

A Situation Analysis of Ghanaian Children and Women

A Call for Reducing Disparities and Improving Equity

PREFACE

Over the past few years, Ghana has earned international credit as a model of political stability, good governance and democratic openness, with well-developed institutional capacities and an overall welcoming environment for the advancement and protection of women’s and children’s interests and rights. This Situation Analysis of Ghanaian children and women provide the status of some of the progress made, acknowledging that children living in poverty face deprivations of many of their rights, namely the rights to survive, to develop, to participate and to be protected. The report provides comprehensive overview encompassing the latest data in economy, health, education, water and sanitation, and child and social protection. What emerges is a story of success, challenges and opportunities.

The findings show that significant advances have been made towards the realisation of children’s rights, with Ghana likely to meet some of the MDGs, due to the right investment choices, policies and priorities. For example, MDG1a on reducing the population below the poverty line has been met; school enrolment is steadily increasing, the gender gap is closing at the basic education level, child mortality has sharply declined, full immunization coverage has nearly been achieved, and the MDG on access to safe water has been met.

However, the report acknowledges that challenges remain in relation to particular areas of child development, such as nutrition, in maternal mortality reduction and access to improved sanitation, and the evidence indicates that some groups of children, such as those living in rural areas and in northern Ghana and those that are orphaned and vulnerable, are not benefiting from growth and poverty reduction as much as other children. These poorest and most vulnerable children are increasingly bearing a disproportionate proportion of the disease burden, of deprivation and of rights violations. The report also highlights the importance of capacity development for sustainable improvements in child friendly services.

The achievements of the Government will be measured, not just by the improvement in the political and economic situation, but by how successful it has been in helping women and children, especially the poorest and most vulnerable, to realize their rights. The Situation Analysis provides useful insights on the extent and depth of some of the achievements, opportunities and challenges. The analysis goes beyond the national averages to uncover some of the trends in inequity and vulnerability by geography, gender and by socio-economic quintiles, among other variables. Hence, beyond describing the problem, it illustrates some examples of successful programmes that are addressing these problems and, where available, provides information on lessons learned and makes important recommendations that Government and its stakeholders could use in improving the situation of children and women in the country. It provides a baseline for the Government of Ghana/UNICEF 2012-2016 Programme of Collaboration.

Overall, there is a strong commitment to accelerating results for the survival and development of Ghana’s children and women, and there is a greatly improved operating environment for implementing the necessary activities. While many vital steps are identified in the plans and policies of many of the sector ministries, the Situation Analysis provides a comprehensive overview, allowing us to understand the overarching situation of children and women in Ghana today, pointing to areas where closer collaboration can increase efficiency and effectiveness, and highlighting some of the challenges that exist in prioritizing our actions for children, including, allocating resources to the poorest and most deprived in the society. The Situation Analysis will therefore serve as an excellent resource for planning, guiding the definition of goals and the identification of actions that will prove most effective in delivering results for Ghana’s children and women.

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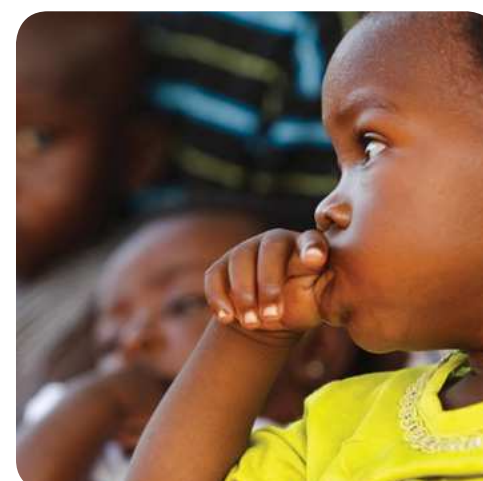
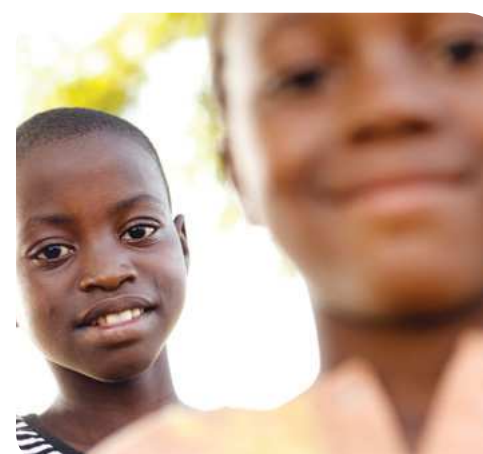
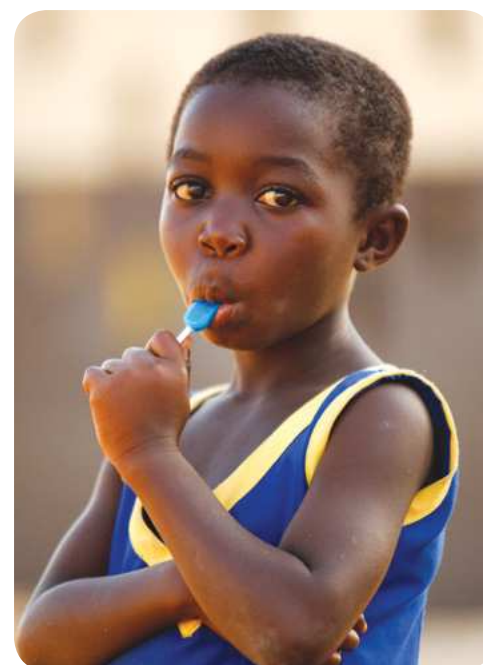
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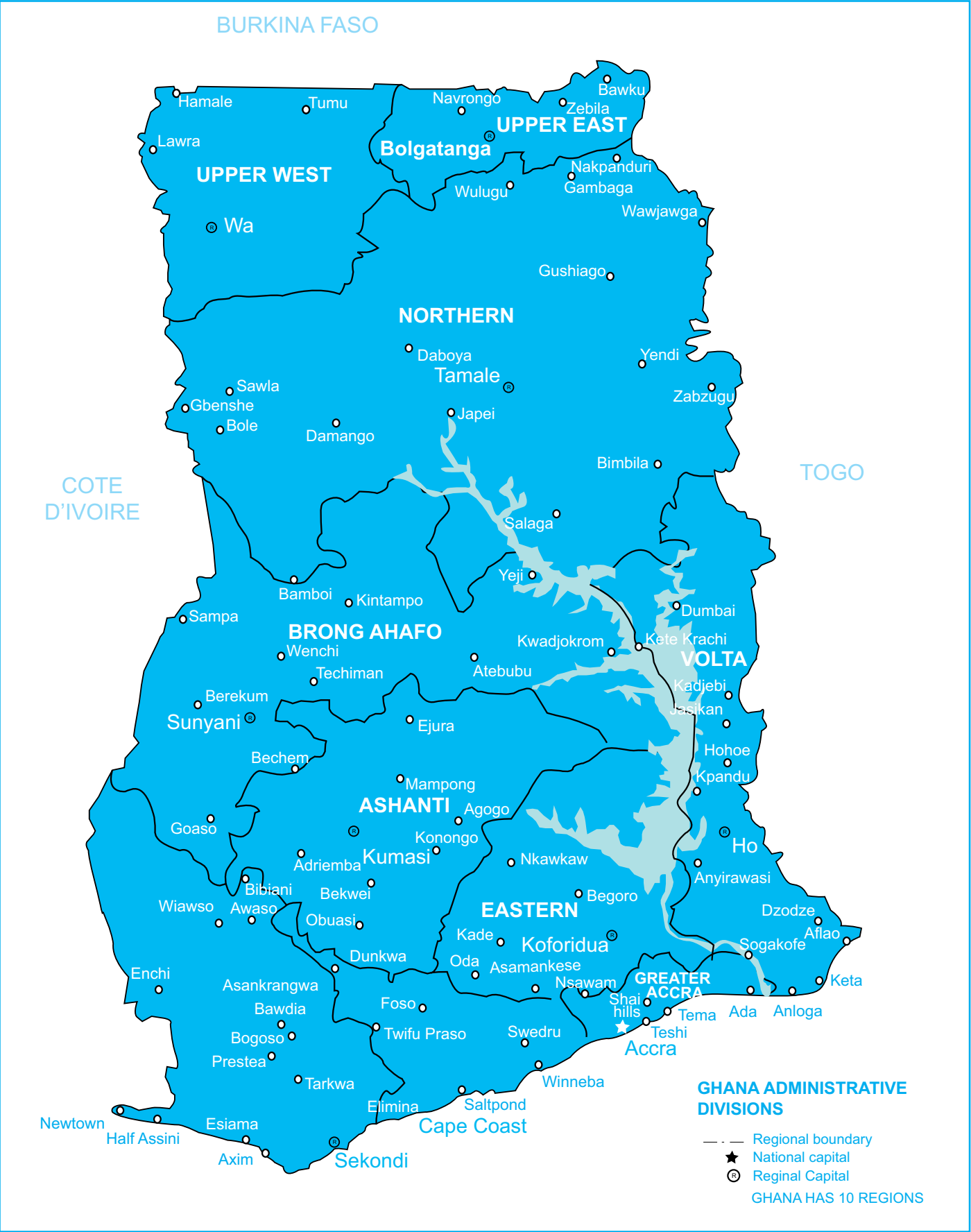
LIST OF ACRONYMS AND ABBREVIATIONS

ACSD	Accelerated Child Survival and Development
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral therapy
BCG	Bacillus Calmette-Guérin (vaccine)
BECE	Basic Education Certificate Examination
CBR	Community-based rehabilitation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CLTS	Community-Led Total Sanitation
CPI	Consumer price index
CRC	Convention on the Rights of the Child
CRRECENT	Child Research and Resource Centre
CSO(s)	Civil society organization(s)
DFID	Department for International Development (United Kingdom)
DOC	Department of Children
DOVVSU	Domestic Violence and Victim Support Unit
DPs	Development partners
DPT	Diphtheria-pertussis-tetanus
DSW	Department of Social Welfare
ECD	Early childhood development
ECCD	Early childhood care and development
ECOWAS	Economic Community of West African States
EFA	Education for All
EMIS	Education Management Information System
EMONC	Emergency Obstetric and Newborn Care
EPA	Environment Protection Agency (Ghana)
EPI	Expanded Programme on Immunization
ESP	Education Strategic Plan
FAO	Food and Agriculture Organization (UN)
FGM	Female genital mutilation
F-CUBE	Free compulsory universal basic education
GDHS	Ghana Demographic and Health Survey
GDP	Gross domestic product
GER	Gross enrolment rate
GES	Ghana Education Service
GH¢	Ghana (new) cedi(s)
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GNCC	Ghana National Commission on Children

GoG	Government of Ghana
GPI	Gender parity index
GPRS I	Ghana Poverty Reduction Strategy (2003–2005)
GPRS II	Growth and Poverty Reduction Strategy (2006–2009)
GSGDA	Ghana Shared Growth and Development Agenda (2010–2013)
GSS	Ghana Statistical Service
HDI	Human Development Index
HIRD	High Impact Rapid Delivery
HIV	Human immunodeficiency virus
IDA	International Development Association (World Bank Group)
ILO	International Labour Organization (UN)
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant mortality rate
IPEC	International Programme for the Elimination of Child Labour (ILO)
ISODEC	Integrated Social Development Centre
ITN	Insecticide-treated (bed) net
JMP	Joint Monitoring Programme (WHO/UNICEF)
JSS	Junior secondary school
LEAP	Livelihood Empowerment Against Poverty
MDBS	Multi-donor budget support
MDAs	Ministries, departments and agencies (Government of Ghana)
MDG(s)	Millennium Development Goal(s)
MESW	Ministry of Employment and Social Welfare
MIC(s)	Middle-income country/ies
MICS	Multiple Indicator Cluster Survey(s)
MiDA	Millennium Development Authority
MLGRD	Ministry of Local Government and Rural Development
MMR	Maternal mortality rate
MMYE	Ministry of Manpower, Youth and Employment
MoE	Ministry of Education
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
MoWAC	Ministry of Women and Children's Affairs
NACP	National AIDS Control Programme
NCRIBE	National Centre for Research into Basic Education (University of Education, Winneba)
NDAP	National Decentralization Action Plan
NDPC	National Development Planning Commission
NEPAD	New Partnership for Africa's Development
NER	Net enrolment rate
NGO(s)	Non-governmental organization(s)
NHIS	National Health Insurance Scheme
NIDs	National Immunization Days
NPA	National Plan of Action
NPECLC	National Programme for the Elimination of Worst Forms of Child Labour in Cocoa

NSPS	National Social Protection Strategy
ODA	Official Development Assistance
ODI	Overseas Development Institute (UK)
ORS	Oral rehydration salts
OVC	Orphans and vulnerable children
PMTCT	Prevention of mother-to-child transmission (HIV)
PoW	Programme of Work
PPVA	Participatory Poverty and Vulnerability Assessment
PRSP(s)	Poverty Reduction Strategy Paper(s)
PTA	Parent Teacher Association
PTR(s)	Pupil-teacher ratio(s)
PSIA	Poverty and Social Impact Assessment
PWP(s)	Public works programme(s)
SADA	Savannah Accelerated Development Authority
SCN	Standing Committee on Nutrition (UN)
SPS	Social Protection Strategy
SSNIT	Social Security and National Insurance Trust
STI(s)	Sexually transmitted infection(s)
SWA	Sanitation and Water for All
SWAp	Sector wide approach
U5MR	Under-five mortality rate
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USA	United States of America
USI	Universal salt iodization
USAID	United States Agency for International Development
UTDBE	Untrained Teachers’ Diploma in Basic Education
WASH	Water, Sanitation, and Hygiene
WCARO	West and Central Africa Regional Office (UNICEF)
WFCL	Worst forms of child labour
WFP	World Food Programme (UN)
WHO	World Health Organization (UN)

MAP OF GHANA





EXECUTIVE SUMMARY

AS Ghana embarks on its third medium-term development plan, the country stands at a crucial turning point. The question now is how to build on its strong institutional foundations, its legacy of open and democratic governance, and its impressive achievements in economic growth to achieve tangible results in human development – which, sadly, are still denied to a substantial proportion of Ghanaians, children and women, chief among them.

Towards the end of 2010, Ghana declared that it had realized its longstanding goal of becoming a middle-income country – that is, one with a per capita GDP of \$1,318 – and it announced a budget for the coming year that would see income begin to flow (at an initial rate of nearly a half-billion dollars a year) from the offshore oil reserves discovered in 2007.

Against this promising background, Ghana faces both challenges and opportunities. The main challenge is to fulfil the promise spelled out in the new development plan to deploy Ghana's resources in an equitable manner to meet the needs of the country's most deprived and marginalized communities. The biggest opportunity is the chance to be among the first developing countries to demonstrate that by prioritizing resources to those areas and groups most in need, the benefits of equity and empowerment will spread such that the rewards of economic growth and political liberalization will be shared by the population as a whole.

While justifiably taking pride in a steady growth rate of around 6 per cent a year in gross domestic product, reducing the fiscal deficit, holding down inflation, and building up international reserves – all while rebounding from the global economic crisis – Ghana's leaders must still address the fact that just under a third of the country's population are living below the upper poverty line, with nearly a fifth of the population living in extreme poverty. For this large segment of the population, middle-income status will remain meaningless unless and until it is translated into policies that transfer wealth to the poor.

Fully half of those living in poverty are children under the age of 18, and most of these live in areas of the country that have long been identified as “*deprived*” regions and districts – both rural and urban – and where a host of governmental and non-governmental agencies have long been at work trying to address the root causes of that discrimination. For all these efforts, tangible improvements have been frustratingly slow due to formidable patterns of marginalization, traditional practices, unfavourable environmental factors, and stubborn resistance to behavioural change.

Employment remains a critical priority for Ghana, with economic growth unmatched by the expansion in job opportunities in the formal economic sector. Low-wage employment in

agriculture remains the livelihood for the vast majority of Ghanaians, men and women alike, and this sector is increasingly subject to the vagaries of climate change, with periods of drought alternating with periods of flooding. This has resulted in a rate of “*vulnerable employment*” of around 75 per cent. Modernization of agriculture is cited as the top priority in the government's medium-term investment plan for 2011 and beyond, and it must be accompanied by a broader restructuring of the economy to create job opportunities beyond the informal sector. This is a matter of particular urgency for youth, in a country with a median age of around 19 years.

This situation analysis highlights this challenge, demonstrating that the great progress that Ghana has steadily maintained since its independence from the United Kingdom in 1957 is still encumbered by the enduring burden of poverty and by stark disparities defined by gender, geography, and socio-economic groupings. These have proved sufficiently daunting as to be likely to prevent Ghana from achieving most of the Millennium Development Goals (MDGs) by 2015.

Although Ghana is one of only a handful of sub-Saharan nations that are on track to achieve the poverty-reduction target of MDG 1, the challenge of poverty underlies virtually every indicator and trend highlighted in this report. As this report demonstrates, the burden of poverty falls most heavily on children and women. Perhaps the most troubling characteristic of poverty in Ghana is its persistent “*inter-generational*” nature: that is, when poverty excludes children from enjoying their rights to education, health care, and protection, it also locks them into a cycle that is tragically bequeathed to the next generation.

Poverty in Ghana is not an exclusively rural phenomenon. Increasing migration has created growing slum communities in and around the main cities, inhabited mostly by children and women. But this poverty has its origins in the marginal existence that is the norm for many Ghanaians for whom agriculture – both in subsistence form and as sharecroppers – is their only source of sustenance. Migration is also fuelled by climate change, which has reduced growing seasons and yields, cut earnings, and created the phenomenon known as “*seasonal hunger*,” which has become the norm for a large number of Ghanaian families.

Furthermore, poverty increases the vulnerability of Ghana's children and women to other self-perpetuating challenges that will require a sustained and concentrated effort – in thousands of local communities – to overcome. Not surprisingly, poor communities have low levels of access to health and education services. Poverty inevitably excludes children from enjoying their rights to education; it prevents women from having access to maternal health care; and it drives a painful wedge into families, prompting children and women to leave their households and migrate to the cities, thus exposing them to exploitation and trafficking.

Households headed by women, whose husbands have left in search of work, are the most vulnerable because of traditional practices that exclude women from economic participation or ownership of assets. Girl children are the most vulnerable of all: the first to leave school and the most susceptible to migration, to living in the street, to early marriage, and to other harmful practices. Women without education, in turn, are those most likely to be found presiding over households in which children are kept from school and who go without adequate health care.

This report shows that Ghana provides a positive enabling environment for understanding and addressing the challenges it faces. The legislative and policy framework is strong on issues of relevance to children and women. The three most recent medium-term plans have been characterized as “*pro-poor*”; and the just-ended second Poverty Reduction Strategy had among its aims to “*eliminate the worst manifestations of poverty, social deprivation, and economic injustice*,” with a specific emphasis on addressing urban/rural and rich/poor disparities and on achieving the MDGs. Attainment of the MDGs has been written into all development planning and specifically into the national plans of action in the key areas of concern, which are being closely coordinated with UNICEF and Ghana’s other development partners.

The Government of Ghana has developed a policy of decentralization to ensure a more equitable distribution of resources and to enhance the delivery of services at the local level, and that mechanism and the challenges encountered in implementing it are discussed here in detail. The report notes that there is a multitude of actors, including the government’s own ministries, departments, and agencies, as well as NGOs and UN agencies, who are ready to assist.

Throughout the report, capacity gaps hindering the effective delivery of services are noted, and the increasing empowerment of district-level officials and committees – often without requisite training and often unequipped with provisions for accountability and transparency in their handling of allocated funds – only underscores the urgency of closing these gaps. The development of human resources at the district level, and of transparent methods of data gathering, monitoring, and accountability, will in the coming years determine to a great extent the success or failure of the government’s decentralization agenda. This is a role that Ghana’s development partners, including UNICEF and other UN agencies working with local community-based and civil society organizations, can usefully fill.

Closing capacity gaps will also entail closing the “*disconnects*” between the policies laid out in admirably pro-poor and pro-child policies, such as the National Action Plans, and the means and resources to activate those policies. This also applies more broadly to policies and procedures instituted to place essential public services – chiefly education, health, and water, sanitation, and hygiene – under the aegis of the District Assemblies.

The report also documents concerns about skewed budget priorities in areas of special concern to children and women. While the multifaceted array of social assistance and social insurance programmes gradually put into place under the National Social Protection Strategy appears to have made a real difference in the lives of the most marginalized and most vulnerable members of society, the report reveals concerns about the effectiveness and targeting nature of the programme, for which reason a needs assessment is currently being carried out.

The issue of fiscal space also arises in the case of the funding of social protection programmes, and there are potentially useful synergies between social protection and human rights-based child protection programmes that need to be developed. Notably, Ghana was the first country to ratify the UN Convention on the Rights of the Child (CRC), and it has integrated the principles of the CRC and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) into national laws, as well as into the programmes of work and Plans of Action of government ministries, department, and agencies. In reality, however, the implementation of

laws continues to need strengthening, particularly in the area of child protection (e.g., child labour and trafficking) and juvenile justice. Moreover, with children’s and women’s issues increasingly being dealt with at the district level by local officials and committees, there is a need for a concentrated advocacy campaign to reinforce the concept of key services as basic human rights.

The glaring disparities between the regions (and between districts within regions) and between wealth quintiles in terms of availability of and access to basic services feature prominently across all sectors in this Situation Analysis, and are documented with data and statistical tables throughout the report. The impact of these disparities on the lives and livelihoods of millions of Ghanaians, particularly children and women, is documented in the sections of this report on the main sectors of health care, education, HIV/AIDS, and child protection. In the first three of these areas, Ghana presents a very mixed picture – somewhat at variance with its progressive reputation and “*middle-income country*” status. For example, while Ghana is, to its credit, on track to meet the MDG 1 targets of halving poverty and reducing malnutrition, the aggregate data conceal results at the regional and district level that show that these targets are still far from being met for hundreds of thousands of Ghanaians, especially children. And malnutrition still accounts for 40 per cent of childhood deaths.

Similarly, while Ghana is largely on track to achieve the MDG 2 targets for universal primary education (with over 80 per cent of school-age children enrolled and remaining in school), there are, again, sharp disparities between the national figures and those for the northern regions particularly.

Ghana is well on track to achieve the MDG 3 target for gender parity in primary education, although not for secondary education where the dropout rate among girls is still high. And, again, in the more rural areas gender parity in both levels of schooling is less prevalent for reasons ranging from employment to migration to child marriage.

Although child survival has improved greatly with the introduction of high-impact healthcare services and with overall economic growth, Ghana remains unlikely to meet the MDG 4 targets for reducing under-five mortality by two thirds by 2015. And it is a matter of great concern that Ghana is far off track in achieving the MDG 5 target of reducing maternal mortality by two thirds. Ghana’s adjusted 2009 rate of 350 maternal deaths per 100,000 live births can be definitively linked to the lack of access to maternal health services, most notably to skilled birth attendants.

On a positive note, Ghana has one of the lowest HIV/AIDS prevalence rates in sub-Saharan Africa (1.5 per cent) and is on target to meet the MDG 6 targets, although tens of thousands of mothers and children do not have access to needed treatment, and efforts to address the social, economic, and cultural factors that feed the infection rate – including risky behaviour among adolescents and youth, whose rate is higher than the national average – have not been totally successful.

One target that Ghana is well on track to meet is that for access to safe drinking water (MDG 7), with access in rural areas actually exceeding that for urban areas. In stark contrast to that success, Ghana is lagging far behind in achievement of the MDG 7 target for improved sanitation, particularly in the rural areas and in schools.

The report also outlines the extensive partnerships (MDG 8) through which Ghana’s government and UNICEF have sought to design, implement, and advocate social and economic policies, legislative measures, and budgets aimed at enabling Ghana to meet its obligations to children and women and to achieve the MDGs. These efforts are apparent across the range of MDG target areas, and also figure prominently in child protection efforts, where Ghana’s partners have played an important role in monitoring and gathering sparse data on such areas of concern as child labour (particularly in the cocoa industry) and child trafficking.

At the end of 2010, as this Situation Analysis was being prepared, a spirited debate was under way in Ghanaian political circles as to how best to use – and share – the oil revenues that were expected to start flowing, albeit modestly, in the first part of 2011. Advocacy on behalf of Ghana’s neediest and most vulnerable citizens, particularly its children and women, has been on-going. The views of children, women and other vulnerable groups have been brought to the fore of these debates. This is evidenced by the participation of children in the ten regional Petroleum Resources Management Consultations organized in February-March 2010 by government, and a two-day event organized by UNICEF and the Department of Children in April 2010 where children across the country participated in learning and sharing exercise on the oil find. A booklet on the outcome of the event entitled Our Oil Our Future Our Voice has been published and widely circulated.



Table 1: Table of basic data about children and women in Ghana

(2009 unless otherwise stated)	
Child population (millions, under 18 years)	10.7
U5MR (per 1,000 live births)	69
Underweight (% , moderate & severe)	14
Urban/rural, poorest/richest (%)	11/16, 19/9
Maternal mortality ratio (per 100,000 live births)	350
Primary school attendance (% net, male/female)	76/77
Survival rate to last primary grade (%)	87
Use of improved drinking water sources (%)	83.8
Use of improved sanitation facilities (%)	13
Adult HIV prevalence rate (%) (2010)	1.5
Child labour (% , 5–14 years old)	34
Birth registration (% , under 5 years)	71
Male/female, urban/rural, poorest/richest (%)	72/70, 82/65, 60/88
GNI per capita (US\$)	700
One-year-olds immunized with DPT (%)	94
One-year-olds immunized against measles (%)	93





INTRODUCTION

It has been 10 years since the last comprehensive Situation Analysis of children and women in Ghana was conducted. Much has changed in Ghana over the past decade, as the country has made progress on the twin paths of political liberalization and economic growth, as well as on achieving a number of the key Millennium Development Goals (MDGs).

Since 2000, smaller situation analyses have been conducted as part of the ongoing evaluation of UN programmes of cooperation with the Government of Ghana. These have, *inter alia*, formed the basis for the elaboration of the current UNICEF Ghana country programme (2006–2010), which, together with the coordinated UN Development Assistance Framework (UNDAF) for Ghana, has been extended to end in 2011, in order to align better with Ghana's medium-term development plans.

