



ENVIRONMENTAL HEALTH PROJECT

Activity Report 114
Ghana
Urban Health Assessment

by

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with

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We hope that this assessment proves useful to USAID/Accra and its partners as they chart a course for future U.S. government assistance in Ghana. The findings and conclusions reported here were compiled during a relatively short period. We, therefore, apologize for any errors in data or interpretation and will greatly appreciate readers' feedback so that we may make corrections in the final report.

Acronyms

AMA	Accra Metro Assembly
AMEHI	Accra Metropolitan Environmental Health Initiative
BASICS	Basic Support for Institutionalizing Child Survival
CBO	Community-based organization
CEDEP	Centre for Development of People
CEDPA	Centre for Development and Population Activities
CENCOSAD	Centre for Community Studies, Action, and Development
CHPS	Community Health Planning and Services
CWIQ	Core Welfare Indicators Questionnaire Survey
CWSA	Community Water and Sanitation Agency
DANIDA	Danish Agency for International Development Assistance
DFID	Department for International Development (Great Britain)
DHS	Demographic and Health Surveys
EGAT	Economic Growth, Agriculture and Technology
EHP	Environmental Health Project
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Services
GLSS	Ghana Living Standards Survey
GPRS	Ghana Poverty Reduction Strategy
GSMF	Ghana Social Marketing Foundation
GYRHS	Ghana Youth Reproductive Health Survey
ISODEC	Integrated Social Development Centre
IMR	Infant mortality rate

JHU/CCP	John Hopkins University/Center for Communications Programs
JICA	Japan International Cooperation Agency
KVIP	Kumasi ventilated improved pit latrine
MLGRD	Ministry of Local Government and Rural Development
MMR	Maternal mortality ratio
MOH	Ministry of Health
MOST	USAID Micronutrient Program
NNMR	Neonatal mortality rate
PHR	Partnerships for Health Reform
PPAG	Planned Parenthood Federation of Ghana
PPPH	Public Private Partnership in Handwashing
PRIME	Performance of Primary Providers in Reproductive Health
PVO	Private voluntary organization
U5MR	Under-five mortality rate
UESP	Urban Environmental Sanitation Project
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

USAID's Environmental Health Project (EHP), together with EGAT/UP and the USAID/Ghana Mission, conducted a rapid assessment of urban health needs in Ghana in July 2002. Although Ghana's cities are growing rapidly, national development policies and international assistance packages have not yet focused attention on the needs of urban populations. USAID/Ghana requested this assessment in preparation for a strategic planning exercise that will determine the future direction of its population, health and nutrition assistance.

Urban growth and poverty. Almost half of the 8.3 million urban residents in Ghana live in the country's two largest cities, Accra and Kumasi. Migration from rural areas to towns and cities drives urban growth, but natural increase also is a significant factor. If the growth rates of the late 1990s persist, by 2020, city dwellers will outnumber those living in rural areas, and the country's urban population will more than double in size. The poor struggle to survive in Ghana's largest cities, paying for most of the services they receive and paying more, in many cases, than their non-poor neighbors. One-fifth of Ghana's total urban population was estimated to be below the official poverty line in 1998–99, but this is probably a serious underestimate. Rates of childhood malnutrition and food insecurity in cities such as Accra are much higher than the officially cited poverty rate. Informal sector employment also has increased dramatically during the past decade. Equal proportions of women and men work in Ghana's cities, but women are twice as likely to be self-employed or working in the private informal sector, most as petty traders. Women in Accra are among the poorest of the city's residents. They begin work earlier in life than their male counterparts, and they stop working later in life than women anywhere else in the country.

Morbidity and mortality. Infant (IMR) and under-five mortality rates (U5MR) in Ghana's towns and cities are 76 and 122 respectively. Although child mortality is higher in rural Ghana, the pattern of mortality is more or less the same: half of all deaths in children under 5 years of age occur before they reach their first birthday, and half of all deaths in the first year occur during the first month of life. Malaria is the number one cause of mortality for children under five, with pneumonia, diarrhea, malnutrition, neonatal causes and measles also contributing to the unnecessary deaths of an estimated 100,000 Ghanaian children each year. Those living in high-density, indigenous and lower-class zones of Accra have been shown to have mortality rates that are three to five times higher than the residents of low-density, upper class neighborhoods. In the early 1990s in Accra, almost half of the city's population was living in these overcrowded neighborhoods.

Government policies and programs. The Ghana Poverty Reduction Strategy 2002–2004 (GPRS) (Ghana 2002) gives little explicit attention to the needs of the urban poor. It calls for regional and rural development strategies and better urban planning to curb the tide of urban migrants and improve life in both rural and urban areas and gives the three northern regions and the central region top priority for most

government investment. The strategy also slates water and sanitation problems for national-level support, as well as more humane pricing of public services, including health services. These policy directions will clearly benefit the urban poor, although they are not specifically targeted to them.

City governments and at least three line ministries and their related agencies have important roles to play in maintaining the health of urban residents. The Ministry of Health (MOH) and Ghana Health Services (GHS) provide health care and implement preventive health programs. MOH policies follow those defined in the GPRS. Special attention is being given to correcting urban-rural inequities in access to health care and allocation of government health personnel. Improved mechanisms for health care financing also are given priority.

The Ministry of Works and Housing (MWH) is responsible for the Ghana Water Company and the management of all urban water systems. This ministry is in the process of privatizing many of its functions, causing concern among advocates for the poor because they fear price increases. The Community Water and Sanitation Agency of the Ministry of Works and Housing is the home of the new Private-Public Hand-Washing Promotion Initiative.

The Ministry of Local Government and Rural Development (MLGRD) has traditionally been the partner for the urban infrastructure projects supported by the World Bank and others, including the Urban Environmental Sanitation Project (UESP). MLGRD supports and delegates many implementation functions to the metro assemblies, which are concerned with sanitation and other public services, law and order and attracting investment to their cities. Metro health officers and teams of environmental health inspectors enforce environmental regulations. A recently published environmental health policy clarifies the role of the metro assembly and its environmental health staff. Both had been unclear and were blamed, at least in part, for past inactivity. Metro chief executives and environmental health divisions have been criticized for placing too much emphasis on top-down planning and enforcement and not enough on involving local communities and improving conditions in the urban slums. The Accra Metro Assembly was the partner for the DFID-funded Accra Metropolitan Environmental Health Initiative (AMEHI) project that ended in 2002.

USAID-supported programs. USAID partners (cooperating agencies and PL480 and private voluntary organizations) partners currently work across all the priority public health interventions, but only in a few cases are they working in urban areas. No case could be found in which USAID's cooperating agencies specifically target or track results in cities separately from their national, district or regional results. Two of the strategies that USAID has supported heavily in recent years—community health planning and services (CHPS) and community health insurance—are now in the expansion phase, but not in urban areas. USAID could easily begin to address urban priorities in the PHN sector by making one or more of Ghana's cities a priority for its bilateral cooperating agency and/or PL480/PVO partners.

Other multilateral, bilateral and foundation-supported programs. With the exception of the large physical infrastructure projects funded by the World Bank, Danish Agency for Development Assistance (DANIDA) and DFID and the recently completed AMEHI funded by DFID, no other large urban health or environmental health programs receive bilateral or multilateral agency support. A new Bill and Melinda Gates Foundation-supported effort to improve the quality of products and services provided by chemical sellers is getting started in rural Ghana, but this initiative will not be implemented in urban areas. USAID cooperating agencies, United Nations Children's Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), and others do fund small-scale projects with nongovernmental organizations (NGOs) and private health providers in Accra and other cities. Examples of the relatively small, but community-focused contributions of the NGO sector include the programs of CENCOSAD and Ghana Red Cross in the slums of Accra and of CEDEP in Kumasi. ISODEC's advocacy work on behalf of the urban poor countrywide also is worthy of mention. In the past, a WHO-initiated Healthy Cities program was started with participation of multiple ministries and agencies, but this was said to have stalled because of its complexity.

Recommendations. Without a targeted effort to address the health implications of rapid urban growth, conditions in Ghana's cities will worsen. This fact, coupled with current inattention to urban poverty by the Government of Ghana and donor community, justifies increased attention to urban health in USAID/Ghana's new health strategy. Based on our analysis, the following urban public health priorities are recommended for USAID/Accra's consideration.

Priority 1. Raise awareness and increase national commitment to improved health and well-being for the urban poor.

Advocating and planning for activities in urban areas is difficult, because useful urban data are not available. Urban averages from studies such as the Ghana Demographic and Health Survey 1998 (GSS and Macro International 1999) and Ghana Youth Reproductive Health Survey (GSMF and others 2000) mask the situation of the poor. Also, the application of a single national poverty cutoff probably contributes to a serious underestimation of the numbers of urban women and children who are living on the brink of or in poverty. Even when data on the urban poor are available from studies such as the Ghana Living Standards Survey, Report of the Fourth Round (GSS 2000a) and Core Welfare Indicators Questionnaire Survey (GSS 2001), the indicators measured often have little public health significance. More data and more advocacy on behalf of the urban poor are sorely needed.

Priority 2. Reduce the cost of health care and improve health outreach in low-income urban communities.

The proportion of urban residents who sought public or private health care when they were sick declined significantly after introduction of user fees in all government health facilities in the 1990s. A national exemption policy mandates free care for paupers, the elderly, antenatal care patients and children under 5 years of age, but this

policy is implemented inconsistently from region to region. Preventive care (immunization and antenatal care) and community outreach to low-income sections of Accra and Kumasi are probably receiving less attention than they deserve. By simultaneously focusing on the costs of curative health care and improving community outreach, USAID has the opportunity to make a major difference in uptake by the urban poor and ultimately the effectiveness of available public health services.

Priority 3. Increase real (compared with theoretical) access to water and sanitation facilities in cities and improve the hygiene behaviors of the urban poor.

Only four of ten urban residents nationwide have piped water in their homes. In Accra, even fewer (7 %) have in-house piped water, and the water supply across the city is inconsistent. All urban residents pay for water, but for the poor, the cost of water purchased from vendors and neighbors can be as much as 20 times higher. Long queues, significant user fees and unhygienic conditions at public latrines make going to the toilet a daily problem for those living in urban slums. In Accra, more than half the population depends on public latrines. Solid waste disposal is another problem for the urban poor. Although progress has been made, municipal officials consider the cost of solid waste disposal to be one of the major challenges they face.

Priority 4. Curb the spread of HIV/AIDS and reduce unplanned pregnancies in adolescents and young adults.

Thirty percent of Ghana's population is between ten and 24 years of age. Age at first sexual intercourse and marriage are high in Ghana's cities, and HIV/AIDS prevalence is still low. Nonetheless, the young are particularly vulnerable to early and unwanted pregnancies and to HIV/AIDS. Current use of contraception is around 20% for both male and female adolescents in Ghana, but use of modern contraceptive methods is much lower. Awareness of HIV/AIDS appears to be almost universal among urban youth, but 90% of those who report using condoms say they do not use them every time. Because of their sheer numbers, Ghana's urban youth clearly deserve USAID's continued investment.

Priority 5. Increase the practice of family planning and use of modern contraceptive methods in the cities.

Ghana experienced a dramatic decline in total fertility rate (TFR) in the past decade, but this was not accompanied by a parallel increase in contraceptive prevalence. In fact, contraceptive prevalence among women of reproductive age changed little from 1993 to 1998 in Ghana's towns and cities. Use of any contraceptive method in urban areas stayed constant at approximately 30%, and use of modern contraceptive methods rose only slightly, from 16% to 17%. Two of 10 married women in both urban and rural areas expressed an unmet need for family planning. These facts demonstrate the clear need for increased attention to family planning promotion and services for all reproductive age groups in Ghana's urban areas.

Priority 6. Improve the effectiveness of urban malaria control efforts by identifying and targeting program interventions to the areas of Ghana's cities with highest malaria transmission.

Malaria is the number one cause of child mortality and morbidity in all age groups in Ghana's largest cities. The national Roll Back Malaria program is just getting off the ground and may need support from USAID in the future. Mass promotion and sales of insecticide-treated materials, including bed nets, will not be an effective strategy in the country's cities unless sales and subsidies are carefully targeted. Bed nets are currently expensive (approximately \$10 each)¹ and not likely to be purchased by those poor families that need them the most, unless special efforts are made. It might also be wise to target the current USAID-supported training of chemical sellers² to the areas of highest malaria transmission.

Priority 7. Tackle nutrition and food security issues among the urban poor.

Rates of stunting and underweight are similar for the urban poor and young children living in Ghana's rural areas. In the late 1990s, food insecurity affected one in four households with young children in Accra, and four in 10 households had less than 80% of their daily caloric requirement available. Rates of iron deficiency anemia are not available for the cities, but the prominent role that anemia plays in the large cities is clear from mortality and morbidity data. Studies indicate that improved care and hygiene at home can improve nutritional status. It is, therefore, recommended that urban health education programs focus on key nutrition and care-giving messages and that they be combined with poverty reduction and income-generating strategies whenever possible.

Options for USAID consideration. To address effectively one or more of the urban health priorities mentioned above, USAID might develop and support different types of activities. Suggested activities are organized below according to their comparative ease of implementation. The list begins with the easiest activities or those for which USAID already has technical competency on the ground and organizational relationships in place. The list ends with the most difficult activities or those that represent new areas of technical work for the PHN Office and/or new organizational relationships, including joint programming with other USAID sectors.

Option 1. Make evidence about the health needs of the urban poor more readily available to planners and policymakers.

USAID is in a position to make a significant contribution to the body of urban health knowledge by:

¹ In this report, dollar figures are U.S. dollars, unless otherwise noted.

² Chemical sellers are the most common private sector distributors of allopathic pharmaceutical products in urban Ghana; they are not professionally trained or recognized.

- Working with USAID's Measure/DHS project to be sure that the 2003 GDHS includes appropriate water, sanitation and hygiene indicators and permits analysis of key urban indicators as they reflect the status of the urban poor (feasibility: excellent, but implies added cost).
- Encouraging USAID partners, (cooperating agency and PL480/PVO) partners to disaggregate their program data (baseline, monitoring and evaluation) for urban and rural populations and, whenever possible by poor and urban-poor communities (feasibility: good).
- Supporting the strategic "packaging" and dissemination of policy-relevant information (feasibility: good, but requires urban health perspective and added costs).
- Establishing and providing support for an urban health working group with members from USAID, its current partners and outside resource persons (feasibility: good, could be done in conjunction with Mission's strategic planning with little additional investment)
- Commissioning secondary data analysis and/or new data collection in cities to paint a clearer picture of the health situation and the needs of the urban poor. (feasibility: more difficult, requires urban health perspective and investment of resources).
- Participating either directly or through its partners or the working group mentioned above on the "slum abatement" subcommittee that, according to the Ghana Poverty Reduction Strategy paper, is to be coordinated by MLGRD in 2003 (feasibility: depends on the Ghanaian government's attitude toward USAID participation).

At the global level, it also is recommended that EHP and USAID simultaneously lobby for a set of core urban health indicators and sampling methods that allow for disaggregation of urban findings by socioeconomic group. This would help make future urban health information collected in Ghana and elsewhere more relevant to the design and monitoring of new urban health programs (feasibility: good in the long term, difficult in the near future)

Overall feasibility: Excellent to difficult depending on the specific activities carried out, as shown above.

Option 2: Encourage USAID partners to work, track and report their results in urban areas.

USAID partners currently work across all of the priority public health interventions above, but only in a few cases are they working in urban areas. No case was found in which USAID's cooperating agencies specifically target or track results in cities separately from their national, district or regional results. By making one or more of

Ghana's cities a priority for its partners, USAID could easily begin to address urban priorities in the PHN sector. USAID's partners could be required to formulate results statements and set targets for the urban health, nutrition, population and HIV/AIDS improvements they intend to achieve. They also might be involved in joint programming with other cooperating agencies, PL480 partners, or USAID sectors to address multiple needs (e.g., sanitation, adolescent reproductive health, family planning, malaria control, nutrition and food security) in one or more of Ghana's fast-growing cities.

Feasibility: Excellent.

Option 3: Adapt, test and expand an urban Community Health Planning and Services (CHPS) model.

The CHPS program involves communities in planning and monitoring their own health actions. It trains and posts community health officers in rural communities; they, in turn, provide primary reproductive, child and adult health services. The CHPS model has been effective in expanding the coverage of primary reproductive health services in hard-to-reach areas. Considerable interest now exists in testing CHPS or something like it in urban areas, but also big questions remain about its applicability. Under this option, USAID would work with GHS and metro or municipal health teams to adapt and test the current CHPS model in several cities. After a defined period of time, stakeholders and beneficiaries would evaluate the urban adaptation and decide on replicating it in other settings. The technical capacity and/organizational arrangements required to carry out this type of activity are already in place. Also, the health teams in Accra, Kumasi, and several other predominantly urban districts have recently initiated CHPS-type interventions without donor support. The lessons learned at these sites could help guide development of the urban CHPS model.

Feasibility: Excellent.

Option 4: Adapt, test and support the community or mutual health insurance scheme in several cities.

National health insurance will help to rationalize the cost of basic health care, but because it is to be implemented under the social security system, it will, at least initially, benefit only those employed in the formal sector. The community or mutual health insurance model may be more appropriate for urban settings, where most residents are self-employed. Mutual health insurance has proved successful in Ghana's rural communities and is currently in the expansion phase, but no standardized approach exists for urban areas. Definition of "community" may be the first issue to deal with in urban areas, as the natural boundaries that define rural settlements are not always useful in complex city neighborhoods. At present, MOH/GHS and DANIDA are providing the bulk of what is required to expand the community health insurance scheme to forty districts across the country and USAID is providing technical assistance to this activity. Although this is again a rural model,

at least two community health insurance schemes have been started in which urban associations have taken the place of rural "communities." The lessons learned in these two cases should be applied during the adaptation process.

Feasibility: Excellent.

Option 5: Support active community involvement in planning for environmental health improvements in urban slums.

The decentralization strategy adopted by the Government of Ghana calls for the active involvement of community residents and town councils in district/metro assembly planning, including their planning for environmental improvements. Ministry, municipal and donor representatives unanimously state that this process is not working as planned. USAID assistance would, therefore, bring community members, area health workers, municipal officials (engineers, environmental health officers, waste management staff and planners) and submetro politicians together to assess existing environmental conditions in urban slum areas and identify needed improvements. USAID might work through a Ghanaian NGO or group of NGOs and MLGRD to provide this type of assistance. To be most effective, this activity should be linked to actual resources for water sanitation and other environmental improvements, such as those that might be offered through a community loan fund (option 6) or an urban infrastructure project. It could be implemented as part of the urban CHPS approach (option 4), or it could be offered in cities that are already implementing World Bank infrastructure projects by working through MLGRD and the relevant metro or district assemblies.

Feasibility: Good, but would require the active involvement of and USAID's interaction with multiple governmental and nongovernmental organizations.

Option 6: Establish a loan program for community sanitation and health improvement in urban areas.

USAID might work with a Ghanaian NGO (or a PL480 PVO or a USAID cooperating agency) and a local bank to establish a program that provides loans and technical assistance to local entrepreneurs and community-based organizations (CBOs) in poor urban neighborhoods. Such a program would mobilize group savings plans with CBOs and provide complementary loans to urban and periurban entrepreneurs that permit them to establish, own and operate new initiatives-or improve and expand existing small businesses-that better living conditions and provide essential services in urban slum areas. Types of community businesses eligible for support might include public toilets and showers, garbage collection schemes, composting or recycling of community wastes, residential latrine or toilet construction, food catering services and so on. The technical expertise required for this effort may or may not be available through USAID's existing PVO and cooperating agency partners. Several are working on water and sanitation in rural areas and several have microcredit or small business development funds that they have set up or are helping to administer; however, none appears to be working in cities at the present time.

Feasibility: More difficult, but worth serious consideration.

Option 7: Provide technical assistance to Roll Back Malaria and selected cities for the development and implementation of urban malaria control strategies.

USAID may wish to offer technical assistance to MOH's Roll Back Malaria program. Such technical assistance would begin with an analysis of urban malaria cases to determine how many are actually malaria and how many are not and what proportion are locally transmitted compared with imported cases. Subsequent assistance might be directed toward helping cities identify breeding sites that are amenable to elimination or reduction and assisting metro or district health teams to improve their targeting of urban malaria control interventions. USAID is already supporting Roll Back Malaria by supporting the integrated management of childhood illness (IMCI), training of chemical sellers to dispense malaria medications, and promotion and sale of insecticide-treated bed nets. More careful tailoring of these strategies to urban needs is advisable. EHP is willing to assist USAID in mobilizing the technical expertise for this option, but more exploration of the need and determination of MOH/GHS interest in this type of technical assistance will be required before proceeding.

Feasibility: Currently unknown.

Option 8: Establish a citywide action network or coalition involving local NGOs, CBOs, the private sector, and government to coordinate, expand and improve urban health interventions.

Sustained urban health improvement requires the coordinated effort of different governmental and nongovernmental organizations, as well as the active involvement of the urban poor. Citywide health networks that engage local government, community-based and a variety of service organizations have been used successfully in other settings to stimulate and coordinate urban health actions. Networks could be formed in Ghana's cities with equal effect to expand or improve the quality of reproductive health services for urban youth, address the causes of child malnutrition and food security, promote community involvement and ownership of urban water and sanitation solutions, improve malaria control or replicate many other urban health interventions. Programs that work through urban networks or coalitions often include small grants to stimulate innovation and encourage expansion of existing services. Technical assistance inputs to upgrade the skills of coalition members and the quality of their work also are a common feature. If the decision is made to work with or through citywide coalitions of this type, USAID should understand that forming such groups requires an initial investment of time and resources. Technical assistance or implementing organizations with vision and strong community and facilitation skills also are an imperative. Most importantly, city health networks should be seen as the means to achieving public health impact and not ends in themselves.

Feasibility: More difficult, but well worth consideration if USAID decides to target one or more cities for work on more than one health priority.

Option 9. Support a program to improve the quality of products and services provided by chemical sellers and pharmacies in Ghana’s largest cities.

The franchising of chemical sellers by GSMF addresses serious issues of access, quality, and cost of medicines—issues that affect both urban and rural residents. Because of the heavy concentration of pharmacies in urban areas and stiff opposition from the pharmacy association, there are currently no plans to implement the franchising scheme in Ghana’s cities. This is unfortunate, but there may also be a valid argument for a different approach in urban areas, one that includes attention to pharmacies as well as chemical sellers. The urban poor rely on the services of both, the advice and products that both provide are deficient, and their prices nationwide also are comparable. Implementation of this option would begin with an assessment of the health seeking behavior of the poor in one or more of Ghana’s cities, plus secondary analysis of existing urban data to determine the specific roles that chemical sellers and pharmacies play, the costs of their services and their knowledge of the health conditions they see and the medicines they dispense. USAID would then support specific interventions to improve the quality of treatment provided by chemical sellers or, if appropriate, by both pharmacies and chemical sellers in urban settings. Inputs might include training and job aids to improve prescribing practices; an expanded line of pre-packaged medicines available at low cost through GSMF; counseling and marketing materials. As it progresses and begins to show results, operations research to test urban variations on the rural franchising scheme might also be included.

Feasibility. The franchising of urban chemical shops is not possible at the present time. However, similar training, social marketing and other inputs might be feasible if offered to pharmacies and chemical sellers to improve the quality of their products and services.

The following table relates each of these activities and project options to one or more of the public health priorities suggested earlier. This is not meant to be an exhaustive list, but it is hoped one that will provide USAID/Accra with food for thought and stimulate further investigation as the Mission moves forward with development of a new strategic plan. Priorities and activity options have been written so that, if the Mission chooses, they might be included as intermediate results, sub-results, and/or actions in the new PHN strategic framework.

Urban Priorities	Options for USAID's Consideration
<p>Priority 1: Raise <i>awareness</i> and increase the <i>national commitment</i> to improved health and well-being for the urban poor.</p>	<p>Option 1: Make <i>evidence</i> about the health needs of the urban poor more readily available to planners and policymakers</p> <p>Option 2: Encourage <i>partners</i> to work, track, and report their results in urban areas</p>
<p>Priority 2: Increase real (compared with theoretical) access to <i>water and sanitation facilities</i> in cities and improve the <i>hygiene behaviors</i> of the urban poor.</p>	<p>Option 5: Support active <i>community involvement in planning</i> for environmental health improvements in urban slums. (Also link community planning to Option 3: Adapt, test, and expand an <i>urban CHPS</i> model)</p> <p>Option 6: Establish a <i>loan program for community sanitation and health improvement</i> in urban areas.</p> <p>Option 8: Establish a <i>citywide action network or coalition</i> involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health interventions (focus on water and sanitation)</p> <p>Option 2: Encourage <i>USAID partners</i> to work, track, and report their results in urban areas (involve partners working on water and sanitation, urban planning, education, democracy and governance)</p>
<p>Priority 3: Reduce the <i>cost of health care</i> and improve <i>health outreach</i> in low-income urban communities.</p>	<p>Option 3: Adapt, test and expand an <i>urban CHPS</i> model</p> <p>Option 4: Adapt, test, and support the <i>community or mutual health insurance</i> scheme in several cities.</p> <p>Option 9: Support a program to improve the quality and reduce the costs of products and services provided by <i>chemical sellers and pharmacies</i> in Ghana's largest cities (all public health-related products).</p> <p>Option 2: Encourage <i>USAID partners</i> to work, track, and report their results in urban areas.</p>
<p>Priority 4: Curb the spread of HIV/AIDS and reduce unplanned pregnancies in <i>adolescents and young adults</i>.</p>	<p>Option 2: Encourage <i>partners</i> and their NGO partners to work, track, and report their results in urban areas (include partners working on adolescent health and development, education, and HIV/AIDS)</p> <p>Option 8: Establish a <i>citywide action network or coalition</i> involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health (adolescent reproductive health and HIV/AIDS) interventions.</p>

Urban Priorities	Options for USAID's Consideration
<p>Priority 5: Increase the practice of <i>family planning</i> and use of modern contraceptive methods in the cities.</p>	<p>Option 2: Encourage <i>USAID partners</i> (and their NGO partners) to work, track, and report their results in urban areas (include partners working on CBD, social marketing, clinical RH services, RH training, etc.).</p> <p>Option 8: Establish a <i>citywide action network or coalition</i> involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health (family planning) interventions.</p>
<p>Priority 6: Improve the effectiveness of <i>urban malaria control</i> efforts by identifying and targeting interventions to the areas of Ghana's cities with highest malaria transmission.</p>	<p>Option 2: Encourage <i>USAID partners</i> and their NGO partners to work, track, and report their results in urban areas (include partners promoting insecticide treated bednets, water and sanitation, and urban agriculture)</p> <p>Option 7: Provide technical assistance to Roll Back Malaria and selected cities for development and implementation of urban malaria control strategies.</p> <p>Option 8: Establish a <i>citywide action network or coalition</i> involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health (malaria control) interventions.</p> <p>Option 9: Support a program to improve the quality and reduce the costs of products and services provided by <i>chemical sellers and pharmacies</i> in Ghana's largest cities (focus: antimalarials and insecticide-treated bednets).</p>
<p>Priority 7: Improve <i>nutritional status and food security</i> among the urban poor.</p>	<p>Option 2: Encourage <i>USAID partners</i> and their NGO partners to work, track, and report their results in urban areas (include partners working on nutrition and micronutrients as well as economic sector partners working on microcredit, microenterprise, vocational training, urban agriculture, and so on)</p> <p>Option 8: Establish a <i>citywide action network or coalition</i> involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health (nutrition and food security) interventions.</p> <p>Option 9: Support a program to improve the quality and reduce the costs of products and services provided by <i>chemical sellers and pharmacies</i> in Ghana's largest cities (focus: micronutrients).</p>

1. Background: Urbanization, Poverty and Health

Experts predict that the economic, social and political factors that drive urbanization will continue until the majority of people in most countries are living in urban areas (Hardoy, Cairncross, and Satterthwaite 1990). In some of the world's largest cities, the poor already make up more than half the population, and their numbers are growing faster than those of other groups.

