

4. **Mobilisation of resources (human, financial):** Inter-sectoral approach to implementing reproductive health activities is needed. This may lead to effective and efficient use of resources. Community financing (Mutual health financing, etc) operating in some communities need to be encouraged and supported.

a. Small and large scale credit to women may help. This will empower women financially and it may lead to making use of the benefits of modern health care when it is needed. The Ministry of women and Children's Affairs is already implementing such a programme but it needs to be strengthened.

5. **Monitoring and Evaluation:** The impact indicators are obtained periodically through the Demographic and Health Survey. Process indicators are being used to collect data on RH. The challenges are:
    - The need to collect accurate information, and
    - The need to strengthen reproductive health database.
6. **Reproductive Health Service Components:** Some components of RH have not had much attention. These include infertility, menopause, sexual health and gender based violence. Programmes need to be developed for these areas.
7. **IEC/Advocacy strategies:** Reproductive Health programme needs to be backed by a comprehensive well targeted, gender sensitive and culturally acceptable IEC/advocacy strategies especially in the areas of Safe Motherhood, Adolescent Health, Family Planning and Gender Violence.
8. **Dissemination of Laws, Policies and Guidelines:** More effort should be made to disseminate all laws, policies and guidelines on reproductive health to the general populace and health workers. This will facilitate the implementation of the reproductive health activities.
9. **Financial Commitment by Health Sector and Partners:** Although reproductive health is a priority in the Ministry of Health/Ghana Health Service Policy and Programme of Work documents, there is the need to for more resources to be allocated to RH activities. With the advent of HIV/AIDS, funding of health programmes has shifted, making implementation of RH programme difficult. Implementation of reproductive health activities in Ghana Health Service has progressed because of earmarked funds by development partners. However, there is still a funding gap in almost all the reproductive health areas. Development Partners in Health should consider allocating more resources in RH in order to sustain and improve on the gains made.
10. **Strong Political Commitment**: It is not enough to have high profile politicians sometimes talk about activities of RH. It is important that RH is put high on the

political agenda through advocacy. Maternal mortality, for instance, needs to become political issue until such a time that the ratio/rate drops to an acceptable level. The RCH Unit of the Ghana Health Service is gathering data to be presented to Cabinet so that maternal mortality will become a notifiable event in the country.

11. **Research:** More research is needed in RH. Ghana needs a well developed research agenda on RH. This should include social behaviour in relation to RH, operations research, acceptability studies and clinical trials.
12. **Costing of RH Programmes:** Costing of RH programmes should be undertaken to help in designing and redesigning of programme activities. This will also facilitate in advocating for more resources for reproductive health.
13. **Co-ordination of Reproductive Health:** There are NGOs working in the RH who are not known and the work they do is neither captured by the Ghana health Service nor the Population Council. Although the GHS has a desk for private sector including NGOs, there is also not much collaboration between the RCH Unit and the private sector Unit.

CONCLUSION.

The commitment of Ghana to reproductive health programme activities is seen in the development of policies, laws and guidelines and in the implementation of programme activities.

A lot has been achieved in reproductive health -the involvement of high profile political figures in some reproductive health activities has been very encouraging, the implementation of exemption policies for antenatal clients and the provision of funds for free delivery services need commendation. Efforts should be made to address all the obstacles in the implementation of the exemption policies.

A lot more needs to be done in reproductive health. This includes strengthening the reproductive health database and costing of RH activities. The Government and Development Partners need to commit more funds to reproductive health activities to improve access and quality. Increased funds are also needed to facilitate human resource development, provision of adequate equipment and supplies, up-scaling of pilot programmes and to conduct research.

The Millennium development targets will not be achieved until more commitment is made and more funds are provided by Government and Development Partners.

The Information, Education and Communication component of the reproductive health needs particular attention. This is because people need accurate and timely information to make sound choices. This is particularly so for the young people as they embark upon their sexual and reproductive lives. They must be able to protect themselves from disease, abuse and exploitation.

The attitudes of health professionals which adversely affect the provision of quality of services need to be addressed. Fortunately, the Ghana Health Service has developed the Code of Ethics which defines the general moral principles and rules of behaviour for all health workers in the Service. The Code of Ethics needs to be disseminated widely and health workers should be made to face disciplinary committee when they infringe on the tenets of the Code.

In-service training involving upgrading of knowledge and skills of health workers should continue to be used as one of the criteria for promotion in the Service.

The implementation of reproductive health can not be done in a vacuum. It has to be linked up with advancing human rights, social justice and equity for the poor, universal primary education, promoting gender equality and empowering women and ensuring environmental sustainability.

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