In recent years many surveys, evaluations, and studies have been conducted by the Government of Ghana, by national and international non-governmental organizations, by UN agencies, and by Ghana's development partners as part of the ongoing assessment of Ghana's progress and the various challenges it still faces. Several analytical reports have resulted from the most recent of these exercises, including a book-length study titled *Children in Ghana*, published by UNICEF and the Ministry of Women and Children's Affairs (MoWAC); a study on social protection and children; and an analysis of children in poverty reduction strategies and budgets. These works analyzed children's rights from a multisectoral perspective. At the same time, the UN Country Team in Ghana has prepared an updated Country Analysis (formerly known as the Common Country Assessment) in preparation for the next UNDAF cycle (2012–2016), providing a comprehensive assessment of Ghana's human development situation.

These valuable reports, assessments, and strategic reviews have resulted in an enormous wealth of data, analysis, and strategic reflection that is readily available and constantly being updated. Taken as a whole, these resources provide a comprehensive overview of the socio-economic situation of the country and of the public policy, social budget, and service delivery environment affecting children and women in Ghana.

An analysis based on disparity and equitable distribution of resources

One of the recurring themes of these reports is the existence across Ghana of wide disparities in the coverage, accessibility, and quality of the basic services that Ghanaian children and women depend upon and are entitled to, notably in education, health care, and water and sanitation. These disparities are not new: succeeding governments of Ghana have long recognized, for

example, that certain areas of the country – notably the three northern regions – have been deprived of their fair share of public services. Much of the problem stems from the fact these areas lack the infrastructure needed to make services accessible to communities in an equitable manner. Inequality in access to basic services between girls and boys, between women and men, and by wealth quintiles also exist across the country, and improving that situation has been factored into the government's most recent medium-term development plans.

An in-depth, equity-focused analysis of these disparities, however, particularly with respect to their impact on children and women, has until recently, been lacking. A recent analysis identifies three categories of disparities: geographic, gender, and group. **Geographic** disparities refer to differences between regions, but will need to be extended to districts as well as data on district level differences becomes available. For example, it will be important to look at the variations among districts in order to target resources to the worst-performing or poorest districts in a region. **Gender** disparities refer to such issues such as the gender parity index in education or the disproportionate burdens on women and girls to fetch water, thereby reducing the time that girls have available for school and homework. **Group** disparities include wealth quintiles, ethnicity, and religion, among others.

This document focuses in particular on the variation in basic services among the Ghanaian population distributed by wealth quintiles; and it gives special emphasis to the extent to which existing policies and resource allocations are focused on reducing or eliminating these disparities. In particular, the report notes that the Millennium Development Goals and other international (and national) commitments to children and women can only be fully realized through greater emphasis on equity. Equitable resource allocation will target greater resources to poorer districts to ensure that disadvantaged children have an equal chance to fulfil their rights. Equity-focused policies also emphasize the use of disaggregated data by policy makers in understanding the different levels of access to services enjoyed by various regions or districts, wealthier and poorer families, males and females. Consequently, specific interventions to ensure that inequities are eliminated are likely to be put in place.

Due to a lack of data, it has not always been possible to analyse accurately whether resources have been distributed equitably. This report, therefore, supports efforts by the Government of Ghana to introduce the Ghana Integrated Financial Management System, which should allow policy makers to track allocations and expenditure by programme and activity, rather than merely by the four types of economic expenditure that are currently used for such reporting (personal emoluments, administration, services, and investments).

This Situation Analysis is very much a 'synthesis report', drawing on available reports, information, and evidence, and applying fresh, equity focussed analysis of the existing quantitative and qualitative data. In preparing this analysis, a number of key documents and studies have been referred to and drawn from, including:

- The Ghana Shared Growth and Development Agenda (GSGDA, 2010–2013)
- The Ghana Demographic and Health Survey (2008)
- The Ghana Maternal Health Survey (2007)
- The Ghana Educational Sector Performance Report (2009)
- The UN Country Team draft Country Analysis (August 2010)
- The UNICEF/government collaborative report on Social Protection for Children in Ghana
- The UNICEF/government joint report (in book form) on *Children in Ghana*

- Many other reports from the government, UN agencies, NGOs, and other stakeholders (see *Bibliography for a complete list*)

This report is organized thematically, beginning with overviews of the political and socio-economic situation of Ghana as at the end of 2010 (with special emphasis on government decentralization and on the enduring challenge of poverty), and continuing with an appraisal of the prevailing legislative and policy framework (citing the various international conventions to which Ghana is a party and the many national action plans and other policies it has put in place), with special emphasis on the human rights environment for children and women. There is also an assessment of the physical and human environment.

The second part of the analysis offers an update on Ghana's progress in achieving the Millennium Development Goals, and then takes up three key types of children's rights as outlined in the Convention on the Rights of the Child: young child survival and development; basic education and gender equality; and child protection from violence, exploitation, and abuse.

The final section of the report offers an analysis of key findings and priorities for future action by government and partners to achieve the MDGs and fulfil the rights of Ghanaian children and women.

This report was prepared over a three-month period at the end of 2010. A consultant was engaged to conduct a desk review of available documentation as well as conceptual and analytical secondary research on the main topics relevant to the situation of children and women in Ghana. The consultant spent six weeks in Ghana, gathering additional material, conducting interviews (including several open discussions with children), visiting schools and health centres, reviewing community-based water and sanitation schemes, consulting UNICEF programme and field staff, and preparing the first draft of the report. This was then circulated for review by all stakeholders, who provided valuable comments and additional input, after which a revised and final draft was prepared. On-going during this period was the selection and preparation of the statistical data, charts, tables, and figures provide graphic evidence of the trends and analysis presented in the narrative of the report.



PART ONE: THE COUNTRY CONTEXT

“Ghanaians enjoy political rights, civil liberties, a free press and access to a justice system that sets them apart from most of the people of sub-Saharan Africa”



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CHAPTER ONE: The governance environment

INTRODUCTION

GHANA has justifiably earned international credit as a model of political stability, good governance, and democratic openness, with well-developed institutional capacities and an overall welcoming environment for the advancement and protection of women's and children's interests and rights.

Sustaining this political credibility will depend increasingly on how Ghana manages and deploys its considerable natural and human resources to the benefit of all Ghanaians – particularly the most vulnerable, starting with the nearly half of the population who are living below the poverty line, of whom roughly half are children under the age of 18 years. The discovery of oil reserves in 2007, the achievement of a fairly steady gross domestic product (GDP) growth rate of around 6 per cent a year, and Ghana's steady march towards "middle-income country" status have presented Ghana's leaders with the very real challenge of striving not so much for an immediate equal distribution of any new-found wealth, but rather for first targeting resources to lift the most marginalized and most vulnerable segments of the population out of poverty and deprivation, so that future resources can truly begin to be shared evenly and equitably by all Ghanaians.

A. POLITICAL FRAMEWORK

Political power changed hands peacefully from the ruling New Patriotic Party to the opposition National Democratic Congress Party in 2008 presidential elections and subsequent run-off elections in 2008–2009, all of which were regarded as free and fair by national, regional, and international observers alike. In principle, Ghanaians enjoy political rights, civil liberties, a free press, and access to a justice system that sets them apart from most of the people of sub-Saharan Africa.¹

Ghana has achieved positive results with regards to "governance indicators," particularly when compared with other sub-Saharan countries and developing countries of similar income status. Reports by the World Bank Institute have shown steady improvement in Ghana's performance

over the period 2003–2008 in six dimensions of governance:

- "voice" and accountability
- political stability and lack of violence
- government effectiveness
- regulatory quality
- rule of law
- control of corruption²

Although Ghana's international ranking on corruption is one of the best among low-income African countries, there has been a steady decline in recent years, a trend that needs to be watched closely.³

B. POLICY FRAMEWORK

National development plans

Ghana has embarked on implementation of its third poverty reduction strategy. The first generation of the **Ghana Poverty Reduction Strategy (GPRS I)** covered the period 2003–2005 and was based on five pillars:

- ensuring sound economic management for accelerated growth
- increasing production and promoting sustainable livelihoods
- providing direct support for human development and for the provision of basic services
- providing special programmes in support of the vulnerable and excluded
- ensuring good governance and increased capacity of the public sector

GPRS I was followed by GPRS II, renamed the **Growth and Poverty Reduction Strategy** and covering the period 2006–2009. Its policy aim was "to eliminate the worst manifestations of poverty, social deprivation and economic injustice from Ghanaian society."⁴ GPRS II laid out as key policy priorities:

- strengthening Parliament
- enhancing decentralization
- protecting rights under the rule of law
- ensuring public safety and security
- managing public policy
- empowering women and vulnerable groups
- increasing access to information
- promoting civic responsibility

² United Nations Country Team, Ghana (UNCT), Ghana Country Analysis (second draft), Accra, August 2010,

³ While there are no specific statistics attesting to the effects of corruption on development in Ghana, the Serious Fraud Office, the government agency responsible for combating economic crime, claimed that indications were that between 5 and 30 per cent of national revenue goes to waste due to practices such as over-invoicing or tax evasion. (Source: UNCT Ghana, Ghana Country Analysis, p. ii.) The last external report on corruption in Ghana, prepared by National Integrity Systems in 2001, is available from Transparency International at www.transparency.org/policy_research/nis/nis_reports_by_country.

⁴ MoWAC and UNICEF Ghana, Children in Ghana, p. 28.

¹ UNICEF Ghana, Annual Report 2009, and United Nations Country Team, Ghana (UNCT), Ghana Country Analysis (second draft), Accra, August 2010, p. 3. See also Government of Ghana, Ministry of Women and Children's Affairs (MoWAC) and UNICEF Ghana, Children in Ghana, Accra, July 2009, p. xix.

This strategy was premised on the goals of transforming the economy to achieve rapid growth, accelerated poverty reduction, and the protection of the vulnerable and excluded within a decentralized, democratic environment. It presents a broader awareness of the human objectives of development, the centrality of poverty reduction, and the social dimension of development.⁵

GPRS II has been succeeded by the third growth, poverty reduction, and development agenda, named the Ghana Shared Growth and Development Agenda (GSGDA), covering the period 2010–2013, which was published and submitted to Parliament in late 2010.⁶

The GSGDA continues the key priorities of GPRS II, with the addition of:

- promoting democracy and the reform agenda
- improving policy management and public-sector reforms
- fighting corruption and economic crime⁷

The GSGDA also articulates seven thematic areas:

- Ensure and sustain macroeconomic stability
- Enhance competitiveness of private sector
- Accelerate agricultural modernization and sustainable natural resource management
- Oil and gas development
- Infrastructure, energy and human settlements
- Human development, productivity, and employment
- Transparent and accountable governance

The document emphasizes that “*Ghana has made great strides towards reducing poverty over the past two decades*” through economic-growth initiatives that have been “*largely pro-poor*” and which have facilitated significant progress in achieving the Millennium Development Goals.⁸

Significantly, the Budget Law does not assume that all social sector spending is pro-poor and instead accounts separately for pro-poor expenditure, showing this figure as a share of total expenditure per sector. If the government spends approximately 20 per cent of its budget on education, approximately 60 per cent of that can then be considered pro-poor according to government standards. The Budget Law does not provide a detailed breakdown of social sector spending, itemizing the resources going to different programmes. This makes it difficult to know, for example, how much the government is spending on particular pro-poor interventions. (Social protection programmes, for example, cut across multiple sectors, including those overseen by the Ministries of Employment and Social Welfare (MESW); Women and Children’s Affairs; Local Government and Rural Development (MLGRD); as well as Education and Health.)⁹

5 Child Research and Resource Centre (CRRECENT), Child Rights Situational Analysis (commissioned by PlanGhana), report, 2010, p. 13.

6 See Government of Ghana, National Development Planning Commission (NDPC), Medium-Term National Development Policy Framework: Ghana Shared Growth and Development Agenda (GSGDA), 2010–2013, Vol. I: Policy Framework, Final Draft, 7 September 2010, siteresources.worldbank.org/GHANAEXTN/Resources/Ghana_PRSP.pdf.

7 UNCT, Ghana Country Analysis, p. 9.

8 NDPC, Medium-Term National Development Policy Framework, 7 September 2010, p. 116.

9 United Kingdom Overseas Development Institute (ODI) and UNICEF, Social Protection and Children: Opportunities and Challenges in Ghana, July 2009, p. 56.

Indeed, poverty-related expenditure increased steadily during the period of the first two poverty reduction strategies, with identifiably ‘*pro-poor*’ expenditure rising from 4.8 per cent of GDP in 2002 to 10.4 per cent in 2007. Most of the spending has been on basic education, health, and rural electrification, which together account for more than 60 per cent of domestically financed poverty-reduction spending.¹⁰ Poverty-related expenditure increased from 26.3 per cent of total expenditure in 2007 to 30.8 per cent in 2008.

Plans and policies focused on children’s rights

A National Programme of Action (NPA), titled “*A Ghana Fit for Children*,” was adopted by the government in 2006. This document was developed along the framework of “A World Fit for Children,” the outcome document of the 2002 United Nations General Assembly Special Session on Children (UNGASS), and has the following specific objectives:

- provide all children in Ghana with quality education
- protect children against violence, exploitation, and abuse
- combat HIV/AIDS and other sexually transmitted infections, and to address the needs of children infected or affected by HIV/AIDS
- enhance children’s participation in debates on issues that affect them
- promote the healthy life of all children in Ghana¹¹

Other policies formulated by the government to improve the welfare and protection of Ghanaian children include:

- Early Childhood Care and Development Policy (ECCD)
- National Social Protection Strategy
- Gender and Children Policy
- National Policy Guidelines on Orphans and other Children made Vulnerable by HIV/AIDS
- Street Children Policy
- Disability Policy
- Draft Child Labour Policy
- National Programme for the Elimination of the Worst Forms of Child Labour in Cocoa
- Education Strategic Plan
- Special Educational Needs Policy Framework
- Policy and Strategy for Improving the Health of Children under Five
- Reproductive Health Policy and Standards
- MoWAC’s Three-Year Strategic Implementation Plan¹²

The Ministry of Women and Children’s Affairs is the coordinating body for agencies working with children and women in Ghana. It was established by merging two separate national commissions (the Commission on Women and Development and the Commission on Children) and was given cabinet status in 2001. MoWAC initiates and formulates policies on child survival and development, gender equality and women’s empowerment, and the protection of women’s and children’s rights. Its implementing wings, the Department of Children and Department of Women, work with other ministries, local and international development partners, and civil society organizations.¹³

10 World Bank, “Country Brief, Ghana,” Washington, D.C., 2008.

11 MoWAC and UNICEF, Children in Ghana.

12 Ibid.

13 CRRECENT and PlanGhana, Child Rights Situational Analysis, p. 16.

Other units that focus institutionally on children and women's issues include:

- The Ministry of Health (through its main implementing agency, the Ghana Health Service).
- The Ministry of Education (through the Ghana Education Service, which has a girls' education unit that promotes gender parity).
- The Ministry of Employment and Social Welfare, whose Department of Social Welfare works with communities to promote equity for the disadvantaged and vulnerable, and which also has a Child Labour unit, which, among other duties, implements the National Programme for the Elimination of the Worst Forms of Child Labour in Cocoa (see *Child labour, below*).
- The Domestic Violence and Victim Support Unit of the Ghana Police Service, which handles cases involving domestic violence, child abuse, and other offences against children and women, and also runs education campaigns against domestic violence and sexual abuse.
- The Commission on Human and Administrative Justice, a human rights organization established in 1993 under the national Constitution, which provides support to vulnerable children and women.¹⁴
- The Anti-Human Trafficking Unit of the Ghana Police, which implements the Anti-Human Trafficking Act, rescuing women and child victims of trafficking.
- The Ministry of Employment and Social Welfare and MoWAC are jointly responsible for policy regarding orphans and vulnerable children (OVCs). However, the actions and policies of the ministries of health, education, and justice also affect the lives of OVCs.¹⁵
- The Ministry of Local Government and Rural Development (MLGRD) facilitates the District Assemblies (DAs) through legislative reforms, policy-making as well as institutional capacity and resource support to enable them to implement their plans and budgets, and to ensure that services for children are delivered effectively and efficiently. One of the key agencies for children at the district level which the MLGRD is directly responsible for is the Births and Deaths Registry.

Decentralization: Devolving power to regions and districts

GHANA'S policy of decentralization has become a key component of its development strategy and a test of its capacity to build confidence with its own citizens as well as with its international development partners.¹⁶ The country is divided into 10 regions, which were further divided in 2006 into 138 districts (since augmented to 170), each with its own District Assembly.

The national Children's Act places responsibility for protecting children with the districts. Section 16 of the Act states: *"A District Assembly shall protect the welfare and promote the rights of children and shall ensure that within the district, governmental agencies liaise with each other in matters concerning children."* In addition, under the National Strategy for implementation of the Convention on the Rights of the Child (overseen by MoWAC), the District Assemblies are given the mandate to protect the welfare and promote the rights of

¹⁴ Ibid., p. 17.

¹⁵ Government of Ghana, Ministry of Employment and Social Welfare (MESW), and UNICEF, National Plan of Action for Orphans and Vulnerable Children, Ghana, June 2010–2012, Accra, 2010.

¹⁶ UNCT, Ghana Country Analysis, 2010, p. ii.

children. Furthermore, they are required to coordinate the activities of government and NGOs relating to children.¹⁷ However, in the concluding observations on Ghana's second periodic report, the UN Committee on the Rights of the Child in 2006 expressed concern about the *"limited capacities of the District Assemblies,"* which hamper the implementation of the CRC at the local level; and recommended that the District Assemblies be sufficiently resourced and staffed *"to strengthen the coordination of activities between the national and district levels."*¹⁸

District Assemblies are caught between, on one hand, legislation and other policies that give them responsibility over certain aspects of children's services and, on the other, a centralized resource allocation system that does not sufficiently empower them to control the majority of the resources (human and financial) required to effectively implement and operate basic social services. Most districts are unable to generate their own revenue (known as internally generated revenue, or IGR). Consequently, poorer districts that need more resources to deliver services are unable to do so because they lack both the requisite resources and the administrative authority. Moreover, regions do not have resources to allocate to districts, so they are unable to target poorer districts with the resources that would give all children an equal chance to benefit from education or health services. Consequently, Ghana's decentralized structure misses a key opportunity to allocate resources to districts where children have the least opportunities to access services that are necessary for their survival, development, and protection.

Implementation for earmarked sectoral funds remains the responsibility of the line ministries through *"de-concentrated"* district offices. District officials, such as the directors of district education and health departments, are appointed by the central education and health services (i.e., the Ghana Education Service and the Ghana Health Service, the operational arms, respectively, of the central Ministries of Education and Health). The district directors report through their regional offices to the centre.¹⁹ Although district health and education offices also report to the District Assemblies, linkages remain to the central line ministries.²⁰

The Ministry of Local Government and Rural Development, and the National Development Planning Commission (NDPC) are jointly responsible for coordinating local government functions and linkages across the different levels of government. The Ministry functions as the Local Government Secretariat, with the political power to nominate district chief executives and 30 per cent of the District Assembly members, who are subsequently formally appointed by the president. The idea behind centrally appointed councillors is to provide a balance between national and local interests.

All district development plans are submitted to the NDPC for consideration and approval; the Commission can request changes in the plans submitted by districts and, unless they can provide reasons that satisfy the NDPC, the plans can be rejected.²¹ A vertical

¹⁷ "Background to Ghana's reporting to the UN Committee on the Rights of the Child," presentation by Sylvester Kyei-Gyamfi of the Department for Children, MoWAC, July 2010.

¹⁸ UN Committee on the Rights of the Child, Consideration of reports submitted by States Parties under Article 44 of the Convention; Concluding observations: Ghana, 41st session, UN document CRC/C/GHA/CO/2, 17 March 2006, paras. 13–14.

¹⁹ World Bank, Africa Region, Education in Ghana.

²⁰ UNICEF West and Central Africa Regional Office (WCARO), Regional Study on Reflection of Children's Interests in PRSPs and Budgets, Ghana Case Study, December 2008, p. 18.

²¹ This is provided for in Act 480, the Planning Systems Act.

planning, budgeting, implementation, and reporting system therefore exists: sector priorities, programmes, and projects are defined by the central government, with implementation targets and resource allocations to meet them set by the central ministries.²² The implementation of basic social services at the district level is carried out by decentralized departments of central ministries, which are still accountable to these central ministries, a situation that undermines the authority of the District Assembly.

Ghana's new decentralization policy is designed to bridge some of the gaps described above, and to provide the country with a critical opportunity to give districts the power to allocate resources to the neediest children. On 24 November 2010, the Cabinet approved a new decentralization policy that established a *"fiscal framework"* to determine the needs of the District Assemblies. In principle, it provided for restructuring public administration financial management to *"disaggregate functions"* among the central, regional and local levels.²³

The MLGRD noted that the new policy would also *"disaggregate the current budgetary resources between the various levels of government,"* and would help to *"transfer functions and resources"* from the centre to lower levels. Each District Assembly's budget would have to be *"the sum of all departments"* under its jurisdiction; training would be built into the policy as a means of capacity building at the local level. With the implementation of *"fiscal decentralization,"* districts will have more control of programme development and utilization of resources. Moreover, leakages and inefficiencies could be expected to decrease, thus increasing the amount of funding available for local health and education services.²⁴ However, this will take time to implement and is yet to be seen in practice.



22 UNICEF WCARO, Regional Study on Reflection of Children's Interests in PRSPs and Budgets, p. 18.

23 GhanaWeb, 24 November 2010: www.ghanaweb.com/GhanaHomePage/politics/artikel.php?ID=198133#.

24 UNICEF Ghana, Strategic Vision for Achieving and Maximising Sustained Results for Children in Ghana, report of the Ghana Country Office Strategic Reflection Exercise, November 2008, pp. 50–51.



CHAPTER TWO: The development environment

A. COMPOSITION OF SOCIETY

There are about 50 ethnic and linguistic groups in Ghana, living within eight broad communities, the largest of which are the Akan, Mole-Dagbani, Ewe, and Ga-Adangbe.²⁵ While there are a number of differences in the social structure and organization of the various ethnic groups, they share many similarities. Extended families are common in all communities, including the grandparents and siblings of the mother and father. Both the grandparents and the paternal mother-in-law can be very influential in these extended family arrangements, particularly as concerns decisions relating to the children of the household – especially girl children.²⁶

According to Children in Ghana, the importance placed on children in the country is reflected in concepts of childhood and child-rearing that are practiced across all ethnic groups. Childhood is seen by most as a time of innocence when individuals need protection from the world around them. The goal of parenting is to bring up children to adhere to the moral and ethical practices of the group. Children receive informal training from a very early age to assume responsibilities in the community as adults. Social norms and values are transmitted to the younger generation by all adults in a community, not only their parents. Indeed, extended families play a major role in the care and socialization of all children, and they are obligated to provide material support until the children are old enough to fend for themselves.²⁷

Youthful population

Children under the age of 15 make up 42 per cent of Ghana's population; 22 percent are in the 10–19 age group; 24.1 per cent of the population are in the 15–24 age group. The median age is estimated at 19.1 years. According to the provisional results of the 2010 Population and Housing Census, Ghana's population is approximately 24.4 million; and the average annual population growth rate is about 2.2 per cent.²⁸ The fertility rate is estimated to have dropped from 6.4 in 1998 to 4.0 in 2008, one of the lowest rates in sub-Saharan Africa, although the rate among rural women is estimated at 4.9, compared with 3.1 in urban areas.²⁹

25 Ghana Statistical Service, 2002, cited in MoWAC and UNICEF, Children in Ghana, p. xviii.

26 MoWAC and UNICEF, Children in Ghana, p. 2.

27 Ibid., pp. 5–6.

28 UNICEF Ghana statistics on UNICEF website, www.unicef.org/infobycountry/ghana_statistics.html. See also MoWAC and UNICEF, Children in Ghana, p. xviii.

29 "Fertility rate in Ghana drops," quoted by Ghana Statistical Service, www.statsghana.gov.gh/news_4.html. Many useful population statistics may also be found at EconomyWatch: www.economywatch.com/economic-statistics/Ghana/Life_Expectancy_Rate/.

As elsewhere, urban population growth and rural-urban migration have led to the emergence of fast-growing and under-serviced slum areas. According to the 2000 census, the number of urban settlements in Ghana increased four-fold between 1948 and 2000, and the urban population increased six-fold, to about 8.3 million. This trend is likely to continue, putting further pressure on urban services for children.³⁰ It is therefore important to disaggregate urban data between wealthier and poorer areas, given that consolidated data often mask the significant hardships that children in high-density slums face.

Table 2: Percentage of male and female inhabitants in urban and rural areas, 1960–2000

	1960		1970		1984		2000	
Sex	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Male	11.9	38.7	14.4	35.2	15.6	33.7	21.4	28.1
Female	11.2	38.2	14.5	35.9	16.4	34.3	22.4	28.1
Total	23.1	76.9	28.9	71.1	32.0	68.0	43.8	56.2

Source: Ghana Statistical Service, *Population Census, 2000*.

One effect of rural-urban migration and the growth of inner-city or peri-urban slum areas is a sharply higher number of vulnerable children living and working in the streets. But the migration of job-seeking men from the rural areas to the cities has other deleterious effects on rural families, including children and women being left to fend for themselves with few resources, resulting in less food, medical care, and education.³¹ According to the World Bank report,³² migrants' families in the north benefit from remittances to a much lower extent than do migrants' families in the forest zone. This suggests that northern migrants occupy the least rewarding economic positions when they migrate. Few northerners became cocoa farm owners, and the conditions under which migrants gain access to land have become less secure in recent decades. Few northern miners became permanent urban residents in the mining towns as they were excluded from subsidised housing and food.³³

Household profiles

The fifth Ghana Living Standards Survey of 2005–2006 (GLSS5) reveals that the mean household size is 4.0, compared to 5.1 in the 2000 population census. The regions with the largest households are Upper West, Northern, and Upper East, with 6.5, 5.5, and 5.3, respectively. The region with the smallest households is Greater Accra (3.4). Most households (70.5 per cent) are headed by males. The gender breakdown of the population is 48.5 per cent males and 51.5 per cent females, indicating a sex ratio of 94 males to 100 females.³⁴

³⁰ MoWAC and UNICEF, *Children in Ghana*, p. 10.