Until the mid-1990s, neither national policymakers nor international assistance agencies gave high priority to urbanization or urban poverty in Sub-Saharan Africa. To some degree, this made sense: rural populations greatly outnumbered urban in all but a few countries, and their much lower health and development indicators tended to justify a predominantly rural development approach. The new millennium, however, has brought increasing recognition of changes in the population structure of Sub-Saharan Africa and the need to pay more attention to the health and development needs of the urban poor.

Less than 20% of Ghana's population lived in cities and towns in 1970; today, 44% are urban residents. The country's two largest cities, Accra and Kumasi, have more than doubled in size since the 1984 census. Although still relatively small when compared with megacities in Asia, Latin America and other African countries, such as Nigeria, the rapid growth of Ghana's cities has strained the ability of its national and local governments to meet the basic health and development needs of urban residents. If growth continues at the same level as in the 1990s, the urban population may well double again within the next 20 years.

Urban areas often look good on paper. Statistics suggest that those living in large cities are better off and have more services than anyone else in the country. These numbers, however, conceal the large disparities found in most urban areas because the poor and their unmet needs are lost within per capita averages. Just as families living in an alley are hidden behind modern, multistory office buildings, the poor and destitute are hidden behind the wealth and well-being of a city's rich and middle class.

Standard population-based surveys mask the true situation in urban areas, and disaggregated data for the urban poor are too often not available. Because few public health projects have targeted Ghana's cities for study or intervention in the past decade, determining exactly where the urban poor reside, what their most pressing public health problems are, and how best to reach and help them solve those problems remains a challenge.

The Environmental Health Project (EHP) of the U.S. Agency for International Development (USAID) is studying urban poverty and supporting community-based and policy-related interventions in a number of the world's largest cities—e.g., Indore, India; Cairo, Egypt; Lima, Peru. USAID/Ghana asked EHP to undertake the assessment reported on here as part of the project's ongoing urban environmental health effort. USAID/Ghana and the USAID/Washington Bureaus for Africa, Population, Health and Nutrition (PHN), and Economic Growth, Agriculture and Trade EGAT/UP funded the effort, which was directed by the EHP Cognizant Technical Officer, with input from the agency-wide Urban Health Task Force.

2. Purpose and Scope of Work

The purpose of this assessment is to provide information about the country's urban health situation and to make related programmatic recommendations to USAID/Ghana's PHN office. This effort is part of PHN's preparation for the Mission-wide strategic planning process that began in the fall of 2002.

2.1. Team Composition

A four-person team fielded by EHP conducted the assessment during July 8–24, 2002, in Ghana. The team included two international and two Ghanaian consultants. Team members included Joan A. M. Awunyo-Akaba, an experienced community health nurse and water supply expert; John K. B. Nelson, an urban planner with environmental health and waste management experience; Carla Rull Boussem, a public health specialist and senior development planner; and Patricia Taylor, a public health specialist and health planner with many years of USAID program design and management experience. Ms. Taylor served as the team's leader.

2.2. Objectives

The objectives of this mission, as specified by USAID and EHP, were to:

- Assess the health needs of the urban poor in Ghana.
- Develop recommendations on possible USAID interventions serving this population.
- Develop a model approach for similar urban health assessments to be conducted elsewhere in the developing world.
- Make recommendations on data collection that specifically target the urban poor and communicate with Measure/DHS about the possibility of over sampling urban poor populations during the 2003 and later Demographic and Health Survey (DHS). Begin similar discussions with the United Nations Children's fund (UNICEF) related to Multiple Indicator Cluster Survey.

As specified in the scope of work, the assessment focused on Ghana's two largest cities—Accra and Kumasi. The assessment team reviewed national policies and programs affecting the urban poor and used a variety of data sources and key informant interviews to describe the situation in Ghana's principal cities in relation to child health, maternal and reproductive health, HIV/AIDS, adolescent health, malaria, and water and sanitation. The EHP team also:

- Identified existing programs and community structures that are serving or might serve as platforms from which to launch urban health interventions
- Assessed intergovernmental roles and responsibilities for health-related service delivery in Ghanaian cities
- Investigated the roles played by private (including mutuelles and local healers) and public health service providers and nongovernmental organizations (NGOs) in delivering health services to the urban poor
- Documented the current involvement of USAID and its cooperating agencies and of other bilateral and multilateral donors in urban health.

Given the breadth of the investigation requested, EHP and USAID agreed that the time allowed would not permit development of a model approach to urban health assessments. Instead, the team agreed to document the approach used in Ghana and make recommendations for future assessments of this type (PSC1) at a later time. Annex 1 includes the full scope of work.

2.3. Process

Before the assessment, the two external consultants participated in a two-day team planning session at EHP headquarters in Rosslyn, Va. A similar planning meeting was held in Ghana during the team's first full day together in the country. USAID scheduled initial meetings with Ministry of Health (MOH) officials, and all other meetings and site visits were scheduled after the team's arrival in the country.

To cover adequately the multiple technical areas and interview the large number of individuals and organizations identified in Accra and Kumasi, the team split itself into two-person subteams after the first day of visits at the national level. Activities in Ghana included:

- Briefings with USAID/Accra, including PHN team members Filomena Maxwell (child health), Jane Wickstrom (reproductive health), Lawrence Darko (population), and Julianna Pwamang (HIV/AIDS), and Art Dannard, the acting PHN officer. The team also met separately with the newly appointed PL480 manager, Andrew Krefft.
- Collection and review of available literature and data on urban health (see the notes on literature and data below).
- Meetings with key government officials in Accra and Kumasi (MOH, GHS, Ministry of Local Government and Rural Development (MLGRD), Accra Metro Assembly, Kumasi Metro Assembly, and Community Water and Sanitation Agency).

- Interviews with representatives and program officers of various multilateral and bilateral agencies (including the World Bank, World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), Danish International Development Agency (DANIDA), Great Britain's Department for International Development (DFID), and Japan International Cooperation Agency (JICA).
- Interviews with USAID's cooperating agencies: John Hopkins University/Center for Communications Programs (JHU/CCP), Ghana Social Marketing Foundation (GSMF), Planned Parenthood Federation of Ghana (PPAG), Centre for Development and Population Activities (CEDPA), and the Linkages, Basic Support for Institutionalizing Child Survival II (BASICS II), Performance of Primary Providers in Reproductive Health (PRIME II), Family Health International, and Policy projects.
- Site visits and interviews with NGOs and community organizations in Accra and Kumasi [Centre for Community Studies, Action, and Development (CENCOSAD), Ghana Red Cross, Ghana Registered Midwives Association (GRMA), and the Integrated Social Development Centre (ISODEC) in Accra and the Centre for Development of People (CEDEP) and the Muslim Youth Training and Counseling Center in Kumasi].
- Site visits to government and NGO health facilities (Maamobi Polyclinic, PPAG "Young and Wise" center/clinic, the Salvation Army UrbanAid Clinic in Accra, the Bantama Submetro Hospital, and an HIV/AIDS program for commercial sex workers in Kumasi.).
- Interviews with Ghanaian researchers (Dr. Sam Adjei, Ghana Health Services (GHS) and Health Research Unit; Dr. Margaret Armar-Klemesu and Dr. E. E. K. Takyi, Noguchi Memorial Institute for Medical Research; and Dr. Richard Bwitrum, Community Health Department of the University of Ghana Medical School).
- A focus group with Ghanaian NGOs, organized by Ghana HIV/AIDS Network (GHANET), a loosely associated group of seventeen NGOs working on HIV/AIDS issues. During this session, participants described life in the poor urban communities where they work and stated their priorities for HIV/AIDS for the next decade.
- Review of findings and development of recommended strategies. The team spent the equivalent of two working days in Ghana reviewing findings, discussing recommendations and writing up a preliminary summary for USAID/Accra.
- A debriefing with the USAID PHN team took place on July 24, 2002. Filomena Maxwell and Jane Wickstrom were present; other PHN team members were out of Accra or the country. A summary of team findings and recommendations guided this debriefing and was left with the Mission.

See Annex 2 for a complete list of those interviewed during the assessment along with their contact information.

After the assignment in Ghana was completed, team members continued to work together via e-mail on this report and produced a PowerPoint presentation. The team leader debriefed at USAID/Washington on August 8 and then incorporated comments and suggestions from both the in-country and Washington debriefings in the findings and recommendations reported below.

2.4. Literature and Data Review

The collection and review of published and unpublished studies and reports, which began in the United States and continued throughout the mission, was not completed until the external consultants returned to the United States and Tunisia. This was an extremely useful and time-intensive part of the assessment because of the wealth of information available for review.

As shown in the box below, a number of nationally representative population-based studies took place in Ghana between 1997 and 2000. Of these, four present findings for total urban and rural populations: Ghana Demographic and Health Survey 1998 (GDHS), Ghana Living Standards Survey (GLSS 4), Ghana Youth Reproductive Health Survey (GYRHS), and the Core Welfare Indicators Questionnaire Survey 1997 (CWIQ). The GLSS 4 presents some estimates for Accra urban, other urban, and total urban residents separately and the CWIQ presents a subset of its findings for urban poor and non-poor subgroups. (See Chapter 5 on data issues for further description and analysis of the indicators and information available from these four national studies).

Key Documents Reviewed

National Surveys and Reports

- *Ghana Poverty Reduction Strategy 2002-2004 (GPRS) (Ghana 2002)*
- *2000 Population and Housing Census (2000 census) (GSS 2002a and b)*
- *Ghana Living Standards Survey, Report of the Fourth Round (GLSS 4) (GSS 2000a)*
- *A Profile of Health Inequalities in Ghana (Bosu, Nsowah-Nuaman, and Ward 2000)*
- *Ghana Youth Reproductive Health Survey Report (GYRHS) (GSMF and others 2000)*
- *Ghana Demographic and Health Survey 1998 (GDHS) (GSS 1999)*
- *Core Welfare Indicators Questionnaire Survey (1997) (CWIQ) (GSS 2001)*
- *Various baseline studies*

Accra and Kumasi Studies and Reports

- *Urban Livelihoods and Food and Nutrition Security in Greater Accra, Ghana, International Food Policy Research Institute (IFPRI), Noguchi Memorial Institute for Medical Research, WHO (Maxwell and others 2000)*
- *An Analysis of Intra-Urban Mortality Differentials Using Existing Data. Collaborative Studies in Accra, Ghana and São Paulo, Brazil and Analysis of Urban Data of Four Demographic Health Surveys (Stephens and others 1994)*
- *Environment and Health: The Case of Greater Accra Metropolitan Area (Songsore 1992)*
- Regional and metropolitan health team annual reports for 2001
- MOH/GHS, Health Management Information System data base of outpatient statistics for Accra and Kumasi, 2001
- Study of urban immunization in one submetropolitan area of Accra (Gyapong and others 1999)

The recent publication of the Ghana Poverty Reduction Strategy 2002–2004 (Ghana 2002) provided useful secondary data and interpretation as well as a good sense of the priorities that have been set at the national level for future government investment.

The document *A Profile of Health Inequalities in Ghana* (Bosu, Nsowah-Nuaman, and Ward, September 2000) was also a useful source of information and one that clearly influenced both the GPRS and the MOH's Five-Year Programme of Work, 2002–2006, published in early 2002.

Most useful of all of the studies were those pertaining to urban Accra. Unlike the national studies, these were in-depth investigations designed to identify risk factors and establish associations between the living conditions and socioeconomic characteristics of the city's population and their health and nutritional outcomes. The assessment carefully reviewed studies by Maxwell and others (2000), Stephens and others (1994), Songsore (1992) and Songsore and McGranahan (1993). The analysis that follows cites them frequently.

3. Findings

This chapter discusses demographic and socioeconomic trends as well as health status and related environmental and socioeconomic conditions in Ghana's urban areas and highlights a number of public health issues of primary concern. The chapter also describes the various government, bilateral, multilateral, and private programs that serve Ghanaian poor. The assessment based its findings on a review of population-based studies, policy documents and reports and on the many interviews conducted during the assessment.

3.1. Demographic and Socioeconomic Trends

The following sections describe Ghana's towns and cities and the characteristics of its urban residents.

Demographic Trends

At the time of the 2000 population and housing census (GSS 2002b), Ghana had 18.9 million inhabitants. Fifty-six percent lived in rural and 44% or more than 8.3 million people lived in urban localities.³

Ghana's urban population more than doubled in absolute terms in the 16-year period before the 2000 census. Although the country's rural population also increased during this period, the proportional increase (27%) represents only about a quarter of that in urban areas.

Greater Accra, on the southern coast of the country, is the most urbanized of Ghana's ten regions. Eighty-eight percent of its 2.9 million people live in what is termed "urban Accra," which includes Metro Accra and large parts of the districts and municipalities of Madina,



³ "Urban" describes settlements of more than 5,000 inhabitants.

Aishaiman, Tema, Tema Newtown, and Ga. Metro Accra alone contained an estimated 1.6 million residents in 2000, and many believe that this was an underestimate.

The country's most populous region, Ashanti, is now 51% urban. Its largest city, Kumasi Metro, and its second largest, Obuasi, have respectively 1.2 million and 150,000 inhabitants. Like Accra, the populations of Kumasi and Obuasi more than doubled between the 1984 and 2000 censuses.

Ghana's two largest cities—Accra and Kumasi—include 3.7 million people or 45% of Ghana's total urban population. Only two other cities in the country boast populations of more than 200,000—Sekondi-Takoradi (population 289,620) in the Western Region and Tamale (population 202,317) in the Northern Region. Ghana's other main urban localities still have relatively small populations, ranging from 43,000–87,000 inhabitants (GSS 2002a).

The Role of Internal Migration

Life in the rural area is sweet, but city life is modern, children can "go anywhere" in their lives.

—*Woman in a Kumasi slum*

Analysis of the 2000 census shows that Ghana's urban growth has resulted more from migration than natural increase (GSS 2002b), although both have played a role. Accra and Kumasi are not only the largest, but also the fastest-growing cities in the country. They attract migrants from all parts of Ghana who come in search of work, education and trade. As in many countries, the belief that life in the city will be better for their families than in rural areas is one of the driving forces behind Ghana's internal migration.⁴

Early migrants to Accra and Kumasi were mainly Muslims from the north, but people from all ethnic groups and all parts of Ghana are now moving into the main cities. New arrivals to Accra often start urban life in the inner, poor and overcrowded sections of cities. As a result, the indigenous Ga community, which is also growing, finds itself squeezed between the expanding bulk of the city and the sea as immigrants from other ethnic groups move in, attracted by the neighborhood's affordability and opportunities to ply their trades (e.g., petty trade or fishing) near the city's center or its harbor. The core of Accra is crumbling, city services are overstretched and deteriorating, and day-to-day life takes more and more effort. Those who cannot find a way out are left with few options to better their lives.

Accra and Kumasi also continue to spread out geographically as new periurban communities spring up, subsuming agricultural areas in the process. As a result,

⁴ A 1995 migration study conducted by the census bureau found that the availability of social services was not a factor "pulling" migrants to cities in Ghana. The argument then that making such services available in urban slum areas will only serve to encourage more migration is not valid in Ghana.

agriculture as a source of livelihood in these areas is increasingly vulnerable (Maxwell and others 2000) and urban residents must seek work in other trades. Both cities also receive considerable numbers of day workers who live outside the city. Although official numbers do not exist, the mayors of both cities recognize that the needs of these daily visitors are affecting already overstressed city services.

Crowding, Housing and Public services

High density alone is nothing to worry about, but when it is joined with lack of amenities and badly maintained homes . . . then it is something to worry about.

—Elderly woman interviewed in 1992 study (Nyarko and others 1992)

Increased population density in inner cities inevitably leads to diminished accommodations and services. When housing, water, sanitation and other public services do not meet the needs of large numbers of urban residents, as is the case in Accra and Kumasi, their health and well being are at risk.

Stephens and others (1994) traced the steadily increasing density of Accra using published reports from the mid-1960s until the 1980s. In 1960, the city's mean density was 36 persons per hectare; by 1970, it had increased to 50.8 per hectare; and in 1984, it was estimated to be 69.3 per hectare. These averages are significant, but they also mask even more significant differentials among urban neighborhoods. For example, the density in Accra New Town had already reached 370 per hectare by 1984. Continuing urbanization since then has made this and several other areas in Accra and Kumasi extremely congested.

In most poor urban neighborhoods, multiple unrelated families rent rooms in houses. In 1992, in low-income areas of Accra, from four to seven families lived together in each house and nearly half the families in the city (46.3%) lived in only one room each. Even in areas defined as middle class with only medium density, overcrowding within houses was common. Although no studies document density and living conditions since 1992, long-time residents of the most densely populated urban areas in both Kumasi and Accra say their neighborhoods are more crowded now than ever before.

Projected Urban Growth

Figure 1 illustrates what growth in Ghana's larger cities could mean for its already vulnerable urban population. To construct this figure, growth rates reported by the GLSS 4 were applied to census data and a straight-line method of calculation was used to estimate annual populations through the year 2020.⁵ Although admittedly an imperfect method for projecting population growth, the figure demonstrates how higher urban growth rates might affect the size of urban and rural populations in future years.

Figure 1: Urban/Rural Population Projections 1970–2020

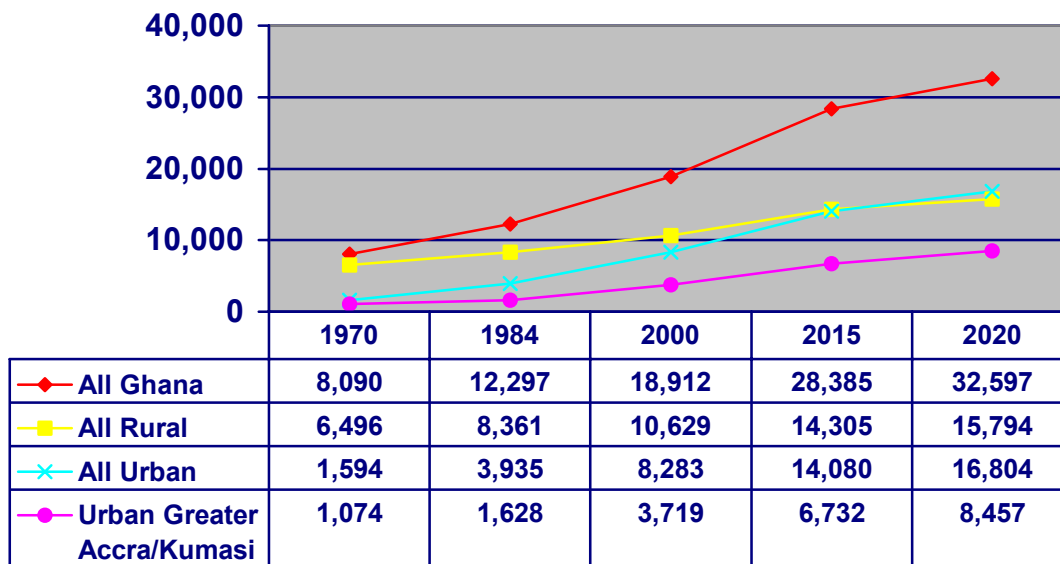


Figure 1: Urban/Rural Population Projections 1970–2020

At the rates applied:

- Ghana's urban and rural populations become equal in size by 2015, at around 14 million each.
- Greater Accra and Kumasi maintain their positions as Ghana's two largest cities well into the next decade.

⁵ Official population projections for Ghana and its largest cities could not be found. The average annual growth rate between the 1984 and 2000 censuses was estimated at 2.7% for Ghana, 4.4 for Greater Accra, and 3.4 for the Ashanti region (GSS 2002a). The growth rates implied in the GLSS 4 were slightly higher: 2% for rural areas and 3.6% for urban areas overall (5.3% for Accra and 3% for other urban areas). The GLSS 4 estimates have been used in this analysis; as a specific growth rate for Kumasi was not available, the rate for other urban areas was used.

- Ghana's rural population increases by a little more than 50% in absolute terms by 2020.
- On the other hand, the urban population more than doubles during the same period.

Even if lower growth rates are achieved, rapid urban growth is likely to continue to put extreme pressure on national and city governments, severely stretching their capacity to provide even basic services to the growing numbers of Ghanaians living in cities.

Urban Poverty

According to the GPRS, real per capita income in Ghana is less today than at independence, 44 years ago.⁶ High inflation, slow growth, persistent deficit spending by the government, and fluctuation in the prices paid for Ghana's primary exports on the global market are blamed for the country's current economic crisis (Ghana 2002).

Given this situation, it is somewhat surprising that official estimates (see Table 1) show poverty rates falling from one-half in 1991–92 to two-fifths of the population in 1998–99.⁷ These same estimates also indicate that urban poverty has fallen, from 27.7% to just under 20% during this period, and that there have been reductions in poverty in all urban and rural zones except the urban savannah. Although rural poverty declined more than urban poverty during this period, its depth seems to have increased. This means that at the time of the GLSS 4, the very poor in Ghana's cities were benefiting less from economic improvements than were those with per capita consumption closer to the national poverty line of 900,000 cedis per year (Ghana 2002 and GSS 2000).

⁶ Mean annual consumption in Ghana was just under 1 million cedis per capita in 1998-99 and consumption in urban zones (1.4 million cedis per year) was almost exactly double that in rural areas (GSS 2000a).

⁷ Prior to the GLSS 4, Ghana's national poverty line was defined as two-thirds of the mean national per capita income, measured by consumption. Ghana Statistical Service established new poverty lines for the GLSS 4 based on adult nutritional requirements and on what it cost at the time of the study to meet them. A lower line of 700,000 cedis per adult per year (\$292 at the time of the GLSS 4) defined extreme poverty, and an upper line of 900,000 cedis per adult per year (\$375) defined poverty.

Table 1. Poverty by Location 1991–92 to 1998–99 (percent of population with consumption less than 900,000 cedis per adult equivalent per year)

	1991–1992	1998–1999
Accra (metro assembly area)	23.1	3.8
Urban coastal	28.3	24.2
Urban forest	25.8	18.2
Urban savannah	37.8	43
Rural coastal	52.5	45.2
Rural forest	61.6	38
Rural savannah	73	70
All urban	27.7	19.4
All rural	63.6	49.5
All Ghana	51.7	39.5

Sources: GLSS 3 and GLSS 4 data as shown in *Poverty Trends in Ghana in the 1990s* (GSS 2000b).

Poverty measurement is an evolving science, particularly in large urban centers. It is important to note that the official rates above are based on a greatly improved, but still conventional consumption-based method of poverty estimation that, experts agree, probably greatly underestimates the magnitude of urban poverty (see Chapter 5 on data issues). The World Bank, DFID and others now argue for the use of noneconomic indicators along with conventional consumption data to quantify and understand urban poverty (Satterthwaite 1997, Wratten 1995, Baharoglu and Kessides 2001, Hentschel and Seshagir 2000).

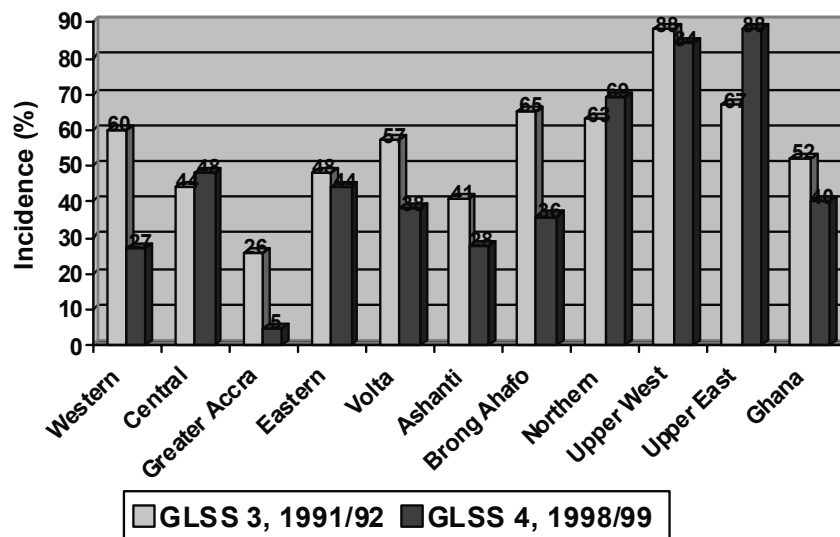


Figure 2: Poverty Incidence by Region 1991–92 and 1998–99

Source: Ghana 2002

During this assessment, the consumption-based poverty findings for Accra and for urban Ghana overall raised questions. Given what is known about the national economy and the effect that structural adjustment had on employment opportunities in the 1990s, the more than 80% decrease in poverty reported for Accra Metro Assembly area (see Table 1) and Greater Accra region (see Figure 2) seems unreasonable. Changes in the methodology used in the GLSS 4 (i.e., changes in methods used to measure consumption, determine the cost of adult-equivalent nutritional units, index the costs of living in different settings, and so on) may have biased the poverty comparison in relation to urban areas and to Greater Accra, in particular. If this is the case, because Accra is home to at least one-quarter of the country's urban population, its rate may be pulling down the overall urban poverty rate. At a minimum, this issue deserves additional study; because if poverty rates for Accra, Kumasi and the other large urban areas are not correct, the size of the urban poor population will continue to be underestimated and neglected in future policy debate.

In addition to household consumption, Maxwell and others (2000) measured childhood malnutrition, food insecurity and informal sector labor rates in Accra. All of these might be considered better indicators of urban poverty than the proportion of the population falling below the conventional consumption-based poverty line. Significantly, all were considerably higher than the official 4-5% poverty estimate based on GLSS 4 data. Fifteen percent of the children surveyed, for example, were underweight and 17% were stunted. Moreover, food insecurity affected more than 23% of all households with young children, and fully 40% of these households consumed less than 80% of daily calorie requirements. Informal sector employment in Accra, with its inherent low wages and insecurity, had also jumped dramatically from two-to-one in 1980, five-to-one in 1990, and finally seven-to-one in 1998. GLSS 3 and 4 data show a similar trend in informal sector, nonagricultural self-employment, which grew during the 1990s in all urban localities as low-level government jobs were eliminated, urban populations continued to grow, and job creation in the formal sector failed to keep pace.

Gender Differences in Employment and Income

Intense economic pressure in urban areas affects girls and women differently than it does boys and men. Table 2 shows that although equal proportions of men and women in urban localities across Ghana work (77.5% male and 75.5% female)⁸, men are three times more likely than women to be employed for wages, and women are twice as likely as men to be self-employed or employed in the informal private sector. It also shows that girls in urban localities begin to work at a younger age and continue until later in life than either their urban male or rural female counterparts. This is particularly true in Accra, where more than 90% of girls are economically active by

⁸ Unemployment and underemployment in urban localities are also significant; however, at 22.5% for women and 24.1% for men, gender differences are minimal. Likewise, there are no significant differences by rural or urban location in unemployment and underemployment.

fourteen years of age and far fewer girls than boys are enrolled in secondary education. Older women in Accra also are more likely to continue working after 65 years of age than women or men in any other urban or rural category (GSS 2000a).

Table 2. Gender Differences in Labor and Income by Location (percent)

	Accra		All Urban		Rural	
	Female	Male	Female	Male	Female	Male
Economically active						
All > 7 yrs of age	77.7	79	75.5	77.5	76	79.2
< 14 yrs of age	93.2	47.9	32.6	18	29.7	26.9
> 65 yrs of age	92.7	62.7	76.4	73.9	79	78
Adult literacy	66	84	55	78	27	57
Unemployed or underemployed			22.5	24.1	19	20.1
Wage employment			12.5	42.4	3.3	14.3
Employer						
Private informal or self-employment (nonagriculture)			71.4	35.5	32.8	15
Type of work						
Trader			48.6	13.5	17.5	4.6

Source: GSS 2000a.