³¹ Ibid., p. 27.

³² World Bank, "Bridging the north-south divide in Ghana, World Bank Development Report, 2006, p.1.

³³ Ibid.

³⁴ Ghana Statistical Service, "Ghana Living Standards Survey: Report of the Fifth Round (GLSS5)," Accra,

According to the 2008 Ghana Demographic and Health Survey (GDHS), 53.8 per cent of Ghana's children live with both parents, while 22.8 per cent live with the mother and 5.6 per cent live with the father. A reported 14.3 per cent of children under the age of 18 years live with neither parent but have both parents alive (15.9 per cent for girls), a proportion that rises with age, reaching 19.8 per cent for the 15-17-year age group.³⁵

Dimensions of foster care

As elsewhere in Africa, the fostering of children by extended-family members is quite common in Ghana, although little reliable data exist on the numbers or reasons for fostering. It is estimated that 19 per cent of Ghana households include fostered children under 18 years of age.³⁶ There is sometimes a fine line between fosterage and child labour, whereby girls, particularly, are taken into extended-family households for the purpose of performing domestic work.³⁷ Whereas in some situations across Africa, particularly in countries racked by conflict or critically affected by the AIDS pandemic, "crisis fostering" can be harmful to the welfare of the child, in Ghana most cases of fostering, particularly of orphans, appear to be traditional and kinship or community based, and are generally regarded to be healthful and in the interests of the fostered child.³⁸

However, for many children, fosterage brings disadvantages in terms of access to education, usually because foster parents cannot afford the costs of school uniforms, materials, lunches, etc. An analysis of 2006 GLSS data found that in four regions of Ghana fostered children were less likely ever to have attended school than biological children or grandchildren. This situation was twice as likely for females, given the regions' wide gender disparity in school attendance. Fosterage was found to be almost twice as common in the Northern region than in others, and in one district studied, fostered boys were more likely to be over-age for their grades, and fostered girls were more likely to drop out.³⁹

B. THE ECONOMIC ENVIRONMENT

Ghana has experienced exceptional economic growth in recent years, although the unprecedented GDP growth rate of 7.1 per cent recorded in 2008 declined to 4.1 per cent in 2009 (short of the national target of 5.9 per cent).⁴⁰ The International Monetary Fund predicted that GDP growth would increase to 5 or 6 per cent in 2010, led by a recovery in construction and business services as well as by anticipation of the projected start of oil production from offshore reserves discovered in 2007.⁴¹ In its 2011 budget and economic policy statement, the government cited provisional figures for the first six months of 2010, showing a GDP growth

³⁵ Ghana Demographic and Health Survey (GDHS), 2008, p. 14.

³⁶ GDHS, 2008, p. 13.

³⁷ Ibid., p. 16, citing a study of child domestic work and fosterage in Northern and Upper East regions of Ghana, UNICEF, 2005.

³⁸ Deters, L. and Bajaj, Dr., "Orphans and Vulnerable Children in Ghana – A Contextual Analysis: ECCD Stakeholders Adapting the Safety Net," unpublished paper, Columbia University, New York, 2008.

³⁹ "Fosterage and Access to Basic Education in Northern Ghana," presentation by Caine Rolleston, Institute of Education, London, November 2010.

⁴⁰ International Monetary Fund (IMF), statement by Mr. Peter Allum at the conclusion of a mission to Ghana, 1 October 2010, available in a Press Release at www.imf.org/external/np/sec/pr/2010/pr10372.htm.

⁴¹ Ibid.

rate of 5.9 per cent, and forecast GDP growth rates of 12.3 per cent in 2011, 9.3 per cent in 2012, and 8.3 per cent in 2013.

Inflation rates, which had increased from 12.8 per cent in 2007 to more than 20 per cent in 2009 (against a target of 14 per cent by end of 2009), began to fall in 2010, reaching 9.16 per cent by February 2011.⁴² The government has projected that inflation would fall to 8.5 per cent in December 2011, and to 7.0 per cent in 2012.⁴³

Near the end of 2010, after 'rebasings' national accounts to a base year of 2006 from a previous 1993 base year, the per capita GDP had risen to a provisional level of \$1,318 for 2010, compared with \$753 that had been previously calculated. This would rank Ghana third among countries in the 15-member Economic Community of West African States (ECOWAS) in per capita GDP, and had the effect (on paper, at least) of instantly propelling Ghana into the ranks of middle-income countries (MICs) – a goal that Ghana had long sought, though previously with a target date of 2020.⁴⁴

In presenting its budget for 2010, the government indicated that financing from domestic sources would account for 6 per cent of GDP and from foreign sources for 4.2 per cent of GDP.⁴⁵ Gross international reserves held by Ghana as of October 2010 were \$3.97 billion, equivalent to more than three months of import cover, well above the target of more than two months' cover called for in the 2009 budget, and the 1.8 months' cover reported at the end of 2008.⁴⁶

On coming to power in early 2009, the government had inherited a fiscal deficit of about US\$1.8 billion, equivalent to 13.5 per cent of GDP. While commodity prices (mainly for gold and cocoa, the two biggest export commodities) had gone up and oil import costs had gone down, the global financial crisis had contributed to a decline in both foreign direct investment and remittances from Ghanaians living abroad, two key sources of foreign exchange. The fall in remittances alone was estimated to have amounted to some \$70 million in the first half of 2009, which surely translated to hardship for many Ghanaian families.⁴⁷ The government's immediate response to the deficit was to restore control over expenditures and to pave the way for structural reforms in the public sector and energy in 2010, which meant cutting spending, including that for public services.⁴⁸

Having restored some budget stability after the declines of the previous years, the government's aim in the 2010 budget was to achieve economic growth through job creation. Sustained growth would be attained through fiscal discipline; the modernization of agriculture and

42 Ibid., and www.mofep.gov.gh/, accessed on 7 April 2011.

43 "2011 Budget Statement and Economic Policy for Fiscal Year 2011," Accra, 20 November 2010.

44 "Ghana records 6.6% GDP growth for 2010," *Economy Times*, Accra, 8–14 November 2010. See also "GDP hits GH¢44.8 bn," *Daily Graphic*, Accra, 9 November 2010.

45 Budget Statement and Economic Policy of the Government of Ghana for the 2010 Fiscal Year, presented to Parliament on 18 November 2009 by Dr. Kwabena Duffuor, Minister of Finance and Economic Planning.

46 Government of Ghana, 2011 Budget Highlights, fact sheet, November 2010. See also PricewaterhouseCoopers, 2010 Budget Highlights, Overall Summary, www.pwc.com/gh/en/publications/ghana-budget-highlights-2010.jhtml.

47 Roundtable discussion on the world economic crisis, "An African Perspective," vice-president's speech, May 2009, cited in UNICEF, 2009 Annual Report, Ghana, December 2009.

48 UNICEF Ghana, Annual Report 2009, p. 3.

infrastructure; and development of oil and gas, information and communications technology, and the private sector.⁴⁹ These same goals were reiterated in the 2011 budget statement presented to Parliament on 18 November 2010, which called for expenditure of about \$8.86 billion, or about 48.8 per cent of projected 2010 GDP of \$18.144 billion. This was against estimated revenues (oil and non-oil plus grants) of about \$7.413 billion, with an overall cash budget deficit of \$1.6 billion, or 7.5 per cent of GDP (the same GDP share as in 2010).⁵⁰

The Finance Ministry predicted an end-of-year fiscal deficit of \$1.76 billion, equivalent to 9.7 per cent of GDP.⁵¹ The International Monetary Fund (IMF) warned that Ghana's budget deficit and public borrowing were larger than envisaged under the \$602.6 million loan programme approved by the IMF in July 2009 to ease financial strains caused by the global economic meltdown. The IMF also indicated that the higher deficits and increase in public debt could present a challenge to Ghana's efforts to maintain or increase public spending to improve service delivery for the most vulnerable groups in the country.⁵²

Development partners

Ghana has traditionally received strong support from donor and development partners. Official Development Assistance (ODA) inflows to Ghana increased from \$578.96 million in 2001 in nominal terms to \$1,433.23 million in 2008, constituting an average annual increase of about 23 per cent during the period. Project aid constituted the bulk (about 64 per cent) of the ODA portfolio in Ghana, increasing steadily during the period, whereas programme aid virtually stagnated. The average annual programme aid as a percentage of total ODA was estimated at 38 per cent between 2003 and 2008, while it stood at 42 per cent for the period 1999–2002.⁵³

The two most important modalities of ODA are traditional projects (over half of resource flows) and Multi-Donor Budget Support or MDBS (around 30 per cent). The MDBS mechanism is important not only in terms of the level of resources (equivalent to roughly 15 per cent of total budgeted expenditure between 2003 and 2005) but also in terms of the forum the MDBS provides for joint sector reviews and policy dialogue. A recent evaluation suggests that, overall, the augmentation of budget resources through MDBS has "helped the government to apply funds in response to needs, which earmarked resources could not have done."⁵⁴ The Public Expenditure and Financial Accountability programme (PEFA) found that fewer than 50 per cent of donor resources were channelled through national procedures.⁵⁵

49 PricewaterhouseCoopers, 2010 Budget Highlights Commentary: Growth and Stability towards a 'Better Ghana', PriceWaterhouseCoopers, www.pwc.com/en_GH/gh/pdf/Ghana-budget-highlights-2010.pdf, undated (2010).

50 "The Budget Statement and Economic Policy for Fiscal Year 2011," *Daily Graphic*, Accra, 20 November 2010. Full text available from Ministry of Finance and Economic Planning, Budget Statement and Economic Policy for 2011, www.mofep.gov.gh/budget2011.cfm.

51 Ibid.

52 "IMF warns Ghana on unsustainable debt build-up," Reuters News Agency, 2 October 2010.

53 UNCT, Ghana Country Analysis, p. x.

54 ODI, Budget Support to Ghana: A Risk Worth Taking?, briefing paper, London, 2007.

55 UNICEF WCARO, Regional Study on Reflection of Children's Interests in PRSPs and Budget.

Oil revenue

For decades, cocoa production has been Ghana's economic mainstay, constituting 57 per cent of overall agricultural exports, contributing about 8 per cent of GDP (although most processing of Ghanaian cocoa is still done overseas), and accounting for 28 per cent of Ghana's foreign exchange earnings.⁵⁶ Cocoa's economic supremacy could be challenged following Ghana's discovery in 2007 of offshore reserves of some 3 billion barrels of light crude oil. Production of between 120,000 and 240,000 barrels a day was projected to start by the end of 2010.⁵⁷ However, oil revenue, though significant, is unlikely to transform the economy.

It is expected that oil production and export will provide additional revenue in the neighbourhood of \$1 billion a year, which is relatively modest compared with other African oil producing countries, notably Nigeria and Sudan. For example, Sudan earns \$2 billion a month from its oil production. At that level, oil would provide Ghana with an additional 7 per cent of GDP annually, but it will be several years before such levels of revenue are realized.⁵⁸ In his budget statement for 2011, the Minister of Finance said that total oil revenue accruing to the budget in 2011 was expected to be \$408 million, equivalent to only 1.9 per cent of GDP.⁵⁹

Economists insist that growth in the agricultural sector will continue to be essential for Ghana to fulfil middle-income country status.⁶⁰ The Ghanaian economy is overwhelmingly agriculture-based, with 70 per cent of the population being directly or indirectly employed in this sector, mostly in subsistence farming and cultivation of cash crops. Agriculture (including crops and livestock, cocoa production and marketing, forestry and logging, and fisheries) has traditionally accounted for nearly 40 per cent of GDP, directly employing approximately 60 per cent of the labour force, and generating more than 55 per cent of foreign exchange earnings.⁶¹

The structure of the economy continues to shift from agriculture and industries in favour of services. The 'rebasings' of the country's accounts in November 2010 gave a greater share of GDP to the services sector (51.1 per cent, compared to 35.1 per cent in the 2009 GDP data) than to agriculture. The revised figures reduced agriculture's share of the economy from 37.7 per cent of GDP in 2009 to 30.4 per cent, while industry's share fell from 27.2 per cent of GDP to 18.6 per cent in the new line-up.⁶²

⁵⁶ International Food and Policy Research Institute, Ghana Strategy Support Program, "The role of cocoa in Ghana's growth and poverty reduction," presentation by Clemens Breisinger, Xinshen Diao, and Shashidhara Kolavalli, Accra, 19 November 2007.

⁵⁷ UNCT, Ghana Country Analysis, p. 13. ⁵⁸ UNICEF Ghana, Annual Report, 2009, p. 3.

⁵⁸ UNICEF Ghana, Annual Report, 2009, p. 3.

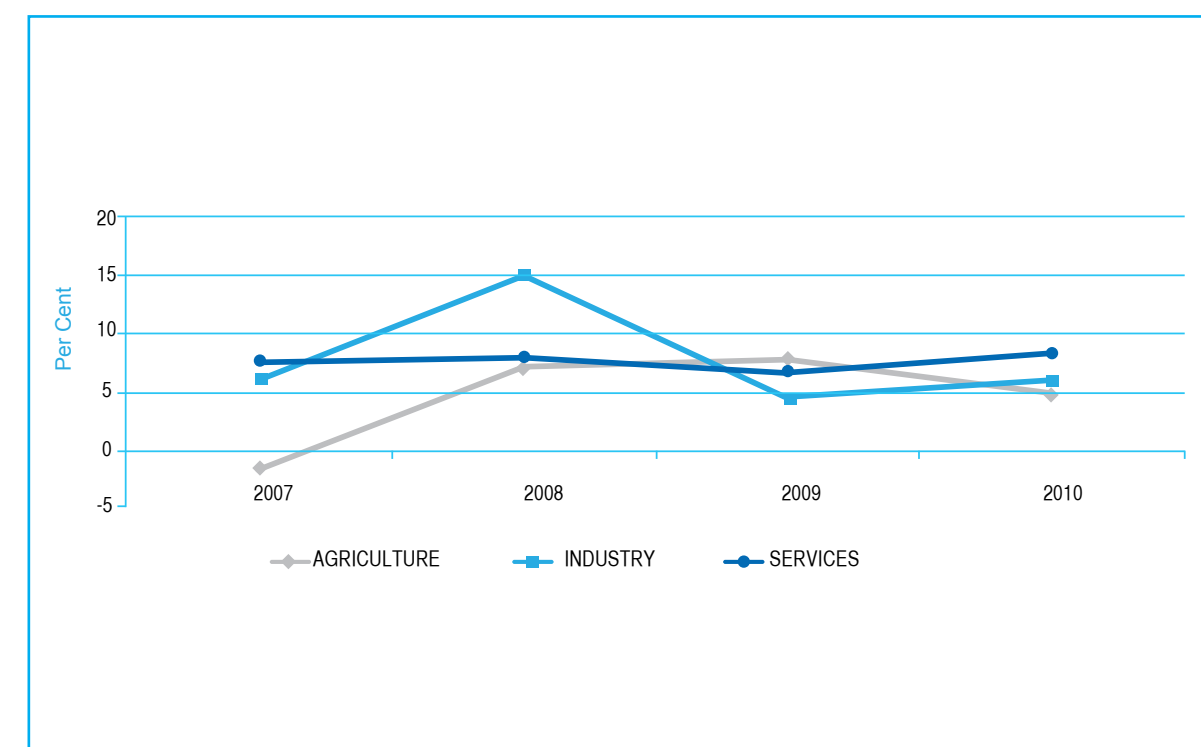
⁵⁹ Ministry of Finance and Economic Planning, Budget Statement and Economic Policy for 2011, www.mofep.gov.gh/budget2011.cfm.

⁶⁰ Integrated Social Development Centre (ISODEC) and UNICEF Ghana, 2009 Budget and Issues Relating to Women and Children Welfare, p. 9.

⁶¹ Government of Ghana, Millennium Development Authority, "About MiDA," www.mida.gov.gh/aboutus.html.

⁶² NDPC, Medium-Term National Development Policy Framework, 2010, p. 8. See also Ghana Statistical Service, quoted in Daily Graphic, Accra, 9 November 2010.

Figure 1: GDP growth rates by sector, 2007–2010



Source: Ghana Statistical Service, National Accounts Statistics, 2010

Agriculture-dependent economy and the risks for poor households

Agriculture is by far the main source of livelihood for the poorest households. Because of the variability of factors affecting agriculture, such as periodic drought (compounded by the lack of irrigation and rainwater storage systems), this dependence carries major risks, especially for children and women and the most vulnerable in society. Other risk factors affecting households living a precarious existence in the subsistence economy include bushfires, post-harvest losses, seasonal uncertainties, and storage, transportation, and marketing problems. A shortage of affordable credit, even to farmers in the flagship cocoa sector, also contributes to making crop-farming a high-risk enterprise.⁶³ Migrant sharecroppers in the cocoa sector lack power in their dealings with farm owners, and may be exploited by moneylenders, which often traps them in a cycle of impoverishment.⁶⁴

Spending priorities for children and women

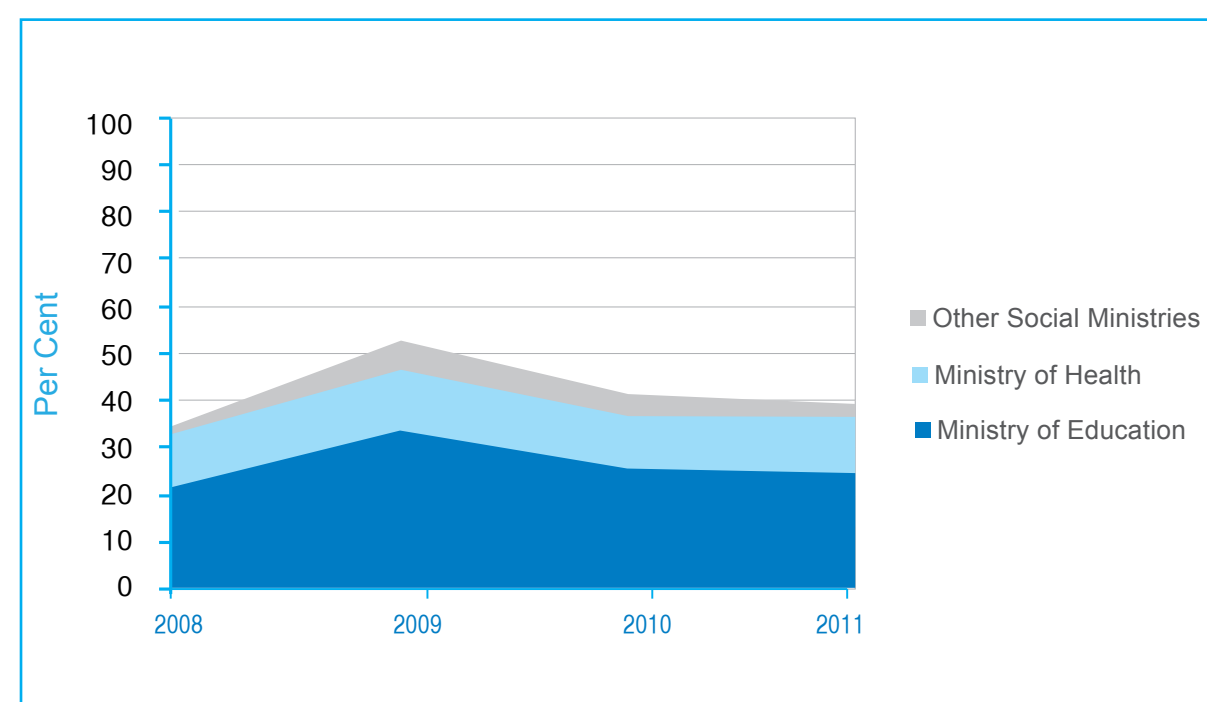
Ghana presents a mixed picture of investments in services for children and women. On a positive note, an estimated 20 per cent of the national budget is spent on education, and Ghana boasts a relatively high per capita expenditure in basic education (about \$160 for primary and

⁶³ ODI, Study on Social Protection and Children in West and Central Africa: Case Study Ghana, report by Nicola Jones with William Ahadzie and Daniel Doh for UNICEF WCARO, 1st draft, May 2008, p. 9.

⁶⁴ Government of Ghana, UK Department for International Development (DFID), UNICEF, and World Bank, Participatory Poverty and Vulnerability Assessment (PPVA), conducted between July 2009 and March 2010, briefing note.

\$240 for junior secondary). Furthermore, major social protection programmes, such as the LEAP cash grant (the landmark cash-transfer programme Livelihood Empowerment Against Poverty, aimed at providing cash to the bottom 20 per cent of Ghana's poor) and the National Health Insurance Scheme (NHIS), have been self-funded by the government, as opposed to other countries where such programmes have been donor-driven. In the 2011 budget, significant efforts were made to protect social programmes by diverting 30 per cent of statutory funds to newly-designated “*Social Improvement Programmes*” (such as LEAP), scholarships, and school feeding. However, the share of the discretionary budget devoted to social services has declined over the past four years (see figure 2, below).

Figure 2: Share of Government of Ghana discretionary funds devoted to the social sector, 2008–2011



Source: ISODEC/UNICEF Budget Analysis report of 2011.

Moreover, personnel emoluments constitute the bulk (between 80 and 90 per cent) of the expenditure in education, health, and other social sectors, leaving few funds to operate other critical components of these services. For example, only about GH¢70,000 (\$47,000) is available to operate all social welfare services, including orphanages, assistance for the disabled, and other disadvantaged groups, in the entire country out of the GH¢1 million allocated to the Department of Social Welfare in 2011.

In 2008, the year of the last election, when extra-budgetary spending amounted to 14.9 per cent of GDP, actual spending on basic education as a proportion of the total education expenditure was only 48.4 per cent – the lowest level in three years – while spending on health services, both planned and actual, was less than the previous three years. Spending on rural water was only half of planned expenditure in that sub-sector, also at a three-year low.⁶⁵

65 ISODEC and UNICEF Ghana, 2009 Budget and Issues Relating to Women and Children Welfare, pp. 19–20.

The government's planned introduction of Programme-based Budgeting (PBB) is an important step towards being able to allocate resources equitably. With this approach, allocation of funds to departments and ministries is based on an analysis of the extent to which such allocations contribute to the reduction in disparities. Such analysis, and subsequent budget allocations, will assist the government in monitoring the extent to which the stated intention to prioritize equitable development is being achieved.

C. THE ENDURING CHALLENGE OF POVERTY

On track for MDG 1

Thanks to its robust economic performance in recent years, Ghana is on track to achieve the MDG 1 targets of reducing poverty and hunger by half by 2015 (but not the target for child nutrition (see Health section, below). The proportion of Ghanaians described as “poor”⁶⁶ fell from 51.7 per cent in 1992 to 39.4 per cent in 1999 to 28.5 per cent in 2006, representing a decline of 45 per cent over the 14-year period. At the same time, those described as “*extremely poor*” declined from 36.5 per cent in 1992 to 27 per cent in 1999 to 18.2 per cent in 2006, representing a remarkable reduction of just over 50 per cent over the 14 years.⁶⁷ The World Bank's recent Poverty Assessment notes that “*poverty reduction resulted from a combination of higher average per-capita consumption and higher inequality. Between 1992 and 2006, the Gini measure of inequality rose from 0.37 to 0.42, positioning Ghana as an average developing country in terms of income inequalities.*”⁶⁸

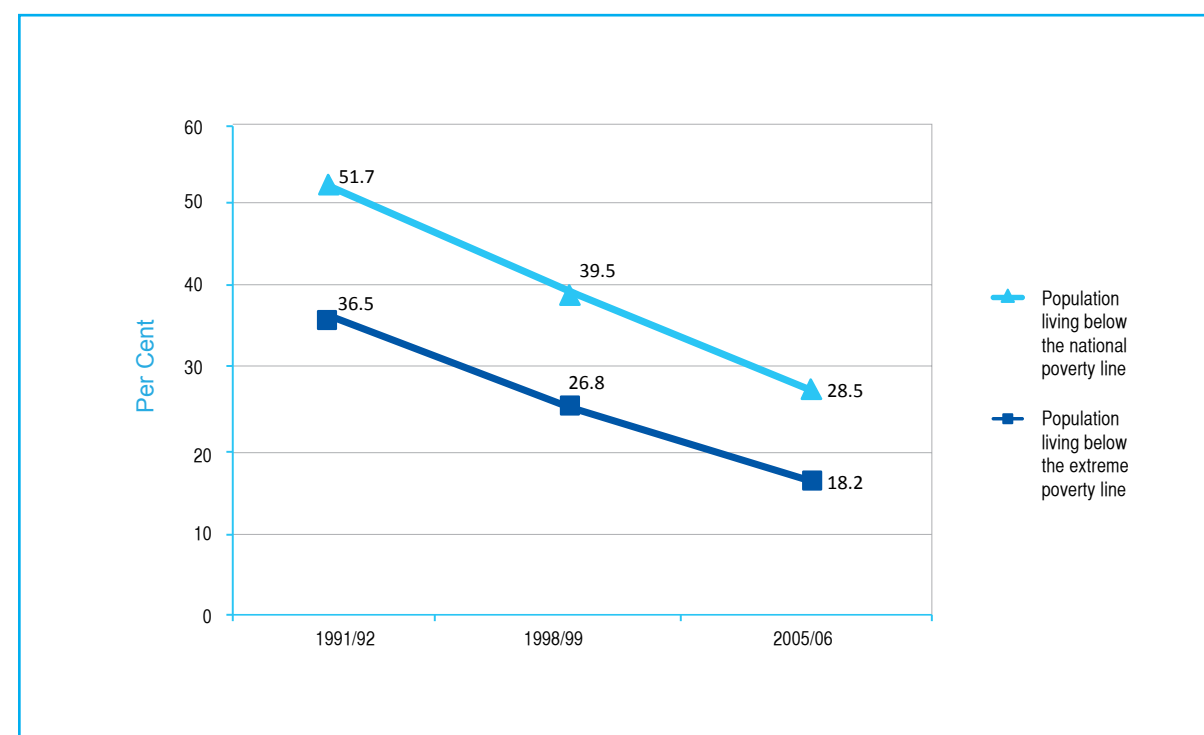


66 In these studies, poverty is characterized by degrees of deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health care, shelter, education, and information. Source: MoWAC and UNICEF, Children in Ghana.

67 CRRECENT and PlanGhana, Child Rights Situational Analysis, pp. 14–15; also UNICEF Ghana, Strategic Vision, p. 50.

68 World Bank, Africa Region, “Tackling Poverty in Northern Ghana,” Report No. 53991-GH, 1 March 2011, p. 3

Figure 3: Trends in poverty and extreme poverty in Ghana, 1991–2006



Source: Ghana Statistical Service, *Patterns and Trends of Poverty in Ghana, 1991–2006*.

As in many countries, economic growth and substantial poverty reduction mask huge regional disparities.⁶⁹ In Ghana, poverty reduction has been slower in the poorest areas of the country, leading to geographic disparities that have widened over time. During the 1990s, poverty declined in all but three regions, and those regions (Northern, Upper East, and Central) actually experienced an increase in poverty during that period. The fifth Ghana Living Standards Survey of 2005–2006 showed that poverty had fallen in those three regions in the subsequent period, but the Upper West region had returned to poverty levels of the 1990s and was now the most deprived region with a poverty rate of 88 per cent.⁷⁰ Consequently, in 2006 there were 2.5 million fewer poor people living in the southern part of Ghana, while 900,000 more poor people lived in the northern sector of the country.⁷¹

In Accra the proportion of people living below the national poverty line increased from 5 per cent in 1999 to 12 per cent in 2005–2006, indicating that although poverty is mainly a rural phenomenon, pockets of poverty exist in larger urban communities as well.⁷²

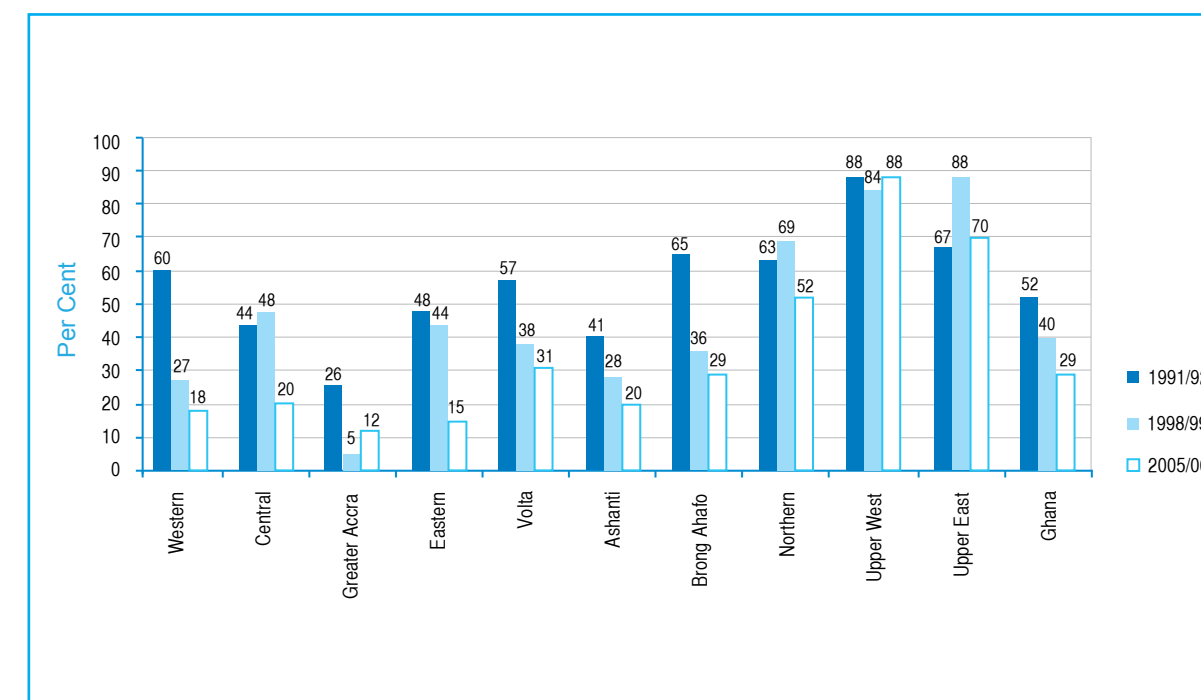
69 For a discussion of this issue see UN Economic Commission for Africa, “Spatial maps: Targeting & mapping poverty,” Working Paper by Adrian Gaud, www.uneca.org/espd/publications/Spatial_Maps_Targeting_Mapping_Poverty.pdf.

70 MoWAC and UNICEF, *Children in Ghana*, p. 23.

71 World Bank, Africa Region, “Tackling Poverty in Northern Ghana,” Report No. 53991-GH, 1 March 2011, p. 5.

72 Ghana Statistical Service (GSS), *Patterns and Trends of Poverty in Ghana, 1991–2006*, GSS, Accra, 2008.

Figure 4: Regional trends of poverty in Ghana, 1991–2006



Source: Ghana Statistical Service, *Pattern and Trends of Poverty in Ghana, 1991–2006*.

The wide geographic disparity in poverty reduction means that future efforts to eliminate poverty in Ghana must focus on the three northern regions. A World Bank report published in March 2011 notes that: “Should current economic and demographic trends continue, poverty could be largely eliminated in the South [of Ghana] by 2030, while still affecting two-fifths of the population in the North (against approximately three-fifths today). Additionally, the likely oil-related boom in services and cities (mostly located in the South), in addition to climate change, threaten to further widen this gap. Thus, any poverty alleviation strategy for Ghana must continue to ensure the reduction in poverty in Northern Ghana at centre stage, and acknowledge its specific causes in the design of possible interventions.”⁷³ This north-south gap is acknowledged at the political level and government initiatives exist to address this gap. The Savannah Accelerated Development Authority (SADA) is expected to support this process. (For more on SADA, see below.)

Food insecurity

Food insecurity exists when people lack sustainable physical or economic access to enough safe, nutritious, and socially acceptable food for a healthy and productive life. Food insecurity may be chronic, seasonal, or temporary, and it may occur at the household or national level. In Ghana, about 1.2 million Ghanaians, representing 5 per cent of the population, are food insecure, according to the World Food Programme’s Comprehensive Food Security and Vulnerability Analysis for Ghana covering 2008–2009. In Upper West region, 34 per cent of the population is food insecure, followed by Upper East with 15 per cent and Northern with 10 per cent, amounting to approximately 453,000 people. Throughout the country, about 2

73 World Bank, Africa Region, “Tackling Poverty in Northern Ghana,” Report No. 53991-GH, 1 March 2011, p. VII

million people are vulnerable to becoming food insecure, given food consumption patterns that are barely adequate and can quickly deteriorate following a natural or man-made shock. Nationwide, 19 per cent of the rural population is currently food insecure or vulnerable to become so, while this is the case for only 10 per cent of the urban population.⁷⁴

Manifestations of child poverty

Child poverty manifests itself in diverse ways: hunger is physically debilitating and emotionally de-motivating. It can lead to irregular attendance at school, and it can drive children (or cause them to be compelled by their families) to seek menial, hazardous, or demeaning employment. Many poor parents see their children as a source of farm labour or as insurance against the uncertainties of old age. This can lead to the displacement or migration of children, including foster arrangements with extended families or strangers in distant and unfamiliar places where they are prey to exploitation and abuse.⁷⁵

According to the Global Study on Child Poverty and Disparities, over the past few decades many children in Ghana have lacked access to some basic needs as worsening economic conditions necessitated gradual withdrawal of government subsidies in the provision of social facilities, amenities, and services. As a consequence, households have had less and less income to provide adequate food and other basic needs for children.⁷⁶

The extent to which children's interests are included in many of the government's policy and strategic documents provides a strong indication of the overall prioritization of child poverty reduction by Ghana's leaders, the degree to which policy orientation addresses the underlying causes of child poverty, and how this policy orientation is aligned with commitments made through international instruments, such as the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and to the Millennium Development Goals more broadly.⁷⁷

Poverty by gender

In the policy framework of the Ghana Shared Growth and Development Agenda (2010–2013), the government acknowledges the persistence of *“feminized poverty due to lower literacy rates, heavier time burdens, and lower access to productive resources and weak communication strategies for government policies on women issues.”* Proposed strategies for reducing this phenomenon include:

- Promoting the economic empowerment of women through access to land, labour, credit, markets, information, technology, business services and networks, and social protection, including property rights.

74 UN World Food Programme (WFP), Executive Brief: Ghana Comprehensive Food Security and Vulnerability Analysis, 2008–2009, April 2009.

75 Government of Ghana, et al., Participatory Poverty and Vulnerability Assessment (PPVA).

76 UNICEF, “Global Study on Child Poverty and Disparities: Ghana National Report,” 2010, p. 10

77 UNICEF WCARO, “Regional Study on Reflection of Children's Interests in PRSPs and Budgets, Ghana Case Study,” December 2008, p. ii.

- Promoting the social empowerment of women through access to education and creating access to health/reproductive health services and rights, legal aid, social safety nets, and social networks.
- Ensuring adoption of affirmative action policy/law to increase participation of women in sectors of leadership and decision-making.⁷⁸

SADA and MiDA: Policies to reduce poverty in the poorest regions

Ghana has taken concrete steps to improve development in the poorest regions of the country. In its new policy framework, the Shared Growth and Development Agenda (2010–2013), the government notes that *“bridging the developmental gap between the northern and southern parts of the country has been a long-stated goal of most post-independence governments of Ghana.”*⁷⁹ To help reduce poverty in the three northern regions, the government in 2008 proposed the establishment of the Northern Development Authority, an initiative that in 2009 was renamed the Savannah Accelerated Development Authority (SADA) and had its range and geographical scope widened to include some District Assemblies in parts of the Brong-Ahafo and Volta regions that share borders with the Northern region.⁸⁰ SADA is in the process of setting-up its Secretariat, and will become operational in the coming months.

Another initiative aimed at reducing spatial income inequalities is the Millennium Development Compact, a five-year plan worth approximately \$547 million, established in 2006 to reduce poverty by raising farmers' incomes through private sector-led, agribusiness development. The programme, implemented by the Millennium Development Authority (MiDA), focuses on increasing the production and productivity of high-value cash and food staple crops in certain areas of Ghana, and on enhancing the competitiveness of Ghana's export base in horticultural and other traditional crops. The programme was to operate in 23 districts in the Northern region, the central Afram river basin area, and the southern horticultural belt in the southeast, where poverty rates are generally above 40 per cent. In the Northern region and parts of the Afram river basin area, the incidence of poverty in the rural population is as high as 90 per cent, with incomes below \$2 a day.⁸¹

MiDA has been operational since February 2007, and its programmes have largely focused on the rural farming communities in the targeted districts. While support has continued to focus on the same areas, some districts have been split into two, and consequently 30 districts have benefited from the project. Support has included improvement in agriculture, commercial training for those in the agriculture value-chain, irrigation projects, land tenure facilitations, improvement of feeder and trunk roads, improvement to ferry services and water extension services, among others. The five-year programme ends in February 2012, after which activities will continue through direct government funding in the relevant ministries.

78 NDPC, Medium-Term National Development Policy Framework, pp. 116, 118.

79 Ibid., p. 117.

80 UNCT, Ghana Country Analysis, p. 24.

81 Government of Ghana, Millennium Development Authority, “About MiDA,” www.mida.gov.gh/aboutus.html.

D. SOCIAL PROTECTION POLICIES AND STRATEGIES

Ghana has instituted a number of social assistance and social insurance policies to address exclusion and vulnerability in society, particularly among children and youth and women. The National Social Protection Strategy (NSPS) of March 2007 is now being updated, with the active participation of NGOs and international development partners. Overall, programmes to date have focused principally on increasing children's access to school, addressing youth under-employment and unemployment, providing affordable health insurance, supporting rural farmers' livelihoods, and addressing the care needs of people with disabilities. So far, four categories of programmes have been implemented:⁸²

- Social assistance programmes, including the education capitation grant (see below for details), a variety of public works programmes, and support for farmers in the form of integrated agriculture input and microfinance programmes.
- Social insurance programmes, centred on the National Health Insurance Scheme (NHIS), which already covers 60 per cent of the population.
- Targeted social service programmes, focusing on school feeding that now reaches nearly 560,000 Ghanaian pupils; supplementary feeding to pregnant and post-partum women, infants, and children; and a community-based rehabilitation programme to integrate persons with disability into their communities.
- The cash-transfer programme LEAP (Livelihood Empowerment Against Poverty), aimed at providing cash to the bottom 20 per cent of Ghana's poor.

The role of LEAP

Established in 2007, LEAP is the front-line response under the NSPS, which identified cash transfers to extremely poor households as a potentially important strategy for reducing vulnerabilities. The programme, which at present is being implemented in 80 of the 170 districts, currently supports about 38,000 households out of the target of 165,000 households in 138 districts by the end of 2012.⁸³ Among the criteria for selection of beneficiaries are:

- community residents over 65 years living on less than \$1 a day and without subsistence support
- caregivers of orphans and vulnerable children
- fisher folk and subsistence farmers
- severely disabled persons without any productive capacity

Cash payments are aimed at decreasing chronic (or shock-induced) poverty, addressing social risk, and reducing economic vulnerability. Payments range from GH¢8 (\$5.60) to GH¢15 (\$10.50) a month, depending on the size of the family – this in a country where a third of the population lives on \$1.25 per day. The Department of Social Welfare, with support from partners, is undertaking a comprehensive review of the programme to improve its processes and systems in preparation for larger-scale coverage.

According to a 2011 World Bank study, LEAP is generally well-targeted, successfully reaching poor households in districts considered poor under the National Development Planning Commission: an estimated 57 per cent of outlays reach the poor, although not necessarily the bottom quintile. However, the study found that coverage remains low, at around 1 per cent of the poor nationally, against 10 per cent as envisaged by the end of 2012; and LEAP is poorly targeted geographically, with the selection of beneficiaries across districts poorly correlated with the actual incidence of poverty in each district (residence in one of the 50 districts classified by the NPDC as poor is a criterion for LEAP eligibility).⁸⁴

The Government of Ghana and its development partners – the World Bank, UNICEF, and the United Kingdom Department for International Development (DFID) – are adjusting LEAP's targeting mechanism to improve its efficiency and effectiveness, and it has been agreed that the tool will work as the Common Targeting Mechanism (CTM) for various ministries; that is, the CTM will use the same system and indicators to identify potential beneficiaries for social protection interventions in Ghana. The government is also preparing a comprehensive single national register for improved pro-poor delivery.⁸⁵

Education capitation grant

Aimed at improving school enrolment and retention rates, this grant is given to school authorities to cover the cost of tuition following the abolition of school fees in 2005. Initially paid at different rates for boys and girls, the grant was later modified, and the government now pays \$3 per child per year. In 2009-2010 the grant was expanded to cover about 5.33 million pupils. There is evidence that the capitation grant has attracted more children to school (at the appropriate age), especially girls (see *Education section*). However, surveys have shown that some families, especially in rural areas, have not appreciated the advantages of the grant in ensuring enrolment and retention of their children in school because of the perceived loss to family income/livelihoods that these children can provide, with the result that dropout levels have actually increased in these areas. Visits to several districts in the north revealed that many schools are not receiving their grant monies in a timely manner. This undermines the intent of the scheme to promote better maintenance and equipment, particularly in the rural areas, as an inducement for children to enrol and remain in school.

The capitation grant is a prime example of an equal but not necessarily equitable programme. Schools with fewer resources and greater needs receive the same amount per child as better-off schools. The amount of the grant is also not calibrated to different operational costs for schools in rural vs. urban areas. The government is considering a new method of allocating the capitation grant based on research from the World Bank and the Ghana Education Service, an initiative that holds the potential for introducing a more equitable allocation.

⁸⁴ World Bank, *Tackling Poverty in Northern Ghana*, pp. 86–87.

⁸⁵ Government of Ghana, Ministry of Manpower, Youth, and Employment (MMYE), *The National Social Protection Strategy (NSPS): Investing in People*, March 2007.

⁸² Lists drawn from ODI, *Study on Protection and Children in West and Central Africa*, pp. 18–19.f

⁸³ Ibid.

School feeding

Supported by the New Partnership for Africa's Development (NEPAD) and introduced in 2004, the country's school feeding programme aims to use schools as an entry point for interventions designed to reduce malnutrition, food insecurity, and poverty in target communities; and it aims to increase school enrolment and retention rates by providing one meal a day to children in deprived districts. In 2008 the programme was expanded to cover nearly 600,000 pupils nationwide, a 45 per cent increase from 2007, to help ease the burden on parents.⁸⁶ The government announced that this had increased to some 850,000 pupils by April 2011 (750,000 through Government funding and 120,000 through World Food Programme support), and it is expected that this will be further expanded to just over 1 million pupils in the coming year.⁸⁷ While the feeding programme should benefit the poorest schools, problems with targeting reveal that some better off schools are benefiting as well.

National Health Insurance Scheme

The National Health Insurance Act of 2003 established the National Health Insurance Scheme (NHIS) with the aim of increasing access to health care and improving the quality of basic health care services for all citizens, especially the poor and vulnerable. The NHIS is funded by a combination of taxes, a 2.5 per cent contribution from the Social Security and National Insurance Trust,⁸⁸ and non-subsidized member premiums. The scheme now covers 60 per cent of the population (see Table 3 below).

Table 3: National health insurance scheme – summary statistics (as of June 2010)

Total registered members (% of population)	15,555,816 (66.4%)
Total card-bearing members (% of population)	13,943,414 (59.5%)
Total active members (% of population)	12,540,780 (53.6%)
Active members as % of total registered members	80.6%

Source: NHIS website.

Contributions from premiums provide a very small part (around 15 per cent) of the funding for NHIS, which comes mainly from value-added and import taxes.⁸⁹ Such premiums as there are come from payroll taxes; and since most members of Ghana's labour force are not in the formal employment sector, most participants do not in fact pay premiums. Exemptions are also made for:

- the indigent
- the elderly (over 70)
- children under 18 years if both parents are enrolled
- pregnant women
- social-security pensioners

⁸⁶ Ibid.

⁸⁷ Government of Ghana, 2011 Budget Highlights, briefing paper, November 2010.

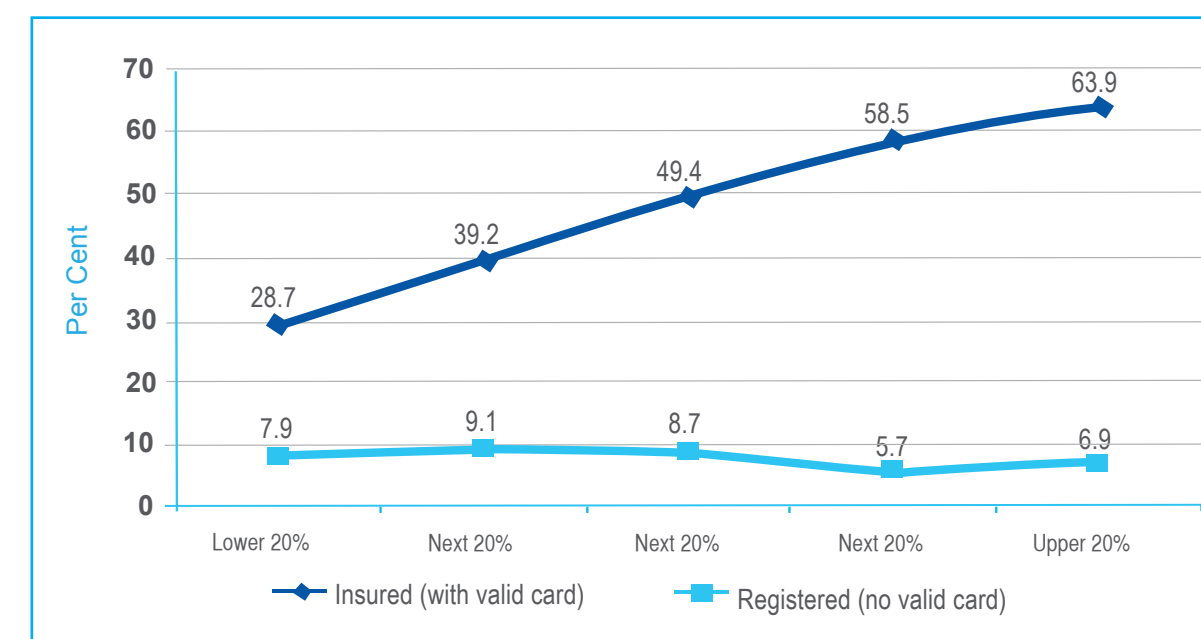
⁸⁸ The SSNIT offers long-term protection to contributors through pension, disability, and death benefits to workers in the formal sector and a small percentage in the informal sector.

⁸⁹ World Bank, Tackling Poverty in Northern Ghana.

Although NHIS covers some 60 per cent of Ghana's population (15.6 million registered by June 2010), the scheme is not considered to be equitable in its coverage of the poor, even if the premium exemptions are well targeted. A 2008 study by the National Development Planning Commission revealed that 64 per cent of individuals in the wealthiest quintile were insured with valid NHIS cards, compared to only 29 per cent of those in the lowest quintile (see Figure 5, below).

A 2011 World Bank study citing the 2005–2006 Ghana Living Standards Survey suggests that the proportion of adults who have ever registered with NHIS was lowest in the poorest quintile, and increased with socio-economic status; many among the poor said they had not registered because the premium was too expensive. (Only 2 per cent of those registered fit into the “indigent” category, whereas 29 per cent of the population lived below the poverty line and 18 per cent were considered “extreme poor” – the latter being equivalent to nine times the numbers of “indigent” exempted from NHIS premium payments.)⁹⁰

Figure 5: Individual NHIS membership by socio-economic group, 2009



Source: NDPC, Citizens' Assessment of the National Health Insurance Scheme, 2009.

There is evidence, however, that the exemptions have improved healthcare access for poorer women. The World Bank study also cites research that demonstrates that exemptions for pregnant women from paying for delivery care in public, mission, and private health facilities reached the poor and was cost effective. Given Ghana's high maternal mortality rate, this is encouraging.⁹¹

Promoting synergies between social protection and child protection

Given that the lead agency chosen to coordinate the implementation of social protection programmes, the Department of Social Welfare is also involved in child protection activities, and that the NSPS specifically identifies orphans and vulnerable children as meriting specific social protection interventions, there is wide scope for enhanced collaboration between social protection and child protection. The NSPS identifies the following categories of OVCs:

⁹⁰ Ibid.

⁹¹ Ibid.

- orphans (especially “double orphans” – children who have lost both parents)⁹²
- children who are defined as poor and needing assistance under the LEAP programme
- abused or neglected children
- children infected or affected by HIV/AIDS, especially children whose parents are not receiving health services or treatment
- marginalized children in “*hard to reach*” areas who are not able to access basic services;
- children exploited by the “*worst forms of child labour*” or trafficked
- children who are homeless and living on the streets or in conflict with the law⁹³

In addition, the target groups for LEAP (e.g., caregivers of orphans) and the conditionality of some LEAP payments (birth registration and non-involvement in child labour or trafficking) have a strong child-protection element. Thus, the development of a single registry system for LEAP could also greatly assist in the monitoring of child protection issues.⁹⁴

Fiscal space for social protection

One of the key axes of debate around the introduction of social protection programmes is financial viability, and it is of particular concern in low-income countries. As Ghana has embarked on the rollout of the NSPS, with a cash transfer programme for the extremely poor, an important question that arises concerns the fiscal scope for expansion from pilot projects to larger programmes in the population as a whole. International figures suggest that the implementation of a basic social protection package should cost between 6 and 8 per cent of GDP in low-income countries (this would include funding for both social assistance, estimated at 2–3 per cent of GDP, as well as slightly more expensive social insurance, which would amount to 3–4 per cent.)

Funding of social protection programmes

The government has routinely funded social protection programmes from HIPC and MDRI funds. However, when these sources were reduced in 2010, the Ministry of Finance created a new category of programme, Social Intervention Programmes, which are funded by utilizing 30 per cent of the District Assembly Common Fund, the Ghana Education Trust Fund (GETFund), and the National Health Insurance Fund. This solution applies only to the 2011 budget, and funding sources for subsequent years are not articulated in the Medium Term Expenditure Framework.

NHIS: The National Health Authority has noted serious concerns about the fiscal sustainability of the programme, since nearly 54 per cent of registered members of the NHIS are exempt from paying premiums;⁹⁵ and if the definition of “*indigent*” is widened, as many believe it should be, the percentage of members receiving exemptions is likely to increase.

92 According to the 2003 GDHS, 16.3 per cent of children under the age of 15 in Ghana have at least one parent dead (excluding children with parental status missing), and 6.6 per cent of children under the age of 15 are not living with either parent and are included in the vulnerable category. Source: Deters and Bajaj, “Orphans and Vulnerable Children in Ghana.”

93 MESW and UNICEF, National Plan of Action for Orphans and Vulnerable Children, Ghana, June 2010–2012, pp. 12, 22–23.

94 ODI and UNICEF, Study on Social Protection, May 2008, p. 53.

95 Ibid.

Typically, social insurance relies on mixed financing from individual contributions and government subsidies. However, the NHIS is largely financed through a 2.5 per cent earmarked addition to VAT and import duties, plus the pass-through by SSNIT of 2.5 per cent of contributors’ income. Modest additional revenue comes from member contributions through the mutual health component of NHIS, as well as some resources from the Ministry of Health and donors.

The NHIS is highly successful in terms of introducing more Ghanaians to the health system, including the poor. However, it faces a major challenge in providing affordable health care to 8 million poor Ghanaians while maintaining a fiscally sound programme.

LEAP cash transfer programme: Funding for the initial rollout of LEAP in 2008 was based on a combination of Department of Social Welfare budget resources plus donor support from both World Bank funding for northern food-insecure districts and HIPC⁹⁶ funds. At the current transfer amount of \$5–10 (GH¢8–15) per household, the estimated cost to reach the target of 165,000 extremely poor households by year five of the programme would amount to the equivalent of 0.09 per cent of GDP, or approximately 0.38 per cent of total tax revenue. It should be noted that this target number of households covers only 5 per cent of the country’s extreme poor.

UNICEF, the World Bank, and DFID are also providing technical assistance and financial support to building the capacity of the Department of Social Welfare to implement LEAP, and to develop a comprehensive monitoring and evaluation framework.