Maxwell and others (2000) expanded on these findings for urban Accra. They found 63% of the working population to be self-employed and almost half of this group at the margin of the economy with no capital, no employees, and no more than a small stock of items on hand for sale. Even though nearly equal proportions of men and women were working, men were again three times more likely than women to have a protected wage job. Eighty percent of working women in Accra were self-employed, the majority as petty traders in the informal sector. These women were among the poorest of the city's residents.

Rising Costs, Decreasing Income, and Other Barriers to Basic Services

In the city, the money drips in and flows out.

—*Chauffeur in Accra*

Without a resourceful wife, a man is sunk.

—*Old Man in Nima*

Studies reviewed and those interviewed during the assessment described the rising cost of living in Ghana's cities. Urban slum residents pay cash for almost everything needed for daily subsistence—food, clothing, rent, transport, schooling, water, electricity and even toilet use. Their well-being depends on the purchasing power of the money they earn. Not surprisingly, the rising cost of living was the chief response to inquiries on how urban life was changing; the meager earnings of households are increasingly insufficient to cover the essentials of daily life.

An elderly woman in Nima described how the cycle of increasing poverty, lower earnings and higher costs directly affects her life. She makes her living by selling ingredients to women vendors who prepare food dishes for sale. As the economy of the area worsens, community residents buy less prepared food from the women vendors, who in turn buy less from the old woman and, in some cases, are unable to pay for the ingredients they do buy. Consequently, the woman makes less money, pays more for the materials she sells, and is increasingly unable to live on what she is able to collect from her steady clients.

In its effort to reduce public sector expenditures, the Government of Ghana introduced or increased user fees for health and most other public services in the 1980s and 1990s. As described in later chapters, not only must poor urban families purchase food, transport, clothing and other necessities at costs that are high relative to their incomes, they must also pay for most, if not all, of the public services they receive. Public toilets, water, health services, and education all come with fees attached and, as is the case with water and toilets, the poor may actually be paying more than their non-poor neighbors (Stephens and others 1994, Maxwell and others 2000).

Unfortunately, this situation is about to worsen for urban residents. The Public Utilities Regulation Committee met in July and authorized a 60% increase in the price of basic utilities, including water and electricity. These new prices were to go into effect on August 1, 2002.

Social Safety Nets

Formal safety nets for the urban poor are largely nonexistent. Exemption policies are in place to protect the poorest of the poor from the costs of catastrophic illness and to encourage their use of preventive health care, but these policies are applied unevenly

across regions and health facilities. Nutrition rehabilitation centers supported by USAID are present in polyclinics in Accra for the care of severely malnourished children; however, their coverage is not clear. A number of NGOs also provide different types of assistance in Ghana's largest cities, however, their programs are still small and few in number.

When faced with financial difficulties, city dwellers must fall back on their families for help. Transfers of food and money among family members—husbands and wives, parents and children, and other close relatives—are common sources of household income. Coping mechanisms at times of crisis include: diversifying and adding income-generating activities; migrating for temporary work; pooling income; reducing expenses; limiting or rationing food consumption, health care and other necessities; changing household composition patterns by sending family members to other households or locations; and selling personal effects (Maxwell and others 2000).

Growing Urban Democracy

One bright note in this assessment is a clear sign of growing democracy and public debate about issues important to the urban poor. Call-in radio talk shows and lively radio debates on a range of problems are common, and NGOs are directly engaging the government in constructive dialogue concerning policy toward the poor and the rights of marginal groups. Discussion on the conditions imposed by the World Bank and IMF for debt relief and an ongoing debate in local newspapers on privatization of water in urban areas are just two of the topics on which the nongovernmental sector is having an impact. Although many challenges lie ahead, this open dialogue contrasts sharply with many other African nations. Any future intervention by USAID and others should encourage and support this important positive trend.

Summary of Key Demographic and Socioeconomic Trends in Urban Ghana

- Forty-four percent of Ghana's 18.9 million people live in urban areas, and almost half of Ghana's 8.3 million urban residents live in the country's two largest cities—Accra and Kumasi. Migration from rural areas to towns and cities is driving urban growth.
- If growth rates of the 1990s persist, the urban population will reach 14 million by 2015, at which point half of Ghana's population will be living in cities and towns. By 2020, Ghana's urban population will reach over 16 million, with twice as many people living in cities and towns as today.
- Of Ghana's total urban population in 1998–99, an estimated 19.4% was below the poverty line. Greater Accra's poverty rate is estimated to be much lower. Both figures are probably seriously underestimated.

- The poor struggle to survive in Ghana's largest cities, paying for most of the services they receive and paying more, in many cases, than their nonpoor neighbors.
- There is reason for optimism as the urban poor are beginning to gain a stronger voice in Ghana's democracy.

3.2. The Health Status of the Urban Poor

Several studies reviewed during this assessment address patterns of morbidity and mortality in Ghana's urban areas and their determinants.

Mortality and Morbidity

Infant mortality (IMR) and under-five mortality (U5MR) in Ghana's towns and cities were 76.2 and 122 respectively during the ten years preceding the 1998 GDHS (GSS and Macro International 1999).⁹ Although still high by international standards, Ghana's childhood mortality risk is significantly lower than in the neighboring countries of Burkina Faso, Côte d'Ivoire and Togo (see Table 3). This is true for urban and rural levels of mortality as well as for the country as a whole.

⁹ Childhood mortality risk measurements include under-five mortality (U5MR), infant mortality (IMR), and neonatal mortality (NNMR). These are calculated in the DHS for the 10-year period before each survey.

Table 3. Childhood Mortality Risk in Ghana and Neighboring Countries (*number per 1,000 children born/percents in italics*)

Indicator	Ghana (1998)	Togo (1998)	Côte d'Ivoire (1998/99)	Burkina Faso (1998/99)
U5MR				
Urban	76.8	101.3	125.2	129.1
Rural	122	157.4	196.8	234.7
IMR				
Urban	42.6	65.3	84.7	67.4
Rural	67.5	85	123.9	113.2
IMR as percent of U5MR				
Urban	55	64	68	52
Rural	55	54	63	48
NNMR				
Urban	23.2	40.7	46.5	30.9
Rural	35.4	42.9	59.8	45.1
NNMR as percent of IMR				
Urban	54	62	55	46
Rural	52	50	48	40

Source: GSS and Macro International 1999 and DHS+ website

Although child mortality is clearly higher in rural than urban Ghana, data indicate that the patterns of mortality are more or less the same. Over half the deaths in children under five years of age occur in infancy regardless of residence. Likewise, more than half of all infant deaths, whether rural or urban, occur during the first month of life. Given Ghana's relatively low overall childhood mortality, both IMR and NNMR might be expected to contribute more to under-five mortality in Ghana's large cities.¹⁰ Additional study would be required to explain this pattern.

Morbidity and mortality patterns in older Ghanaians are shifting toward chronic diseases, but the illnesses that affect young children in Ghana's cities have changed

¹⁰ As countries and communities control the most common and easily preventable causes of child deaths (diarrhea, vaccine preventable diseases, and so on), the proportion of U5MR attributable to IMR usually increases. The same is true with NNMR; as U5MR and IMR begin to drop, NNMR normally becomes more pronounced. When U5MR falls below 100, as it has in urban Ghana, it is not unusual for IMR to reach 70 % or more and NNMR to contribute 40% or more of U5MR. Ghana's urban centers deviate from this pattern with proportionally lower IMR (55%) and NNMR (30%). This may be a good sign, if it indicates that NNMR is falling proportional to IMR and U5MR. But it also indicates that there is still considerable excess infant and child mortality in Ghana's cities that could be controlled more effectively.

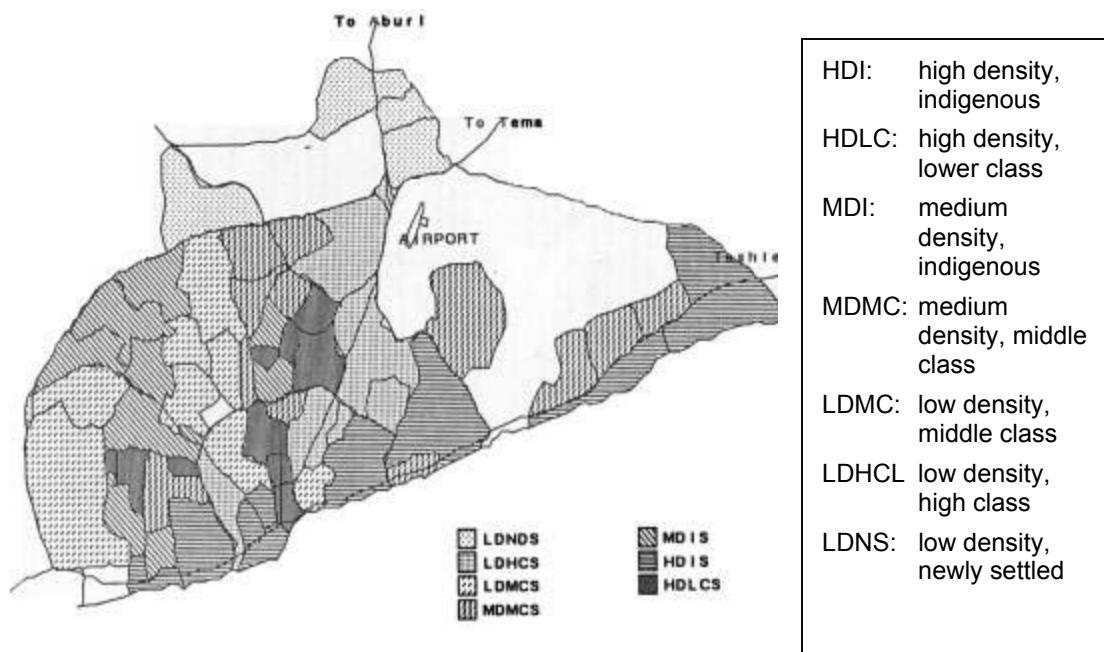
little in the past decade. The 2001 annual reports for Metropolitan Accra, Greater Accra and Kumasi show that the five top reasons for visits by children under 5 years of age to public health facilities were malaria, upper respiratory tract infection, diarrhea, skin disease, intestinal worms and malnutrition/anemia. Significantly, more than 40% of all child consultations in these cities were for malaria.

Ghana's published maternal mortality ratio (MMR) stands at 214 per 100,000 live births. The coastal belt has the lowest MMR (193) and the northern zone has the highest (245). No estimates for urban compared with rural populations were found (Twum-Baah and others 1994).

Countrywide data on adult mortality by urban and rural residence were not available.

Intraurban Mortality Differentials—Accra

At least three groups of researchers in recent years (Songsore and McGranahan 1993, Stephens, and others 1994, and Maxwell and others 2000) have explored mortality and/or morbidity differentials among groups in Accra. In the early 1990s, Songsore and his colleagues categorized neighborhoods in Accra by density, ethnic makeup and socioeconomic class, resulting in classification of seven different types of socioenvironmental zones. Also in the early 1990s, Stephens and others (1994) used these or similar socioenvironmental classifications to map (see map below) and compare cause-specific mortality rates across the city. This effectively described the differential mortality experienced by those living in poor, overcrowded neighborhoods.



Key findings of the Stephens and others 1994 study include the following:

- In the early 1990s, 46% of Accra's residents were living in high density and/or lower class zones of the city.
- The most commonly reported causes of death in all ages in urban Accra were circulatory (24.2%), infectious and parasitic (18.2%), respiratory (12%), nutritional and/or anemia (9%), neoplasms (6.3%), and pregnancy- or perinatal-related (3.4%).
- The most commonly reported causes of death in children under 14 years of age were anemia (15.6%), malaria (13.1%), perinatal (9.6%), pneumonia (9.2%), and nutritional (6.9%).
- Deaths from infectious diseases were clustered in high-density, lower-class (HDLC) areas and medium-density indigenous (MDI) areas in the low-lying western parts of the city that are prone to flooding and provide poor services.
- Malaria mortality was concentrated in high-density, lower-class areas-also low lying and swampy-where clean water is plentiful for the breeding of anopheles mosquitoes. The economically and educationally deprived most often inhabit these flood prone and ill served areas of the city.
- Death from circulatory disease was two to three times more likely for those living in the high- and medium-density indigenous areas and in the high-density, lower-class areas of the city (about 67% of the total population) than for residents of low-density high- and middle-class areas.
- Those living in Accra's high-density indigenous and lower-class areas had mortality rates that were three to five times higher than those living in the city's low-density, upper-class neighborhoods.

Maxwell and others 2000 also explored the socioeconomic and behavioral factors affecting nutrition and health outcomes in urban Accra. Later sections of this report present findings from that study.

3.3. Environmental Health

Since the mid-1980s, efforts to expand basic services to urban slum areas-in particular in Accra and Kumasi-have been continuous; however, improvements have not kept pace with a rapidly expanding population. According to the Ghana Poverty Reduction Strategy 2002–2004, only 9% of the total urban population of Ghana have a safe method of disposing of garbage, 34% have a latrine in the household, and 70% have access to safe water (Ghana 2002).

Inadequate water, sanitation and hygiene are closely related to poverty. It is the poor and less educated in urban areas that most likely lack access to basic infrastructure

and services. Environmental conditions in poor urban slums favor the vectors, pathogens and parasites that cause disease. The presence of human waste and piles of garbage coupled with a lack of water to maintain hygiene conditions means trouble. Overcrowding and poor nutrition worsen the picture. Not surprisingly, at the end of the 1990s preventable infections and parasitic diseases remained the leading causes of morbidity and mortality among residents of the Accra Metro Area.

In 1992, Ghanaian geographer Jacob Songsore at the University of Ghana, collaborating with the Stockholm Environmental Institute, conducted one of the few existing studies in Accra linking ill health to urban environmental conditions. The study directly associated poor environmental conditions in urban neighborhoods with illness episodes and showed that the prevalence of diarrhea in children under six was higher when access to adequate water and sanitation was lower. A subsequent study by Songsore and McGranahan indicated that several environmental factors when present in low-income households were responsible for a two- to four-fold increase in diarrhea in children under six (see Table 4).

Table 4. Relative Risk of Diarrhea Among Children Under Six in Accra (based on 500 observations)

Factor	Odds ratio	Confidence interval of 95%
Use pot for storing water	4.3	1.7–11.1
Water interruptions are common	3.1	1.4–6.6
Share toilet with more than five households	2.7	1.2–5.8
Purchase vendor-prepared food	2.6	1.1–6.2
Open water storage container	2.2	1.1–4.3
Outdoor defecation in locality	2.1	1.1–3.9
Many flies in food area	2.1	1.1–3.8
Do not always wash hands before preparing food	2.0	1.1–3.8

Source: Songsore and McGranahan, 1998

These findings are consistent with those of studies in other countries and with EHP's experience in environmental health, which show that:

- Although cleaner water cuts the risk of contamination from food and drink, providing more water to a household or a community leads to greater benefits than merely providing clean water.
- Handwashing done properly and at critical times can block many of the pathways that cause diarrhea.

A recent baseline study carried out by the Private-Public Partnership for Hand Washing project found that all of the households surveyed nationwide had some

water available at the time of the interview (Community Water and Sanitation Agency, undated). Those concerned with improving the health of both children under five and adults in urban areas in Ghana, however, must consider the amount of water available and the ease of access to affordable water sources in urban slum areas.

As women and children are the main managers of the household environment and are most at risk from household environmental problems, access to water and sanitation services should be of particular concern to health planners. Specific aspects of environmental health conditions in urban areas in Ghana—water, toilets and latrines, solid waste disposal, and urban malaria—are described in more detail in the following sections, as well as the challenges they present to urban planners.

Water

Right in the capital city, there are vast areas where potable water is not available. People living in such areas have been abandoned to cruel fate by the Ghana Water Company. In some areas [others, however,] can afford to use [potable] water to keep their gardens evergreen.

I read in the Daily Graphic that ten barrels of water cost only 1,000 cedis by the correct rate of the GWC. So why do I have to spend 45,000 cedis per week on a small tanker of water? Is this fair?

The last time I saw water flow through our taps consistently was six years ago. After that, we were "privileged" to have our taps cough out some water once in a blue moon. When in 1998 new pipes were laid, we heaved a sigh of relief . . . since the project was completed, however, even the "privilege" of occasional water has vanished . . . not a single drop of water has flowed.

—Residents of Teshie, a neighborhood in urban Accra in the Daily Graphic, February 2, 2001, and the Times, March 2001 (ISODEC, 2002)

Among the urban poor, water appears to be a critical resource in short supply. Although the GLSS 4 estimated that 80% of all urban residents and 100% of those living in Accra had access to piped water, as the quotes above demonstrate, these are misleading statistics. Nationally, the 1998 GDHS found that only four of every ten respondents (41.4%) living in urban areas in Ghana had piped water in their homes and that a similar number (42.6%) purchased water from a public tap or neighbor's residence. Similarly, the GLSS 4 reported that approximately 40% of urban families were relying on neighbors and vendors for their water.

Certain areas within both Accra and Kumasi clearly have less access to safe and adequate quantities of water than others. Stephens and others (1994) reported that areas of Accra with poor supplies of water were concentrated in the high-density lower-class sectors, such as Nima, Maamobi, and Accra Central, where mean consumption was less than 60 liters per day. In that study, 55% of households in Accra shared water with other households and only 18% had exclusive water use in their homes. Later in the decade, Maxwell and others (2000) also showed that 54% of the families of young children in Accra depended on wells and vendors for their water

and that another 38% depended on piped water outside their homes, probably shared among several families. Only 7% had water pipes in their homes.

Underlying all these figures is the daily reality of interrupted availability, long lines, and high prices, because even when households have piped water, supply is not constant. In most areas with household pipes, the water supply is cut at some time during the day. In certain neighborhoods, the water supply is even more infrequent. In one area in Kumasi, water had not been available for three days. In these neighborhoods, standpipes where water can be purchased at a much higher price than household tap water are at a considerable distance.

Nearly all urban residents pay for water, but those without access to household water supply pay the most. Families with household water connections are either metered and charged based on their consumption or they pay a flat rate each month. Purchasing water from a vendor, a standpipe, or other middleman is considerably more expensive, placing an extra burden on the poor.¹¹ In addition, urban residents who must go out for water lose precious time, a critically important commodity in cities.

In Ghanaian cities, provision of water is the responsibility of the Ghana Water Company, a private company monitored by a public services commission. During the assessment, this commission authorized a significant raise in water prices to go into effect on August 1, 2002.

Given water availability problems, almost all households in poor urban neighborhoods store water. Although the assessment could not study the means of water storage in houses, slum area residents suggested improvements could be made in this area.

Toilets and Latrines

The public toilets in Accra are dehumanizing.

—Government engineer

Just entering the public toilets in our neighborhood will make you sick.

—Young mother of two in Kumasi slum

Visit an urban slum area at 5:00 in the morning, and you will see the problem first-hand: the lines at the latrines are long.

—Government physician

¹¹ Stephens and others (1994) estimated that five buckets of water a day could cost a family from 3,000 (\$5) to 12,000 cedis (\$20) per month. At that time, homes with water pipes and meters were charged 300-1,380 cedis (less than \$0.50 to slightly more than \$2.00) per thousand gallons, whereas unmetered premises were charged a flat rate of 645 cedis (approximately \$1.00) per month. Clearly, those without easy access to water were paying prices up to twenty times higher and receiving less water than those with household water connections and reliable water service.

Clean, well-maintained latrines are at the top of the list of needed improvements cited by urban slum residents in Kumasi and Accra, and by NGOs and government officials working in urban areas. Long queues, significant user fees and unhygienic conditions at public latrines make going to the toilet a daily problem for those living in urban slums. (It is not uncommon for people to remove their shirts or jackets before entering to avoid carrying the stench of the toilet with them throughout the day.) In many cases, children are not allowed to use public facilities, being turned away to defecate in the streets and alleys where they run and play. When houses do have toilet facilities, they are often in poor condition and shared by multiple families.

Most poor urban households depend on public toilets and latrines. There also are many families in cities like Accra and Kumasi that still do not have access to even these public facilities. Government statistics understate the severity of this problem. In 1998–99, for example, 78% of all urban families, including those in urban Accra, were said to have access to a toilet or latrine (GLSS 4); however, this finding had more to do with the GLSS 4's definition of "access" as living within a certain distance of a public latrine or toilet than it did with use.

Figure 3 shows the distribution of toilets and latrines by socio-environmental area in Accra in the early 1990s. The poorest families appear to the left (HDI or high density, indigenous and HDLC or high density, lower class) and the wealthiest on the far right (LDHC or low density, high class). In this study, more than 40% of families shared toilets or latrines in all socio-environmental categories except the wealthiest. Moreover, 36% of those living in crowded communities, such as Ga Mashie in Central Accra (HDI), and 43% of those in similar non-indigenous neighborhoods, such as Maamobi and Nima (HDLC), reported having no toilets or latrine facilities at all. Although this situation has undoubtedly improved since the early 1990s, even the study by Maxwell and others (2000) in the latter part of the decade found that 16% of families with young children had no toilet or latrine facilities and 54% depended on public latrines.

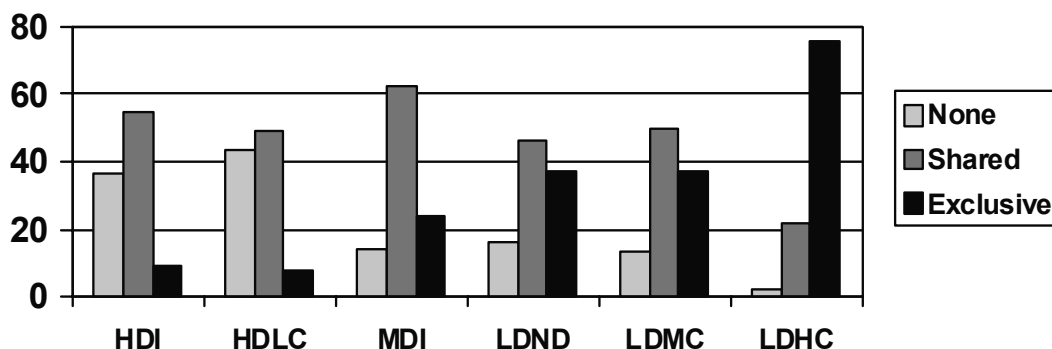


Figure 3: Toilets by Socioenvironmental Zone in Accra

Stephens and others (1994) (percent of households)



Figure 4: A poorly maintained public latrine on the outskirts of Maamobi, Accra.

The unmet demand for sanitation facilities has turned public toilets into a lucrative business in poor urban areas. Both Kumasi and Accra have contracted the management of public latrines to the private sector. In many cases, district assemblymen are managing public latrine facilities. Maintenance of public latrines was said and observed to be a serious

problem in Accra, where the population per toilet is clearly much higher than it should be and KVIP (Kumasi ventilated improved pit) latrines are used inappropriately

Solid Waste Disposal

Garbage is another issue in urban slum areas in Ghana. In 1994 Stephens and others reported that many houses were more than 500 meters from central refuse containers. As a result, household wastes were dumped into drains or at unauthorized refuse sites or burned, resulting in poor sanitary conditions. Where containers were available, many people still opted to throw their waste on vacant plots and at the side of the road. Given the lack of toilet facilities, xcreta were often disposed of in public containers.



Figure 5. Solid waste disposal continues to be a major challenge for city government.

The situation appears to have improved somewhat since 1992. According to the GLSS 4, later in the decade 83% of all urban families dumped their trash (presumably, in city dumpsters), 7% burned it, and 10% relied on household garbage collection.

Municipal officials consider disposal of solid waste to be one of the major challenges they face. Although they are making progress, population growth and safe environmental management still present great challenges. Visits to urban slum areas support their concerns: whereas garbage collection containers are present in many

areas, so are overflowing garbage containers due to lack of regular pickup or simply too many people served by too few containers. The Kumasi Metropolitan Assembly reports spending 30% of the city budget on garbage collection services and still cannot meet the need for services throughout the city. Solid waste disposal, consequently, remains an important problem in urban slum areas.

In the 1990s, several programs introduced donkey-driven carts to collect refuse from houses along the narrow pathways common to most of Ghana's urban slum areas. Although some of these programs may still be functioning in Accra, none now operate in Kumasi, according to Kumasi Metro Assembly officials.

Community groups in both Kumasi and Accra deal with garbage in their areas by forming cleanup committees and organizing community members to unclog garbage-filled streams and canals. One of these cleanups in Nima, Accra, involved a local women's group, supported by the Ghana Red Cross. They cleaned out the garbage-ridden stream that runs through their neighborhood. The group continues to pick up new garbage accumulating in the stream every week. They say that flooding is much less common now that the stream is open, and the area is a healthier and more pleasant place to live.

Programs that are focusing or have focused on urban water, sanitation and hygiene in the past include the following:

- Urban Environmental Sanitation Project (UESP) funded by the World Bank
- Accra Metro Environmental Health Initiative (AMEHI) supported by DFID
- The Private-Public Hand-Washing Promotion Initiative supported by the World Bank and involving Unilever Corporation and other commercial soap producers
- NGO programs such as those of CENCOSAD, Ghana Red Cross, and others that have encouraged community self-help to clean up neighborhoods and improve waste disposal
- Land reclamation/flood control and waste disposal infrastructure programs funded by DANIDA, DFID, the World Bank, and others.

These programs are described in greater depth in Section 3.8.

Urban Malaria

As mentioned earlier, malaria is the chief reason for outpatient consultations nationally and in Accra and Kumasi. Diagnosis and treatment of malaria in public health facilities is most often presumptive, that is, laboratory confirmation of malaria parasites is not required. For this reason and because the words for malaria and fever in the local language are the same, over-reporting of malaria is likely substantial. Nonetheless, as malaria constitutes more than 40% of outpatient visits in most

facilities and as Accra and Kusami have plenty of low-lying areas and seasonal flooding, there is no doubt that malaria is hyperendemic and a serious problem for the urban population.

Studies of care seeking and treatment of malaria indicate that the primary source of care is the local chemical seller or pharmacy. They also report that the majority of those seeking malaria treatment do not complete the full course of treatment required; when the fever stops and symptoms alleviate, the ill person simply stops taking the pills (Agyepong and others 1994).

Strategies adopted in Ghana by Roll Back Malaria, which is relatively new, include the promotion of insecticide-treated materials, especially bed nets; detection and treatment of malaria in young children using the integrated management of childhood illness (IMCI) protocol; treatment of pregnant women during antenatal care; and studies to monitor drug resistance, health-seeking behavior, and so on. An interesting program initiated by JHU/CCP and Roll Back Malaria with technical input from BASICS II focuses on awareness raising and training of chemical sellers as primary sources of malaria treatment in both urban and rural areas.

Challenges in Environmental Health

Several factors make improving environmental and health conditions in urban areas especially challenging. Urban areas are diverse and complex. The poor, in dire need of services and support, are mixed in with those who are better off, and it is often not evident how best to use available resources to improve living conditions for those most in need. Solutions for urban areas are also anything but simple. Space is at a premium. Where can new public latrines be built? Conversely, how can a household toilet program be successful when most of the poor in urban areas rent their homes or do not have land tenure? Moreover, professionals are often not trained for the urban context. Engineers, for example, are trained to design sewer and water systems for new, not heavily congested, urban tracts of land. Installing these systems in built-up areas calls for different training and, in some cases, different technologies. Most important, change is probably the only "constant" in Ghana's rapidly expanding cities. Urban poor areas are always in transition. Some areas improve, while others worsen. A program that once worked may not work a year later. The main challenge of those charged with serving urban areas is to remain abreast of changing needs and resources and to adjust programs and plans accordingly.

3.4. Reproductive Health

Men and women living in urban settings enjoy greater access to education, information, health services and employment opportunities. At the same time, they may be isolated from traditional support systems and struggling in an urban cash economy to feed, clothe and house themselves and their families. The young are particularly vulnerable to reproductive health risks in large cities. This section

summarizes what is known about urban fertility patterns, HIV/AIDS, adolescent and maternal health in Ghana's urban localities.