School Feeding Programme: In the case of the School Feeding Programme, the costs have been shared between the Ministry of Local Government, Rural Development, and Environment and donors (especially the Dutch Government). The World Food Programme has also been supporting the school feeding programme, especially in the three northern regions.

Education capitation grant: The ECG was funded by the Ministry of Education, with \$14.7 million in 2005–06, when the nation-wide programme commenced. This amount was increased to \$15.1 in 2006–07 and to \$15.8 in 2010–11, showing government’s commitment to ensure proper flow of resources to schools, after abolishment of fees and discontinuation of other revenue collection at school level.

According to analysts there are only two genuinely sustainable means of creating additional fiscal resources to support government programs: revenue mobilization and reallocation. Aid is relevant, but basing social protection funding on aid flows is unlikely to be sustainable owing to the long-term obligations arising from social protection programmes.⁹⁷ The ability of the government to invest more in social services and infrastructure is linked to their revenue-raising capacity. In Ghana, the tax base has been broadened and this has helped to increase government revenues from 12 per cent in 1990 to about 17 per cent in 2010. Capacity development that improves tax collection and administration will further increase government revenues but will also help Ghana to build up a sustainable system for financing its own development. Additionally, ensuring that policy-making processes are accountable, inclusive and transparent will continue to increase the impact of growth on poverty reduction.⁹⁸

96 HIPC is the Heavily Indebted Poor Countries, an IMF/World Bank scheme initiated in 1996 to help countries manage their debt.

97 Funding breakdown and analysis from ODI and UNICEF, Social Protection and Children, 2009.

98 OECD DAC, Promoting pro-poor growth in Ghana – implementation challenges and issues for donors, 2007.



CHAPTER THREE: The human rights environment for children and women

A. LEGISLATIVE AND NORMATIVE FRAMEWORK

Ghana was the first country in the world to ratify the 1989 United Nations Convention on the Rights of the Child, in February 1990; in 2005 it ratified the 1990 African Charter on the Rights and Welfare of the Child; and in 1986 it ratified the 1979 UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), though not all the provisions of that Convention have been incorporated into Ghanaian law, and the Optional Protocol to the Convention has not yet been ratified, despite the fact that it was approved by parliament in 2002. (For a complete list of international human rights-related treaties signed and ratified by Ghana, see Annex 2 to this report.)

Recognition from the CRC Committee

Ghana has made two periodic reports to the UN Committee on the Rights of the Child, most recently in 2006. In its Concluding Observations on the second periodic report, the Committee noted with appreciation Ghana's adoption of laws aimed at protecting and promoting the rights of the child, including the *"Children's Act"* (Act 560, see below) of 1998, and the Juvenile Justice Act (Act 653) of 2003.⁹⁹

However, the Committee said it remained concerned about inadequate implementation of existing laws, *"creating a gap between law and practice"*; it particularly singled out the lack of adequate human and financial resources for an effective and systematic implementation of the Children's Act and other laws and regulations relevant for the promotion and realization of child rights in Ghana.¹⁰⁰

Ghana's 1992 Constitution, in Article 28 of Chapter 5 (*"Fundamental Human Rights and Freedoms"*) sets out the rights of the child in Ghana as follows:

- The right to special care, assistance, and maintenance as is necessary for its development from its natural parents;
- The right, whether or not born in wedlock, to a reasonable provision from its parents' estate;
- The right to receive care, maintenance, and upbringing from parents;
- Protection against exposure to physical and moral hazards;
- Protection from engagement in hazardous work;

- The right not to be subjected to torture or other cruel, inhumane, or degrading treatment or punishment;
- The right not to be deprived of medical treatment, education, or social or economic benefits by reason of religious beliefs.¹⁰¹

Chapter 6 of the Constitution obliges the state to enact appropriate laws to ensure the *"protection and promotion of all basic human rights and freedoms,"* including those of children, the disabled, the aged, and other vulnerable groups. It specifies that the state should be *"guided by international human rights instruments"* in doing so.¹⁰²

Children's Act and Child Panels

The 1998 Children's Act (Act 560) calls for respect for the principle of *"the best interests of the child"* when decisions are made that affect children's lives. Laws have also been passed governing children's rights to inheritance, and prohibiting harmful cultural practices. Additionally, mechanisms have been established theoretically permitting children or their parents to seek redress when violations occur. This has included the setting-up of district-based Child Panels, established under the Children's Act, which have quasi-judicial powers and which permit children's participation in the proceedings and can be instituted at no charge.¹⁰³ However, they have been established in only 70 of the country's 170 districts, and the lack of resources can obstruct their ability to function.¹⁰⁴

B. GAPS AND DISPARITIES IN FULFILLING HUMAN RIGHTS

In its Concluding Observations to Ghana's most recent periodic report, the UN CRC Committee noted a number of areas where it felt inadequate human and/or financial resources were being deployed in ensuring the promotion and realization of children's rights in Ghana. These included, inter alia:

- *"inadequate"* resourcing of District Assemblies to ensure their capacities as the implementing body for children's issues at the local level
- limited capacities for early detection and treatment of children with disabilities
- inadequate reproductive health services and the lack of mental health services for adolescents
- limited access by HIV/AIDS-infected children and mothers to antiretroviral medication
- lack of data on child trafficking in Ghana¹⁰⁵

While the rule of law is an entrenched reality in Ghana, some sections of the population are routinely denied access to justice because they cannot afford to hire legal representation.

¹⁰¹ MoWAC and UNICEF Ghana, *Children in Ghana*, pp. 107–108.

¹⁰² Ibid., p. 108.

¹⁰³ Ibid.

¹⁰⁴ Information from UNICEF Ghana, Child Protection Section.

¹⁰⁵ UN Committee on the Rights of the Child, Consideration of reports submitted by States Parties: Ghana, UN document CRC/C/GHA/CO/2, 17 March 2006, *passim*.

⁹⁹ UN Committee on the Rights of the Child, Consideration of reports submitted by States Parties under Article 44 of the Convention; Concluding observations: Ghana, 41st session, UN document CRC/C/GHA/CO/2, 17 March 2006, para. 4.

¹⁰⁰ Ibid., pp. 9–10.

Further, the national judiciary suffers from a lack of adequate capacity and resources to administer justice.¹⁰⁶ The UN Committee on the Elimination of Discrimination against Women, in its Concluding Comments to Ghana's most recent periodic reports to the Committee, noted that access was a particular problem for women in Ghana. It expressed concern that:

“ Although women's access to justice is provided for by the law, women's ability in practice to exercise this right and to bring cases of discrimination before the courts is limited by factors such as limited information on their rights, lack of assistance in pursuing those rights, and legal costs.¹⁰⁷ ”

Women's rights

In Ghana today women's share of poverty is much higher and their share of formal employment is much lower than that of men, and these conditions have changed little in recent years despite Ghana's economic success and the government's poverty reduction strategies. Seventy per cent of food-crop farmers are women, responsible for food security in their households, and yet their access to and control over land, information on land rights issues, and access to formal credit from banks and other facilities remains limited.¹⁰⁸

Progress in increasing the number of women in Ghana's public life suffered a setback when the 2008 elections reduced the number of women elected to Parliament from 25 to 20 (out of 230 MPs), putting Ghana below the international average of 13 per cent female representation. Although both the Chief Justice of Ghana and the Speaker of Parliament at present are women, the proportion of women in administrative and political leadership posts showed a rather sharply declining trend between 2008 and 2009.¹⁰⁹

Violence against women remains a major concern in Ghana. As elsewhere, most of this violence and abuse occurs in the home, and, as elsewhere in sub-Saharan Africa, it is all too often justified by both the perpetrator and the victim. One study in Ghana found that 49 per cent of women felt that a man was sometimes justified in beating his wife. (In the northern regions, over 76 per cent of women accepted wife-beating as sometimes justified.) Men actually appeared less tolerant of wife-beating than women in this study, with 32 per cent of men saying it was sometimes justified.¹¹⁰

In addition to establishing the Ministry of Women and Children's Affairs, the government has initiated an Affirmative Action Programme and has developed a National Gender and Children's Policy Framework. According to the Ministry of Health, these announced strategies are aimed at mainstreaming gender concerns into the development process in order to improve the social, legal/civic, political, economic, and cultural conditions of Ghanaians, particularly children and women.¹¹¹

¹⁰⁶ UNCT, Ghana Country Analysis, p. 8.

¹⁰⁷ UN Committee on the Elimination of Discrimination against Women, Concluding comments of the Committee on the Elimination of Discrimination against Women: Ghana, 25 August 2006.

¹⁰⁸ UNCT, Ghana Country Analysis, p. vi.

¹⁰⁹ NDPC and UNDP, 2008 Ghana MDG Report, p. 27.

¹¹⁰ Ghana Statistical Service, Ghana Health Service, and ICF Macro, Ghana Demographic and Health Survey 2008 (GDHS, 2008), Accra, December 2009, cited in ODI, Study on Social Protection, p. 15.

¹¹¹ Government of Ghana, Ministry of Health (MoH), Health Sector Gender Policy, Final Draft 1, November 2008.

The UN Committee on the Elimination of Discrimination against Women has expressed concern that the definition of discrimination against women contained in Ghana's 1992 Constitution is not in conformity with the definition contained in Article 1 of CEDAW, which Ghana ratified in 1986.¹¹² The Committee noted that the existing legislative framework was inadequate to ensure compliance with all provisions of the Convention for Ghanaian women.¹¹³

Children and disability

Data on disabilities among Ghana's adults and children are limited and diffuse. In 2000, when a new National Disability Policy was being developed, it was estimated that 10 per cent of the population was disabled; at least half of whom (approximately 1 million) were children.¹¹⁴ This would not be far out of line with estimated global numbers of disabled persons.¹¹⁵ A 1997 survey by the Ghana National Commission on Children (GNCC) found that hearing, vision, speech, and limb impairment were the most prevalent disabilities among children. Not surprisingly, children with disabilities from poor homes and rural areas are the most at risk of discrimination and of lacking care and attention.¹¹⁶ Data from the 2006 MICS Survey reveal that 16 per cent of children aged 2–9 years were reported to have at least one disability. The approach used in the survey rests on the concept of functional disability developed by the World Health Organization (WHO), and aims to identify the implications of any impairment or disability for the development of the child (e.g., sight impairment, deafness, difficulties with speech, delays in sitting, etc.).¹¹⁷

It is expected that the passage of the Disability Act in 2006 will stimulate positive action in favour of children and others with disabilities. However, as in every culture, the true elimination of prejudice requires pro-active socialization and awareness-raising, even within families. Children with disabilities comprise a group whose rights are often violated: they are often subjected to neglect, discrimination, and even abuse, and they are often denied the right to an education. It is widely assumed that, among virtually all socio-economic groups in Ghana, there are families and communities who customarily conceal or otherwise deny the existence of disabled children among them, and thus the foremost challenge in implementing both national legislation and community-based action on disabilities must be first to locate these children and then to ensure access to rehabilitation services and inclusive programmes for those with disabilities.¹¹⁸

¹¹² The definition of discrimination contained in the Convention reads: "For the purposes of the present Convention, the term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." The Ghanaian Constitution, in Article 17 (2) says simply: "A person shall not be discriminated against on grounds of gender, race, colour, ethnic origin, religion, creed or social or economic status."

¹¹³ UN Committee on the Elimination of Discrimination against Women, Concluding comments, 25 August 2006.

¹¹⁴ MoWAC and UNICEF, Children in Ghana, p. 62.

¹¹⁵ See World Health Organization (WHO), "Disease incidence, prevalence and disability." www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_part3.pdf.

¹¹⁶ UNICEFGhana, Situation Analysis of Children and Women in Ghana 2000, Accra 2002, cited in Children in Ghana, p. 62.

¹¹⁷ Ghana Statistical Service, Multiple Indicator Cluster Survey, 2006, p. 106.

¹¹⁸ MoWAC and UNICEF, Children in Ghana, pp. 62, 137.

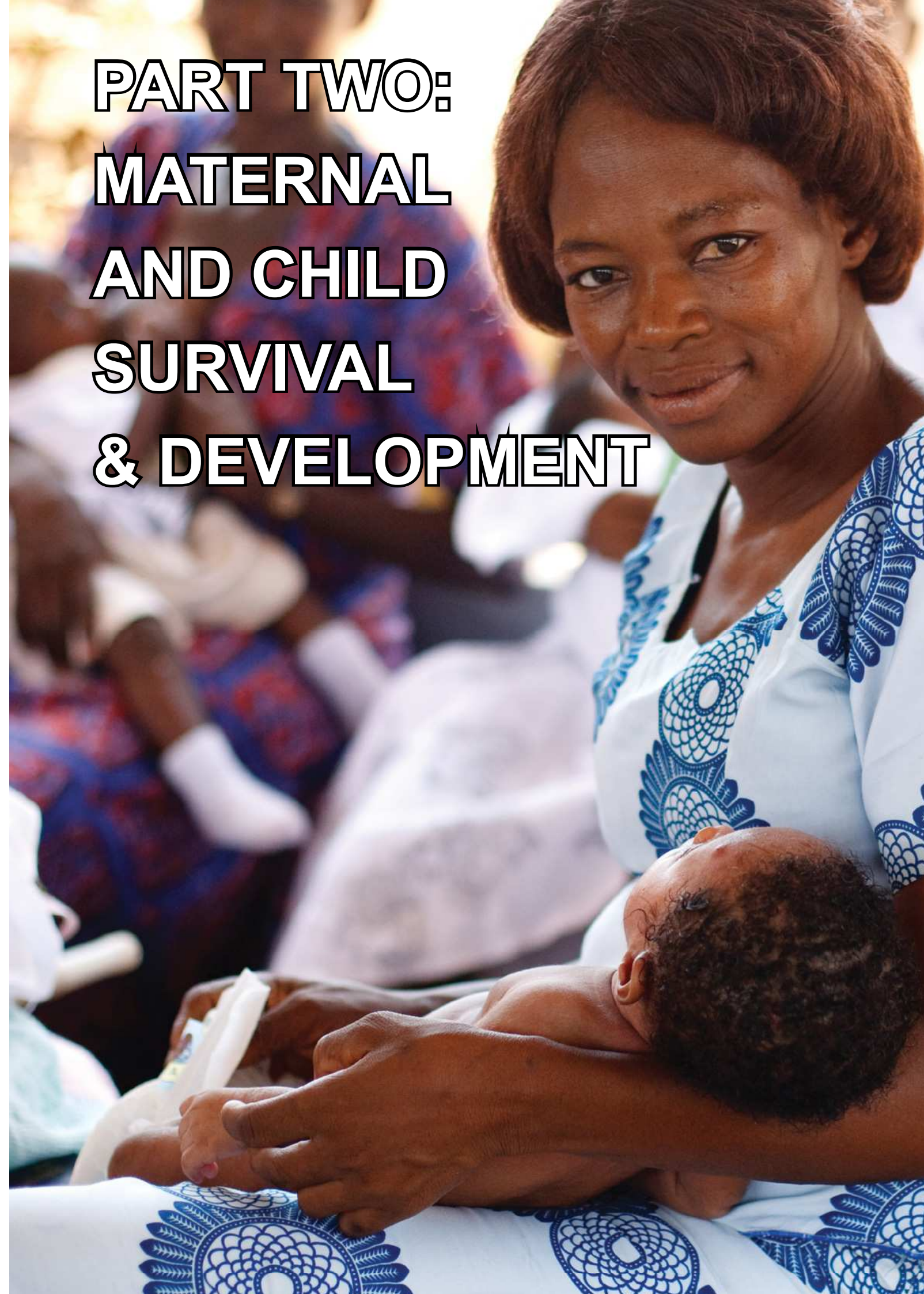
On 3 December 2010 it was reported that the government had approved the ratification of the United Nations Convention on Persons with Disability (PWD) to pave the way for the implementation of the Disability Act. The chairman of the National Council for Persons with Disability was quoted as saying that the Council was working with the Ministry of Local Government and Rural Development to ensure that the 2 per cent of the District Assemblies Common Fund allotted for PWDs at the district level would be released to them.¹¹⁹

The Department of Social Welfare noted in 2003 that fewer than 2 per cent of children with disabilities had access to specialized services. As with other social programmes in Ghana, the poorer, rural areas offer the fewest services for people with disabilities; in the Upper East region, for example, 75 per cent of people with disabilities have no access to assistance.¹²⁰ Reported disability rates for the three northern regions are exceptionally low compared with the other regions, probably due to reluctance on the part of the more traditional communities in the north to disclose information about disabled persons in their households.¹²¹

The model of community-based rehabilitation (CBR), used successfully in many countries, is being applied in Ghana under the aegis of the Department of Social Welfare. It aims to promote the social inclusion of children (and adults) with disabilities through teacher and parent training and through public education and awareness-raising.¹²² The aim is to rehabilitate the disabled in their own environment, with integrated family and community support. At the district level, CBR teams drawn from the gamut of stakeholders plan and implement disability-friendly activities at the community level, aided by social grants provided under the National Social Protection Strategy.¹²³ Clearly, however, there are many communities, particularly in the more deprived regions, who have yet to be reached even by needs assessments for disabled services.



PART TWO: MATERNAL AND CHILD SURVIVAL & DEVELOPMENT



119 "Ghana to ratify UN Convention on Disability," Ghanaian Times, 4 December 2010.

120 MoWAC and UNICEF, Children in Ghana, p. 62.

121 CRRECENT/PlanGhana, Child Rights Situational Analysis, p. 50.

122 MoWAC and UNICEF, Children in Ghana, p. 62.

123 MMYE, The National Protection Strategy (NSPS): Investing in People.

“Significant progress has been made in recent years in improving child and maternal well-being in Ghana”



CHAPTER ONE: Health of children and women

INTRODUCTION:

Every child has the right to the best possible start in life. The conditions of a child's birth and the environment in which the child spends the first few years of its life are critical in determining his or her survival, healthy growth, and development. Within this context, access to health, nutrition, water, and sanitation services are vital to children's survival and development. It is in the first few years of life that most brain development occurs and children learn to sense, walk, think, play, and communicate. For these reasons the choices made and actions taken on behalf of children during this critical period affect not only how the child develops but also how a country progresses.¹²⁴

Starting in 1996, the principles, objectives, policies, and strategies that have guided the implementation of health programmes in Ghana have emanated from the Ministry of Health's succession of five-year Programmes of Work (PoWs), covering 1997–2001, 2002–2006, and now 2007–2011. The current PoW is aimed at:

- ensuring that Ghanaians live long, healthy, and productive lives (current overall life expectancy in Ghana is estimated at just under 60 years) and reproduce without risk of injury or death
- reducing risks of mortality, morbidity, and disability, especially in marginalized groups
- reducing inequalities in access to health, reproductive-health and nutrition services and health outcomes¹²⁵

The Ministry of Health (MoH) also developed the Child Health Policy (2007–2015) to provide a framework for planning and implementing health programmes. The Policy proposes a '*child centred*' rather than a '*programme centred*' approach, therefore calling for greater collaboration among different programmes. The MoH has also developed an Under-Five Child Health Strategy (2007–2015) to guide in the implementation of the Child Health Policy.

Significant progress has been made in recent years in improving child and maternal well-being in Ghana. However, these gains have been uneven across the country, and large numbers of Ghanaian children and women have not benefited equally from the country's overall economic growth and poverty reduction.

¹²⁴ UNICEF, The State of the World's Children 2011, UNICEF, New York, February 2011, p. 135.

¹²⁵ ISODEC and UNICEF Ghana, 2009 Budget and Issues Relating to Women and Children Welfare.

A. MATERNAL SURVIVAL AND HEALTH

The rate of pregnancy-related deaths of women stands in sharp contrast to Ghana's other achievements in maternal and child health. Ghana is making progress, but not enough for meeting the MDG 5 target of reducing maternal mortality by three quarters by 2015. According to the Maternal Mortality Survey of 2007, the maternal mortality ratio was 451 deaths per 100,000 live births. The Maternal Mortality Estimation Group issued new estimates for 2009, and Ghana's maternal mortality is now estimated at 350 deaths per 100,000 live births (the MDG target is 185 per 100,000).¹²⁶

The principal direct determinants of maternal mortality in Ghana are pregnancy/labour related complications, with bleeding, infections, and unsafe abortions being the main direct causes of maternal deaths.¹²⁷ Indirect causes include pre-existing diseases appearing during pregnancy, while underlying causes include a number of social, cultural, and economic factors, as well as health systems capacities.¹²⁸ Significantly, even the rate of maternal deaths for deliveries in healthcare institutions has not changed dramatically – falling from 216 per 100,000 in the base year of 1990 to 201 per 100,000 in 2008 (the MDG 5 target is 54 per 100,000).¹²⁹

Disparities in skilled births attendance

Antenatal care (ANC) and childbirth care provide good indicators of maternal health care in Ghana. Specifically, antenatal care indicates the proportion of women who were attended to at least once during pregnancy by skilled health personnel (doctors, nurses, and midwives). Regular contact with skilled health personnel during pregnancy is critical as it allows women to identify and possibly correct potential health problems, in addition to receiving general health advice on tetanus immunisation, good nutrition, HIV/AIDS, malaria, and hygiene. The Ministry of Health recommends that pregnant women should attend at least four ANC visits during every pregnancy.

Antenatal care coverage in Ghana is very equitable across regions and wealth quintiles, and has improved significantly in recent years, with the proportion of women seen at least once by skilled health personnel during pregnancy increasing from 92 per cent in 2003 to 95 per cent in 2008. Also, over 90 percent of pregnant women in all regions received antenatal care from a skilled provider, and little variations exist between women from different wealth, residence, and education backgrounds. Further, there is an increasing trend among pregnant women to have four or more ANC visits. In 2008 nearly four in five (78 per cent) pregnant women had four or more ANC visits, as recommended, an increase from 69 percent in 2003. Although women in urban areas are more likely than women in rural areas to make four or more visits, the increase between 2003 and 2008 was actually larger for women in rural areas (from 61 to 72 per cent). Additionally, in 2008 slightly more than half (55 percent) of women went to their first ANC visit during the first trimester of pregnancy, as recommended, an increase from 46 percent recorded in 2003. These increases are seen as the direct result of increased health

¹²⁶ UNICEF statistics, based on Maternal Mortality Survey of 2007.

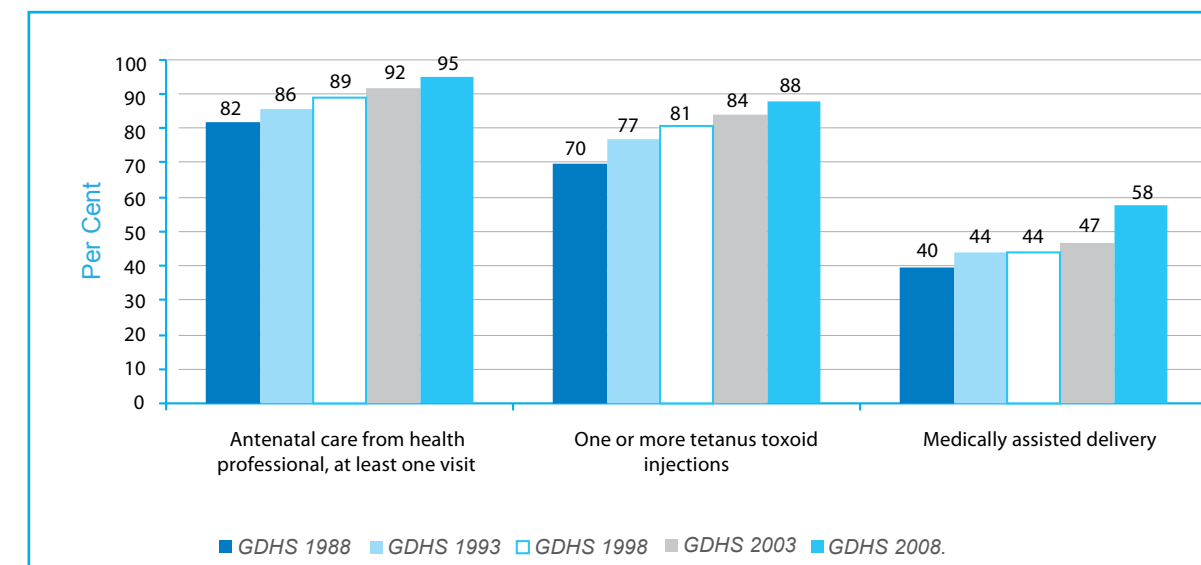
¹²⁷ NDPC and UNDP, 2008 Ghana MDG Report, and UNICEF Ghana, Annual Report 2009.

¹²⁸ NDPC and UNDP, 2008 Ghana MDG Report, p. 37, citing MoH, Ghana Health Service Provision Assessment Survey, 2003.

¹²⁹ Ibid., table, p. 90.

services in Ghana, with the vast majority of ANC care provided by nurses and midwives, and doctors accounting for 23.5 per cent nationally (33.9 per cent in urban areas, 16.4 per cent in rural areas).

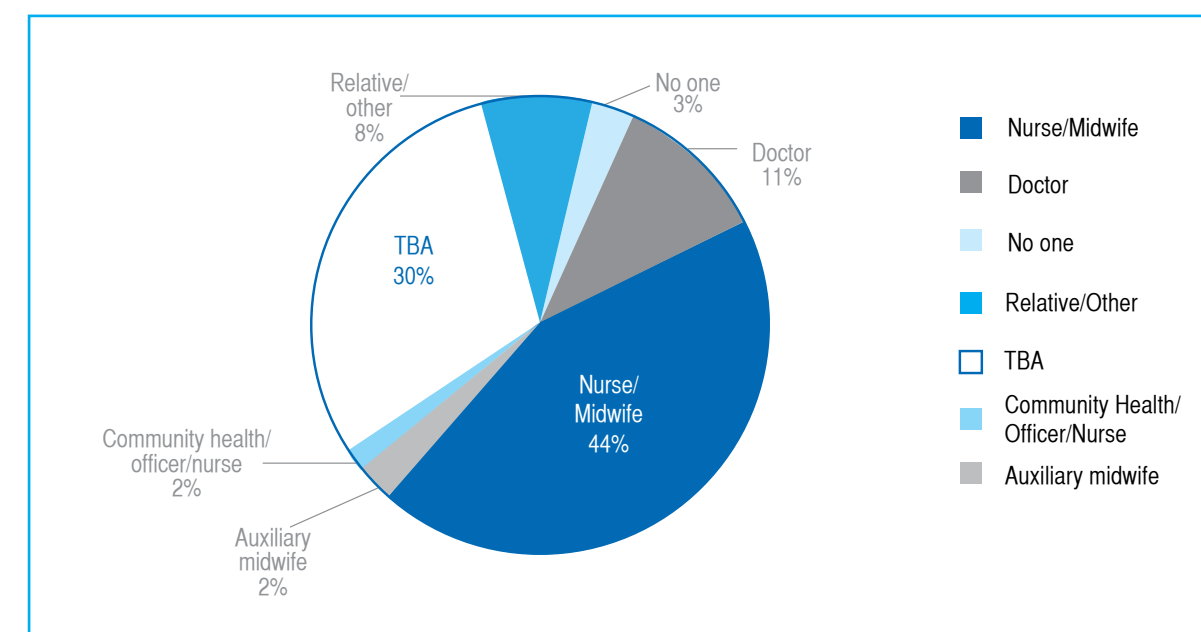
Figure 6: Trends in maternal care indicators, 1988–2008



Source: GDHS 1988, GDHS 1993, GDHS 1998, GDHS 2003, GDHS 2008.

While the proportion of pregnant women making the recommended four ANC visits was 78 per cent in 2008, only 59 per cent have access to skilled birth attendants, 30 per cent of births are delivered by a traditional birth attendant, and about one in ten births is assisted by a relative or receives no assistance at all (see Figure 7, below).

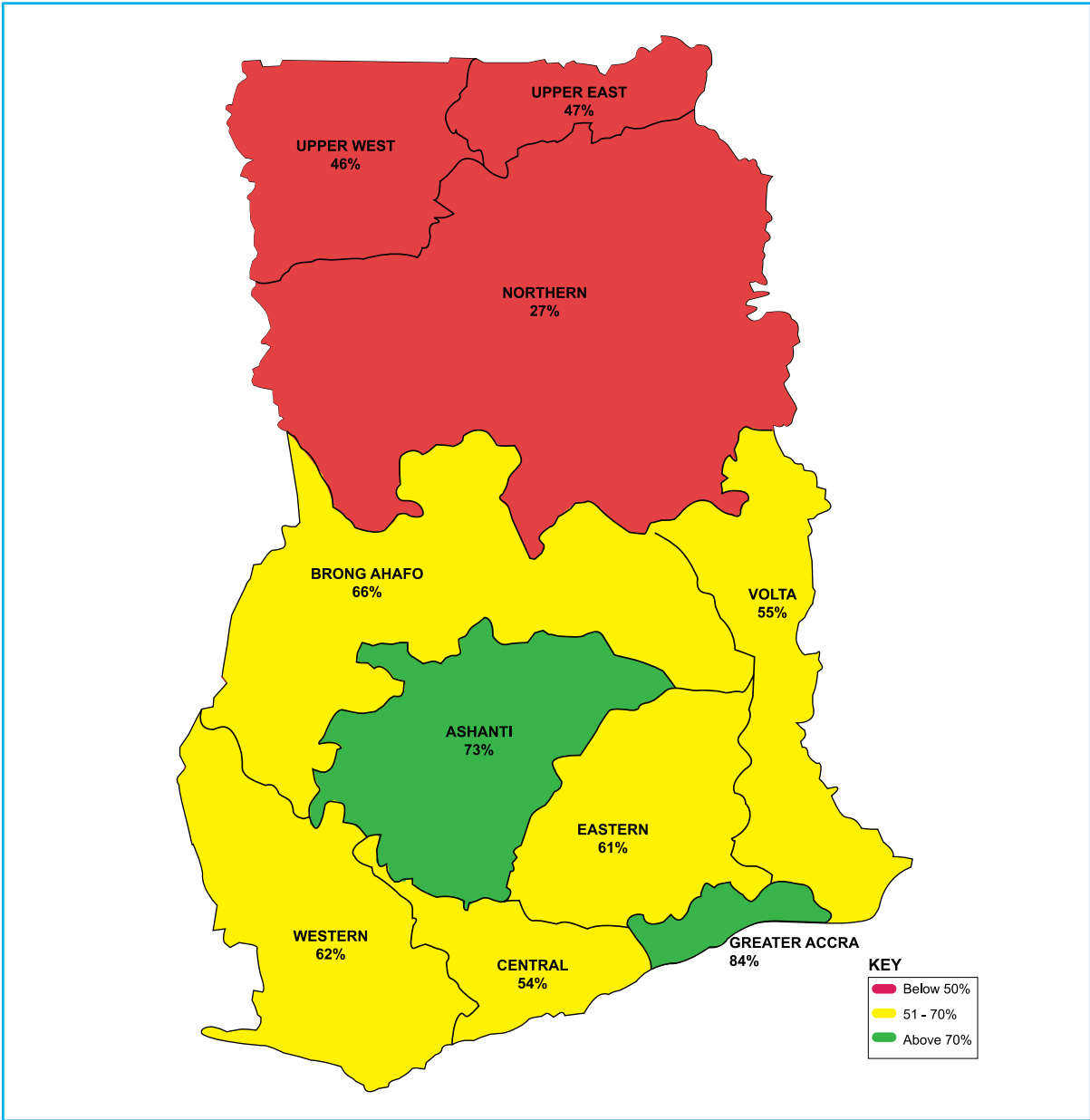
Figure 7: Assistance during delivery, 2008



Source: GDHS 2008.

There continue to be significant disparities in access to skilled birth attendance at delivery according to location, income status, and educational levels.¹³⁰ In the three northern regions the rate of access to skilled birth attendants was less than 50 per cent (and as low as 27 per cent in Northern region), while in Greater Accra region the rate was 84 per cent. Regarding income status, nearly 95 per cent of women from the wealthiest quintile had access to a skilled birth attendant at delivery, compared with 24 per cent from the poorest quintile. With free access to maternal health care during pregnancy and the post-natal period available through the National Health Insurance scheme, it is expected that more women will access services in future.¹³¹

Figure 8: Percentage of women delivered by skilled providers, 2008



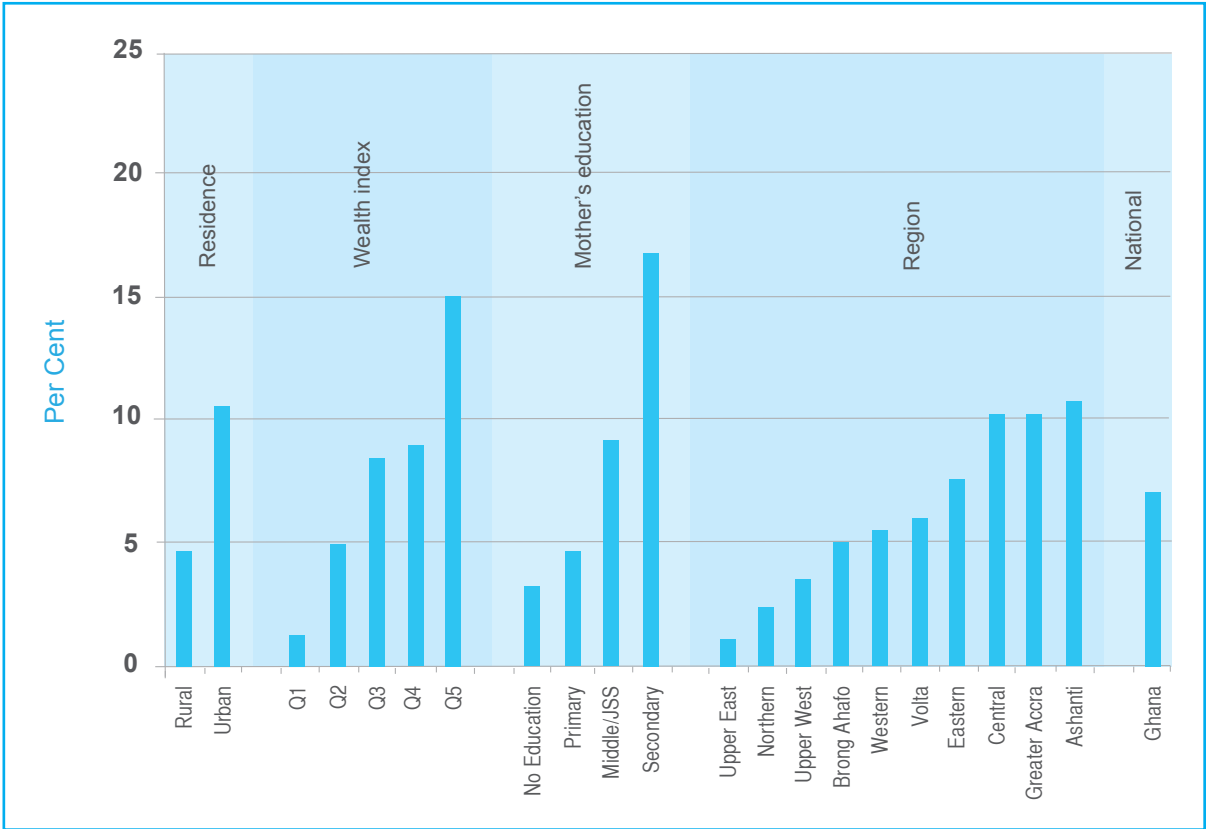
Source: GDHS, 2008.

130 Skilled birth attendant ratio by population groups: richest/poorest: 95 per cent/24 per cent; secondary/no education: 92 per cent/36 per cent; and urban/rural: 84 per cent/43 per cent.

131 UNICEF statistics, UNICEF Ghana, Annual Report 2009.

Emergency obstetric and newborn care (EMONC) is poor in many regions, with once again the three northern regions facing the greatest challenges. Preliminary results from the 2010 EMONC Needs Assessment observed a lack of basic infrastructure, such as water and power supplies, blood transfusion services, operating theatres, and poor geographical access to facilities and referral services. While the global estimate of 5–15 percent access to caesarean sections is considered adequate in a given population, the 2008 GDHS revealed that only 7 percent of women delivered by C-section, and this proportion is much higher for women in the wealthiest quintile (15 percent) compared to those in the bottom quintile (1 percent).

Figure 9: Percentage of women with access to emergency obstetric services (C-Section), 2008



Source: GDHS, 2008.

Skilled care for mothers is critical in the days immediately following birth. Up to 45 percent of all maternal deaths occur within one day of delivery, and 65 percent occur within the first week. This period is also critical to newborn survival as well, given that 50 to 70 per cent of life-threatening newborn illnesses occur within the first week of life.¹³² A postnatal check-up within the first week of delivery is therefore an important strategy for ensuring optimal maternal and newborn health. In Ghana, the first postnatal check-up is advised within the first three days of delivery, and subsequent check-ups are scheduled as appropriate. The 2008 GDHS reveals that about 57 per cent of women received a postnatal check-up within 24 hours of delivery, and an additional 11 per cent within 1–2 days. Another 7 per cent of women received postnatal care 3 to 41 days after delivery. Twenty-three per cent of women did not receive any postnatal care.

132 Academy for Educational Development (AED), the Manoff Group, and USAID, 2005. Maternal survival: Improving access to skilled care, a behaviour approach, CHANGE project. Washington, DC (www.manoffgroup.com).

Women delivering in a health facility are more likely to have a postnatal check-up within the first two days, compared with women delivering elsewhere. Also, women in the highest wealth quintile are about twice as likely to have an early postnatal check-up as women in the lowest wealth quintile, and a similar pattern is seen by level of education. Women in the Northern region are least likely to have access to a postnatal check-up within the first two days (45 per cent), probably because facility-based delivery care is also lowest in this region.

B. CHILD SURVIVAL

The principal indicator used to measure the level of child well-being and its rate of change in a country is the under-five mortality rate (U5MR). The rate of under-five mortality is the result of a wide variety of factors: the nutritional health and the health knowledge of mothers; the availability, use, and quality of maternal and child health services; family income and food availability; access to clean water and safe sanitation; and the overall safety of the child's environment. The under-five mortality rate measures one end result of the development process, and therefore presents a good overall picture of the health status of Ghanaian children and of Ghanaian society as a whole.

Measuring the rates of neonatal (under one month) and infant (under one year) mortality is also critical, as these rates acknowledge the particular vulnerability of newborn children and children in their first year of life. Neonatal mortality in particular is a reflection of the circumstances surrounding the birth of the child, such as the mother's health, the environment in which the child is delivered, and the care the newborn received in the first few days of life.

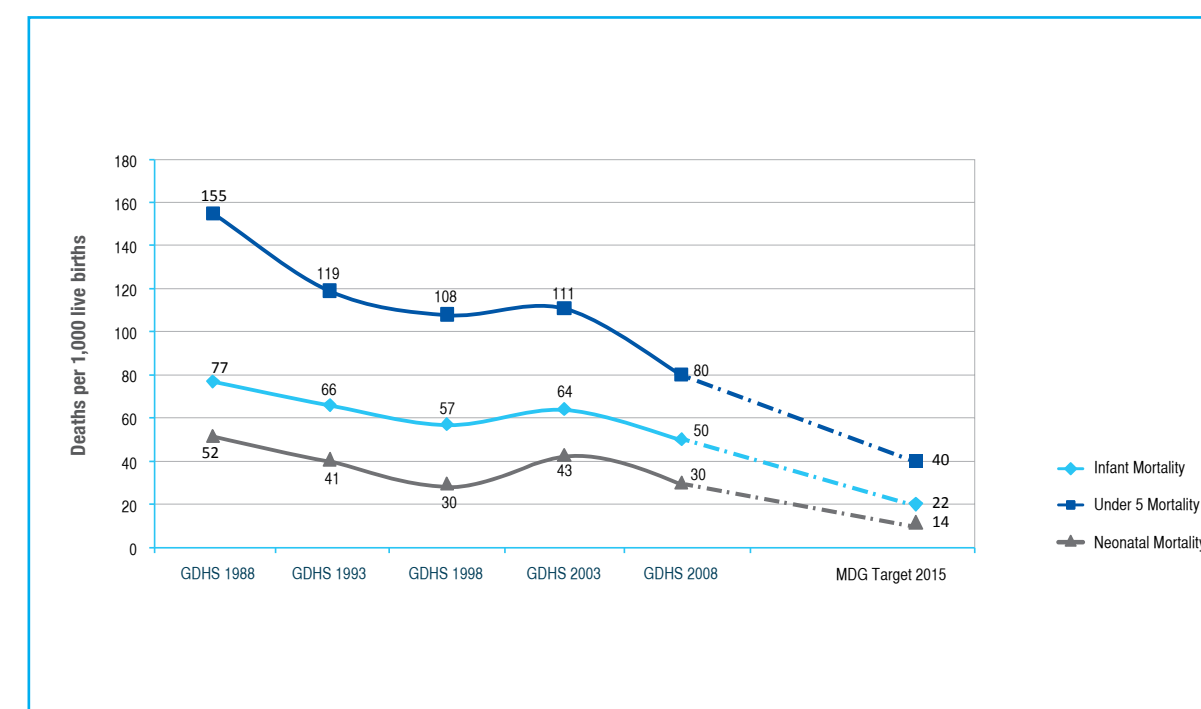
In recent years Ghana has made significant progress in securing the basic rights of children to survival and a healthy life. Since 2003 infant mortality rates (deaths in the first year of life) have declined by 22 per cent, from 64 deaths per thousand live births, as recorded in the GDHS of 2003, to 50 per thousand in GDHS 2008; while the U5MR has declined by about 28 per cent, from 111 deaths per thousand live births to 80 per thousand over the same period. Further, the Inter-Agency Group on Child Mortality has calculated Ghana's U5MR at 64 deaths per thousand live births as at 2010.¹³³

The neonatal mortality rate (deaths in the first month of life) in the 2008 GDHS was 30 deaths per thousand live births, a 30 per cent decline from the rate of 43 per thousand recorded in 2003, which was similar to the rate recorded a decade earlier. Overall, infant mortality accounts for 64 per cent of all under-five mortality in Ghana, neonatal deaths account for 60 per cent of deaths in infancy. Additionally, half of neonatal deaths occur at home.¹³⁴

¹³³ UNICEF, WHO, World Bank, UNDESA/Population Division, Levels & Trends in Child Mortality: Estimated developed by the UN Inter-agency Group for child Mortality Estimations, Report 2011, UNICEF, New York, September 2011, p. 13

¹³⁴ MoH, "Child Health Situation Analysis in Ghana," 2007, www.moh-ghana.org/UploadFiles/Publications/Childhealthsituationalanalysis090825083908.pdf.

Figure 10: Trends in childhood mortality in Ghana, 1988–2008



Source: GDHS 1988, GDHS 1993, GDHS 1998, GDHS 2003, GDHS 2008.

Since 2003, Ghana has seen a significant reduction of U5MR nationwide for all wealth quintiles; however, the reduction in U5MR has been greater in the highest wealth quintile, and the distribution of U5MR reduction rates by wealth has become increasingly unequal.¹³⁵ According to the 2008 GDHS, a child in the Upper West region is nearly three times more likely to die before age five than a child born in Greater Accra. There were indications that four out of the 10 regions – Upper East, Western, Brong Ahafo, and Volta – were on track to achieve MDG 4 on under-five mortality, while the rest were not.¹³⁶ Still, the rates of decline in U5MR were higher in the three northern regions, where the high impact rapid delivery (HIRD) approach, had a measurable effect on reducing child mortality and malnutrition.

The decline in both infant and under-five mortality indicates that the targets set under the second Ghana Poverty Reduction Strategy (GPRS II) – an infant mortality rate of 50 per thousand and an under-five mortality rate of 95 per thousand by 2009 – have been achieved. However, the current annual average rate of reduction of child deaths is not sufficient to attain the targets set under MDG 4 by 2015.¹³⁷ To achieve the target for under-five mortality, the less-than-30 per cent decline in under-five deaths seen in the past five years is going to have to be translated to 50 per cent over the next five years. This is seen as possible, but to achieve it will require some major scaling-up of high-impact child health and nutrition interventions.¹³⁸

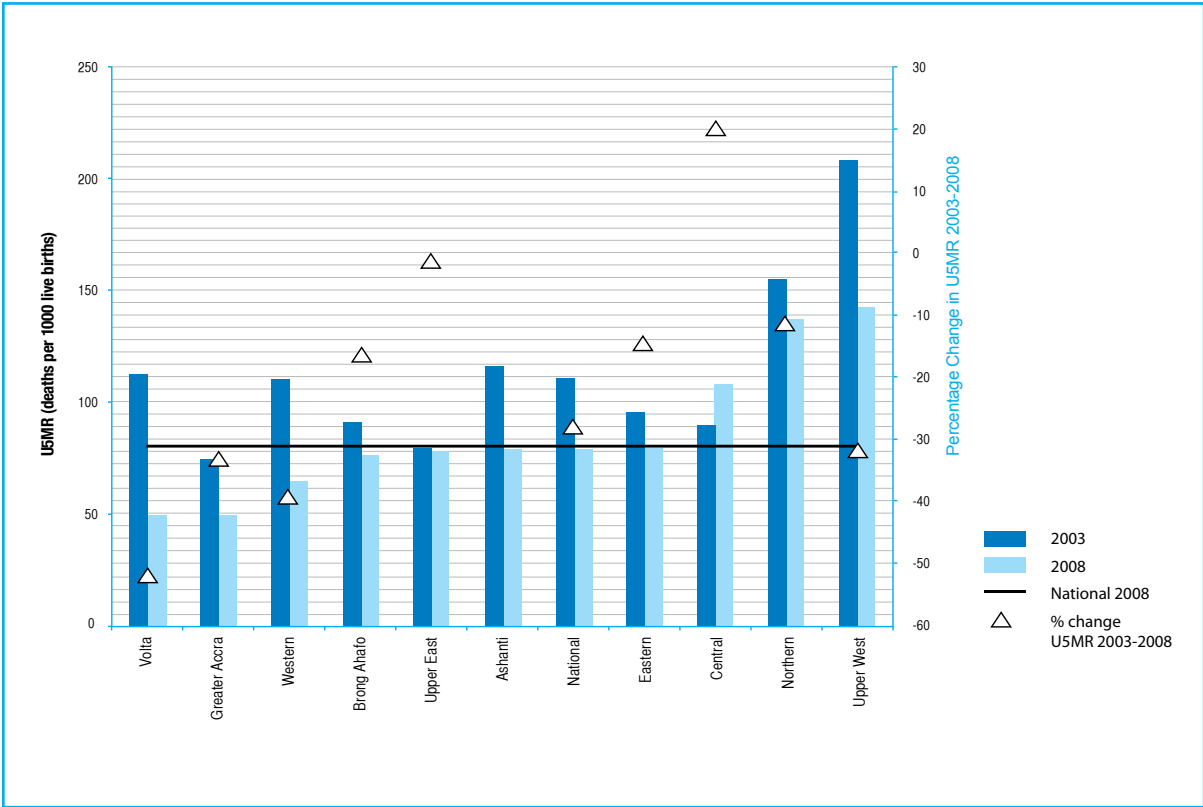
¹³⁵ MoH, Independent Review: Health Sector Programme of Work 2009 – Ghana (draft), April 2010, p. 4.

¹³⁶ UNCT, Ghana Country Analysis, p. vii.

¹³⁷ NDPC and UNDP, 2008 Ghana Millennium Development Goals Report, p. 31.

¹³⁸ Interview with chief of UNICEF Ghana health section, 2 November 2010.

Figure 11: Regional under-five mortality, 2003 and 2008



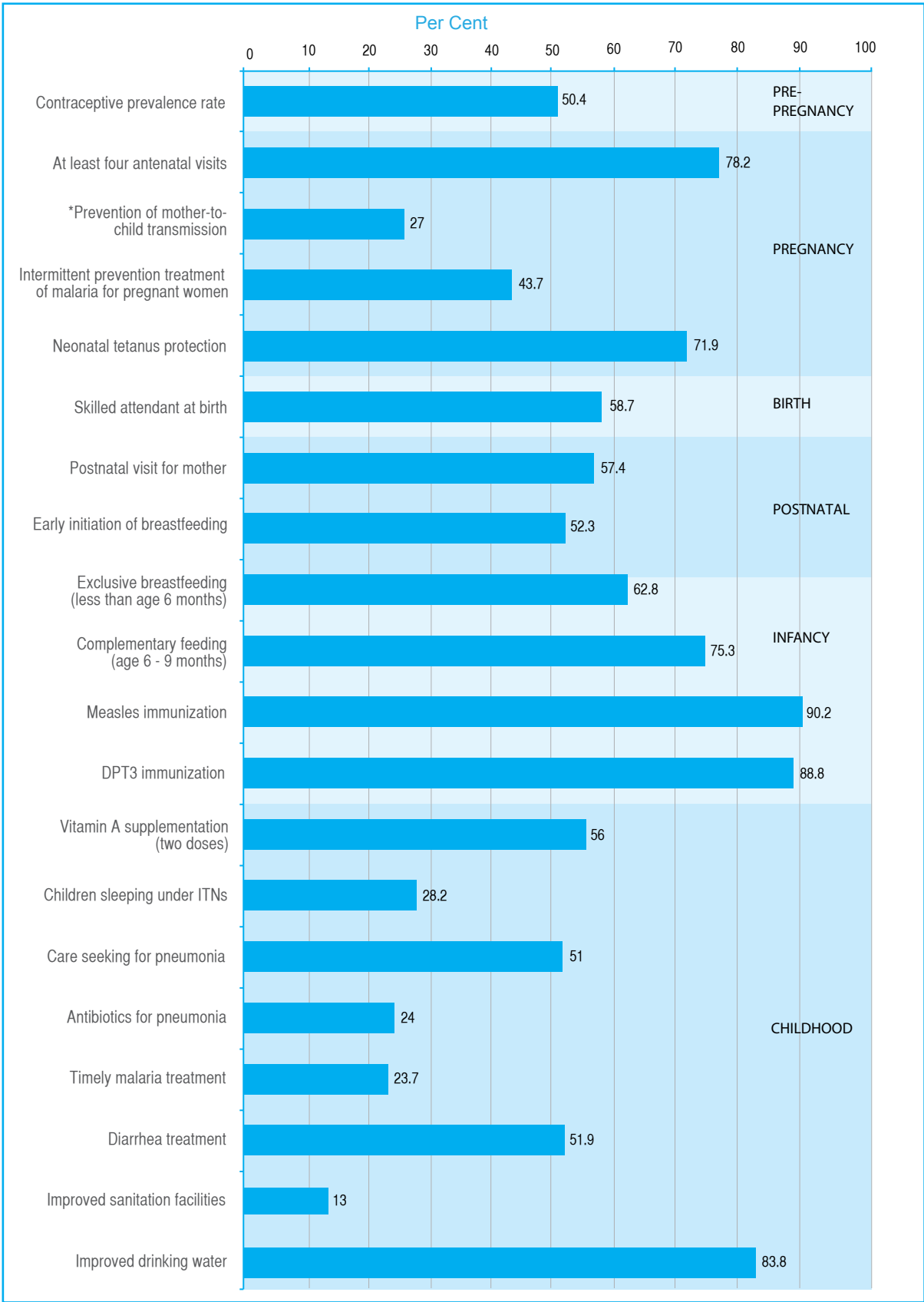
Source: GDHS 2003 and GDHS 2008.

C. CHILDHOOD ILLNESSES

A major public health intervention to address childhood illness has been the development of the Integrated Management of Childhood Illness (IMCI) programme, which has three components: building the capacity of health professionals, strengthening the health system, and improving family and community health practices. While important progress has been made in reducing childhood illnesses, the overall situation remains daunting. Particular successes and challenges in combating childhood illness in Ghana in the areas of malaria, acute respiratory infection, diarrhoea, and vaccine preventable diseases are evidenced in Figure 12, that shows the distribution of coverage of 20 interventions crucial for child survival. Of these, only the two vaccination interventions and access to safe water are reaching 80 percent of the children who could benefit from them.



Figure 12: Continuum of care for health outcomes, 2008



Source: GDHS, 2008 and Children & AIDS: Fifth stock taking report, 2010.