Urban Fertility Patterns and Contraceptive Prevalence

Table 5 presents key reproductive health indicators from the 1998 GDHS by urban/rural residence. Given the difference in physical access to health facilities and trained health providers in urban and rural Ghana, many of the indicators are surprisingly similar.

Table 5. Key Reproductive Health Indicators from 1998 GDHS (percent)

	Urban	Rural	Ghana
Total fertility rate (TFR) (mean number of births per woman)	3	5.4	4.6
Currently married women using family planning method (percent of all women of reproductive age)	30	18	22
Currently married women using modern family planning	17	11	13
Unmet need for family planning	22	24	23
Antenatal care by trained attendant	95	87	89
TT immunization during last pregnancy (2 doses)			
Trained attendant at last birth	88	62	69
Postnatal care	58	50	51
Vitamin A administered within 6 weeks of birth	31	26	27
Height <145 cm	1	1	1
BMI < 18.5 kg	5	13	11

Source: GSS and Macro International 1999.

Ghana's total fertility rate (TFR)¹² declined from 6.4 in the mid-1980s to 4.6 at the time of the 1998 GDHS. TFR is lowest in Greater Accra Region (2.7), and overall, urban TFR is just slightly over half TFR in rural areas. The dramatic decline in TFR has not, according to the Measure/DHS web site (www.measuredhs.com), been accompanied by a similar increase in contraceptive prevalence.¹³ Between 1993 and 1998, family planning use in Ghana overall increased only slightly, from 20% to 22% for any method and from 10% to 13% for modern contraceptive methods. Most of this increase was due to increased acceptance of contraception in rural areas.

Contraceptive prevalence among women of reproductive age in Ghana's towns and cities changed little from 1993 to 1998. Use of any contraceptive method in urban

¹² The total fertility rate is the average number of births to women during their reproductive lifetimes.

¹³ Questions on whether the small increases in contraceptive use between 1994 and 1998 were sufficient to lead to the dramatic decline in TFR detected by the GDHS have prompted a number of interesting secondary analyses of GDHS 1998 data, as well as questioning of the GDHS 1998 findings themselves.

areas stayed constant at approximately 30%, and use of modern contraceptive methods rose only slightly from 16% to 17%. Two of ten married women (21.6%) in Ghana's urban centers expressed an unmet need for family planning. The unmet need for family planning in rural areas (23.6%) does not differ significantly.

Many of the organizations visited during the assessment offer family planning commodities and/or services in urban areas. GSMF distributes and promotes contraceptives to pharmacies, chemical sellers and other urban outlets. Planned Parenthood Federation of Ghana (PPAG) offers family planning at its regular and youth clinics on the outskirts of Accra and reported having approximately sixty community-based distribution (CBD) agents in low-income areas of Metro Accra. Likewise, CEDPA supports a network of NGOs that are promoting and distributing modern contraceptives, some in urban locations. Most of the adolescent reproductive health programs mentioned below are also promoting and distributing contraceptives, as are GHS and NGO-supported health facilities. Nonetheless, the lack of family planning programs focusing specifically on the urban poor was surprising.

HIV/AIDS

HIV rates are still low in Ghana when compared with rates in neighboring countries. Although adult prevalence was estimated at just over 3% in 2001, considerably higher rates have been documented in commercial sex workers, patients with sexually transmitted illnesses, and other high-risk groups. Truck drivers, miners and the commercial sex workers who service these and other populations are at especially high risk of the disease in Ghana, as are the young in Ghana's largest cities, because of their changing lifestyles and the impact that poverty can have on their behavior.

The successful "Stop AIDS, Love Life" communications campaign developed with technical assistance from JHU/CCP, Family Health International's impressive programs with the uniformed services and youth, PPAG's "Young and Wise" program, and other programs like them have focused on creating awareness about HIV and its prevention. Simultaneously, GSMF is making inroads in the social marketing of condoms and with a new program of outreach to the vulnerable populations of young apprentices that are working in the country's largest cities.

Ghana Red Cross, CEDPA and those participating in GHANET focus groups are all working in one way or another to raise awareness about HIV/AIDS. Assessment interviews and discussions indicate that behavior change must be the goal from here forward and that peer education is an effective strategy. Participants also suggested taking a closer look at social networks of youth and their changing living conditions, profiling the clients of commercial sex workers to determine their connection to the general population, increasing access to treatment and counseling for sexually transmitted diseases and establishing voluntary counseling and testing centers in urban localities.

Adolescent Reproductive Health and HIV/AIDS Prevention

The sheer number of youths and young adults living in cities must be taken into account when considering urban health needs and priorities. Three out of ten Ghanaians are between the ages of ten and 24; hence, in Ghana's largest cities, the number of youth and young adults is significant. This raises a new set of issues for those planning for urban areas. Recent trends noted by NGOs working in urban slums suggest changing living patterns among urban youth and troubles arising from the difficulties young people encounter in settling successfully in urban areas. School leavers are now migrating to urban areas on their own, and young people are beginning to live in groups, rather than in extended family situations. When the young cannot find jobs, some turn to prostitution, drugs, and other illegal pastimes. NGOs also note that the high cost of living and difficulty finding employment are often a shock to the young who move into the cities. Although many probably wish to return home, most were said to stay because they fear that returning home without something to show from their move would label them as failures.

The average age at first sexual contact and age at marriage for women are relatively high in Ghana. According to the GDHS, they are both holding steady. From 1988 to 1998, the age of first sexual contact increased from 16.6 years to 17.6 years and the age of first marriage increased from 18.3 years to 19.1 years. This holds true in both urban and rural areas. Urban ages at first marriage and first sexual intercourse for boys and girls are both slightly higher than rural.

The 2000 Ghana Youth Reproductive Health Survey Report paints a more complete picture of youth sexuality in urban and rural areas (GSMF 2000). In its nationally representative sample of males and females ages 12–24, the modal age at first sexual intercourse was 18 years for both males and females. A little more than a third of males (36.5%) and two-fifths of females (41.3%) reported having had sex at the time of the survey, with no significant difference between urban and rural youth. The mean age at sexual debut for the overall sample was 16.8 years for males and 17.3 years for females. By age 15, however, 21% of males and 25% of females had had sex at least once.

Forty two percent of the young women and 22.3% of the young men who had ever had sex had also experienced at least one pregnancy. Moreover, 15.7% of the sexually active females had experienced at least one provoked abortion. Although pregnancy occurred to almost twice as many females in rural as urban areas, equal proportions (50%) of those living in urban and rural settings who became pregnant chose abortion.

Current use of contraceptives in the overall sample was reported at around 20% for both males and females. Of those who had ever had sex, 56% of males and 50% of females reported currently using a contraceptive method. Contraceptive use in urban areas was slightly higher for both males and females than in rural areas. Condoms were the most commonly used method, followed by pills and non-modern contraceptive methods, such as rhythm, withdrawal, abstinence and other traditional

methods. Sexually active youth said they would be most likely to obtain contraceptives at a health facility, drug store/chemical shop, PPAG clinic or pharmacy.

A recent study of young women in Accra who had experienced abortion reported that a significant number of the girls had tried to use the rhythm method, but they (and their teachers!) had misunderstood the time of month during which pregnancy could occur. To avoid pregnancy, they thought they needed to practice abstinence or use condoms during menstruation only (unpublished study by MACRO for USAID).

Although solid evidence was unavailable, adolescent pregnancy is said to be common in urban Accra. Many young girls become dependent on older boys and men for support because their families cannot continue to provide them school fees, money for petty trading, clothing, and in some cases, food and shelter. Although many of the unions formed are consensual, others are not. Twenty-one percent of females 20–24 years of age reported having been sexually coerced at some point during their youth. This was more likely to have occurred in urban than rural areas. Coercion was said to take various forms: from gifts and money to threats and use of alcohol, and even pressure from parents or guardians.

Awareness of HIV/AIDS appears to be almost universal among urban youth, and awareness of the protective role of condoms is highest among those in Greater Accra and the Central Region. Nonetheless, 90% of those who reported using condoms said that they did not use them every time.

Many of the NGOs visited in Accra and Kumasi are implementing programs that focus on youth development, HIV/AIDS prevention and fertility management. A number of them provide training and some level of protection for young girls. The programs run by CENCOSAD and Ghana Red Cross, for example, include vocational training and reproductive health services for unmarried adolescent mothers and other young girls who are considered to be at high risk of pregnancy. Ghana Red Cross supports community-run hostels for kayayee (young, mostly homeless girls who work as porters in city markets) and street children. CENCOSAD runs a family planning clinic and provides seed money for vocational training programs.

All of the youth programs visited or discussed during assessment interviews include a strong element of HIV/AIDS education, although few seem to provide family planning services. The Ghana Registered Midwives Association, MOH/GHS, and others are focusing on making clinical services more youth friendly by training health providers and setting aside areas in their clinics specifically for their adolescent and young adult clients. The actual level of family planning service delivery at these sites was not clear.

Maternal Health

A woman's physical condition, including her nutritional status, the care she receives during pregnancy, her access to and use of trained attendants at birth, and her ability

to reach good-quality emergency obstetrical care if problems occur are all determinants of her own and her newborn's health and survival.

Information about maternal nutritional status is available for urban Ghana from the GDHS 1998 and for urban Accra from the Maxwell and others study conducted during the same period. Body Mass Index of less than 18.5 kg/m² in women of reproductive age is an indicator of maternal under nutrition and a pregnancy risk factor. A maternal height of less than 149 centimeters is, likewise, an indicator of chronic maternal malnutrition and a predictor of obstructed labor. Ghanaian women score well on most nutritional indexes. GDHS 1998 findings show 5.4% of urban women with body mass index below 18.5 kg/mg² and only 1% with height less than 149 cm. Similarly, in urban Accra, 6% and 3.2% of women scored below BMI and height cutoffs respectively. (Maxwell and others 2000)

Use of antenatal care is relatively high in Ghana. In the GDHS, 89% of women overall reported at least one antenatal visit during their most recent pregnancy, with 95% in urban areas and 87% in rural. In urban Accra, Maxwell and others found a similar proportion: 97% reported at least one antenatal visit and 44.5% reported an antenatal visit during the first trimester, as prescribed. Although these figures could always be improved, they do indicate that services are available and used.

Urban women have much greater access to health facilities and to trained physicians, nurses and midwives at the time of delivery than women in rural areas. Although rural women reported a trained attendant at almost two-thirds of their deliveries within the past five years, most were with a trained traditional birth attendant. By contrast, traditional birth attendants, untrained and trained, delivered fewer than 18% of all infants in Ghana's towns and cities.

Given the high level of secondary and tertiary medical care in Accra and Kumasi, high levels of maternal deaths would be surprising in these cities. Nonetheless, the Greater Accra Regional and Metropolitan Accra Health Teams have defined Safe Motherhood as their theme for the current year. They say that they have succeeded in upgrading the skills of many government midwives, but are currently frustrated by the lack of basic equipment and supplies available in polyclinics and other fixed sites. Without these items, staff are not able to practice newly acquired skills.

The costs of prenatal (despite exemption policies that should make prenatal care free of charge), delivery, and postnatal care may also be higher than many families are able to afford. Whatever the underlying reasons, health policymakers in urban Accra and Kumasi clearly believe that maternal health, particularly emergency obstetrical services, emergency transport, and specialized obstetrics and gynecological care should be strengthened.

USAID and UNFPA have funded Safe Motherhood program activities in Ghana for many years, both through the MOH and the Ghana Registered Midwives Association (GRMA). Life-saving skills training, basic essential obstetrical care training, equipment and other inputs supported by USAID and UNFPA have most certainly

benefited urban as well as rural populations. USAID has now reduced its support to GRMA, which nonetheless continues to participate in the self-directed learning activities of PRIME II. PRIME II, JHPIEGO, and Engender Health are addressing issues related to Safe Motherhood in their individual training efforts with the MOH and others.

3.5. Child Health and Nutrition

Child survival is determined by a complicated set of factors, many already discussed above. They include the health and nutritional status of mothers, access that families have to trained birth attendants and emergency obstetrical care, availability and uptake of preventive health services, child feeding and hygiene practices in the home, and use of trained medical professionals when children are sick. Having the financial means, water supply, sanitation facilities, time and social supports needed to practice behaviors essential to child health is also important. This section addresses preventive child health services, nutrition, and care seeking.

Malaria is the number one cause of mortality for children under five. Pneumonia, diarrhea, malnutrition, neonatal causes, and measles also contribute to the unnecessary deaths of 100,000 Ghanaian children each year. Table 6 summarizes a number of the key child health indicators for urban and rural Ghana from the most recent DHS (GSS and Macro International 1999).

Table 6. Key Child Health Indicators (percent)

	Urban	Rural	Ghana
Children with diarrhea in last 2 weeks	17	18	18
Children with diarrhea given oral rehydration solution (ORS) or recommended home fluids (RHF)	40	33	35
Children with diarrhea treated with ORS, RHF, and/or increased liquids	69	69	69
Children with diarrhea taken to a health facility or provider	26	26	26
Children with acute respiratory infections (ARI) taken to health provider	37	24	26
Children with fever taken to health provider by source of care:	51	36	40
Government health facility	36	30	32
Private medical facility	14	5	7
Pharmacy/drug store/chemist	12	18	16

Source: GSS and Macro International 1999.

Immunization

Ghana's immunization rates are generally higher than those of other West African countries. Urban immunization rates have not yet reached the 80% national target for full immunization, but they are consistently in the mid-60% to mid-70% range.¹⁴ This is true whether estimated based on population-based surveys or calculated using administrative data from public sector health teams. In 1998 the GDHS reported DPT3 coverage of 84% and full immunization coverage at 72% in children 12–23 months of age. The countrywide GLSS 4 and the Maxwell and others (2000) Accra-specific study in the late 1990s confirmed these relatively high coverage rates.

Where lower than expected immunization has emerged as a problem in urban areas, because the urban health system is more complex than the predominantly public sector system in rural areas, solutions to coverage problems also are more complex. For example, one recent study of immunization in one of Accra's submetro areas found that high-income families were, in fact, contributing to lower than expected National Immunization Day (NID) and routine immunization coverage. This was because they tended to use private health services, where immunization was not necessarily provided (Gyapong and others 1999)

The metro health director and polyclinic staff visited in Accra during this assessment demonstrated good understanding of immunization coverage in the city, as did the

¹⁴ Immunization rates are often found to be a problem in urban areas because national immunization programs have focused most of their attention on expanding rural coverage.

Kumasi health director. In Accra, graphs on the polyclinic's wall showed last year's coverage and mid-2002 coverage. Clinic staff had clearly also been engaged in microplanning in an effort to increase coverage in zones with lower than expected rates at mid-year. In Kumasi, a proposal prepared by the metropolitan health director and her staff to improve immunization status demonstrated their recognition that achieving 80% coverage required a better job of informing the public, mobilizing and equipping private medical providers to immunize their clients, and expanding vaccination points through all channels.

A great deal of attention was being paid to community outreach and microplanning in Metro Accra; less seemed to be being paid in Kumasi. This may, however, have had more to do with insufficient time to explore this aspect of the area's health system during the assessment's Kumasi visit.

Nutritional Status of Children

According to WHO, more than 50% of all infant and child deaths in developing countries are associated with malnutrition. Urban data on childhood malnutrition from the GDHS (see Figure 6) and the 1997 CWIQ (see Figure 7) demonstrate the importance of collecting and using disaggregated urban data whenever possible. Overall levels of stunting and underweight in rural and urban areas are compared. When only urban/rural aggregates are used, the nutritional problems of the urban poor are all but hidden. When disaggregated data, such as those from the CWIQ are available, it is clear that levels of malnutrition (underweight and stunting) are similar for the urban poor and rural populations.

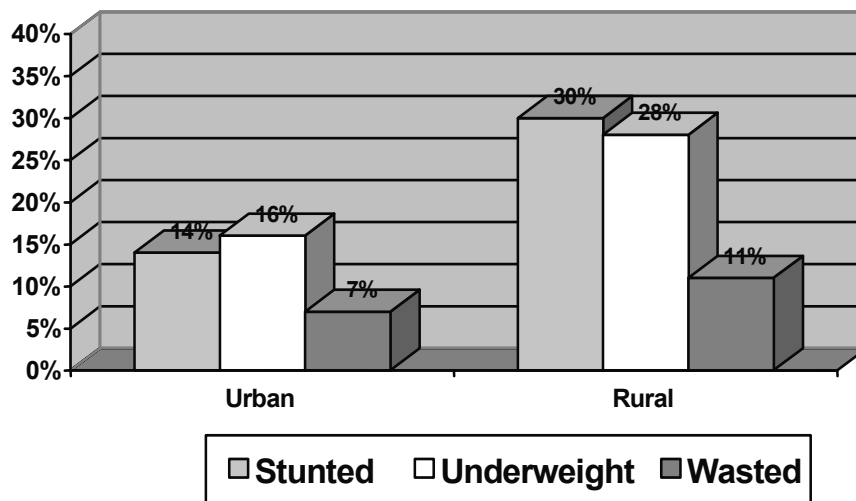


Figure 6: Nutritional Status of Children (GDHS 1998)

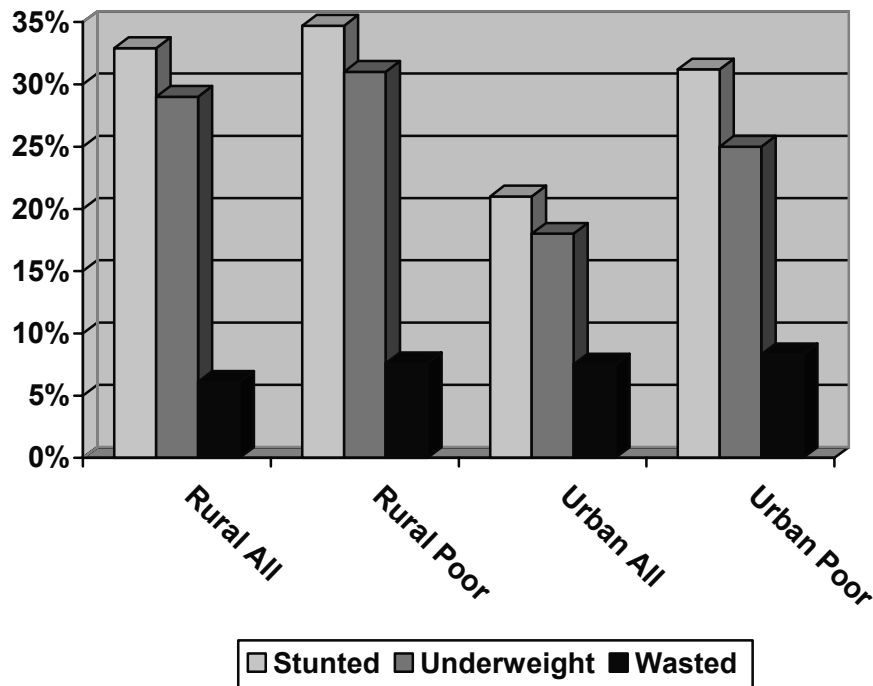


Figure 7: Nutrition Status of Poor/Nonpoor Children (CWIQ 1997)

Micronutrient Deficiencies

Vitamin A deficiency is associated with increased risk of death in young children. No data specific to levels of Vitamin A deficiency in urban areas were available. Iron deficiency anemia is a serious problem in all parts of Ghana, and iron supplementation during pregnancy is part of antenatal and well and sick child protocols. USAID's MOST project is currently working with the MOH to develop a comprehensive national anemia prevention strategy. Whether that strategy will address urban micronutrient deficiencies separately is not clear. A meeting with the MOST country representative or the GHS nutrition department was unfortunately not possible during the assessment.

Breastfeeding

Early breastfeeding and exclusive breastfeeding through four months of age have a positive impact on nutrition, infection prevention, postpartum recovery of the mother and child spacing. Early breastfeeding (within an hour or two of birth) is not common in Ghana. As Table 6 shows, however, most mothers (69%) in urban areas do put their infants to the breast within 24 hours of birth, in contrast to only 49% in rural settings. Exclusive breastfeeding through at least 4 months of age is an important way to prevent diarrhea and other infections in young infants. Unfortunately, exclusive breastfeeding is virtually nonexistent in Ghana in either rural or urban settings. This is a serious problem and one that will not be solved unless health providers, mothers

and their families are convinced that prelacteal and supplementary feeding is not only not required but also harmful to the health of their infants. The Linkages Project is working in the north of the country to improve breastfeeding and complementary feeding practices.

Growth Monitoring

Growth monitoring is a part of routine well-child clinics in Ghana, in both urban and rural areas. The coverage of this preventive service in Accra appears to be higher than in many countries. Sixty-four percent of mothers in the Maxwell and others (2000) study, for example, had taken their children under three years of age to a growth-monitoring session during the past month. BASICS II has raised concerns about the quality of growth-monitoring sessions and is beginning to work on improving counseling and community ownership in the Ga district of Greater Accra.

Childhood Illness: Prevention, Care Seeking and Treatment

Malaria was not only the primary cause of child death, but also the top reason for consultations at government health facilities in both Accra and Kumasi in 2001. Respiratory tract infections and diarrhea were also among the top five reasons for childhood clinic visits.

Table 6 shows that diarrhea incidence in children is comparable in urban and rural areas. Rates of home treatment with ORS and/or recommended home fluids differ slightly, but when increased liquids are added to the equation, no difference exists by residence.¹⁵

Seeking care from a health facility is more common in urban than rural areas for ARI and fever, probably due to greater physical access to formal health providers and clinics; however, choice of care providers is remarkably similar. Approximately one-third of both urban and rural residents rely on government health facilities when children are sick. Pharmacies, drugstores and chemists are used in similar proportions for treatment of ARI and fever. Urban and rural residents vary noticeably only in their use of private medical clinics, which are more commonly found in cities. Only about a third as many rural as urban residents seek private medical care.

MOH/GHS is addressing the quality of care for sick children in the home and in public health facilities by introducing IMCI. BASICS II and WHO provide technical assistance for this effort. Early implementation of IMCI was carried out in four districts, including the Ga District in Greater Accra. Expansion is now beginning to more than twenty new districts across the country. The decision to merge Roll Back Malaria and IMCI implementation was made in early 2002 and should have a positive impact on the results of both programs. Training of community health officers in the care of sick children using an adaptation of the IMCI training is also being discussed

¹⁵ Oral rehydration therapy is defined in this case as giving oral rehydration solution, increased liquids, and/or recommended home fluids to children with diarrhea.

with the Community Health Planning and Services project. None of these programs has a specific focus on urban areas, but they are training health providers who will ultimately work in urban areas.

GSMF is addressing malaria prevention in young children and pregnant women through the promotion and sale of insecticide-treated bed nets in pharmacies and other sites. JHU/CCP is also working with Roll Back Malaria to train chemical sellers to dispense and advise mothers on proper malaria treatment.

Care Giving and Hygiene Practices

The series of studies carried out by IFPRI, Noguchi Memorial Institute, and WHO in the late 1990s looked specifically at differences in the nutritional status of infants and young children in urban Accra (Maxwell and others 2000, Ruel and others 1999, Armar-Klemesu 2000). Outcomes-stunting, wasting, and underweight-were studied by socioeconomic strata, as were the care-giving and hygiene practices of the mothers of the children observed. An index of poor, neutral and good care was developed using such variables as early initiation of breastfeeding, absence of prelacteal feeding, giving special weaning foods, helping young children eat, attending growth-monitoring sessions, completing immunizations, attending antenatal care, and so on. A hygiene index was also constructed based on observation of eleven hygiene-related aspects of caregivers and compounds. The findings of this study included the following points:

- Better care-giving practices are associated with better nutritional status.
- Good hygiene practices are associated with a lower prevalence of diarrhea in the previous two weeks and with lower levels of stunting and undernutrition.
- Poor care is associated with malnutrition, stunting and underweight.
- Good care results in Z-scores (nutrition status) that are 0.5 higher in the lowest socioeconomic group.
- Maternal education is the only variable associated with the nutritional status for both the urban poor and non-poor children.
- Maternal education is also the only variable that is positively associated with scores on both the care-giving and hygiene indexes.
- Household expenditure levels are associated with hygiene behaviors, but not with care giving. Even poor mothers can provide good care to their young children.
- No positive or negative association exists between women's work patterns and childcare practices. This is an encouraging finding, because two-thirds of all primary caregivers of young children were involved in some form of income-generation outside the home.

Based on these results, the researchers concluded that interventions directed toward improving the care-giving practices of low-income women in urban Accra could result in reduced levels of childhood malnutrition and related illness (Ruel and others 1999; Maxwell and others 2000)

3.6. The Costs and Utilization of Health Care

In the 1990s the proportion of urban residents that sought health care—public or private—when they were sick declined significantly (GSS 1992, GSS 2000a and GSS 2001). Numerous authors attribute this decline to the introduction of user fees in all government health facilities in the late 1980s (Bosu, Nsowah-Nuaman, and Ward 2000; Maxwell and others 2000; and Ghana 2002).

An exemption policy exists at the national level. Paupers, the elderly, antenatal care patients, and children under 5 are supposed to receive health services free of charge throughout the country. Studies, however, show inconsistent interpretation and implementation of this policy from region to region and budget allocations generally insufficient to meet the need. Nonetheless, in 1999 the Greater Accra and Ashanti regions spent almost 200 cedis per capita less than budgeted on exemption waivers and, at 491 cedis per capita, Greater Accra had one of the lowest exemption rates in the country (Bosu, Nsowah-Nuaman, and Ward 2000).

Residents in the low-income neighborhoods of Kumasi and Accra interviewed during the assessment were quick to complain about the cost of care in local polyclinics and hospitals. Although antenatal care is supposed to be free of charge, several women said that they had been asked to pay. Families also complained that they were asked for large deposits before performance of diagnostic tests and forced to pay for clinic registration at each visit, even for follow-up visits. Many said this is why they prefer to go to pharmacies directly, when they can.

3.7. Programs that Serve the Urban Poor

City governments, a number of national agencies, and at least three line ministries—Health, Local Government and Rural Development, and Works and Housing—have important roles to play in maintaining the health and well-being of urban residents. NGOs, private medical professionals, and community-based organizations also provide health services and perform important health-related functions in urban neighborhoods.

Government of Ghana

Administratively and politically, cities and towns in Ghana are divided into metropolitan areas, municipalities, and smaller urban localities. Three metropolitan areas currently exist: Metro Accra in Greater Accra, Metro Kumasi in Ashanti, and Metro Sekondi-Takoradi in the Western Region. This assessment focused on the two largest metropolitan areas—Accra and Kumasi.

In Ghana's largest cities, the metro or district health teams focus on delivery of key preventive and curative health services (i.e., immunization, well child, antenatal, family planning and so on). They manage most government polyclinics and hospitals, as well as fixed and outreach clinics, and work under the direction of the regional health director, Ghana Health Services and the MOH. Responsibility for environmental health has been delegated to the metropolitan assemblies and their medical officers who work autonomously, but under the umbrella of the MLGRD. The Ministry of Works and Housing is responsible for urban water supply through the Ghana Water Company.

Metro Assemblies

Metropolitan assemblies (or metros) are made up of two-thirds elected and one-third appointed representatives. They govern as a city council might in the United States, meeting regularly, overseeing the preparation of annual plans and budgets, introducing new initiatives and representing their constituencies. Metros are divided into submetros, many of which have populations the size of or larger than most of Ghana's rural districts. Submetros elect representatives to the metro assembly and have town councils where neighborhood leaders and assemblymen interact. Submetros have much less financial and political autonomy than do their metro assemblies. The assessment could not determine whether town councils are active or not in the metro areas.

A metropolitan chief executive, often called the mayor, and his or her staff manage day-to-day city business in a metro area. The metro chief executive is appointed, not elected. Although directly responsible to the metro assembly, he or she works under the supervision and with the support of the regional minister and MLGRD.