Malaria

As noted, malaria is one of the three main causes of child mortality in Ghana despite the fact that it is both preventable and can be treated. Meeting the target of MDG 6 – reducing the under-five mortality rate from malaria – is within reach, but it still presents challenges. The under-five malaria mortality rate was estimated at 2.1 per cent in 2007, the most recent year for which estimates are available.¹³⁹ It is further estimated that some 30–40 per cent of outpatient cases seen each year, including 900,000 children under five years of age, are suspected to be malaria, and that more than 60 per cent of hospital admissions of children under five are cases of malaria.¹⁴⁰

Ghana is now implementing a malaria control programme with a goal that generally aims at reducing death and illness due to the malaria disease by 75 per cent by the year 2015 in line with the attainment of the MDGs. This goal is to be achieved through overall health sector development, improved strategic investments in malaria control, and increased coverage towards universal access to malaria treatment and prevention interventions.

One of the key targets agreed to at the Abuja Roll Back Malaria (RBM) summit was to ensure that 60 per cent of those suffering from malaria should be able to access and use correct, affordable, and appropriate treatment within 24 hours of the onset of symptoms. In areas where malaria is common, WHO recommends that any fever in a child is treated as if it were malaria and that the child be given a full course of anti-malarial tablets. Results from the 2008 GDHS reveal a high prevalence of fever among children, with 20 per cent of all children under five years of age reported to have had fever in the two weeks prior to the survey. Among children with fever, 43 per cent were given anti-malaria drugs, and only 24 per cent were given the drugs within 24 hours.

Ghana still has not achieved the 2005 Abuja target of 60 per cent of children sleeping under an insecticide-treated bed net (ITN). In an effort to make mosquito nets more affordable, the Government of Ghana has since 2002 waived taxes on the importation of nets into the country. Development partners have also contributed by supplying some ITNs for distribution at subsidized costs to pregnant women and children under five in disadvantaged areas of the country. These nets are distributed through routine public health services. As a result of these interventions, household ownership of ITNs increased dramatically from 3 per cent in 2003 to a peak of 33 per cent in 2008, the last year for which there are data.¹⁴¹

Households in the Upper East region report the highest level of ownership of ITNs (47 per cent), followed by households in the Upper West and Brong Ahafo regions (46 per cent each); the lowest level of ownership is in households in Greater Accra (20 per cent). Households in the lowest and second lowest wealth quintiles are more likely to own at least one mosquito net than households in the other wealth quintiles due to the subsidizing of ITNs. Nationally, the average number of ITNs per household is 0.5.¹⁴² However, it is not yet clear whether the higher level of ownership among poor households and households in the northern regions is translating into lower morbidity and mortality rates due to malaria.

¹³⁹ ISODEC and UNICEF, Budget Analysis, August 2009.

¹⁴⁰ MoH, Ghana Maternal Health Survey 2008, cited in 2008 Ghana MDG Report, p. 41.

¹⁴¹ GDHS, 2008.

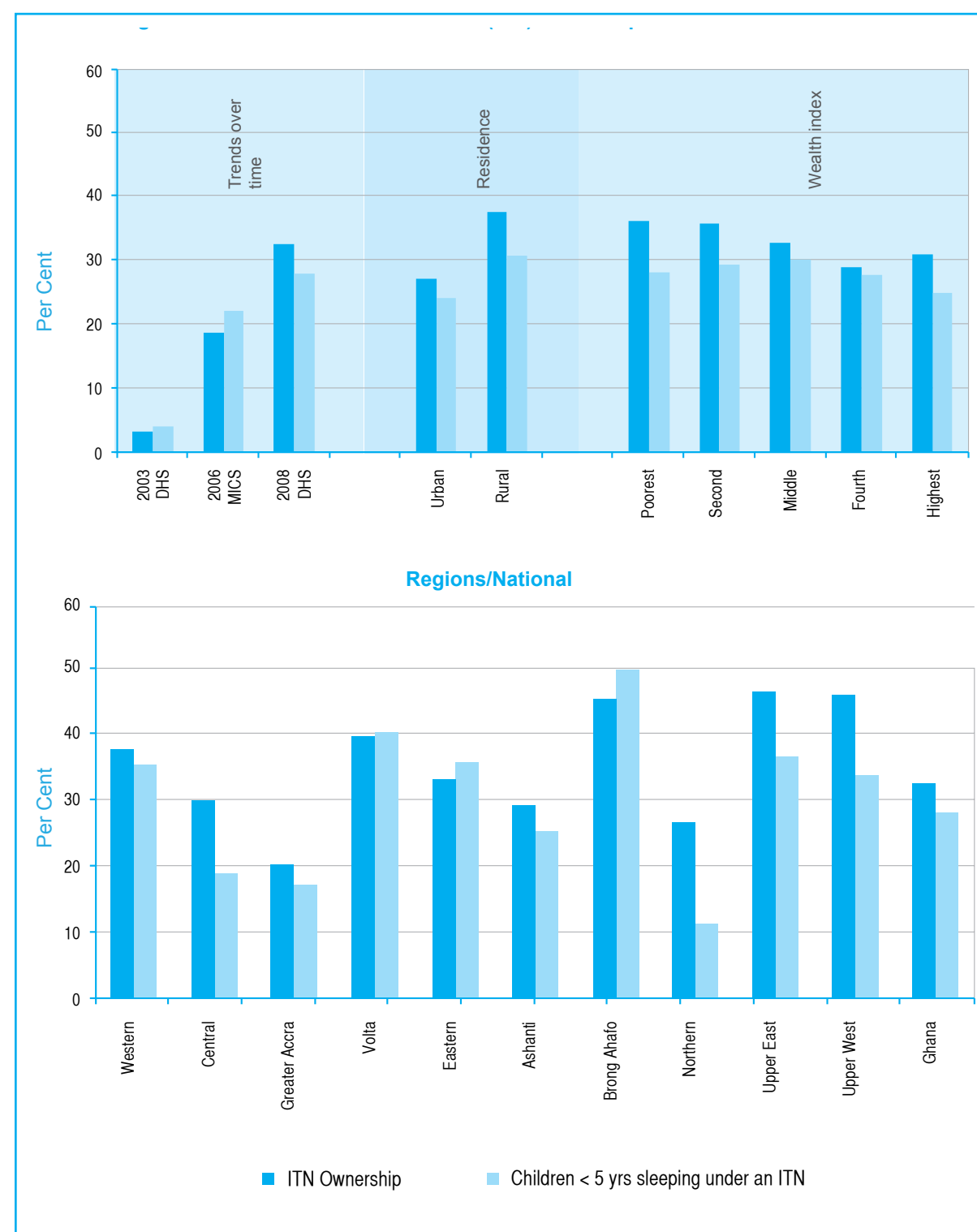
¹⁴² Ibid.

The proportion of children sleeping under an ITN increased from 3.5 per cent in 2003 to 28 per cent in 2008 (see Figure 13). Among children under five, those less than one year of age are most likely to have slept under an ITN (35 per cent), and children in rural areas are more likely than those in urban areas to have slept under an ITN. The proportion of children who slept under an ITN is highest in the Brong Ahafo (50 per cent) and lowest in the Northern region (11 per cent).

Interventions to reduce mortality rates from malaria need to include ensuring that everyone has improved access to ITNs. In this regard, the government in collaboration with its roll-back malaria partners has now embarked on a universal access “hang up” campaign, beginning May 2011, which envisages the free distribution of one long-lasting insecticide-treated net for every two persons in Ghana. In terms of ITN utilization, the campaign is initially targeting the most vulnerable regions of the country.



Figure 13: Insecticide-treated bed net (ITN) ownership and utilization, 2003-2008



Source: GDHS 2003, MICS 2006, GDHS 2008.

Acute respiratory infection (ARI)

Like malaria, acute respiratory infection is among the leading causes of morbidity and mortality among young children in the country, with pneumonia being the most serious infection. The World Health Organization estimates that 60 per cent of ARI deaths can be prevented by the selective use of antibiotics, but the success of treatment relies upon early detection and access to medical facilities. According to the 2008 GDHS, about 6 per cent of Ghanaian children under five years of age had shown symptoms of ARI in the two weeks preceding the survey, with children aged 12–23 months being the most affected (7 per cent). In addition, the level of ARI symptoms among children living in urban areas (5.7 percent) was slightly higher than among those living in rural areas (5.1 per cent). In 2008 nearly one fourth of children (24 per cent) under five who had symptoms of ARI received antibiotics for their illness.

Diarrhoea

Diarrhoea is another major cause of child morbidity and mortality in Ghana. The problem becomes more frequent in children six months and older, when they begin to crawl and eat complementary food. According to the 2008 GDHS, nearly one in five children (19.8 percent) under the age of five had experienced diarrhoea in the two weeks preceding the survey. Children 6–11 months were most likely to have had diarrhoea (27.2 per cent), compared to children below six months. Among children with diarrhoea, only 41 per cent were taken to a health facility for treatment, and 66.8 per cent were given oral rehydration therapy solution, an effective means of treating the dehydration resulting from diarrhoea.

Vaccine-preventable diseases and immunization

The National Expanded Programme of Immunization (EPI) for improving immunization coverage among children against vaccine preventable diseases has made substantial progress in recent years. EPI has ensured that immunization coverage is equitable across regions and wealth quintiles, and as a result Ghana is on track to meet the MDG 4 target of 100 per cent coverage of immunization against childhood diseases by 2015 (the rate in the base year of 1990 was only 61 per cent, illustrating the progress achieved).¹⁴³ Already, over 90 per cent of one-year-olds are immunized against measles, formerly a key child-killing disease. Additionally, 97 per cent of children have received the BCG vaccine (against tuberculosis), 94 per cent have received the first dose of DPT vaccine (against diphtheria, pertussis, and tetanus), and 97 per cent received the first dose of polio vaccine (though only 89 per cent of children received all three required doses of the polio vaccine).¹⁴⁴ According to GDHS results for 2008, 70 per cent of Ghanaian children will have been immunized against measles by the time of their first birthday, and 80 per cent of children aged 12–23 months will have received all the basic vaccinations.¹⁴⁵ Vitamin A supplementation levels are also high, primarily because it has been linked with “national immunization days.”¹⁴⁶

Ghana’s success in vaccinating children across all regions, wealth quintiles, and genders is noteworthy and could serve as a lesson for how to ensure that other interventions are equitably distributed.

¹⁴³ NDPC and UNDP, 2008 Ghana MDG Report, table, p. 90.

¹⁴⁴ CRRECENT/PlanGhana, Child Rights Situational Analysis, p. 28.

¹⁴⁵ UNICEF Ghana, Annual Report 2009.

¹⁴⁶ MoH, “Child Health Situation Analysis in Ghana.”



CHAPTER TWO: Nutrition

INTRODUCTION

Malnutrition is the main underlying cause contributing to the high level of child mortality in Ghana. It is also closely linked to future educational outcomes, as malnutrition seriously affects the immediate and future cognitive development of the child.

The causes of malnutrition among children are interrelated and complex. The primary causes are insufficient access to food, inadequate maternal and child caring practices (particularly poor breastfeeding practices), insufficient access to safe water and sanitation, and poor health care. These, in turn, result in inadequate dietary intake and disease, and the interaction of the two lead to increased morbidity and mortality.

Box 1: Nutrition's contributions to the attainment of the MDGs

Goal 1: Eradicate extreme poverty and hunger

Malnutrition erodes human capital, reduces resilience to shocks, and reduces productivity (impaired physical and mental capacity).

Goal 2: Achieve universal primary education

Malnutrition reduces mental capacity. Malnourished children are less likely to enroll in school, or more likely to enroll later.

Goal 3: Promote gender equality and empower women

Better-nourished girls are more likely to stay in school and to have more control over future choices.

Goal 4: Reduce child mortality

Malnutrition is directly or indirectly associated with more than 50% of all child mortality. Malnutrition is the main contributor to the burden of disease in the developing world.

Goal 5: Improve maternal health

Maternal health is compromised by an anti-female bias in allocations of food and health care. Malnutrition is associated with most major risk factors for maternal mortality.

Goal 6: Combat HIV/AIDS, malaria, and other diseases

Malnutrition hastens the onset of AIDS among those who are HIV-positive, weakens resistance to infections, and reduces malarial survival rates.

On an individual level, malnutrition places the child at risk of entering a downward spiral of further malnutrition and infection. Insufficient dietary intake leads to an immuno-deficiency and an increased susceptibility to infections. Infections, in turn, lead to a further reduction in nutrient intake. As a consequence, the child suffers from frequent infections that become progressively more severe and longer lasting. The child fails to regain weight lost during one infection before the onset of the next, thus increasing the chances of death.

Studies carried out in rural districts of Ghana have shown that children with stunted growth or thinness-for-age are often held back by their parents from enrolling in school at the right age, and that stunted growth in the early years of a child's life may affect school performance in later years, and may even encourage dropping out. This indicates a link between child nutrition/child health and education that could be reflected in MDG results for both areas.¹⁴⁷

Ghana undertook a nutrition landscape analysis in 2008 with the aim of assessing existing gaps and constraints in the area of child and maternal nutrition, and to identify opportunities to integrate and scale-up nutrition-related actions.¹⁴⁸ Results of the analysis are important for accelerating support towards achieving the nutrition-related MDGs in Ghana. Among the gaps identified was the lack of a national food and nutrition policy, which Ghana is currently developing, and to which results of the landscape analysis will provide important inputs.¹⁴⁹



¹⁴⁷ Buxton, Christiana, Malnutrition and Access to Education among School Children in Ghana, presentation, University of Cape Coast, Ghana (n.d.).

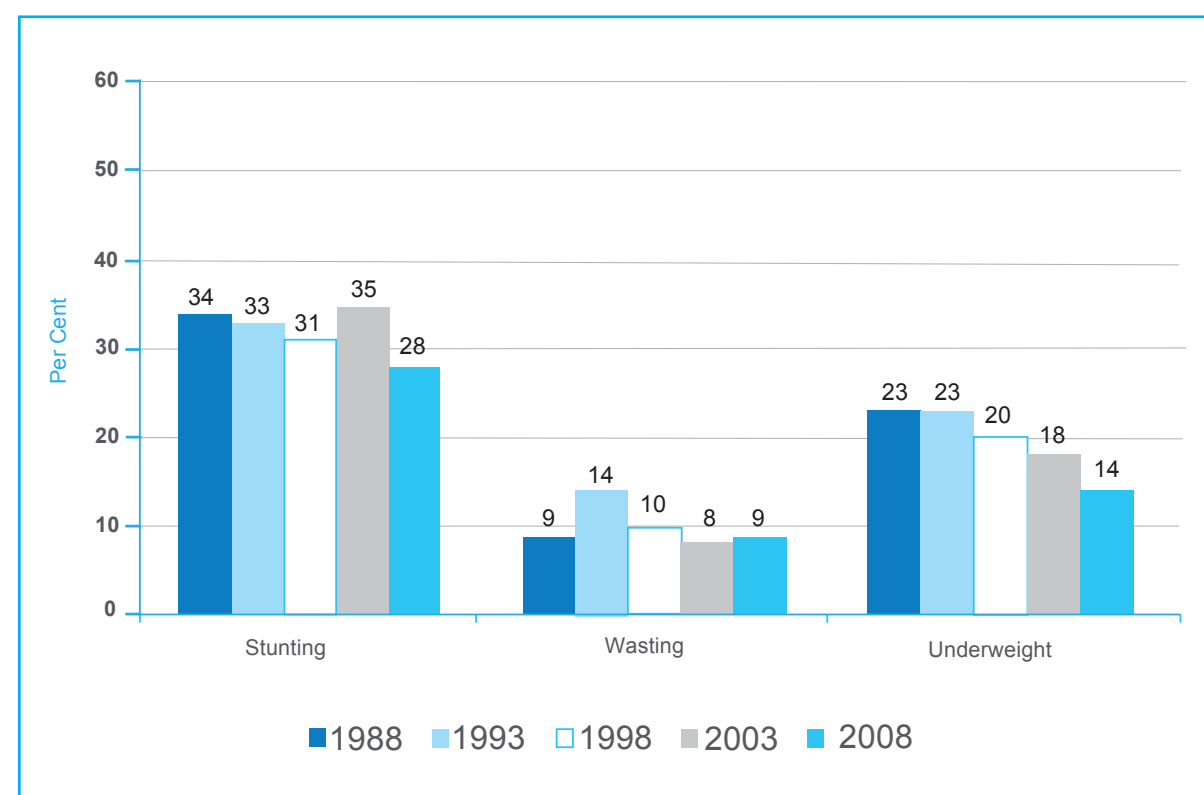
¹⁴⁸ United Nations, "Landscape Analysis on countries' readiness to accelerate action in Nutrition," SCN News, No. 37, 2009, p. 31.

¹⁴⁹ Ibid.

Source: UN Standing Committee on Nutrition, *Fifth Report on the World Nutrition Situation: Nutrition for improved development outcomes* (2004).

Today, malnutrition contributes to approximately 40 per cent of childhood deaths in Ghana. Still, improvements in food availability have contributed to a significant decline in malnutrition, especially in children under five years of age. As indicated in Figure 14 (see below), the proportion of underweight children declined from 23 per cent in 1988 to 18 per cent in 2003 and dropped to 14 per cent in 2008, thereby surpassing the MDG 1 underweight target of 15.5 per cent. However, wasting (a measure of acute malnutrition), has not changed since 1998, and is at the same level as it was in 1988. It is however projected that wasting rates in Ghana will be negligible by 2015.¹⁵⁰

Figure 14: Trends in nutritional status of children under-5 years, 1998-2008



Source: GDHS, 2008.

The proportion of Ghana's children who are stunted (a measure of chronic malnutrition) did not change significantly between 1988 and 1998. It then increased from 31 per cent in 1998 to 35 per cent in 2003, and has since fallen only slightly, to an estimated 28 per cent in 2008, meaning that Ghana is unlikely to meet its MDG 1 stunting rate target of 15 per cent by 2015.¹⁵¹ The rate of severe stunting was estimated at 10 per cent in 2008.¹⁵² Children with low birth weight were more likely to be stunted than average children (showing a 40 per cent prevalence of stunting), indicating that chronic malnutrition was affecting mothers during pregnancy as well as after birth.

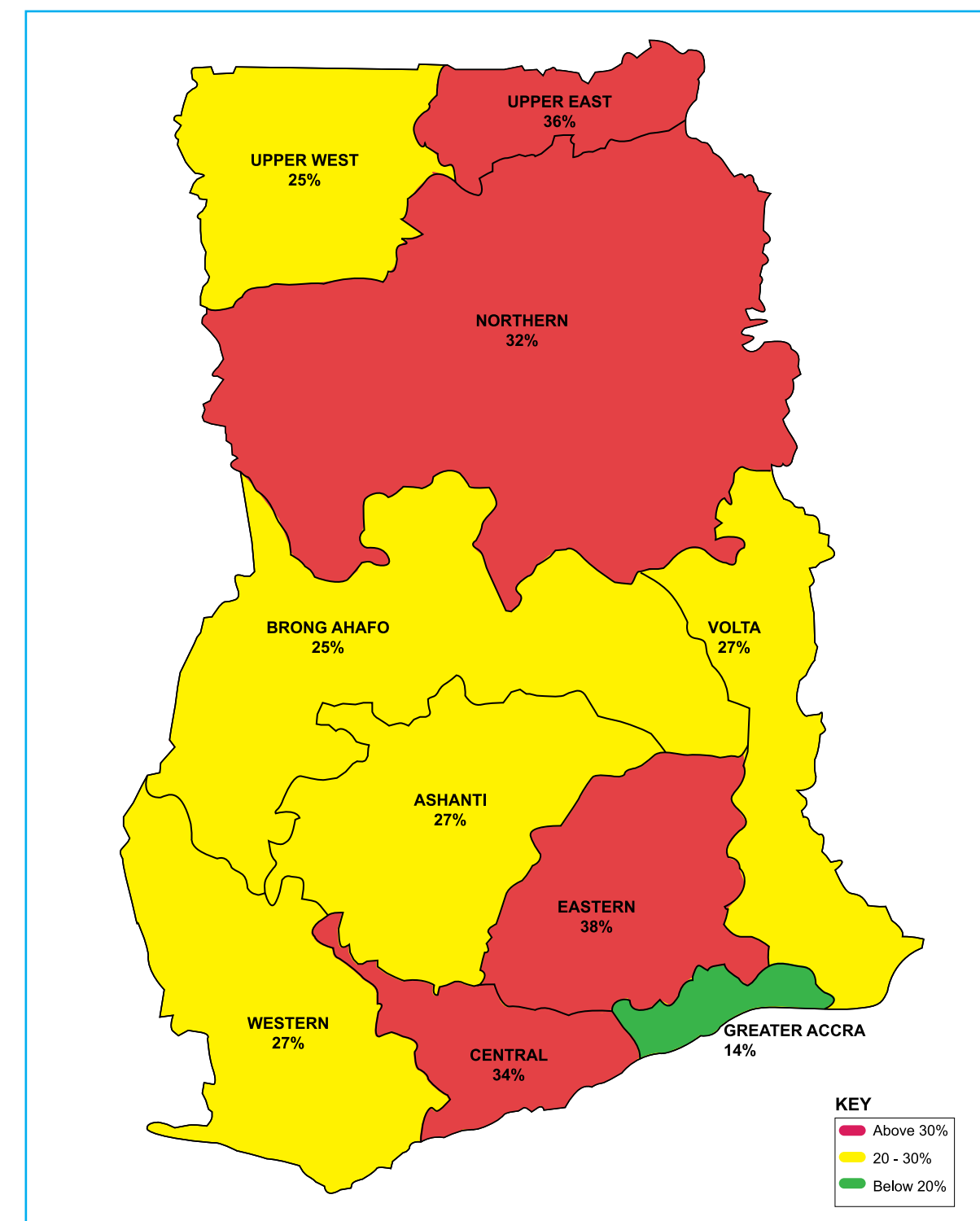
¹⁵⁰ NDPC and UNDP, 2008 Ghana MDG Report, pp. 14–15, and table, p. 89. See also UNCT, Ghana Country Analysis, p. 23, citing World Food Programme, Comprehensive Food Security and Vulnerability Analysis.

¹⁵¹ NDPC and UNDP, 2008 Ghana MDG Report, pp. 14–15, and table, p. 89.

¹⁵² GSS, et al., Multiple Indicator Cluster Survey 2006 (MICS 2006), Accra, 2006, cited in ODI, Study on Social protection and children, p. 10.

As in other areas, geographic, gender, and group disparities are also found in malnutrition. Male children are slightly more likely to be stunted than female children (30 per cent, compared with 26 per cent). Stunting also varies by region (see Fig 15, below); it is highest in the Eastern and Upper East regions (38 and 36 per cent, respectively) and lowest in the Greater Accra region (14 per cent). Thirty-five per cent of children in the poorest quintile are stunted, compared to 14 per cent from the wealthiest quintile.

Figure 15: Per cent of children under-5 years stunted (too short for age), by region, 2008



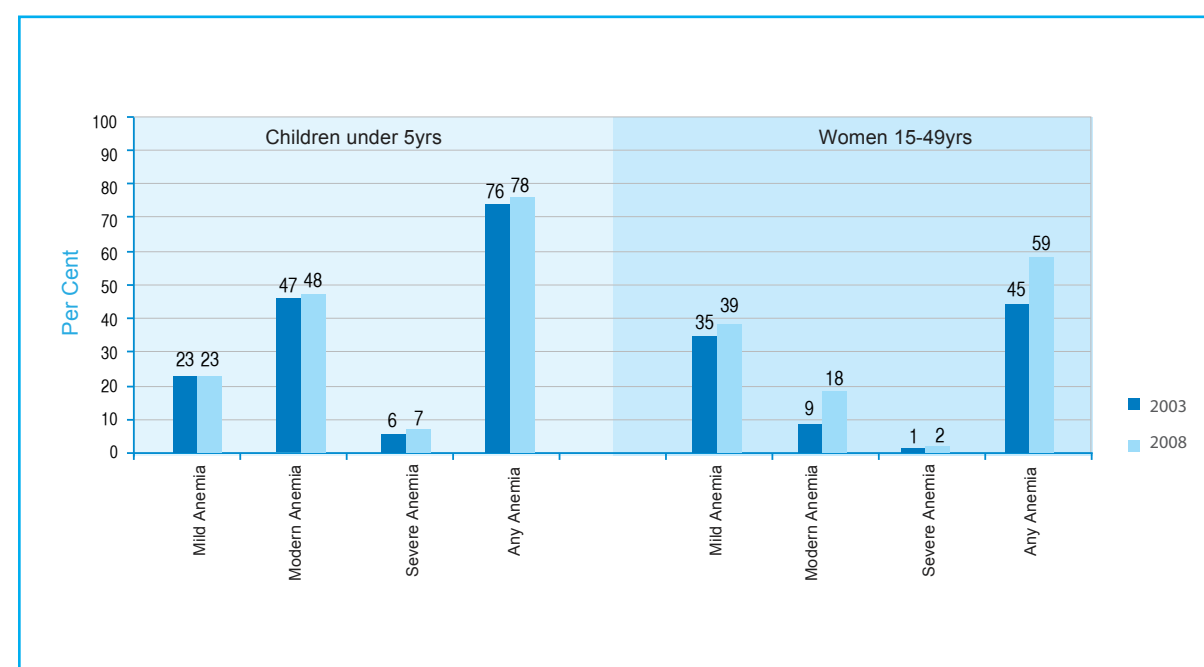
Rates of anaemia

Iron deficiency is the major cause of anaemia and remains one of the most severe and important nutritional deficiencies in Ghana today, thus constituting a serious public health problem. The World Health Organisation lists iron deficiency as one of the top risk factors for “lost years of healthy life” in developing countries. Severe iron deficiency causes iron deficiency anaemia, which impairs the cognitive development of children from infancy through adolescence. Anaemic infants and children grow more slowly than those who are not anaemic, and are apathetic, anorexic, and without energy.

The 2008 GDHS reveals that anaemia prevalence among mothers and children remains very high. Three quarters of children were estimated to have some level of anaemia (23 per cent were mildly anaemic, 48 per cent moderately anaemic, and 7 per cent severely anaemic), while 59 per cent of women of child-bearing age were anaemic (most mildly so). In addition to iron deficiency, the most common causes of anaemia are malaria and intestinal worm infection.