The mayor and metropolitan assembly are responsible for raising revenues, investing in city infrastructure, maintaining law and order and managing all aspects of environmental health. This includes setting and enforcing policies related to hygiene in city markets and slaughterhouses, maintaining standards of private and public sanitation, and managing collection and disposal of solid, liquid and human waste in the metro area.

Kumasi and Accra Metro Assemblies each have engineers, waste management specialists, a metro medical officer and a number of environmental health officers and inspectors who work under the medical officer and are responsible for the environmental health functions mentioned above. A recently published environmental health policy, for the first time, defines the roles of the metro and municipal environmental health staff. This policy will, it is hoped, help improve coordination between the metro health teams and the metro assembly medical officer and his or her team.

Ministry of Local Government and Rural Development

MLGRD is responsible for developing the capacity and supervising district and metro assemblies. The assessment, due to limited time, could not delve deeply into this ministry, so concentrated on understanding the city governments that it supports. MLGRD has been the implementing agency for a number of large World Bank infrastructure projects in Accra, Kumasi, and Ghana's other large cities. Early in those projects, much of the implementation was in the hands of MLGRD staff and consultants. MLGRD has more recently acted as broker and monitor for infrastructure projects, delegating implementation to metro and district assemblies.

MOH/GHS

The 1996 Ghana Health Services and Teaching Hospital Act created GHS as a semiautonomous agency of the Government of Ghana with responsibility for managing and supporting preventive and curative health services. At the same time, the MOH's role was redefined to include regulatory, development, and oversight functions for the wider health system. Greater fiscal decentralization within the health system was also a goal of this reform. GHS staffing and the transfer of functions from the MOH to GHS have taken a number of years, but these two entities are now beginning to function separately. Interviewees in both organizations indicated that they also are beginning to focus on different agendas.

MOH's role in metro and submetro areas is carried out at a distance. MOH establishes health sector policies that affect both the public health system and Ghana's private health providers. MOH also works at the national level to allocate the health budget through the annual budget process. Moreover, through its human resources department, it establishes personnel levels and determines the training needs of public health staff.

GHS now supervises all primary and secondary government health facilities and all categorical public health programs. GHS treats submetros as they do districts in other parts of the country. Each submetro in Accra and Kumasi has its own health team and typically either a large polyclinic with outpatient and maternity services or a general hospital and a number of fixed clinics and outreach sites for which the submetro health team takes responsibility. It appeared that the primary focus of MOH and GHS was firmly on provision and quality of curative health care. A recent decision to upgrade polyclinics in Accra and Kumasi to general hospitals was clearly on everyone's mind.

Submetro health teams and facilities come under the supervision and budgetary control of the metro health director, who in turn is responsible to the regional health director. With creation of GHS, all regional and metro health officers now come under the direct authority of the director general of health services. Accra Metro now has one teaching hospital, six general and specialty hospitals, six polyclinics converting to general hospitals, seventeen fixed clinics, and four semiautonomous hospitals and clinics. Kumasi Metro has one teaching hospital, nine general and

specialty hospitals, four polyclinics converting to general hospitals, and five fixed clinics.

Submetro health teams deliver preventive and curative health services and health staff are assigned to particular services within each facility. Well-child and antenatal clinics that include immunization and growth monitoring are normally held on established days each week at polyclinics and fixed clinic sites and once a month at other outreach sites. Community health nurses are responsible for home visits in Accra and must cover assigned zones in their submetros.

In addition to the fixed health services, a number of categorical public health programs are intended to guide and provide supplementary inputs to district health teams. Their officers in charge work under the direction of the GHS director of public health at the central level and under the regional health directors. In the cities, those responsible for the activities of these programs are members of the metro and submetro health teams, which have multiple functions. These categorical programs provide the training, equipment, support, and monitoring that providers need to deliver preventive health services, including immunization, maternal health and family planning. Most of the categorical programs are donor supported. None of those studied appeared specifically to target or exclude cities.

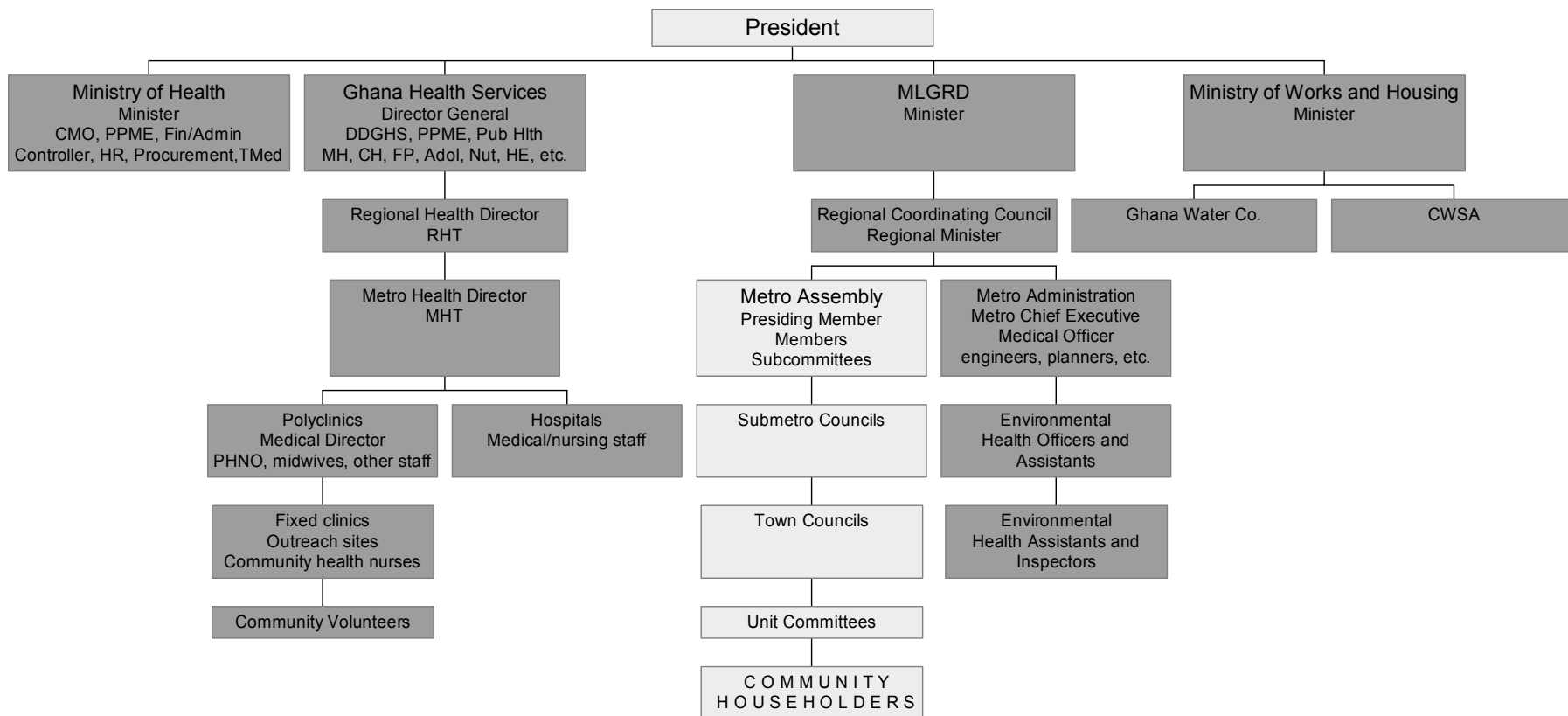


Figure 8: Government Ministries, Departments and Agencies with Responsibility for Urban Health

Ministry of Works and Housing

The entities responsible for water supply in Ghana are Ghana Water Company and the Community Water and Sanitation Agency (CWSA), both operating under the Ministry of Works and Housing.

Ghana Water Company is responsible for delivering water in the large cities and for maintaining infrastructure in Accra and Kumasi. At present, the Accra Metro Assembly is in the process of privatizing the management of the city's water system. How the new system will function and what responsibilities will remain with Ghana Water Company in the future are not clear.

CWSA implements rural water and sanitation projects only, using a model that engages communities in planning, financing and managing their own water systems. CWSA also is the implementing agency for the new Private-Public Hand-Washing Promotion Initiative. This project does not explicitly target urban residents, but because the marketing and sales interests of the private soap producers and distributors fuel it, its behavior change strategies will probably target urban residents.

This short assessment was only able to scratch the surface of these agencies and the Ministry of Works and Housing. It is likely that this ministry also is involved in the large public works projects in most of the cities.

Democracy, Decentralization and Coordination at the Metro Level

In 1988, Law 207 initiated a process of governmental reform under which responsibility for delivering a wide range of public services was partially devolved to local governments (metro and district assemblies). Under this law, responsibility for health service delivery, administration of schools and local delivery of other public services was passed to district and metropolitan assemblies.

It was not clear whether the offices of other line ministries have been absorbed under the metro and district assemblies, but the intended transfer of authority to local governments has clearly not taken place in the case of the health sector. Regional and metro health directors participate in citywide planning, but also appear to retain control over health sector budgets, personnel and assets. An exception is environmental health, which has been completely shifted to metro assembly medical officers and their staff.

Metro chief executives, on behalf of their metro assemblies, are responsible for coordinating the inputs of all line ministries and government agencies working within their jurisdictions. The Accra and Kumasi chief executives seemed to have had some success in this role. They mentioned forming multisectoral working groups and task forces to plan and carry out both ad hoc and more routine interventions in the cities. The chief executives, however, clearly do not have any significant control over the use of public health sector resources.

The submetro level seems to be well established within the health sector, but less well established under the metro assembly, MLGRD, and Ghana Water Company, which all manage their operations at metro or regional level.

USAID-Supported Programs

The assessment considered the current and potential involvement of USAID programs in urban areas. Given the impact of local governance and economic development on health in urban areas, the democracy, economic development and education sectors at USAID also may be important partners in future urban work; however, time did not permit investigation outside the PHN sector during this assessment.

Bilaterals and Cooperating Agencies

The technical focus of USAID/Accra's health, population and nutrition sector has been reproductive health, child health, and HIV/AIDS prevention. Under its bilateral agreement with the Government of Ghana, the Mission is currently supporting three large programs with the MOH/GHS, GSMF and PPAG. Many of USAID/Washington's cooperating agencies are also active in Ghana. At USAID/Accra's request, they provide technical assistance to the comprehensive bilateral health program and, in this role, act as advisors and funding agents for a number of smaller projects with NGOs and governmental agencies.

Two of USAID's PHN bilateral projects currently have activities that deliberately target and/or provide services in urban areas. They are the social marketing work of GSMF and the urban family planning and youth centers, clinics and outreach programs operated by PPAG. The other programs do not exclude the cities, but neither do they specifically target, define or monitor results separately for urban areas.

Two MOH/GHS programs that are currently undergoing expansion are the Community-based Health Planning and Services (CHPS) project and the Community Insurance Program. Both represent program approaches developed to meet specific needs in rural areas. JHU/CCP and PRIME II are working directly with MOH to expand the CHPS program nationwide. Partners for Health Reformplus (PHRplus) and DANIDA are supporting the ministry's expansion of the community-based insurance scheme.

The assessment explored whether these approaches could be adapted and applied in cities as well as rural communities to address problems related to the use and costs of health services. Many of the government health and cooperating agency staff interviewed supported the proposed adaptation and contributed important insights regarding testing of CHPS and community insurance models in Ghana's cities. Several also raised serious questions about the appropriateness and need for both approaches in the cities, particularly given their relatively recent introduction in rural areas and still limited coverage. Comments pro and con are discussed in Chapter 6 on recommendations and next steps.

Private Voluntary Organizations: PL480 and PVC Office Grants

USAID/Accra also works with a number of private voluntary organizations (PVOs) in Ghana, both under the PL480 and the USAID/Office of Private and Voluntary Cooperation (PVC) umbrella. CARE, World Vision, Adventist Development and Relief Agency, Project Concern, and others are running projects funded by USAID on child survival, reproductive health, community development, agricultural development, water and sanitation, and other issues in many parts of the country. At the present time, the PL480 program officer said that none of them were, to his knowledge, working in cities. Given the overwhelming needs for water and sanitation and food security inputs in Ghana's urban centers, the PVO community could be an important group to involve in future urban programming.

Democracy and Other Sectors

Limited time prevented exploration during the assessment of another USAID sector: democracy. Given the governance, district management and general capacity-building issues to be addressed in large urban areas, understanding how the Mission's governance projects are working and finding common ground for future programming could prove important. EHP's experience in India with this type of cross-sectoral programming has been positive. In that case, USAID's Regional Urban Development Office and PHN Office joined forces to plan urban child health programs in a number of large cities. Similar cross-sectoral partnerships between health and economic development and health and education also might be considered should USAID/Accra decide to target one or more of Ghana's urban centers for future assistance.

Other Bilateral and Multilateral Donors

The World Bank, DFID and DANIDA have historically been key Government of Ghana partners on urban infrastructure and environmental health projects. UNICEF has provided funding in the past to CENCOSAD for its urban health work, but future plans call for increased focus on disease control in the northern regions and rural areas of the country. JICA is not involved in urban health or infrastructure at the present time.

Urban Environmental Sanitation Program (UESP)

UESP, funded by the World Bank, provides primary and secondary drainage works, landfill and sewage treatment, disposal equipment, institution strengthening, vehicles and equipment. The current stage of the project will be implemented in deprived areas of the country's four largest cities: Accra, Kumasi, Sekondi-Takoradi and Tamale.

This project is the most recent in a series of urban infrastructure projects supported by the World Bank since the mid-1970s. Earlier projects provided a standard package of services, which included roads, footpaths, street lights, drainage, new water supply points, latrines and communal solid waste containers in all areas. With the move toward decentralization, project planning is now based on specific interventions to be

generated at the local level and presented for funding. The capacity for developing local plans varies greatly among areas and this may affect the program and its output. Land tenure has in the past also been a problem. A number of useful reports summarize lessons learned and changes made in UESP's approach. (Stephens, Doe, Dzikumu, and Tetteh 1999).

Accra Metro Environmental Health Initiative (AMEHI)

AMEHI promoted partnerships between the Accra Metro Assembly (AMA) and communities toward a healthier city and environment. The project focused on community participation, intersectoral collaboration among the AMA, the ministries of health and education, and Ghana's fledgling Environmental Protection Agency, capacity building of the AMA, including regulatory reform, and information for improved decision making. Activities included training municipal staff in environmental health policy and planning and environmental health officers in community assessment and promotion. This included a focus on changing the AMA's approach to enforcing and reforming environmental and hygiene regulations. The project also developed health education materials for use in schools and communities and worked to establish a management information system that linked environment and health information in the city. Program documents also mention a community projects fund for environmental health initiatives, but interestingly, none of the individuals at DFID or the AMA mentioned this aspect of the project during interviews there.

AMEHI ended in mid 2002 and will not be renewed. DFID has joined the group of donors contributing directly to the multidonor basket of funding in the health sector and, therefore, will no longer support urban environmental health initiatives directly. Instead, it will concentrate on providing technical assistance and participating in the SWAP planning and monitoring process.

Public-Private Partnership to Promote Handwashing

The Private-Public Partnerships in Handwashing (PPPH) is now under way in Ghana under the leadership of the Community Water and Sanitation Agency. Key public sector institutions and private sector soap producers and distributors, including Unilever, have been brought on board with support from the World Bank. Development partners have been identified, and initial studies have been completed. Using study findings, CWSA is now designing a national handwashing campaign and developing program supports. Although this program does not target urban areas exclusively, it relies heavily on media strategies for promotion and therefore is likely to have an impact in the large cities and small towns where access to radio and television are greatest.

Private Sector Programs and Services

Ghana's private sector can be divided into four main subgroups: NGOs and community-based organizations (CBOs), private health providers, private companies that provide health services and private companies that support health programs.

Ghanaian NGOs and CBOs

Organizations such as the Ghana Red Cross, CENCOSAD, PPAG, GSMF, Salvation Army, CEDEP, ISODEC and others are clearly playing an important role in the poor communities of Accra and Kumasi. Several of the members of GHANET also have activities in these cities.

NGO activities are broad in scope. They tend to focus on socioeconomic development as well as health. Activities by the NGOs in the communities include vocational training and temporary housing for vulnerable youth; microcredit groups; early childhood development and daycare centers; mother's clubs; delivery of clinical reproductive health services; social marketing of contraceptives, condoms and bed nets; community-based distribution of contraceptives and condoms; and peer education training of youth for prevention of HIV/AIDS and unwanted pregnancy. NGOs also play an important advocacy role; groups such as ISODEC tackle government policies they believe will have a disproportionately negative effect on the city's poor, such as privatization of the water supply system in Accra.

With the exception of the larger NGOs (e.g., PPAG and GSMF) that have already received many years of continuous donor funding, most NGO programs in the two cities visited are probably reaching limited populations. Although their community-level experience is invaluable, in most cases their organizational and technical capabilities are still quite limited.

Ghana Red Cross and other NGOs have formed women's groups that now play an active role in promoting health in some urban neighborhoods. These and other community-based organizations (CBOs) are plentiful in Ghana's poor urban neighborhoods. Churches, mosques, social clubs, sports clubs, traditional councils and other grassroots groups play an important role in the lives of the poor by providing support for funerals, births, illness and many other important life events. Although most CBOs exist to meet other needs, their members also share concerns about family and environmental health. Experience in other settings in Africa indicates that CBOs could become an important resource in future urban health programming.

Private Physicians, Nurses and Midwives

Private physicians, nurses and midwives provide an estimated 78% of delivery care to pregnant women and children in urban areas (GSS and Macro International 1999). The numbers of providers by type were not available, but two organizations working with these professionals to improve their quality of care were identified:

- Ghana Registered Midwives Association. This association received direct USAID funding for many years and is credited with raising the status and improving the quality of midwifery in Ghana. Although direct funding has ended, the association is working with PRIME II on their self-directed quality improvement training. The organization also has trained its members to set up youth-friendly reproductive health services. Private nurse midwives operate small maternities and primary care clinics in all of Ghana's cities. The association represents and works with both private and public sector midwives.
- The Society for Private Medical and Dental Professionals. This group represents private practitioners, many of whom work in urban centers. Most of Ghana's private medical professionals, in fact, are clustered in large cities. UNFPA is working with the society to train private providers in safe motherhood, management and delivery of reproductive health services and to raise awareness and recognition of gender-based violence.

Pharmacies and Chemical Sellers¹⁶

Ghanaian pharmacies and chemical sellers provide health care directly to clients in both urban and rural areas. Studies indicate that at least 60% of first contacts for illness nationwide are with these two private sector providers. There are currently over 1,300 registered pharmacies in Ghana, 85% of them in Accra and Kumasi. Chemical sellers and chemical shops are more numerous than pharmacies in rural and urban areas; unfortunately, the assessment did not find data citing their numbers or describing their geographic distribution.

Chemical shops are currently registered, provided orientation, and regulated by the Pharmacy Council. They are permitted to sell over-the-counter preparations and a restricted list of “prescription” drugs, including antimalarials, ORS, oral contraceptives, condoms and vaginal foaming tablets. They may also retail but not insert IUDs and they are key sites for the sale of insecticide-treated bednets. Although chemical sellers are not legally permitted to dispense antibiotics or give injections, reports indicate that most of them do.

Recent assessments by MSH’s Strategies for Enhancing Access to Medicines (SEAM) project in Ghana (March 2001) show high prices and generally poor quality of care provided both by pharmacies and chemical sellers. When confronted with a simulated case of acute respiratory infection, 22% of pharmacies and chemical sellers inappropriately recommended an antibiotic. Likewise, 61% inappropriately recommended chloroquine, and only 14% provided any information on how to take

¹⁶ Information in this section is from the MSH/SEAM website, a PowerPoint presentation entitled, “Targeting Improved Access: SEAM Program Ghana, Project Implementation Progress Report, September 2002”, and informal discussions with MSH/SEAM staff.

the medicines they recommended. In the case of chemical sellers, 90% agreed to sell a partial dose of antibiotics, resulting in an inappropriate treatment.

Programs working to improve the quality of products and services provided by pharmacies and chemical sellers include the JHU/CCP initiative with Roll Back Malaria to train chemical sellers on appropriate malaria treatment (described earlier). A promising new GSMF initiative to franchise chemical sellers in rural areas is also getting started. This program is worth further mention.

GSMF's socially marketed products (contraceptives, condoms) already reach over 75% of chemical sellers. By franchising and providing additional support to them, GSMF aims to bring competition to the marketplace, thereby improving the quality and reducing the costs of products and services. The franchise scheme introduces pooled procurement; purchase of generic drugs; direct delivery of products; fixed pricing, branding and social marketing of franchise medicines; improved logistics and information systems; training, monitoring and supervision of chemical sellers; and unannounced inspections of franchised chemical shops. As the program proceeds, the list of products sanctioned for sale in chemical shops may be expanded to include some antibiotic treatments; a pre-packaged STI treatment will be the first tested, once the scheme is underway. Chemical sellers also will be equipped to re-treat insecticide-treated bednets at low cost.

This program is carried out with the active participation of the Pharmacy Council and support from MSH/SEAM. At present, there are no plans and, in fact, there is strong opposition from the pharmacy association to its implementation in urban areas. This is understandable given the concentration of pharmacies in cities, but it is also unfortunate. Although data specific to the public's use of chemical sellers in urban areas were not found by the assessment, the quality of their services is likely to be as relevant to the public's health in urban as it is in rural Ghana. The documented drop off in use of health providers of all kinds was more pronounced in urban than in rural areas in the 1990s, presumably because of cost. Where chemical sellers offer credit or allow clients to purchase only partial and therefore less expensive treatments, as has been shown in Ghana, cash-strapped urban populations will naturally gravitate toward them. The quality of the advice and products they provide, therefore, is critical.

More information about the health care-seeking patterns of the urban poor and the importance of chemical sellers is clearly required to advocate successfully for expansion of the franchising scheme in urban settings. Given the strength of opposition to the scheme from the pharmaceutical sector, the recommended interim strategy is to make sure that all training programs for chemical sellers, as well as other inputs intended to improve the quality of care they provide, are made available not only to franchisees in rural areas but also through other mechanisms to chemical sellers in the cities. There also may be a valid argument for including some urban pharmacies, as well as chemical sellers, in future interventions. The SEAM assessment mentioned above showed similar problems—high prices and low quality of care—in both types of establishments.

Traditional Practitioners

According to the GDHS, traditional practitioners provide limited services in Ghana's largest cities. This assessment did not explore their role, but it would be worth investigation, particularly in secondary cities where traditional practices may be more pronounced than in Accra and Kumasi.

In summary, although many Ghanaian government and international assistance agencies are working to improve the health of Ghana's population, few explicitly target the urban poor or the country's cities and towns for intervention. Likewise, except for metro assemblies and metro health offices, these agencies do not disaggregate data or explicitly report on their urban work. Large donor-funded environmental projects, such as UESP and AMEHI, have had some success in urban Ghana. NGOs and CBOs are present in the cities, and many are working on both health and socioeconomic issues simultaneously. Most NGOs, however, and virtually all CBOs have limited resources and capacity for expansion. USAID's own bilateral and cooperative agency-managed programs currently have limited involvement with cities. Some of those that might have positive results in urban settings, such as CHPS and the community health insurance scheme, currently have no plans for urban implementation. At least one scheme, the franchising of chemical sellers, has been accepted for rural implementation but opposed in urban areas because of opposition from the pharmacy association.

3.8. Public Health Issues of Primary Concern

Based on the above assessment, the following public health issues appear to be of primary and immediate concern in Ghana's cities:

- Water and sanitation. Improving access to water and sanitation facilities in cities and simultaneously changing the hygiene behaviors of the urban poor.
- Malaria. Strengthening urban malaria control efforts by identifying and targeting program interventions to areas of Ghana's cities with high transmission.
- Adolescent reproductive health. Curbing the spread of HIV/AIDS and reducing unplanned pregnancies in adolescents and young adults.
- Family planning. Increasing the use of modern contraceptives by all reproductive age groups to plan and space births.
- Childhood nutrition and urban food security. Improving care giving and combining nutrition and poverty reduction strategies to improve the ability of poor urban families to feed their mothers and young children adequately.

- Cost and quality of health services in cities. Reducing the costs of essential health services, including medicines, to the urban poor and improving health outreach in urban communities.

These are addressed again in detail in Section 6: Conclusions and Recommendations.

4. Policy Analysis

In Ghana, poverty has been and is still considered a predominantly rural problem. As indicated below, policymakers propose to stem both urban growth and poverty by improving life in rural areas, developing the agricultural sector, addressing inequities in the availability of health and education services and stimulating the planned development of small towns. Although it appears that poverty, malnutrition and food insecurity are already significant problems in Ghana's largest cities, the country's urban areas have low priority in national policy. Metropolitan assembly policies focus on increasing city revenues and improving life for city residents, but these same policies and/or the ways in which they are applied often penalize the urban poor.

National policies reflect how countries propose to address problems associated with rapid urbanization and urban poverty. Policies also have implications for the success of future urban interventions. This assessment of urban health needs in Ghana included a review of the policy environment in which future urban initiatives might be carried out. It focused on identifying pro-poor policies, as well as those that are having or are likely to have a negative impact on the urban poor whether they were intended to or not. Laws, regulations and development strategies are all considered public policy statements, each carrying a different legal weight and allowing a different level of flexibility.

A comprehensive table in Annex 5 compares the policy perspectives of Ghana's national government, the development ministries involved in the cities and the metro assemblies and chief executives. The policies and priorities mentioned are generally logical, given the mandates and concerns of the agencies involved. The publication of the GPRS earlier this year was a major step forward. The next two sections summarize what the GPRS and MOH/GHS five-year plans say about national priorities and strategies and how they are relevant, either directly or indirectly, to the urban poor and to future work to improve health in urban areas. The last section briefly discusses the policies of the two metro assemblies visited and their impact on the poor.

4.1. Ghana Poverty Reduction Strategy

The Government of Ghana completed its most recent poverty reduction strategy for 2002–2004 (GPRS) in February 2002 (Ghana 2002). GPRS follows a number of earlier plans, including Vision 2020 (published in 1995) and the First Medium-Term Development Plan (MTDP) 1997–2000. Policies in these earlier documents reportedly focused on economic growth, human development, rural and urban development and creation of an enabling environment. Decentralization, public-sector

capacity building, an improved legal framework and reduced reliance on foreign aid were seen as key objectives.

The authors of the GPRS point out that few of these earlier policies were implemented. They attribute this to a lack of coordination between the National Development and Planning Commission and Ministry of Finance and to the fact that neither Vision 2020 nor the MTDP was developed in sufficient detail to guide the annual budget process. For example, the MTDP called for stimulating the development of mid-sized towns as important centers for economic and social activities. Nonetheless, the GPRS points out that urban infrastructure projects in the late 1990s continued to be mostly in the major urban centers and that the government's environmental policies had little impact in either rural or urban areas

The process that led to publication of the GPRS started in 2000. Although essentially complete at this point, the GPRS is considered by the National Development and Planning Commission to be a "living document." Its authors acknowledge that they did not have the time or, in some cases, the data needed to address all possible subjects, including many related to urban poverty. Nonetheless, the GPRS is an impressive document with important implications for future Ghanaian government and donor investment. Policies relevant to the current assessment are discussed below.

National Priorities

Although acknowledging the existence and importance of urban poverty, the GPRS focuses mostly on addressing the extremely low levels of development in the northern, central and rural parts of the country. Medium-term priorities include infrastructure, modernized agriculture based on rural development, enhanced social services (health and education), good governance and private-sector development. The GPRS directs little investment toward Ghana's largest urban centers.

Why the urban poor are not given more attention in the GPRS became an important question raised in the assessment. Why did the national subcommittees engaged in the GPRS planning process not believe the poor in the country's large cities deserved more attention? Several possible answers emerged from the literature and from discussions with government officials. They include:

- *The perception and reality of "urban bias."* National planners clearly believe that Ghana's largest cities, particularly Accra, have received a greater share of the country's resources in the past than its predominantly rural regions:
 - *A disproportionate per capita investment in Accra has dramatically skewed opportunities, life styles, and quality of life in favor of this metropolitan area to the disadvantage of those living elsewhere.*

—GPRS, p. 17

- *Disparities in levels of poverty and the rate of poverty reduction are particularly evident between the north and the south and Accra and the rest of the country respectively. The exceptionally rapid growth of Accra-Tema and the significant reduction in poverty there has been fueled by the massive injection of donor aid largely spent locally on goods and services over the past two decades.*

—GPRS, pp. 17 and 176

The GPRS uses urban/rural and regional differences in poverty and health indicators to justify the priority given to the three northern regions and the document's focus on rural agricultural development. To rectify past bias, formulas for resource allocation also are proposed that favor the northern and central regions. Increased attention to rural poverty and the plight of the northern and central regions is certainly warranted, but there is no reason why this focus should preclude simultaneous efforts to address poverty and poor health in Ghana's urban localities.

- *Lack of and misleading data about the magnitude and health-related dimensions of urban poverty.* The urban bias argument is perpetuated by lack of meaningful urban data. The leaders of the national poverty reduction process recognized they did not have needed information to address urban poverty, even though development of the GPRS was informed by a number of nationally representative sample surveys and important secondary analyses of data (i.e., Poverty Trends in Ghana in the 1990s [GSS 2000b], A Profile of Health Inequities in Ghana [Bosu, Nsowah-Nuaman, and Ward 2000], GLSS 4 [2000], GDHS 1998, and CWIQ 1997). These studies provide national urban/rural comparisons and, in several cases, citywide indicators for Accra. The CWIQ also disaggregates data for the urban poor and non-poor. Because of averaging and problems with the indicators measured, however, they also unfortunately underestimate the number of poor in Ghana's cities and mask the conditions under which they live (see Chapter 5). Other studies cited in this report, such as Stephens and others (1994) and Maxwell and others (2000), provide more in-depth and, thus, more useful information about the urban poor. Their focus on only Accra, however, may have made their findings difficult for the GPRS subcommittees to use in constructing their national analysis.
- *Use of Greater Accra as the "gold standard" for comparisons with all other regions.* Greater Accra clearly scores better on most developmental indicators than other regions. For this reason, the analyses that contributed to the GPRS often held Greater Accra's socioeconomic, health and development indicators constant and compared or indexed all other regions with or to them (GSS 2000a; Bosu, Nsowah-Nuaman, and Ward 2000). This had the effect of biasing the geographic prioritization process against Greater Accra and, as a result, Accra and its poor were given lowest priority for national poverty investments. Given the regional inequities that exist in the country and the potential that city governments, such as the Accra and Kumasi Metro Assemblies, have to raise their

own revenues for city services and infrastructure, these large cities should clearly be in a different category than Ghana's rural communities and small towns. The perception, however, that those in Accra and Kumasi are uniformly better off and better served than those in other parts of the country is simply not correct. If left unchallenged, this misperception could contribute to a crisis in Ghana's largest cities in the next five to ten years.

The relative absence of attention to the issues of urban poverty in the GPRS is a serious concern because the policies of Ghana's national development agencies and its international donors will almost certainly follow the GPRS framework. For this reason alone, the need exists to focus greater attention on documenting the magnitude and dimension of urban poverty in Ghana. Ensuring that urban poverty is prominently featured during the next round of poverty discussions at national and regional levels is also important.

Emphasis on Urban Planning

Like the MTDP before it, the GPRS calls for improved urban planning and comments on the pivotal role that small towns will play in the country's future ". . . as catalysts for social, economic, and cultural development and change." The authors go on to say that if this is to happen . . .

. . . there must be a departure from the present chaotic, inefficient, unplanned urban systems that currently prevail. The planning of towns to serve as an integral part of the national economy is an essential element in national development, growth and poverty reduction.

—GPRS, p.23

If emerging towns and areas of Ghana's large cities are planned to the degree proposed by the GPRS, those who live in or migrate to them will clearly be better off in the future than they are today. But although planned urban areas are certainly the ideal, little evidence exists that Ghana has the legal, administrative, planning or financial systems in place to develop and implement them quickly enough to stop the growth of urban slums. Furthermore, several million people already living in the poor sections of existing cities would not necessarily be affected by this long-term strategy.

Slum Upgrading and/or Abatement

The GPRS section on special programs for vulnerable and excluded populations mentions the issue of slum upgrading, but emphasizes upgrading long-standing, high-density slums, such as those found in the center of Accra. Community participation in slum improvement schemes is mentioned. Slum abatement through improved urban planning and greater investment in poor rural regions and small towns, however, is definitely a clearer focus of the GPRS. This was also the perspective of at least one of

the metro chief executives interviewed.¹⁷ Recognizing that not enough attention had been paid to the urban poor in the current GPRS, the final sections of that document call for a multisectoral subcommittee on slum abatement led by MLGRD, to be formed in 2003 during the next round of the national poverty reduction debate.

4.2. Health Sector Priorities

In the section of the GPRS on health, the focus is on ensuring locational equity, improving quality of care, establishing a model health center for every district in the country, phasing out the "cash and carry" user fee system, and replacing it with more humane and more sustainable systems of health care financing. The GPRS also mentions improving the efficiency of service delivery and achieving an optimum balance between preventive and curative health care.

The MOH 5-year Programme of Work was clearly developed under the GPRS framework. Its five strategic pillars—improved quality, access, efficiency, partnerships and financing—apply to the delivery of an essential package of health services and improved equity and access for the poor. Attention is given to improving health worker performance and responsiveness to client needs, improving financial, geographical and socio-cultural access to care, and improving partnerships with households and communities, between private and public sector providers, and with other ministries, departments and agencies. The CHPS model is seen as a key element of the MOH/GHS strategy to achieve these results, as is establishing the regulatory and policy environment for health insurance and developing exemption policies and practices that favor the poor. To further address the inequities of the past, attention is given to deploying health resources to currently under-served regions of the country. Although it is not mentioned in the Programme of Work, during assessment interviews, MOH and GHS officials spoke of the need to decongest the teaching hospitals in Accra and Kumasi, where many of the country's doctors and nurses are currently posted.

Like the GPRS, the MOH 5-Year Programme does not make explicit reference to the needs of urban populations. Nonetheless, if implemented in the cities and towns, the actions called for in both documents will respond to some of the most serious issues affecting the urban poor. For example, all efforts to reduce health care costs by revising the government's cash and carry user fees, expanding and improving application of exemption policies, and eventually replacing user fees with more humane methods of financing health care costs are clearly needed and welcome in urban areas. Likewise, the call for an expanded view of the health sector, one that includes partnerships with communities, civil society, NGOs and improved

¹⁷ The Accra Metro Assembly was embroiled in a legal suit with the slum community of Sodom and Gomorrah in central Accra during this assessment. AMA insisted that the residents move from the area around the lagoon to permit its reclamation and development. No provisions were made for their resettlement, so the residents took AMA to court saying that the Assembly had moved the residents to this location in the first place. The city's position was that the slum's presence cost the city millions of cedis per day and, therefore, it would be removed.

coordination between the public and private health sectors, is welcome. In line with this, the MOH/GHS recently developed guidelines for contracting NGOs and proposed to work more closely with the private medical sector.

4.3. Environmental Health Priorities

Strategies for improving environmental health conditions in urban areas, although not in initial summary sections of the GPRS, are proposed in the body of the document. These relate to:

- Improving the management of the water supply in crowded urban areas, such as central Accra, and reforming the pricing system.
- Improving access to sanitation through more aggressive marketing of household latrines, including alternatives to the KVIP in densely populated urban areas, by district assemblies.
- Enforcing regulations that require landlords to provide latrines for their tenants, again through district assemblies.
- Establishing stronger environmental health departments in the district and metro assemblies.
- Improving coordination with other ministries to address water and sanitation issues.
- Increased dialogue among communities, civil society, NGOs, district assemblies, and the offices of line ministries when planning and monitoring development interventions of all kinds.

These strategies are encouraging. One concern, however, is that the GPRS hardly discusses how national ministries, departments and agencies, including the MOH and MLGRD, will undertake or support these policy thrusts.

The recent publication of a new national environmental health policy was a major step forward. This new policy defines, for the first time, the roles, professional status and training needs of environmental health staff working in metro and district assembly health offices. Those interviewed during this assessment expressed the feeling that confusion between the MOH, MLGRD and metro and district assemblies as to their respective responsibilities had been a major impediment to effective environmental action at local level. Outdated environmental regulations and policies still need work, however, as they continue to be an obstacle to effective action at metro level.

4.4. Metro Assembly Policies

Metro chief executives are concerned with sanitation, water and other public services, as well as generating revenues needed to improve and manage those services and attracting investments to the city. The Accra metro chief executive is justifiably proud of the progress that the AMA is making in terms of solid waste disposal (garbage collection points and land fill management), drainage and wastewater management. AMA also is involved in a massive reclamation project around the city's large lagoon area, which had earlier been choked with garbage. The Accra and Kumasi metro chief executives appear to be playing a role in coordinating the many government agencies and offices working in their cities, although they still exert relatively limited control over the budgets and staff of line ministries.

The biggest complaint against the metro assemblies is their traditional pursuit of a "command and control" versus a participatory approach to the city's development. Passing and enforcing public ordinances to produce a more hospitable urban environment is certainly praiseworthy. However, according to interviewees and the literature reviewed, city ordinances and their enforcement often penalize the poor. They also tend to fail because market forces and the survival instincts of poor city residents are stronger than any laws, fines, or enforcement techniques the AMA employs. Examples of AMA policies and enforcement practices that have had or will have a disproportionately negative effect on the poor include:

- Outlawing of pan latrines without provisions for an affordable alternative.
- Fining street vendors and seizing their merchandise for operating without proper permits.
- Failed attempts to move street vendors into central markets that are cleaner, but also farther from foot traffic and regular customers.
- Threatening the removal by force of slum areas.

Metro health officers charged with enforcing environmental regulations and public sanitation in the cities clearly have a monumental task before them. The Accra metro health officer sees environmental health as the number one problem for the poor and has set the following goals for his department:

- Improve the image and credibility of environmental health personnel.
- Operate in partnership with different groups of stakeholders (including traditional councils, market leaders, food and drugs board, tourist board, medical houses, education service, school teachers, the city's waste management department, and so on).
- Decentralize environmental health services.

- Provide adequate sanitary facilities in all town councils (including slaughterhouses, refuse containers, public toilets and urinals in public places, and pounds for arrested animals), sensitize landlords to provide residential sanitary facilities, make sure schools have adequate sanitary facilities, and more.
- Conduct inspection of all premises regularly.
- Regulate sanitation and enforce all sanitary by-laws.

He also told us that the AMA had recently decided to encourage household facilities instead of building any more public latrines or toilets in low-income areas. Given the population density of inner Accra, land tenure issues in the city's slums, and the cost of household toilets, this new policy direction may or may not be successful.

Those planning future water and sanitation initiatives in urban Ghana should keep in mind that the Metro Environmental Health Departments may face a serious conflict of interest when trying to work with poor communities to improve their sanitation and hygiene. This is because they are required and have an important incentive to levy fines. In Accra, for example, the department is dependent on the revenue it generates through fines for its operations. Unless a comparable incentive is created to encourage its officers to work with communities on environmental education and slum improvement activities, the pressure to impose and collect fines will most certainly undermine other community efforts.

4.5. Summary

The GPRS clearly indicates that future efforts to address urban water and sanitation problems will receive national-level support. Likewise, the GPRS and the MOH Five-Year Programme of Work both give high priority to supporting more humane pricing of public services, including health. The GPRS and policies like those adopted by the AMA, however, pay little attention to understanding or meeting other needs of the urban poor. Instead, the Government of Ghana calls for regional and rural development strategies and better urban planning to curb the tide of urban migrants and the metro assemblies focus on improving infrastructure and enforcing regulations to improve the lives of city dwellers, often at the expense of the poor. This approach has proved unsuccessful in other countries in the past; it is not clear why the government believes its experience will be any different. Although Ghana's cities are still relatively small, the national government and metro authorities should be encouraged and supported in their efforts to tackle rapid urbanization and poverty as the inextricably linked phenomena they are.

5. Data Issues

The scope of work for this urban assessment called for a review of existing data sources and instructed the team to recommend future data collection efforts to quantify and bring urban health issues to the attention of policymakers.

As mentioned earlier, since 1997, Ghana has benefited from a series of nationally representative, population-based studies. These have included the GDHS 1998, CWIQ 1997, GLSS 4, 2000, and GYRHS 2000. All of these produced useful data about urban populations. The CWIQ even teased key findings out for the urban poor. Three Accra-specific studies addressing socioeconomic (Maxwell and others 2000) and socioenvironmental risk factors (Songsore and McGranahan 1993 and Stephens and others 1994) also have shed light on intraurban differentials and the impact of urban poverty on mortality, morbidity, nutritional status and food security in Ghana's largest city.

Even with all of these studies available, however, it is still difficult to establish the true magnitude of urban poverty or its impact on urban health in Ghana. From the perspective of the EHP team, problems with existing data collection and presentation include:

- Nationally representative studies do not include findings for the urban poor.
- Use of the national poverty line in urban areas almost certainly underestimates the number of urban poor.
- Standardized indicators are lacking for measuring and tracking environmental health and other urban health conditions.
- The indicators used in key national surveys bias the debate toward access to infrastructure and curative health care.
- Existing urban data are not always used to guide policy decisions.

Each of these issues is reviewed below.

Nationally Representative Studies Under Represent the Urban Poor

Urban averages mask the problems of the urban poor. The analyses leading up to the GPRS relied almost exclusively on nationally representative studies and on the regional and urban/rural comparisons they offered. In most of these studies, sample sizes were too small to allow for analysis of urban findings by socioeconomic

category. The CWIQ is the only national study that has attempted to measure and report separately some of its indicators for the urban poor.

Figures 4 and 5, earlier in this report, demonstrate how the use of aggregate compared with disaggregated urban data can underestimate the problems of the urban poor. In that analysis, the nutritional status of urban children appeared to be much better than that of rural children. But when urban data were presented separately for urban poor and non-poor children, rates of undernutrition and stunting among the urban poor were comparable to those of rural children. The urban/rural comparisons in Annex 4 of this report also demonstrate what happens when only aggregate urban/rural or regional comparisons are available.

Sampling that allows planners to present their findings separately for the urban poor and non-poor is clearly needed. Oversampling of cities during the 2003 DHS and during the next GLSS and CWIQ would be one solution. Special in-depth studies of poverty and health in urban areas may also be desirable, particularly in those cities that are targeted for intervention.

5.1. A Single National Poverty Line Underestimates Urban Poverty

In the GPRS, Ghana's largest cities—Accra and Kumasi—are given lowest priority for future government investments. This decision was made because of their lower-than-average poverty rates and better-than-average positions on other development indicators. Although logical, the data that were available to those making this important decision did not adequately represent the situation of the urban poor.

Findings from the various rounds of the GLSS have been used to determine national, regional, urban and rural poverty trends. Comparison of GLSS 3 (1992) and GLSS 4 (2000) data show significant drops in poverty in most regions of the country. Although this is clearly a welcome finding, some of the estimates from the GLSS 4 seem unreasonable. The dramatic decline in poverty and the low poverty rate established for Greater Accra are good examples. Estimated at 26% in 1992, the proportion of Greater Accra's population living below the poverty line in 1998 was found to be only 5%. If correct, this rate would represent a greater than 80% reduction in poverty in just six years. As a reduction of this magnitude is highly unlikely even under the best of financial circumstances, the poverty rate established for Greater Accra is probably in some way flawed.¹⁸ Because Accra's population contributes over one fourth of the country's urban population, it may be distorting the urban poverty rate in general.

¹⁸ The EHP team members on this mission do not have advanced training in economics, so must leave discussion of methodological issues that might have affected the most recent GLSS 4 poverty estimates to those with such background.

A number of experts have challenged the use of conventional, consumption-based poverty lines to estimate poverty in urban areas. Satterthwaite argues, for example, that national poverty lines are generally set too low to measure the true cost of living in cities (1997 and 2001).

Wratten points out that both needs and living costs vary between rural and urban areas and between urban settlements of different sizes, making the use of a single national poverty line that is based on consumption difficult (1995). Both of these experts point to the importance of access to family resources, education, information, and legal rights, as well as money in urban settings and the difference that corrupt compared with efficient governments can play in making services and other resources more or less accessible to the urban poor.

Method Adopted for Establishing Upper and Lower Poverty Limits

In conjunction with the GLSS 4, investigators used a new and improved method to estimate the proportion of population below the poverty line.

- The minimum daily nutritional requirements for an adult was established.
- A basket of food that met that requirement was defined and costed.
- The costs of similar baskets of food and a basic supply of consumables were measured in different parts of the country and indexed.
- The “poverty” and “extreme poverty” cutoffs were established.
- Household and per capita consumption were measured.
- All individuals consuming less than 900,000 cedis per adult equivalent per year were defined as “poor.”
- All individuals consuming less than the lower poverty line of 700,000 cedis were defined as

To overcome the limitations of consumption-based poverty measurement, The World Bank and DFID now recommend more complete poverty assessments in cities. Such assessments measure multiple sets of indicators, including income/consumption-based poverty rates, health and education outcome indicators, and indicators of access to basic services such as water, sanitation, electricity, garbage collection, schooling, health centers and hospitals, transport, childcare, and so on (Hentschel and Seshagir 2000; DFID 2002)

The committees responsible for preparing the GPRS used both the conventional poverty cutoffs to establish regional priorities and a more complete analysis, similar to the one recommended by the World Bank. Health, education, and other socioeconomic indicators were analyzed and used to identify deprived regions and groups, and a great deal of attention was paid to understanding and targeting inequities. Participatory techniques were also employed to develop working definitions of poverty with the poor. The bad news, as stated earlier in this report, is that this group of planners had little nationally representative data describing the situation of the urban poor available to them. As such, the urban poor were not represented in what was, otherwise, a very comprehensive analysis.

Until the national poverty line actually reflects the real costs of survival in Ghana's cities, it should not be used to describe or determine what proportion of Ghana's city dwellers are, indeed, poor. Rates of childhood malnutrition (see Table 7), food insecurity (see Figure 9), and informal sector employment, where available, are

probably much better indicators of urban poverty. Where data by socioeconomic quintile or socioenvironmental group for an urban population are available, they should be used and used often to remind planners and policymakers that urban poor and nonpoor populations do not score the same on key poverty and health indicators.

Table 7. Estimates of Childhood Malnutrition in Urban Areas (*percent*)

Study	Stunted	Underweight
GDHS Urban all	14	16
CWIQ Urban poor Urban all	31 21	25 18
Maxwell and others (2000) Accra urban	17	15

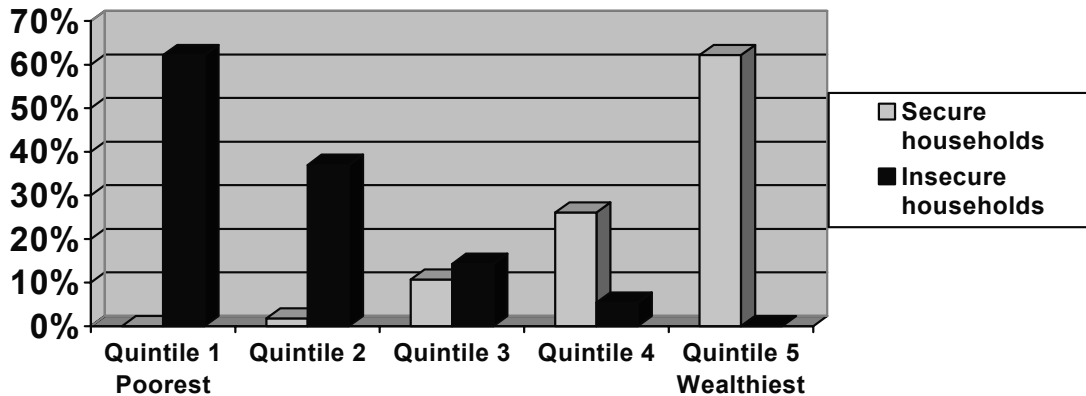


Figure 9: Food Insecurity, Accra

Maxwell and others (2000)

5.2. Lack of Standardized Indicators for Urban Health

Even when disaggregated data for the urban poor are available (as in the CWIQ), the indicators chosen and/or the way they are defined may not be meaningful from an environmental or public health perspective. This is because they either measure the wrong things or are just plain confusing. Across studies, another problem is the measurement of different indicators, which makes study findings almost impossible to compare over time and among groups. As shown in Tables 8 and 9, each of the national and city-specific studies carried out in Ghana since 1997 has measured different indicators in relation to safe water and sanitation.

Table 8. Water Indicators Measure Theoretical Access, But Not Cost or Quantity Available (percent)

Water Sources	Accra	All Urban
GLSS 4 (2000)		
Piped	100	80
Well	0	11
Natural	0	9
GDHS (1998)		
Piped		84
Well/borehole	NA	9
Other		7
CWIQ (1997)		
<10 min. away	98 (Greater Accra)	90 (all urban) 86 (urban poor)
Safe water (piped, well, or purchased)	90 (Greater Accra)	92 (all urban) 83 (urban poor)
Maxwell and others (2000)		
Indoor pipes	7	
Standpipe compound	38	NA
Vendors and wells	54	

Table 9. Sanitation Indicators Measure Theoretical Access, But Not Cost or Use (percent)

Sanitation facilities	Accra	All Urban
GLSS 4 (2000)		
Flush toilet	25	14
KVIP latrine	35	46
Pit latrine	18	17
Pan/bucket	17	13
None	5	9
Maxwell and others (2000)		
Flush toilet	10	NA
Private pit latrine	20	
Public latrines	54	
None	16	
CWIQ (1997)		
Access to flush toilet	30	16
Access to any toilet	95	91
Waste Mgmt Dept. (1992)		
Private toilet	40	NA
Public toilet/charging fee	25	
Pan latrine	20	
KVIP latrine	5	
None	10	

The indicators generated by the GLSS and CWIQ are generally appropriate for measuring improvements in urban infrastructure and reductions in the physical distance people must travel to reach safe water sources, toilets, latrines, and health facilities. However, from a public health perspective, these indicators are not the most important ones in an urban area and, therefore, they tell an incomplete and misleading story.

By focusing almost exclusively on physical proximity to safe water, toilets and health facilities in urban areas, the GLSS and CWIQ surveys overestimate access and use by the urban poor.¹⁹ Physical proximity to a toilet or latrine says nothing about whether the facility is used regularly, maintained properly or cost-effective. Likewise, living near a health facility means less in a town or city than it might in an isolated rural area. This is particularly true if the cost of seeking care is prohibitive, schedules are

¹⁹ The GDHS also measures household water source by urban and rural residence. Again, because of the way the question is asked, it measures physical access to a water pipe, well, and so forth, but not the actual availability of safe water. The GDHS did not in 1998 include access to sanitation facilities as an indicator.

not coordinated with the working hours of the poor population or other cultural barriers intervene.

Other health indicators measured through the CWIQ, the only national survey that has presented disaggregated findings for the urban poor, focus on childhood nutritional status and the use of curative health services. Both these indicators have proved useful in urban settings, but weak for understanding preventive health service uptake and household behaviors. The GDHS is the superior instrument in this regard, but to date, its sampling has not permitted separate findings on the urban poor.

The need clearly exists, not only in Ghana, but also globally, for agreement on a set of meaningful urban environmental sanitation and health indicators for incorporation in all future national and city-specific surveys. To be meaningful, these indicators should focus not only on physical proximity to services, but also their use and the ability of the urban poor to pay for them. To the degree that socioeconomic and health indicators can be cross tabulated for urban populations, this should be encouraged.²⁰ Whether this means drawing urban samples that are large enough for quintile analysis, oversampling in several low-income areas in conjunction with a national survey, or conducting a special urban slum study will probably depend on the resources available.

5.3. Existing Urban Data Not Used in Policy Formulation

Even when urban data are available to policymakers and planners, they are not always used. This may be because studies such as Stephens and others (1994) and Maxwell and others (2000), while informative, also seem to be written more for academics than for policymakers. It also is possible that because they were initiated and supported by university researchers outside of Ghana, these studies may not have generated sufficient local ownership to guarantee their subsequent use at national level. Or, as neither of these studies was nationally representative, it may simply have been too difficult for planners to use them in the national analyses that led to the GPRS. Whatever the reason, exploring ways to use existing data about the urban poor during national and local policy debate is worth USAID's future attention.

5.4. Summary

Nationally representative data on the health and socioeconomic situation of Ghana's urban poor population are needed. Standardized indicators for measuring urban environmental sanitation and hygiene behaviors would also greatly enhance the quality of urban data and facilitate their use. Indicators that focus on physical

²⁰ The PowerPoint slides in Annex 6 include a number of examples of urban indicators by socioeconomic quintile or socioenvironmental sector. These slides are particularly powerful, because they show the distinct differences in the health status and living standards of the urban poor and nonpoor.

proximity to water, sanitation and health services, and availability of trained health professionals are important; however, they can distort national health plans by focusing too much attention on infrastructure and too little attention on preventive and behavioral aspects of public health, not to mention health outcomes.

Important socioeconomic and environmental factors that affect health status may include:

- Costs associated with use of public toilets and latrines
- True availability of water (compared with the presence of a water system)
- Cost of water for the poor
- Pricing of public and private health services
- Ability of the poor to pay for latrine use, water, food, housing and health care
- Presence and/or concentration of solid and liquid waste and other environmental pollutants in high-density, low-income areas of cities.

Care should be taken when choosing national indicators not to overemphasize infrastructure and curative health care at the expense of more cost-effective primary health care and environmental health interventions. Greater ownership and more user-friendly presentation of urban study findings would also improve their use by policy makers.

6. Conclusions and Recommendations

The findings that have been presented indicate that Ghana's urban poor are probably underestimated in number and most certainly underserved by current government and donor-financed programs. They also are given considerably less priority in national development and poverty reduction strategies than they deserve, given the rapid growth of Ghana's cities and the number of poor Ghanaians already living in them. This is at least partially because national data fail to paint an accurate picture of the socioeconomic and health conditions in Ghana's towns and large cities. It also reflects a desire to correct what is perceived as "urban bias" in the government's past investment strategies.

6.1. Urban Issues Deserve USAID's Investment

At current growth rates, Ghana's total population could reach almost 35 million by the year 2020. By that time, 17 million Ghanaians will live in towns and cities, compared with only 8.3 million today.²¹ Services in the country's largest urban centers are already stretched to the limit and urban poverty, malnutrition and food insecurity are significant problems in urban areas. Because Ghana's urban centers are growing much more rapidly than its rural villages, it is important for the Government of Ghana and the donor community to define and address issues of urbanization, urban poverty and the health of the urban poor now, not 15 years from now when the country's urban population will have nearly doubled.

²¹ These projections are again based on the growth rates and method of calculation explained in footnote 5.

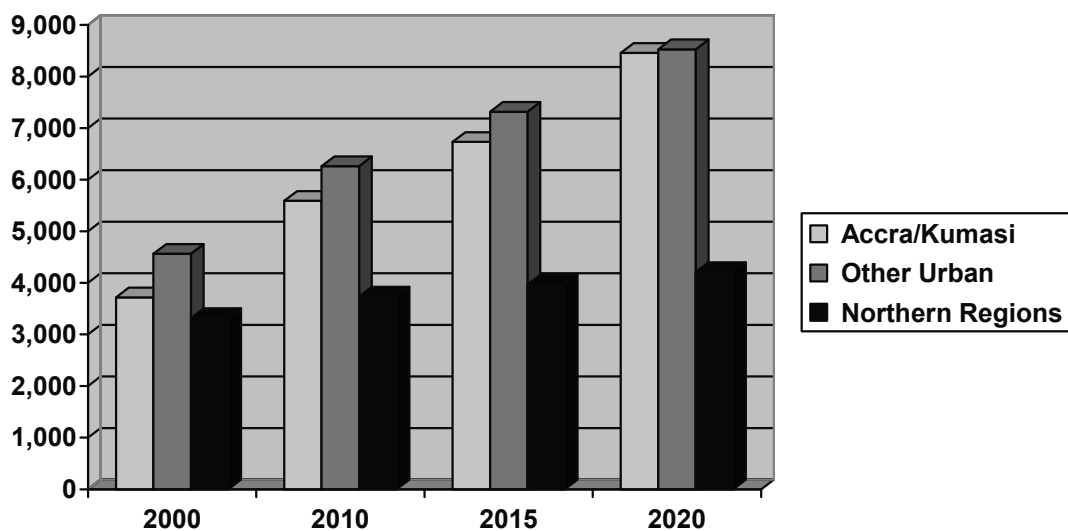


Figure 10: Comparison of Population Growth in Urban Centers and Northern Regions 2000-2020 (thousands)

It is strongly recommended that USAID/Accra's PHN sector study consider urban health and development issues in the design of its next country strategy. This is not an argument against continuing to support programs intended to improve health and development indicators in the northern and central regions of the country; however, urban areas, including the large metropolitan areas of Accra and Sekondi-Takoradi in the South, Kumasi in the Ashanti region, and Tamale in the north, should also receive priority in future government and donor policies and programs.

6.2. Strategic Options for USAID Consideration

The following sections describe strategic options on urban public health priorities and possible urban health activities and platforms for consideration by USAID.

Urban Public Health Priorities

Definition of options for investment in the public health arena normally begins with a statement about the public health priorities on which any new investment strategy should focus. Based on the rapid assessment of urban health needs reported on here, the following public health objectives are of immediate concern in Ghana's cities and worthy of further investigation. They are organized according to priority, but are not intended to be a final or exhaustive list.

- **Priority 1:** Raise awareness and increase national commitment to improved health and well-being of urban poor.

- **Priority 2:** Increase real (compared with theoretical) access to water and sanitation facilities in cities and improve hygiene behaviors of urban poor.
- **Priority 3:** Reduce the cost of health care and improve health outreach in low-income urban communities.
- **Priority 4:** Curb the spread of HIV/AIDS and reduce unplanned pregnancies in adolescents and young adults by making information and reproductive health services (family planning, sexually transmitted illnesses, and voluntary counseling and testing) more available to them.
- **Priority 5:** Increase the practice of family planning and use of modern contraceptive methods in cities.
- **Priority 6:** Improve the effectiveness of urban malaria control efforts by identifying and targeting program interventions to areas of Ghana's cities with the highest malaria transmission.
- **Priority 7:** Improve nutritional status and food security among the urban poor.

USAID's bilateral programs already work in some way in all of the technical areas mentioned above, although without an explicit urban focus. Although this assessment did not permit the depth of investigation required to recommend that one or more of these priorities be adopted as part of USAID's new strategic framework, they have been included as possible urban PHN results or subresults for this purpose. Should USAID decide to tackle any one of these priorities, more information collection in Ghana's cities and towns is advisable.

Possible Urban Health Activities and Platforms

To address one or more of the urban health priorities mentioned above, USAID might develop and support different types of activities. MLGRD, MOH/GHS and city government and district assemblies are natural partners for some of the interventions described below, whereas coalitions of NGOs that already have a presence in the cities might be more appropriate for other interventions. Technical assistance and administrative management of urban activities might involve one or more of the current or future bilateral organizations, one or more of USAID's cooperating agencies, and/or one or more of its PL480 partners. Although the possible activities listed below are described as USAID options, this is clearly not an exhaustive list, but rather a point of departure for USAID discussion.

Option 1: Make evidence about the health needs of the urban poor more readily available to planners and policymakers.

Rationale. Urban health issues are not currently on anyone's agenda at the national level. As discussed earlier, they were actually given only limited consideration during development of the GPRS. Urban issues may be better understood at the metropolitan

assembly level, but this does not guarantee that the needs of the urban poor are considered when plans are generated and new city ordinances or regulations passed. Planning for activities in urban areas has been ad hoc with little relevant analysis to guide or help planners in establishing priorities. At the global level, the World Bank's CWIQ and Living Standards Survey and USAID's DHS measure different and sometimes not very meaningful variables, which makes comparison and monitoring of results extremely difficult. Many USAID cooperating agencies are already working in urban areas, but not systematically collecting or presenting urban baseline, activity, or outcome data. USAID will support the next DHS in 2003 and has the opportunity to advocate for more attention to urban health issues in the future.

Description. USAID has been instrumental in the past, through its support of the DHS and other studies, in helping to understand national health, population and nutrition issues. In this case, USAID would support the analysis and packaging of existing data and implementation of new studies that help to quantify and bring issues of urban poverty and health to the attention of planners and policymakers. USAID also would advocate for attention to urban health by establishing a working group on urban health issues and/or participating in the Government of Ghana's discussions about urban poverty reduction. Specific activities might include one or more of the following:

- With the DHS planned for 2003 in Ghana, work with MEASURE/DHS to oversample urban areas, collect data on urban health needs, and present disaggregated data for the urban poor and non-poor and for as many of the large cities as time and resources permit. A sample large enough to allow separate analysis of key urban indicators by socioeconomic quintile should be the minimum requirement (feasibility: excellent).
- Lobby for use of a standardized set of urban health indicators, especially urban environmental health indicators, to be included in the GDHS and all subsequent national studies with significant urban sampling (feasibility: good to difficult).
- Encourage all USAID-supported programs with activities in urban areas to collect and report separately information on urban health, population and nutrition. Many of the USAID cooperating agencies and PL-480 partners are in a position to do this (feasibility: good).
- Commission additional analysis of existing urban health data (GLSS 4, for example) and new studies to answer pending questions about the health needs of low-income populations in Ghana's primary and secondary cities, as required. More information is needed to understand mortality and morbidity patterns among the urban poor; the impact of environmental conditions on their health and survival; their health-seeking behavior and the relative importance of chemical sellers, pharmacies, private practitioners, public health facilities and other health agents in urban areas; etc. (feasibility: more difficult, because it requires an urban health perspective to guide study teams and a potentially large investment).

- Once additional urban findings are in, target national policymakers, donor organizations, members of the metro assemblies and town councils in large cities, as well as NGOs and civil society organizations with an informational campaign designed to raise awareness and change attitudes toward the urban poor. Prepare, package and distribute case studies, fact sheets and white papers describing the causes and particularly the health and development consequences of urban poverty. Paint as clear and compelling a picture as possible of health conditions in the slums of Accra, Kumasi, and other urban areas of Ghana (feasibility: good, but requires an urban health perspective and investment).
- Support creation of a forum on urban health or a national-level working group to share information about urban health issues and lessons about what has and has not worked in Ghana and other countries (feasibility: good, because it could be done in conjunction with the Mission's strategic planning with little additional investment).
- Participate in and or support the active participation of the urban health working group described above in the slum upgrading or abatement subcommittee that is being formed to continue the cross-cutting work on the GPRS. The GPRS calls for creation of this subcommittee in 2003 under the leadership of MLGRD (feasibility: depends on the attitude of the National Planning and Development Commission toward USAID participation on the subcommittee).
- At the global level and in Ghana, promote the standardization of a set of core urban health indicators and urban sampling methods that allow for disaggregation of urban findings by socioeconomic or socioenvironmental group. This will help to make future urban health information more relevant and useful to the planners and evaluators who must use it to design programs and monitor results (feasibility: good in the long term, but difficult in the short term).

Feasibility. Excellent to difficult, as indicated above.

Platform and organizational partners:

- USAID PHN would direct this set of activities, perhaps with assistance from one or more of its cooperating agencies.
- Organizations to involve in an urban health working group might include MLGRD, UESP, city government, Ghana Statistical Service, University of Ghana, Noguchi Memorial Medical Research Institute, USAID cooperating agencies and PL480 partners, large NGOs such as CENCOSAD, ISODEC and CEDEP that are currently working in urban areas, and other donor agencies that have supported urban health interventions, such as the World Bank, DFID and DANIDA.

Option 2: Encourage USAID bilaterals, cooperating agencies, and PFL480 partners to work, track and report their results in urban areas.

Rationale. USAID partners (cooperating agencies, and PL480 partners) currently work across all priority public health interventions, but only in a few cases are they working in urban areas. None of USAID's cooperating agencies specifically target or track results in cities separately from their national, district or regional results. By making one or more of Ghana's cities a priority for its partners, USAID could easily begin addressing urban priorities in the PHN sector.

Description. USAID would identify and encourage its partners to work in high-priority urban areas. At a minimum, USAID's partners would be required to formulate results statements and set targets for the urban health, nutrition, and population improvements they intend to achieve. This strategy might also involve joint programming by multiple cooperating agencies to achieve a set of PHN objectives in one or more of Ghana's fast-growing cities. Specific actions on USAID's part, from the simplest to the more complicated, might include:

Simple:

- Request that current USAID partners include urban PHN interventions in their proposals for future USAID funding.
- Require that all USAID partners that are working in urban areas formulate results statements and monitor and report on their work in urban areas.

More ambitious:

- Work with the national and regional health and MLGRD offices to identify one or more cities for pilot urban interventions.
- Designate or request proposals for PHN interventions in the designated urban center or centers from a number of USAID's partners.
- Select those partners that will be involved in the pilot urban effort, including a lead or managing partner that will coordinate inputs from different agencies and act as the point of contact for local authorities and communities.
- Support a strategic planning session of the chosen partners, local health, MLGRD, district or metro assembly members, representatives of the private health sector and community members to design a pilot intervention.
- Implement and evaluate this intervention or set of interventions and learn from successes and failures.
- Expand and replicate the strategy, if appropriate.

More ambitious still:

- Design a new urban health project.

- Go through open procurement for an implementing agency or agencies.
- Task the implementing agency or agencies with the strategic planning and implementation of the pilot urban effort described above.

Feasibility. Good to excellent.

Platform and organizational partners:

- USAID would implement this strategy internally, working directly with its bilateral partners, cooperating agencies and PVO partners and potentially in partnership with other sector offices.
- MOH/GHS and/or MLGRD would be involved in determining priority urban areas and interventions.
- This work would be carried out under bilateral, field support and PL480 agreements.

Option 3: Adapt, test and expand an urban CHPS model.

Rationale. CHPS has been proven an effective model for expanding the coverage of primary care services and improving health behaviors in areas with limited geographic access to trained health providers and government health facilities. CHPS was first developed at the Navrongo research site as an experimental intervention and then implemented in twenty pilot districts nationwide. It has been adopted by MOH/GHS and is currently being expanded with technical assistance from PRIME II and JHU/CCP to cover most of the country.

CHPS calls for training and placing a community health officer in the community. The community is required to provide housing, and the community health officer both visits community members house-to-house and attends patients at a fixed site. Expansion of the CHPS program will bring many opportunities for adapting and implementing the model in metropolitan and municipal districts.

Because CHPS is essentially a rural model, its careful adaptation and application to the urban setting is necessary. The standard community entry approach, for example, may require modification for large cities, where multiple overlapping "communities" exist. CHPS or something like it has attracted considerable interest as an alternative to the current system of monthly outreach clinics in urban areas; natural experiments are starting in Metro Accra and Kumasi without outside support.

Key informants for this assessment generally supported the applicability of the CHPS model in the urban context; however, at least one respondent implied that the cost of health care might be a more important factor to address than physical proximity to trained health personnel in urban areas. Another suggested that moving the CHPS model into the urban area before it is off the ground in rural areas could undermine

the model's expansion. Both of these are valid points for consideration, if USAID decides to support testing of CHPS in one or more cities.

Description. The CHPS model of community-based reproductive and child health care would be adapted and then tested in several of Ghana's cities. After a defined period, the urban adaptation would be evaluated to determine whether it should be replicated in other settings. USAID-supported actions might include:

- Provide technical assistance to the metropolitan health teams in Accra and Kumasi and those in other urban sites that are experimenting with community-based health service delivery to determine what works and what does not work in large cities.
- Conduct a formal workshop to share lessons learned from CHPS in urban settings and begin a systematic adaptation process.
- Revise the standard CHPS manuals and training, as required.
- Implement the urban CHPS approach in two or three cities.
- Monitor the results and evaluate the pilot interventions after 6–8 months of operation.
- Use the findings to revise the urban CHPS strategy as needed.
- Involve beneficiaries in adaptation and testing and incorporate their perspective and experience.

Feasibility. Excellent. USAID has the technical capacity and organizational arrangements already in place to carry out this activity.

Platform and organizational partners:

- The platform for CHPS in a given urban setting would be the metro health team of the MOH/GHS.
- National- and regional-level GHS officials will be involved in the adaptation and evaluation process. Other organizations to involve might include the submetro health teams, large CBOs whose members could benefit from and support CHPS, private sector health providers in pilot communities, and researchers who could be enlisted to evaluate the urban CHPS effort.

Option 4: Adapt, test and support the community or mutual health insurance scheme in several cities.

Rationale. The cost of urban survival, including the cost of health care, has increased dramatically in Ghana's cities. Studies show that city dwellers are using health providers of all types less often than they were a decade ago. This is widely attributed to the advent of the government's "cash and carry" user fee system and to the decline of the country's economy in the past two decades. National health insurance will help to rationalize the costs of basic health care, but as it is to be implemented under the social security system, it will first address the costs of those employed in the formal sector. Most urban residents are self-employed or employed in the informal health sector. Although mutual health insurance has proved successful in Ghana's rural communities, no specifically urban adaptations of the model could be identified.

Description. The process of adapting and testing the mutual health insurance model would follow the same steps as those related to adaptation and testing of the CHPS model in urban areas (see option 3 above). In this case, definition of community is the first issue to address.

Feasibility. Good. USAID has the organizational arrangements in place to provide technical assistance for this trial activity.

Platform and organizational partners:

- The platform for work on community financing in a given urban setting would be the metro and submetro health teams of MOH/GHS.
- Organizations to involve in this effort would include large community-based organizations whose members could benefit from a mutual insurance arrangement, private insurance companies, and health providers who are targeted to participate or provide technical advice to such an effort.
- At present, MOH/GHS and DANIDA are providing the bulk of what is required to expand the community health insurance scheme to forty districts across the country. USAID provides technical inputs. If USAID were to become directly involved in funding the start-up of insurance plans in urban areas, a new implementation mechanism might be necessary.

Option 5: Support active community involvement in planning for environmental health improvements in urban slums.

Rationale. The decentralization strategy adopted by the Government of Ghana calls for development plans that incorporate environmental health improvements. These plans are to include a list of priority needs generated at the local level with direct community involvement. Town councils are to forward these locally identified needs on to their district assemblies for incorporation into district development plans. Ministry, municipal, and donor staff unanimously indicated that this process is not

working as planned: community needs are not being obtained and community members are not involved in planning. Assistance is needed to facilitate community and local government collaboration and routinely solicit input from the community.

Increased community participation in planning and better-focused community plans will result in:

- Communities that are motivated to address community environmental problems.
- Municipal development initiatives that are more likely to improve conditions in urban areas.
- Local government with the skills (including those of environmental health officers) to work together with communities to solve problems.
- Increased community capacity to advocate for their own needs.

Description. Bring community members, area health workers, municipal officials (engineers, environmental health officers, waste management staff, and planners), and area politicians together to assess existing environmental conditions in urban slum areas, identify needed improvements, and develop a list of priority needs and proposed actions. The planning steps should incorporate participatory learning and appraisal techniques, group techniques to analyze and incorporate existing research and data in decision making, and participatory workshop planning processes. Specific actions by USAID/Accra might include the following:

- Support for a Ghanaian NGO to manage community aspects of the planning process. As no single NGO has the capacity to manage multiple planning exercises concurrently or the necessary knowledge of each of the participating communities to coordinate area planning successfully, the managing NGO will be expected to involve other NGOs working in the target areas as partner organizations in implementation.
- Document and draw on experiences of the district water and sanitation team of the Community Water and Sanitation Agency in developing sanitation plans for rural areas.
- This community planning initiative should be closely coordinated with the implementation of the CHPS model in urban areas.

Where World Bank-supported urban infrastructure projects are ongoing, this activity might be effectively coupled with them to improve local planning and uptake of household and community inputs.

Feasibility. Good, if combined with resources to stimulate water, sanitation, and other environmental health actions. It would require the active involvement of and USAID's interaction with multiple governmental and nongovernmental organizations.

Platform and potential partner organizations:

- Although city government, specifically the environmental health departments of metro and district assemblies, should play a leading role in each city, MLGRD might be the most appropriate home for this effort once it expands to more than one urban area. Working through MLGRD would, it is hoped, help to institutionalize the community environmental planning methodology developed.
- Potential partner organizations might include large NGOs with experience in participatory planning and urban development, planning consultants, representatives of the government ministries and departments responsible for water and sanitation and other aspects of environmental management, and large CBOs.
- A single NGO might be chosen to lead such a planning effort in coordination with city government and MLGRD. An alternative to this would be enlisting the help of one of USAID's cooperating agencies or PVOs to play this role.

Option 6: Establish a loan program for community sanitation and health improvement in urban areas.

Rationale. The poor in urban slum areas either do not have access to basic sanitation services or are now paying for services that do not meet minimum standards. Other services important to an urban family's health and well being—food stands with nutritious, well-prepared, and safely stored fast foods or quality day care services for preschool children of working mothers—also are not readily available. By supporting members of a poor community to set up and operate essential services, living conditions in slum areas will get better, incomes of area residents will increase, and the health and well-being of families will improve.

Description. Provide loans and technical assistance to local entrepreneurs and community-based organizations in poor urban neighborhoods that permit them to establish, own, and operate new initiatives or improve and expand existing small businesses that better living conditions and provide essential services for the poor living in urban slum areas. Types of businesses eligible for support might include:

- Public toilets and showers
- Garbage collection
- Compost/recycling
- Residential latrine/toilet construction
- Food catering services.

Actions for USAID consideration might include:

- Support a Ghanaian NGO (or a PL480 PVO or a USAID cooperating agency) to establish a loan program in collaboration with an area bank. The program would mobilize group savings plans with community-based organizations and provide small loans to urban and periurban entrepreneurs. Respected community members would serve on the appraisal board for new loans.
- The program would assist participating groups in both management and technical issues (e.g., the development of business plans and record-keeping systems, choice of appropriate technology for public toilets, ways to maintain food quality standards, or market services) as needed.
- Combine such a loan fund with other activities described here, including option 5, community planning for environmental health improvements; option 3, urban CHPS; and option 7, implementation of urban malaria control strategies.

A community finance foundation similar to the one that is proposed here has been operating successfully in Kumasi since 1999.

Feasibility. More difficult, but worth serious consideration, especially if combined with other activity options.

Platform and organizational partners:

- The preferred platform for this type of loan program is a well-established Ghanaian NGO with ongoing work in urban areas and proven ability to manage a community loan program. Such NGOs could be partnered with PVO partners or cooperating agencies for technical and administrative support.
- City government, particularly the environmental health division and medical officer; MLGRD; NGOs that are already working in urban areas; CBOs (such as women's groups or tenant associations); and local entrepreneurs who might become recipients of environmental improvement loans should be involved in this program.
- The advantages and disadvantages of implementing such a loan fund through MLGRD or city government should be explored. Our recommendation is that a Ghanaian NGO, USAID cooperating agency, or PVO be enlisted in partnership with one or both of the above to manage such a fund.

Option 7: Provide technical assistance to Roll Back Malaria and selected cities for the development and implementation of urban malaria control strategies.

Rationale. Malaria is the primary reason for consultation in public health facilities and one of the top causes of death in Ghana's cities; however, because few cases are confirmed through laboratory exam, overreporting is probably a significant factor. Nonetheless, malaria is known to be hyperendemic in Accra and many other parts of

the country. Accra and Kumasi have serious drainage problems. Low-lying, swampy areas exist on the outskirts and within the centers of both cities. Urban malaria control strategies differ from rural strategies for a number of reasons. First, because malaria-carrying mosquitoes do not breed in polluted water, many of the poorest and most crowded sections of a town may not be the areas of highest malaria transmission. The anopheles mosquito, however, undoubtedly breeds in the freshwater that collects in and around the city, and transmission may be much higher in those areas. Second, it may make more sense to target breeding sites rather than promote the use of insecticide-treated bed nets in cities. Urban breeding sites tend to be far fewer than in rural areas and can be pinpointed. In addition, large numbers of individuals are at risk of infection in an urban area and, therefore, large numbers would need to own and use the relatively expensive and yet not universally available bed net. Mass marketing of insecticide-treated materials, in short, is not always the most cost-effective way to control urban malaria.

Description. USAID should offer technical assistance to Roll Back Malaria and selected cities for the development of appropriate urban malaria control strategies. USAID might tailor the interventions it already supports (promotion and sale of insecticide-treated materials, training of chemical sellers, and training of health providers in integrated management of childhood illness) to achieve better results in the urban area or work in one or more cities to identify problems and help with developing and implementing a local strategy. To determine whether this particular option is worthwhile, recommended steps include the following:

- Conduct research on what proportion of reported malaria cases are real malaria.
- Determine what proportion of the actual malaria cases originated in the city, rather than being imported to the city from a rural area by day laborers or other seasonal migrants. This normally involves studying a population of young schoolchildren in depth, because they are not likely to move in and out of the city.
- If many actual malaria cases and transmission occur and are found to be local (compared with imported), find the breeding sites for anopheles mosquitoes and evaluate them in terms of location and the feasibility of reducing their number.
- Investigate treatment patterns in urban settings. Do they differ from those in rural areas? Several studies in Ghana have sought to answer these questions for the population in general. A smaller study in areas of urban poverty might be necessary to determine whether the urban poor have access to care and what kind. It is known that they seek care from public facilities, chemical sellers, pharmacies, formal and traditional or "not so qualified" providers, public sector clinics, and so on. What drugs these providers use to treat malaria in the urban poor and their effectiveness could have implications for an urban malaria strategy.
- Promote the presumptive treatment of pregnant women. This is probably already part of the national protocol for antenatal care and treatment of malaria during pregnancy, but could not be verified.

Feasibility. Currently unknown, because this recommendation and their ongoing program interventions could not be discussed with the Roll Back Malaria staff.

Platform and organizational partners:

- The most appropriate client for this assistance at the national level is Roll Back Malaria.
- The epidemiology unit of MOH and local researchers should also be involved in any studies to determine malaria prevalence.
- At the city level, a task force on malaria control might be required to bring the metro or district health team together with the environmental health team of the district or metro assembly.
- Coalitions of governmental and nongovernmental agencies in each city should also be involved to promote community involvement and sustainability of environmental interventions.
- USAID partners working on malaria control interventions should also be engaged in this effort.
- USAID could carry out this work under existing bilateral projects.
- EHP is ready to provide technical assistance, as required.

Option 8: Establish a citywide action network or coalition involving local NGOs, CBOs, the private sector, and government to coordinate, expand, and improve urban health interventions.

Rationale. A successful urban health strategy generates awareness and action to solve one or more health problems. Because of the scope and complexity of urban health problems, experience shows that this often requires coordinated effort among many different governmental and nongovernmental organizations, as well as the active involvement and ownership of communities themselves. In other settings, USAID missions are supporting the formation of urban health coalitions or alliances to raise awareness about and mount interventions that focus on specific health problems. In India, for example, the USAID mission and EHP are working with a citywide coalition to define urban health priorities and launch specific interventions. In Nigeria, USAID has supported networks of CBOs and private medical practitioners in several cities. Likewise, in Bangladesh, USAID has supported networks of NGO service providers and municipal health authorities to further national urban health goals. In some cases, these programs have included small grants programs. In all cases, they have provided material support and technical inputs to upgrade the skills and quality of coalition members' work.

An urban action network or coalition is not an end in itself, but the means to an end. Such a network could be used with equal effect to (a) provide or improve reproductive health and other essential services for urban youth, (b) address the issues of child malnutrition and food security, (c) promote the urban water and sanitation planning and loan schemes described earlier, (d) improve targeting and effectiveness of urban malaria interventions, and/or (e) adapt and replicate a variety of other urban interventions that address public health priorities.

Description. In this case, USAID with the appropriate ministries and local government authorities would identify a city or cities for intervention and define an initial set of public health objectives. A series of workshops and consultations with organizations working in the targeted urban centers would involve discussion of what is known about the health situation of the low-income communities. Participants would be invited to form an urban health coalition around one or more public health objectives, and an initial plan of action would be generated with them. Depending on how much is known about the health problems in the target area, formative research might be required before finalizing an overall plan for technical assistance and support. If a small grants program were to be included, urban coalition members would be invited to submit proposals. These proposals would be reviewed and selections made in an open and transparent fashion. Whether small grants are part of the agenda or not, technical assistance would be provided to all coalition members according to the needs that they have helped to define. Such group assistance might include baseline and formative studies, development of information, education and communications strategies, training programs for organization staff, and so on.

Feasibility. More difficult than some of the others, but well worth consideration if USAID decides to target one or more cities for work on multiple health priorities.

Platform and organizational partners:

- The urban health coalition itself is the platform for health action. To guarantee participation by all potential partners, its leadership must be seen as neutral, that is, having no vested or conflicting interest with other coalition members.
- Organizational partners might vary depending on the public health objectives of an urban initiative, but, at a minimum, they should include representatives of city government, local health and water and sanitation officials, NGOs, key CBOs, and those USAID PVOs and cooperating agencies working in the defined urban area. Local research and training organizations may also be involved, as appropriate.
- Programs of this type are normally carried out with technical and administrative support from either a USAID cooperating agency or a bilateral contractor.

Option 9. Support a program to improve the quality of products and services provided by chemical sellers and pharmacies in urban settings.

Rationale: The franchising program for chemical sellers, which has been started by GSMF with support from MSH/SEAM and the Bill and Melinda Gates Foundation, addresses serious issues of access, quality, and affordability that affect both urban and rural residents. Because of the concentration of pharmacies in urban areas, however, there are currently no plans to implement the franchising scheme in Ghana's cities. Those involved with this scheme warn that stiff opposition from pharmacy interest groups has been a formidable obstacle to urban implementation.

The model developed by GSMF for franchising chemical sellers is potentially much more powerful and sustainable than any piecemeal approach to improving the quality of their services. But unless there are powerful champions for franchising in the cities - champions who are also willing to fight for the program—a better strategy might be to first allow the rural scheme to produce results and then, once it does, to begin pushing in earnest for its adaptation and implementation in the cities.

An argument can also be made for focusing on pharmacies as well as chemical sellers in urban areas. The urban poor rely on the services of both, and the quality of advice and products that both provide is known to be deficient. In this case, more information is needed to judge the relative importance of pharmacies versus chemical sellers before proceeding with the design of an urban intervention.

Description: The role of pharmacies and chemical sellers in treating malaria is well known; their role in treating ARIs, STIs, pregnancy-related conditions, diarrheal diseases and chronic illnesses in urban areas is less well documented. This effort should begin with an assessment of the health-seeking behavior of the poor in one or more of Ghana's cities; secondary analysis of existing urban data should also be undertaken to determine the specific roles that chemical sellers and pharmacies play, the costs of their services to the poor, and their knowledge, as a group, of the health conditions they see and the medicines they dispense. The SEAM baseline study may be helpful in this regard. With this information in hand, USAID would then support the design and implementation of specific interventions to improve the quality of treatment in urban settings.

There are a number of interventions that are already being implemented with urban chemical sellers. These could be intensified and offered, as appropriate, to pharmacies and chemical sellers in the future. They include short training courses to improve prescribing practices, such as the current effort by JHU/CCP and RollBack Malaria to improve malaria treatment practices. Expanding the line of pre-packaged products that are available to chemical sellers and pharmacies at wholesale prices might also improve treatment and result in lower prices to consumers. Likewise, producing job aids and counseling materials on the recognition of danger signs and the need for referral to higher level health providers might prove beneficial for poor clients. Finally, experimenting with networks of pharmacies and smaller satellite chemical

shops might produce better results in Ghana's cities than the franchising of chemical sellers alone.

Feasibility. Franchising of urban chemical shops appears to be impossible at the present time. Training, social marketing and other efforts to improve access to and quality of critical medicines in urban areas appears to be good.

Platform and organizational partners.

- The Pharmacy Council, SEAM/Ghana, GSMF and those in charge of the Ministry of Health's Rational Drug program would be natural partners in an effort to improve quality of care in pharmacies and chemical shops.
- If pharmacies as well as chemical shops are included in an intervention, the pharmacy association should also be engaged in the effort.
- The implementation mechanism for this work could be a USAID bilateral project or cooperating agency.

As mentioned earlier, this list of strategic options (public health priorities and possible activities) is not meant to be exhaustive. It is hoped, however, that it will provide USAID/Accra with specific programming ideas for consideration and develop further as the Mission moves forward with development of its new strategic plan.

6.3. Follow-up and Recommended Next Steps

The EHP Team departed Ghana on July 24, 2002, after a debriefing with Dr. Filomena Maxwell and Jayne Wickstrom at the USAID Mission. Follow-up to the mission on EHP's side has included:

- Preparation and presentation of a PowerPoint summary of findings and recommendations at USAID on August 8, 2002
- Preparation of this report, which was circulated to USAID/Accra and USAID/Washington before being finalized.

Recommendations to USAID/Accra for the possible use of this document during the Mission's strategy development process are as follows:

- USAID may wish to organize an internal review of the assessment's findings and recommendations. If a joint effort between the PHN, PL480, and democracy or economic development sectors is anticipated, all these groups should be involved in this review and discussion.
- To inform its staff and partners further about urban health issues, the Mission may wish to invite Ghana's urban "experts" to talk about their research findings and

program experiences. Researchers from Noguchi Memorial Medical Research Institute could be invited to speak to Mission staff and representatives of the cooperating agency, PVO, and bilateral community about the findings of the urban livelihoods study in Accra (Maxwell and others 2000). Staff of the UESP or former staff of AMEHI might likewise be asked to speak about the lessons learned in urban programming.

If USAID decides to include urban health in its new long-term strategy, the following activities would be appropriate in the next three to six months:

- Support an urban health working group that includes USAID staff; government, cooperating agency, donor, and NGO representatives; researchers; and so on (the concept of this working group is described under option 1, above. USAID could provide the venue for the meetings, a small amount of funding for secondary data analysis or preparation of briefing documents, and so on.
- Participate or designate one or more of the USAID partners participate in the national poverty reduction subcommittee that will address the cross-cutting issues of slum upgrading and abatement. The GPRS calls for establishing this subcommittee in 2003.
- Work with MEASURE/DHS and its Ghanaian partner organizations to address sampling and indicator issues raised in this report.

Annex 1: Scope of Work

Task Order

Urban Health Assessment—Ghana

Overall Purpose

To complete an assessment (i.e., a desktop study with original research including stakeholder interviews both in Ghana and in the US) of the health needs of the urban poor in Ghana and provide a road-map for future Mission interventions. The assessment information will be used to feed into the development of the Mission country strategy. Careful consideration should be given to opportunities for conducting urban health interventions in Accra as well as 2 or 3 secondary cities.

I. Objectives

- To assess the health needs of the urban poor in Ghana.
- To develop recommendations as to possible USAID interventions to serve this population.
- Develop a model approach for similar Urban Health Assessments to be conducted elsewhere in the developing world.
- To make recommendations on data collection that specifically targets the urban poor and communicate with Measure DHS plus about the possibility to over-sample urban poor populations during 2003 and later DHS. Begin similar discussions with UNICEF related to their MICS.

II. Background

The USAID Mission has made significant progress in improving the health of Ghana's poorest citizens. However, recent demographic changes have given us reason to re-examine the scope of these interventions. It is particularly important that, as Ghana's population increasingly resides in cities, we find new ways to ensure the health and well-being of the urban poor. Ghana is a democratic West African nation with a population of roughly 20 million people. In 1992, 31.4 per cent of Ghana's population lived in poverty (34.3 per cent in rural areas, 26.7 per cent in cities) with 74.6 per cent of its population living on less than \$2 per day and 39 per cent living on less than \$1 per day.²² The urban population currently constitutes 38 per cent of the total population and is growing at over twice the rate of rural areas (4.2

²² World Bank Development Indicators

and 1.7 per cent respectively).²³ At the current growth rate, the population residing in Ghana's cities will double in just 18 years, placing unsustainable pressure on the urban economy, infrastructure, and environment.

Urban poverty is growing as quickly as the urban population. Poverty in Accra, for example, grew from 9 per cent in 1987 to 20 per cent in 1993. More recent statistics are not available but there is no reason to think these trends have reversed. The urban poor face many of the same health challenges as their rural counterparts. At the same time, their dependence on the cash economy leaves them particularly vulnerable to macroeconomic shocks and structural adjustment programs that can cut into the profit margins of small scale entrepreneurs, raise the price of basic foodstuffs, and lead to an inability to access much needed health services. Given rapid urbanization, it is important that we achieve better understanding of the health conditions of the urban poor. We must also assist in the development of effective platforms from which urban public health services can be delivered. If we do not, we may miss an important opportunity to maximize the impact of USAID's health programs in Ghana.

At independence, Ghana was the wealthiest country in sub-Saharan Africa. Unfortunately, since the oil crises of the 1970s, Ghana has struggled through the ups and downs of chronic debt, fiscal turmoil and political change. GDP growth rates have been highly unstable, fluctuating between 4 and 5 per cent, on average, for over three decades. The economy is currently experiencing considerable distress due to a severe drop in the world price for cocoa and an increase in oil prices. The effect of these shocks has been compounded by shortfalls in donor support and weak fiscal policy. Economic growth was only 3.5 per cent in 2000.

The government has signed three structural adjustment agreements with the IMF - first in 1971, again in 1981 and most recently, in 1995. Some progress was made during the three-year time frame of the third agreement but fiscal deficits remain large. The adjustment process is necessary if Ghana is to achieve long-term prosperity. However, its immediate impacts have created new challenges for low income urban wage earners, the "new" urban poor (primarily civil service workers who have been laid off), the indigenous Ga peoples, and households headed by single women.²⁴

Despite considerable progress since independence, Ghana still faces serious challenges to the health of its population. In 1997, life expectancy in Ghana was 60 years. In 2000, life expectancy had actually dropped to 58. Just under 4 per cent of Ghana's adult population is infected with HIV/AIDS a phenomena which has resulted in over 170,000 orphaned children to date.²⁵ While total fertility rates have fallen from 6.4 births per female in 1988 to 4.6 in 1998, women continue to have more

²³ UN Population Division

²⁴*Urban Livelihoods and Food and Nutrition Security in Greater Accra, Ghana*. IFPRI www.ifpri.org/pubs/abstract/abstr112.htm

²⁵ UNICEF

children than they desire and suffer from many problems related to pregnancy and childbirth. Maternal mortality rates are 210 per 100,000. The prevalence of modern contraception use is only 10.1 per cent, on average, for women and 19.9 per cent for men. Men and women in the poorest income quintiles exhibit a prevalence that is half the national average.²⁶

Ghanaian children are beset by a number of diseases and high rates of malnutrition. While infant and under-five mortality rates have been cut in half since 1960, they are still high (57 and 108 per cent respectively).²⁷ Malaria is the number one cause of mortality for children under five, with pneumonia, diarrhea, malnutrition, neonatal causes, and measles also contributing to the unnecessary death of 100,000 Ghanaian children each year. Only 40 per cent of Ghanaian children are seen at a health facility during an episode of fever and these tend to be the more severely ill. The DHS found that 13.8 per cent of children under-five had experienced ARI in the two weeks prior to being surveyed. Twenty-six per cent of those affected had been taken to a health provider. Improved nutrition could prevent four out of every 10 deaths of children under 5.

More research needs to be done if we are to fully understand the health conditions of the urban poor in Ghana. Health statistics in Ghana, rarely desegregate urban data sets in way that would reveal the health conditions of the urban poor. At best, they are combined with those of better off urban residents creating statistical averages that hide the challenges faced by poor populations. In many cities, the poorest urban populations are not even sampled, leaving us with little if any information about their health and access to services. There is good reason to be concerned about this lack of data as, in many countries, the health of the urban poor is as bad, if not worse than that of their rural counterparts. The urban poor often live in unsanitary, crowded conditions, which are breeding grounds for infectious disease. Further, while they may be close to medical facilities, research has shown that the urban poor face a number of barriers to accessing these services. Financial restraints and social taboos can act as barriers, as can lack of education and, in the case of peri-urban slums, even transportation.

The limited data that is available on the urban poor in Ghana gives cause for concern. A recent Core Welfare Indicators Questionnaire supported by the MELISSA Program shows that while more of the urban poor have access to health services (49.7 per cent) than the poor living in rural areas (23.2 per cent), about the same percentage actually makes use of available health services (18.9 per cent compared to 16.7 per cent). Basic health indicators for children appear to be very similar with slightly more of the rural poor being underweight, yet slightly more of the urban poor showing signs of wastage. There is also room to be concerned as the current economic turmoil has been shown to adversely effect the nutritional status and food security of the urban

²⁶ DHS

²⁷ DHS, 1998

poor.²⁸ We need to more clearly understand the health impacts of economic transition on these populations. We also need to gain a clearer understanding of the way in which we might have to change our traditional interventions to more effectively reach the urban poor.

A clear understanding of the roles and responsibilities of different layers of government is an important first step to more effectively delivering health services to the urban poor. The central government has always had a circumspect view of decentralization - in part due to a fear that the empowerment of local governments would lead to conflict between the 90 different ethnic groups that coexist in Ghana. Despite these concerns, Ghana initiated a massive decentralization process guided by the passage of law 207 in 1988. The result was a partial devolution of the responsibility for the delivery of a wide range of services to local governments. A parallel attempt to decentralize health services was initiated in the same year.

The delivery of public health services in Ghana has traditionally been controlled by the Ministry of Health, which manages the regional and district health administrations, 9 regional and 85 district hospitals and the subdistrict administrations and health centers. In 1996, the Ghana Health Service and Teaching Hospital Act was passed, giving way to an accelerated process to decentralize the delivery of public health services. Reforms were designed to decentralize fiscal responsibilities within the health sector and reassign responsibility for service delivery to a new, autonomous state agency - the Ghana Health Service (GHS). The role of the Ministry of Health was to be scaled back to one of formulation and oversight. The full transition has yet to be implemented and the exact effect of the decentralization of services on the health of Ghanaians remains to be seen. There is also considerable confusion over the relationship between the 110 district assemblies formed under law 207 and the local public health delivery units. Law 207 places the responsibility for local health service delivery under the purview of the district assemblies. However, it is unclear that this shift in control will actually happen and DAs are currently relegated to a very marginal, advisory role within the public health system.

To date, the mission's health activities have been focussed in three areas: family planning, HIV/AIDS and child health. The mission has experienced considerable success in addressing the challenges to be faced in these areas. However, the mission has yet to fully investigate the challenges faced by the poor living in cities. UNICEF, WHO, DFID, the MELISSA PROJECT, JICA, DANIDA and the World Bank also support health projects in Ghana, though their interventions in urban areas are limited. IFPRI has recently initiated a program to analyze the food security of the urban poor in Ghana. Their research should be useful to the project at hand.

²⁸ Maxwell, Daniel; Carol Levin; Margaret Armar-Klemesu; Marie Ruel; Saul Morris; and Clement Ahiadeke. *Urban Livelihoods and Food and Nutrition Security in Greater Accra, Ghana*. Research Report 112. IFPRI. 2000. www.ifpri.org/pubs/abstract/abstr112.htm

Statement of Work

a. Assessment Tasks

1. Collect and synthesize materials that describe the health status of poor urban residents. Information should be collected on the effects of childhood diarrhea, HIV/AIDS, malnutrition, TB, malaria, perinatal, under five and maternal mortality and morbidity of urban (poor) residents.
2. Analyze demographic patterns of urban poor residents (origins, rural/urban relationships, migrations).
3. Analyze the need for urban family planning interventions.
4. To the best of their ability, the contractors should assess the health conditions of urban poor children in Ghanaian cities, paying close attention to the risk factors and behaviors contributing to their overall health status and collecting statistics where possible. Factors to include:
 - a. availability of antenatal care,
 - b. length and use of breastfeeding,
 - c. ORT use,
 - d. vaccination rates,
 - e. vitamin A supplementation,
 - f. nutritional status,
 - g. care seeking and case management for key illnesses
 - h. environmental health factors related to key childhood illnesses (DD, malaria, ARI) to include
 - i. Potable water sources: availability, accessibility, affordability for the urban poor
 - ii. Excreta disposal options for the urban poor
 - iii. Solid waste disposal
 - iv. Flooding, drainage and stagnant water
 - v. Housing conditions, crowding

- i use of preventive practices such as hand washing, safe in-home water storage, safe disposal of children’s feces, use of insecticide treated bednets.
5. Analyze existing programs and community structures that could serve as a platform from which urban health interventions are or could be launched;
6. Assess intergovernmental roles and responsibilities for health-related service delivery in Ghanaian cities and the strengths and pitfalls of decentralized control over the delivery of these services;
7. Assess the role of both private (including “mutuelles” and local healers) and public health service providers, USAID and other bilateral/multilateral donors, and NGOs in the delivery of health services to the urban poor.

b. Recommended Approach

The contractor should draw from a number of sources to complete this analysis. At a minimum the contractor should fully analyze USAID sponsored projects implemented in Ghana by MOST, BASICS, Partnerships for Health Reform (PHRplus), LINKAGES, PRIME II, JHPIEGO, EngenderHealth, JHU/CCP, and NGOs/PVOs.

The contractor should also understand the Mission's involvement in the CHIPS program (www.ghana-chips.org).

The contractor should interview officials (both in DC and Ghana, as relevant) from UNICEF, WHO, DFID, the MELISSA PROJECT, IFPRI, and the World Bank as these organizations have either recently completed or are supporting on-going health-related projects in Ghana.^{29 30}

The contractor should also interview persons from organizations that have addressed, or are addressing, family planning and safe motherhood issues in Ghana.

Interviews should be conducted with local NGOs working in slums to get their take on health conditions where they work and the contributing factors behind these conditions.

While in Ghana, the contractor should be sure to contact the Ministry of Health in Ghana and interview a selection of local government officials and donors who are charged with the implementation of public health projects. The purpose of these interviews will be to collect references and data that might not otherwise be available, glean a broad picture of government and donor activities in the health sector, and

²⁹ See the attached bibliography for background materials that might focus the lines of inquiry.

³⁰ The USAID/Washington team can help the contractor acquire a copy of a recently completed health sector donor map for Ghana, which should be helpful in this endeavor.

achieve a clear understanding of potential points of intervention to support successful delivery of health services to the poor in Ghanaian cities.

Interviews should be conducted with local NGOs working in slums to get their take on health conditions where they work and the contributing factors behind these conditions.

Suggested USAID interventions should account for the need for urban health services amongst the poor, the activities of other donors and the Ghanaian government, current and potential USAID mission activities as well as funding possibilities and limitations. The contractor should analyze the costs and benefits of allocating scarce resources to this pursuit.

c. Steps of Assignment

- Participate in a Team Planning Meeting to clarify purpose, outcomes, final products, roles and responsibilities.
- Conduct literature review designed to analyze available data and information as to the health status of poor urban residents in Ghana and platforms for health service delivery. *(NB. contractor is authorized to pay for particularly relevant publications if they are not otherwise available at no cost)*
- Interview donor counterparts here in DC (in particular, the World Bank) who are currently working on projects related to the health status of the urban poor in Ghana.
- Travel to Ghana - collect data and interview donors, NGOs and government officials regarding the health status of the urban poor, the platforms available for urban health services delivery and their quality, the relationships between governmental, non-governmental and private-sector service providers.
- Contact local representatives of Measure/DHS Project and UNICEF to discuss adapting upcoming DHS and MICS to collect data specifically about the urban poor.
- Debrief the Ghana USAID Mission on findings and key recommendations.
- Compose a draft assessment. Send electronically to mission and DC team members for evaluation.
- Develop a PowerPoint presentation of initial draft of assessment and present to a DC audience chosen by the team. Hard and electronic copies of the presentation should be available.
- Collect and incorporate AID responses to first draft into second draft document. Send to counterparts in DC and the Mission for comments.

- Incorporate second round of comments into final draft.

Deliverables

The final document should include a detailed analysis of:

- The health status of poor populations Accra and 2 or 3 secondary cities (to be identified in concert with USAID/Ghana).
- The availability of health-related services (including access to potable water and sanitation) in the target geographic areas.
- The current and ideal roles and responsibilities of the different levels of government, donors, NGOs and the private sector in health service delivery, including environmental health, in the targeted Ghanaian cities.
- The capacity of different levels of government, within NGOs, in the private sector to deliver health-related services.
- Lessons to be learned from existing success stories in the delivery of health services, including environmental health, to the urban poor in Ghana.
- Recommendations as to future USAID interventions (including health delivery services, environmental health, and policy reform, as appropriate)- in Accra and 2 or 3 secondary cities - that will improve the health of the urban poor in Ghana. This should include how DHS and MICS surveys could be adapted to collect data specifically about the urban poor.

Upon completion, the contractor will provide 10 copies of the assessment that details urban health needs in Ghana and outlines a few ways USAID could intervene to improve the situation. The result should include a blueprint for an urban assessment tool that can easily be used in other developing countries. A draft of the product will be provided by August 15, 2002, and the finished product is due no later than September 15, 2002.

Qualifications

The completion of this task will require the attention of a one senior-level health professional with technical expertise in design and delivery of health programs, especially for USAID, in developing countries. The second position will require a broad public health background including experience in environmental health and experience working with USAID. Both team members should be well versed in the institutional and organizational context for urban slum public health and environmental programs, especially in West Africa, and have a clear understanding of the strategy development process.

The contractor(s) selected to head the assessment team should, at minimum, have the following qualities:

- Work experience in Ghana or similar West African countries.
- 4+ years of USAID program relevant experience.
- Good writing skills and a proven ability to produce a quality document in a timely fashion.

The contractors will work in concert with 2 Ghanaian consultants approved of by the Mission. The qualifications of the Ghanaian consultants should complement the contractor team. A person with a strong understanding of the Ghanaian institutional context for urban health work will be particularly useful. The Ghanaian counterparts will participate in all meetings and field visits, and share responsibility for the final product. Exact roles, responsibilities and contributions will be determined during the planning meeting once the contractors arrive in Ghana.

Relationships and Responsibilities

The contractor will report directly to SO 3 team leader. The Mission will be supported by three team members in USAID/Washington: Holly Fluty-Dempsey (USAID/AFR), John Borazzo (USAID/BGH/EHP), and Stephanie Wilcock (USAID/EGAT/UP). If the contractor needs assistance while in the US, the contractor should contact a member of the Washington team to determine whether a solution can be found without burdening the Mission. Unless there is a specific request to the contrary from the Mission or Ms. Fluty-Dempsey, the Mission and the entire Washington team should be cc'd on all e-mails.

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Level of Effort

Tasks	Facilitator	Health Spec.	EH Spec.	AM	AAM	Eddy	Craig	Eckhardt	Sandy	May	David	Ghana Consultant #1	Ghana Consultant #2
1. TPM	2.5	2	2	1	2	.5	.5	.5	.5				
2. Literature Review in U.S.		2	2	1	1								
3. U.S. Interview donors/Cas		2	2										
5. Travel to Ghana		2	2	.5	1								
6. Prep meetings		2	2									2	2
7. Interviews with GOG and Cas		3	3									3	3
8. Field visits in Accra		1	1									1	1
9. Field visits to Kumasi and Takoradi		5	5									5	5
10. Draft assessment in Ghana + debrief		2	2									2	2
11. Return to U.S.		1	1										
12. PowerPoint presentation in DC		1		1	1	.5	.5	.5	.5				
13. Finalize Document		1	1							1	2		
TOTAL	2.5	24	23		5	1	1	1	1	1	2	13	13

SCHEDULE

Team Planning Meeting	June 24, 25
Desktop literature search and	
Interviews with CAs/donors	June 26-28
Arrive in Ghana	July 8
Prep meetings in Accra	July 9,10
Interviews in Accra	July 11, 12
Field visits to Accra slums	July 13 (Sat.)
Field visits to Kumasi and Takoradi	July 15-20
Draft and debrief Mission	July 22,23
Return to U.S.	o/a July 24
PowerPoint in DC	week of August 5
Finalize draft document	August 15
Finalize document	September 10

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Child and Teen Focus
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ISODEC

CEDPA

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GUNSA

Bible Society

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Also:

Kumasi Health Team Proposals prepared by Dr. Agatha Akua Bonney

- Improving the Ambulance Rescue Services in Ashanti Region,
- Malnutrition in the Kumasi Metropolis: The role of Rehabilitation Centers,
- Improving Immunization Status of Children in Kumasi
- Enhancing maternal health care services in Kumasi
- Better health through effective health education on personal hygiene and the environment in Ashanti Region, Ghana

EHP notebook with: (A) Water and Sanitation Indicators Measurement Guide; (B) Prevention of Diarrhoea in Young Children in Developing Countries; (C) Effects of Improved Water Supply and Sanitation on Ascariasis, Diarrhoea, Dracunculiasis, Hookworm Infection, Schistosomiasis, and Trachoma; Family and Community Practices Which Promote Child Survival, Growth and Development: A Review of the Evidence.

Annex 4: Comparison of Urban/Rural Indicators Cited in the GPRS

The following indicators are among those that were used in priority setting exercises during the GPRS process. In most cases, they clearly justify directing special attention to the northern regions, but they do not justify placing urban issues or the country's largest cities at the bottom of the national priority list. Our commentary points out what is actually being measured in each case and, when appropriate, why those living in Ghana's urban areas, too, deserve the national government's attention.

Population living in poverty

5 % Greater Accra

19% Urban

69-88% Three northern regions

(GPRS, 2002-2004)

Extremely high poverty rates in the northern regions justify giving them top priority. However, the true extent of urban poverty is underestimated. If urban poverty is as high as 30%, which is very possible, then 2.5 of the 8.3 million Ghanaians who currently live in cities and towns are living in poverty. Even though this number is comparable to the number of poor in the three northern regions, the urban poor are given very low priority in the GPRS.

U5MR

77/1,000 urban

122/1,000 rural

171/1,000 Northern region

(GDHS, 1998)

MMR

193 coastal

245 north

(Twum-baah in Bosu, et al, 2000)

The magnitude of difference in child and maternal mortality is expected when comparing well-equipped and well-staffed urban centers with resource poor rural areas. This indicator definitely supports the government's efforts to increase personnel and facilities in the north, but urban rates are not yet high enough to justify inattention to maternal or child health in the cities.

Access to safe water

92% urban

83% urban poor

51% rural

(CWIQ 1997)

This indicator tells us that there is piped water within walking distance, but it tells us nothing about the cost, the quantity a family is able to purchase, or how they store their water. All of these are more important indicators in terms of health in urban areas than is physical proximity to a water pipe or to a vendor who is selling piped water.

Births attended by doctor/nurse or midwife

78% in urban

33% in rural

(GDHS, 1998)

This indicator justifies the government's strategy of posting newly trained health professionals in rural areas. This indicator tells us about access to Western trained health providers and the degree to which people use their services. Urban and rural rates on this indicator may never be equal because of the natural tendency of highly trained individuals to move to the cities. The goal is to have all births attended by a trained attendant, not necessarily by a physician or nurse, although proximity to this level of trained health provider when emergencies occur is important.

Allocation of government inputs

1.9 = ratio of government expenditure in urban versus rural areas.

Accra and Kumasi teaching hospitals account for half of all publicly employed doctors (Bosu et al 2000).

The teaching hospitals clearly have many more physicians and nurses assigned to them than is equitable. This justifies the government's effort to reallocate personnel and decongest the teaching facilities. Hospitals, most of which are in urban areas, also consume an unfair share of the national health resources. At the same time, however, when the teaching hospitals are factored out, Greater Accra and Kumasi have the highest ratios of population to primary and secondary health facilities in the country.

Annex 5: Summary of Government Policies

Level of Government	Pro-urban, pro-poor policies?	Policies potentially detrimental to urban poor?
National: Ghana Poverty Reduction Strategy (2002-2004)	<ul style="list-style-type: none"> • All pro-poor • Focus on northern regions, rural development, agricultural development • Focus on better urban planning to improve urban environment • Urban water and sanitation needs given some attention • Slum upgrading only in long-established neighborhoods • Slum abatement subcommittee (multisectoral) to be established under MLGRD in 2003 • Strengthening of District Assemblies and their Environmental Health Departments • Engage civil society, NGOs and community in planning and monitoring 	<ul style="list-style-type: none"> • Urban issues given little priority • Accra seen as lowest priority for poverty reduction and development investments, because of past “urban bias” • Application of national poverty line to establish priorities for investment biased against large cities and poor who live there • Donor assistance, per sector wide approach, will adhere to GPRS priorities
National: Ministry of Health/Ghana Health Services from “Second Health Sector 5-Year Programme of Work, 2002-2006, and interviews with MOH officials at national level and GHS officials at regional, metro and submetro levels	<ul style="list-style-type: none"> • More attention to cost-effective preventive interventions • Conversion of submetro polyclinics to general hospitals to improve quality of care and decongest teaching hospitals • Increased outreach to deprived areas, but community outreach model (CHPS) is not yet adapted for urban areas • Sustainable financing arrangements that 	<ul style="list-style-type: none"> • Improved resource allocation to target the poor and vulnerable, including redistribution of health workers to deprived areas. These are mostly rural areas and northern regions. • No specific focus on urban areas as they are not considered deprived • Present cash and carry fee system keeps poor from accessing health care, • Current exemption policies are neither applied consistently nor

Level of Government	Pro-urban, pro-poor policies?	Policies potentially detrimental to urban poor?
	<p>protect the poor – health insurance, social security schemes – but these schemes are not yet adapted for urban areas or urban poor</p> <ul style="list-style-type: none"> • Intersectoral collaboration for health related issues like sanitation and nutrition • Expanded view of health sector, partnerships with communities, civil society, NGOs and health sector and between public and private sectors • Decentralizing health staff management – more local control 	<p>funded appropriately</p>
<p>MLGRD Interviews with Engineer and those involved in UESP program</p>	<ul style="list-style-type: none"> • Local planning and implementation of infrastructure projects • Development of capacity within District Assemblies • Publication of Environmental Health Policy defining role of District Assemblies and Environmental Health Offices 	
<p>Ministry of Works and Housing</p>	<ul style="list-style-type: none"> • Privatization of urban water system, if this implies improved availability at reasonable cost • Replacement, expansion of water infrastructure in urban areas 	<ul style="list-style-type: none"> • Privatization of urban water system, if this implies higher fees and no improvement in water availability
<p>Metro Assemblies From interviews with Metro Chief Executives and Metro Medical Officers in Accra and Kumasi</p>	<ul style="list-style-type: none"> • Improving infrastructure – drainage, processing of human and liquid wastes, roads, etc. • Solid waste disposal - landfills, collection and disposal 	<ul style="list-style-type: none"> • Privatizing/contracting out management of city services (+ and -) • Enforcement of sanitation and hygiene regulations • Decongesting city streets by fining and forcing street vendors into assigned areas

Level of Government	Pro-urban, pro-poor policies?	Policies potentially detrimental to urban poor?
	<ul style="list-style-type: none"> • Privatizing/contracting out city services (+ and -) • Improved coordination and joint planning by the sectors working in cities 	<ul style="list-style-type: none"> into assigned areas • Revenue generation – using public lands productively, increasing fees for utilities, collecting fines, etc. • Selective application Matching contribution for household toilet connections – too high for urban poor to pay • Slum abatement