As might be expected, anaemia is most prevalent among people living in rural areas, in families with less-educated mothers or younger mothers, and among people living in poorer households.¹⁵³ Similarly, women who were uneducated, in the lowest income quintile, and/or living in rural areas were more likely to be anaemic than average.¹⁵⁴

Figure 16: Trends in anaemia status among children under-5 years and women 15–49 years, 2003 and 2008



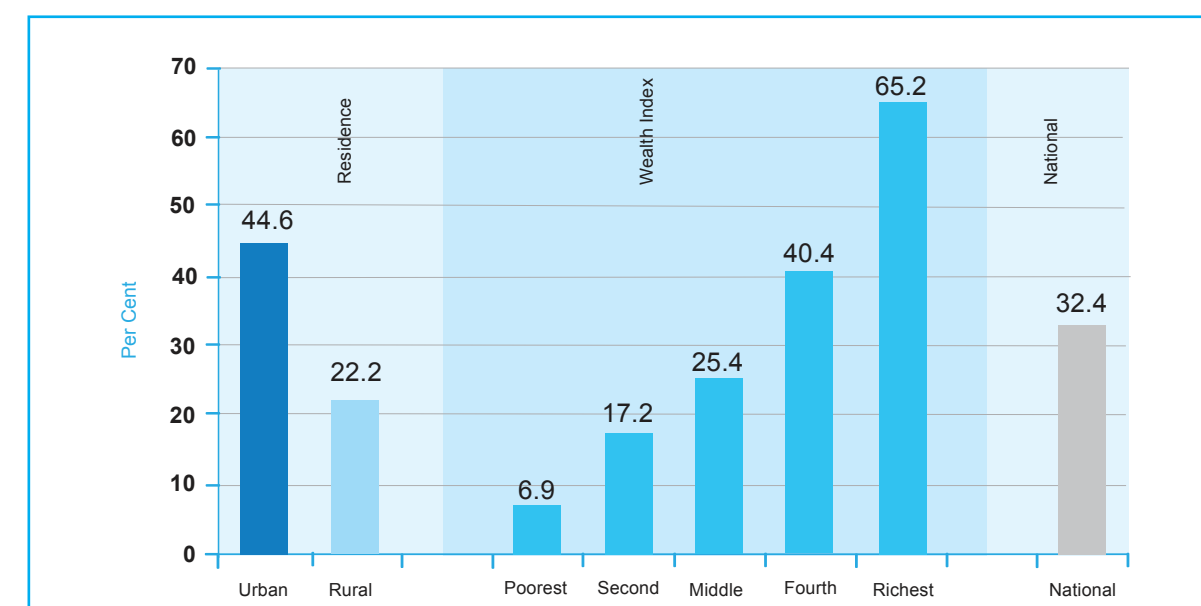
Source: GDHS, 2008.

Universal salt iodization (USI)

Continued shortfalls have been experienced in efforts to achieve universal salt iodization in Ghana. According to UNICEF Ghana's 2009 Annual Report, “the achievement of USI has faced many challenges, including weak enforcement of laws, limited availability of potassium iodate, and the presence of a large number of small-scale producers (estimated between 5,000 and 10,000) who are difficult to monitor.”¹⁵⁵ In the 2006 Multiple Indicator Cluster Survey, the proportion of households consuming iodized salt was 32 per cent (see Figure 17, below).

Regional variations exist in the use of adequately iodised salt. It was lowest in Northern, Volta, and Upper East regions (around 12 per cent), and highest in Brong Ahafo, Greater Accra, and Ashanti regions (around 55 per cent). The likelihood of using adequately iodized salt is twice as high in urban areas compared to rural areas. Additionally, only 7 per cent of poorest households use adequately iodated salt, compared to 65 per cent of wealthiest households.

Figure 17: Household consumption of adequately iodised salt, 2006



Source: MICS, 2006.

Breastfeeding

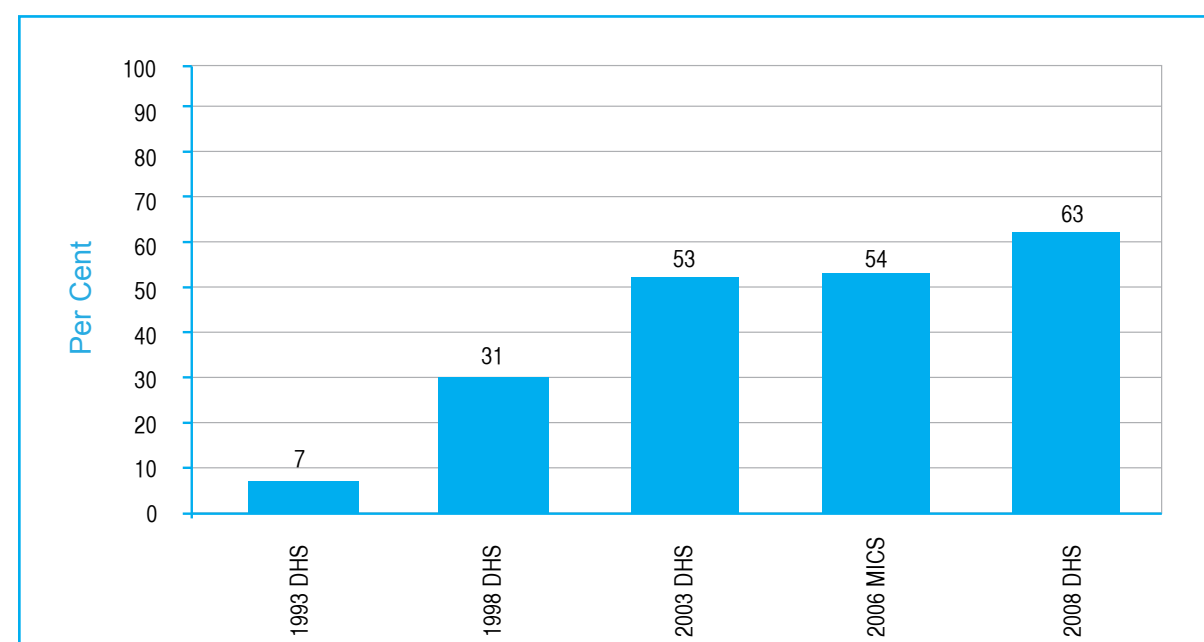
Practices related to infant and child feeding have an important bearing on the nutritional status of young children, both in terms of macronutrient and micronutrient deficiencies. Breast milk provides a complete source of nutrition during the first six months of life, fulfils half of the child's nutritional requirements during the second six months, and fulfils one third of requirements in the second year of life. According to the 2008 GDHS, 52 per cent of newborns are breastfed within the first hour of life, and 82 per cent within the first day. Virtually 100 per cent of Ghanaian children are breastfed, although non-breast milk preparations are sometimes introduced during this period. The rate of exclusive breastfeeding increased from 7 per cent in 1993 to 63 per cent in 2008 (see Figure 18).

¹⁵³ MoH, “Child Health Situation Analysis in Ghana.”

¹⁵⁴ GDHS 2003, cited in ODI, Study on Social protection and children, op. cit., p. 10.

¹⁵⁵ UNICEF Ghana, Annual Report 2009.

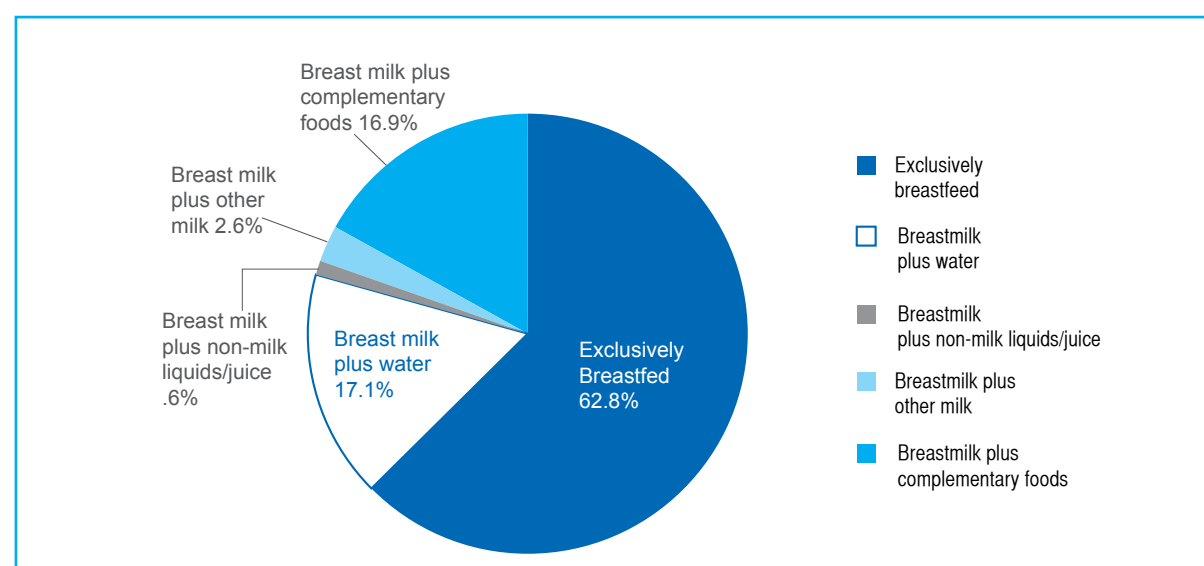
Figure 18: Percentage of infants under 6 months exclusively breastfed, 1993-2008



Source: 1993 DHS, 1998 DHS, 2003 DHS, 2006 MICS, 2008 DHS.



Figure 19: Breastfeeding status of children under 6 months, 2008



Source: GDHS 2008.



CHAPTER THREE: HIV and AIDS

INTRODUCTION

Ghana is making good progress in reversing the spread of HIV and AIDS. Indeed, the national prevalence has dropped from 3.6 per cent in 2003 to 1.5 per cent in 2010, below the West African average.

The number of Ghanaians living with HIV and AIDS is estimated at 222,000 (57 per cent female and 43 per cent male). Children constitute approximately 15 per cent (about 32,000) of the total population living with HIV and AIDS.¹⁵⁶ In 2010 there were 12,890 new recorded infections, and 16,319 recorded AIDS deaths, a decrease from about 20,000 deaths in 2006.¹⁵⁷ It is projected that the number of persons living with HIV and AIDS will decrease steadily (though only slightly) by 2015 to approximately 215,000 – this despite the combined effects of population growth and an increasing number of HIV-infected persons that are living on ART. According to the National AIDS Control Programme (NACP), this is due to the projected decline in new infections over the same period.¹⁵⁸ The estimated number of AIDS related deaths in 2010 was 18,500, with a projected decrease to about 15,600 deaths in 2015.¹⁵⁹

Potential to achieve MDG 6 target

In terms of the proportion of the population affected, trends in HIV prevalence have gone up and down incrementally in recent years. A downward trend in the national rate was recorded between 2003 and 2005, from 3.6 per cent to 2.7 per cent, followed by an increase to 3.2 per cent in 2006 and then further reductions – to 2.6 per cent in 2007, 2.2 per cent in 2008,¹⁶⁰ 1.8 per cent in 2009,¹⁶¹ and 1.5 per cent in 2010.¹⁶² The 2010 prevalence rate puts Ghana potentially on track to achieve the MDG 6 target of 1.5 per cent by 2015, if the current trend is sustained.¹⁶³

¹⁵⁶ National AIDS Control Programme, National HIV Prevalence and AIDS Estimates Report 2010–2015, March 2011, p. 15.

¹⁵⁷ Ibid.

¹⁵⁸ Ibid., p. 18.

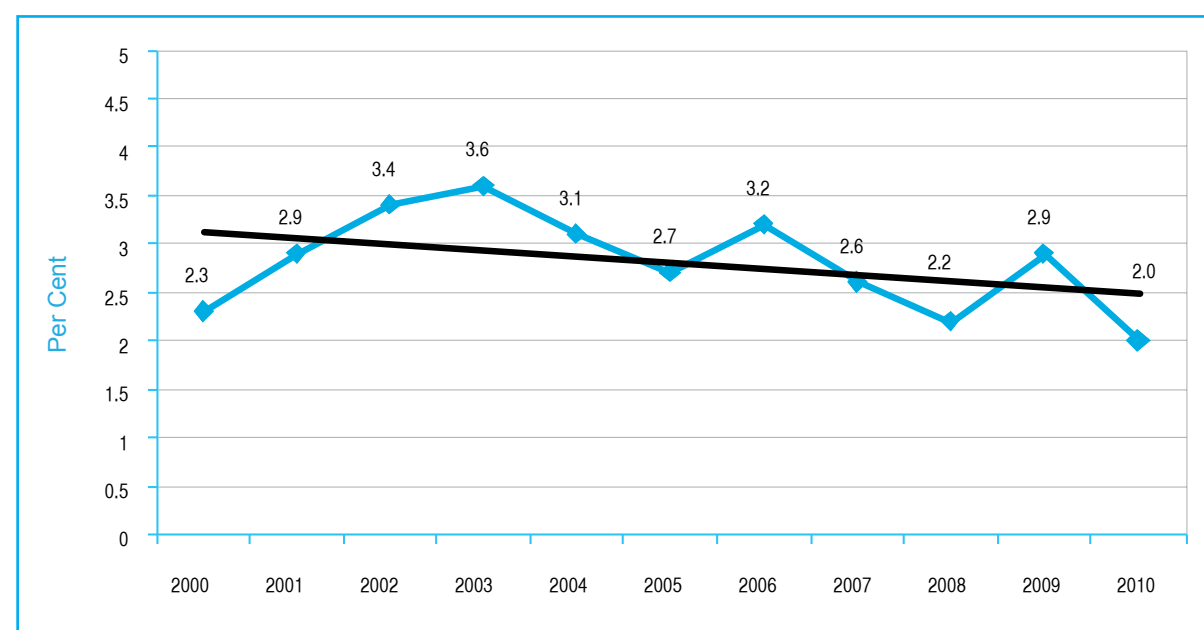
¹⁵⁹ National AIDS Control Programme, National HIV Prevalence and AIDS Estimates Report 2000–2015, 2010.

¹⁶⁰ NDPC and UNDP, 2008 Ghana MDG Report, p. 39.

¹⁶¹ Joint United Nations Programme on HIV/AIDS (UNAIDS), Ghana country profile page on the UNAIDS website, www.unaids.org/en/regionscountries/countries/ghana/, as of March 2011.

¹⁶² Ibid.

¹⁶³ UNCT, Ghana Country Analysis, and UNICEF data.

Figure 20: National HIV prevalence among pregnant women, 2000–2010

Source: NACP, HIV Sentinel Survey Report, 2010.

HIV prevalence among pregnant women by region and age

The national median HIV prevalence, which increased in 2009 to 2.9 per cent after declining for two consecutive years, decreased to 2.0 per cent in 2010. In earlier years there had been a steady increase, peaking at 3.6 per cent in 2003, from 2.3 per cent in 2000. The 2010 drop represents the beginning of a third consecutive declining trend within the period 2000 and 2010. It also reinforces the picture of a declining trend in HIV prevalence among pregnant women in Ghana, as displayed by the linear trend analysis curve (see Figure 20, above).¹⁶⁴

Rates of HIV prevalence among pregnant women vary by region, from 0.7 per cent in the Northern region to 3.2 per cent in the Eastern region.¹⁶⁵ Only Eastern and Ashanti regions recorded prevalence of 3 per cent and above. Prevalence also differs between urban areas (which showed a mean rate of 2.6 per cent in 2010) and rural areas (1.6 per cent). The urban centre with the highest prevalence rate for pregnant women was Agomanya, in the Eastern region, with 7.8 per cent, while the lowest was Nalerigu, with just 0.8 per cent.¹⁶⁶ By age group, the highest prevalence was among ages 30–34 and 35–39 (2.8 per cent in 2010) and the lowest among ages 15–19 (1.1 per cent). Prevalence among all youth 15–24 years, which is used as a marker for new infections, was 1.5 per cent.¹⁶⁷ Prevalence among pregnant women increased from 1.9 per cent in 2008 to 2.6 per cent in 2009,¹⁶⁸ and declined to 1.5 per cent in 2010.

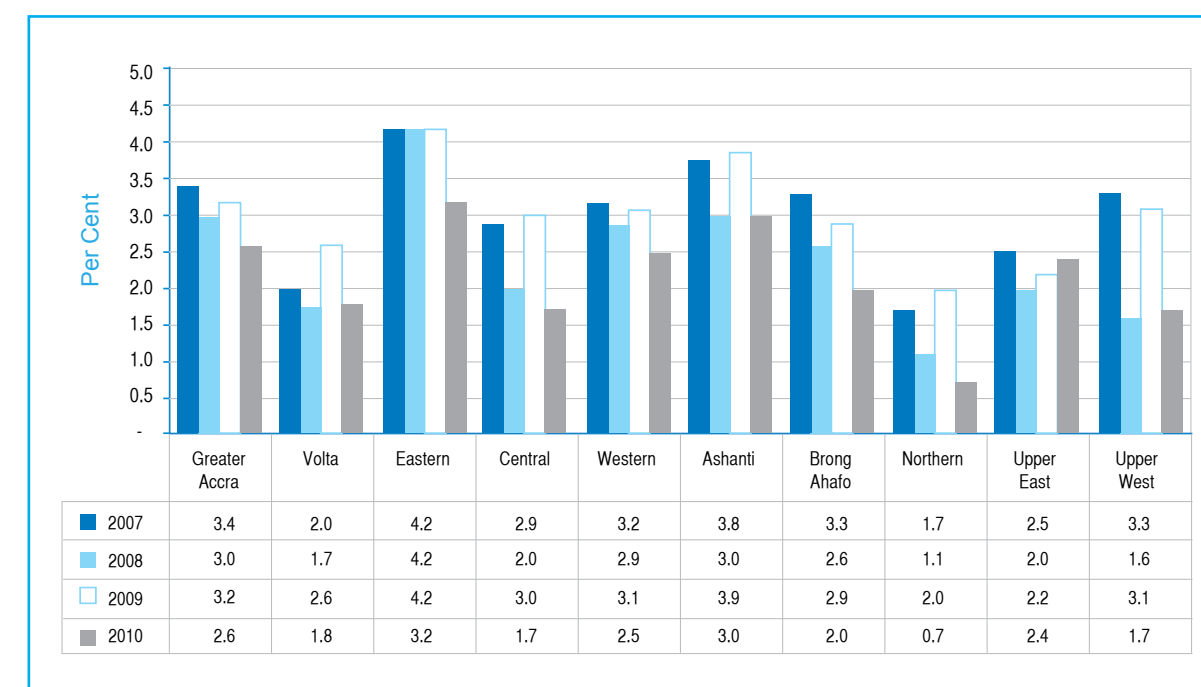
¹⁶⁴ National AIDS Control Programme, National Sentinel Survey Report, 2010, March 2011, p. 31.

¹⁶⁵ Ibid., p. 26.

¹⁶⁶ Ibid., p. 28.

¹⁶⁷ Ibid., p. 29.

¹⁶⁸ NDPC and UNDP, 2008 Ghana MDG Report, p. 39.

Figure 21: HIV Prevalence among pregnant women – trends by region, 2000–2010

Source: NACP, HIV Sentinel Survey Report, 2010.

Risk factors

The main modes of HIV transmission, according to the Ghana AIDS Commission, are heterosexual contact (80 per cent), mother-to-child transmission (15 per cent), and blood transfusion (5 per cent). High prevalence in the two main urban centres of Accra and Kumasi has been attributed to commercial sexual activity. Nationally, prevalence rates are higher among women than among men.¹⁶⁹ Factors that put Ghana at risk of a broader epidemic include high levels of transactional sex, high-risk sexual behaviour among youth, marriage and gender relations that disadvantage women and make them vulnerable to HIV, urbanization, inaccurate perceptions of personal risk, and poverty.¹⁷⁰

“Poverty creates conditions for social transactions, including sex and child labour, health hazards, and other risky behaviour that make the poor more susceptible and vulnerable to HIV infection. For instance, high youth unemployment, limited job opportunities, and the associated risky survival strategies all promote commercial sex work, early sexual relations, and child labour – conditions that enable HIV and poverty to mutually reinforce each other.”¹⁷¹

¹⁶⁹ MoWAC and UNICEF, Children in Ghana, p. 149.

¹⁷⁰ United States Agency for International Development (USAID), Ghana: HIV/AIDS Profile, September 2010, www.usaid.gov/our_work/global_health/aids/Countries/africa/ghana_profile.pdf.

¹⁷¹ UN Development Programme (UNDP), Ghana Human Development Report 2004: Breaking the HIV/AIDS Chain – A Human Development Challenge, UNDP, Accra, 2005, cited in MoWAC and UNICEF, Children in Ghana, p. 150.

Children and HIV/AIDS in Ghana

HIV/AIDS affects children in a number of ways: infants born to HIV-positive mothers are at risk of infection from birth;¹⁷² children become orphans when their parents die of AIDS and may become increasingly impoverished, leading them to drop out of school and possibly live on the street, thus becoming more vulnerable themselves to contracting HIV; and children and adolescents may be susceptible to infection through early sexual contact, rape, or defilement.¹⁷³ Additionally, the emotional impact of HIV/AIDS on children is devastating, as they witness their parents or guardians becoming increasingly ill and very often dying.¹⁷⁴

As indicated above, it is estimated that some 32,000 children aged 0–14 were living with HIV/AIDS in Ghana as of 2010, and that more than 177,000 children had been orphaned by AIDS. An estimated 3,500 children were thought to be newly infected by HIV in Ghana in 2010, and about 2,600 children died of AIDS.¹⁷⁵ Out of an estimated 18,900 children needing antiretroviral therapy, only 13 per cent – about 2,400 children below age 14 – were receiving treatment as of December 2010.¹⁷⁶

According to Ghana's 2010 report pursuant to the General Assembly Special Session on HIV/AIDS (UNGASS), government services for orphans and vulnerable children, including AIDS orphans, were significantly scaled-up in 2009, but still reached only 7.4 per cent of the OVCs in the country.¹⁷⁷ The Department of Social Welfare introduced a Care Reform Initiative in 2009, designed to support the transition of orphaned and vulnerable children, including those affected by HIV and AIDS. More than 260 children were transferred from institutions to family-based care in 2009, including 241 who were returned to their own families.¹⁷⁸

Prevention of mother-to-child transmission (PMTCT)

In recent years the number of pregnant women accessing testing and counselling services has risen sharply in Ghana: according to NACP data, in 2006 only 36,000 women accessed these services; by 2008 the number had risen seven-fold to more than 257,000.¹⁷⁹ Of these, just over 6,000 women, or 2.3 per cent, tested positive for HIV.

172 The Ghana AIDS Commission reported in 2004: "Without treatment, about 25–40 per cent of infants born to HIV-positive mothers contract the disease either during pregnancy, during birth, or through breastfeeding. Most of these children will develop AIDS and die within two years; very few survive past the age of five. As the HIV/AIDS epidemic spreads in Ghana, AIDS will increasingly become a major cause of child death, one that threatens to continue to reverse many of the recent gains made by child-survival programmes." (Cited in MoWAC and UNICEF, *Children in Ghana*, p. 151.)

173 MoWAC and UNICEF, *Children in Ghana*, p. 151.

174 Ibid., p. 155.

175 National AIDS Control Programme, *National HIV Prevalence and AIDS Estimates Report 2009–2015*.

176 Ibid., pp. 14, 16.

177 Ghana AIDS Commission, *Ghana's Progress Report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS, Reporting Period January 2008–December 2009* (submitted March 2010), pp. 53–54; available on the UNAIDS website, www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/ghana_2010_country_progress_report_en.pdf.

178 UNICEF Ghana, *Realising the Rights of Children*, brochure, 2009.

179 Ibid.

However, overall Ghana has done poorly in enabling and ensuring access of pregnant women to PMTCT services, mainly due to regional gaps in the availability of such services. By the end of 2008 more than 12,000 HIV-positive pregnant women were still waiting to benefit from PMTCT services – more than double the number who received those services in the same year.¹⁸⁰ Although the estimated percentage of HIV-positive pregnant women who received antiretroviral drugs for PMTCT increased ten-fold from 2005 to 2009 (from 2.5 per cent to 27 per cent), only 12 per cent of babies born to HIV-positive women received ARVs in 2009.¹⁸¹ Consequently, efforts by UNICEF and other development partners have been concentrated on establishing or upgrading PMTCT centres, including the training of staff, in five of the least-served regions (Central, Eastern, Northern, Upper East, and Upper West).¹⁸²

Early infant diagnosis

Progress has been slow on early diagnosis, care, and treatment of children infected with HIV. Recent evidence has demonstrated that a significant number of lives can be saved by initiating ART for HIV-infected infants immediately after diagnosis and as early as within the first 12 weeks of life. In its 2010 UNGASS report, Ghana conceded that sufficient data on mother-to-child transmission of HIV had not been systematically collected in 2008 and 2009. However, the government has declared that efforts were being made through (1) the development of guidelines and staff training in early infant diagnosis and (2) the provision of appropriate infrastructure for testing to enable future monitoring and, in turn, to take the necessary programmatic actions.¹⁸³ More work needs to be done in Ghana to conform to WHO guidelines recommending that all infants younger than one year of age with confirmed HIV infection should begin ART, regardless of their clinical or immunological stage.¹⁸⁴

Knowledge and behaviour change among young people

HIV prevalence among adolescents and young people is still above the national average at 1.9 per cent. Although the peak age groups for HIV prevalence in Ghana are 25–29 and 30–34 years, there is evidence to suggest that many in that group were infected during their mid-to-late teen years.¹⁸⁵ However, comprehensive knowledge about AIDS, another MDG indicator, was only 28 per cent and 34 per cent, respectively, among women and men aged 15–24 years.¹⁸⁶ Therefore, educating adolescents and young people about HIV/AIDS must be a priority. The Ministry of Education introduced the HIV Alert School Model (ASM) in 2006 to train teachers on integrating educational messages about HIV/AIDS into regular teaching and learning. A Knowledge, Attitudes, Behaviour, and Practices (KABP) study conducted in 2010 to evaluate the impact of the ASM on Ghanaian pupils in the areas where it has been implemented

180 UNICEF Ghana, UNICEF in Ghana, information package, 2010.

181 "Children and AIDS: Fifth Stocktaking Report," 2010.

182 UNICEF Ghana, *Realising the Rights of Children*.

183 Ghana AIDS Commission, *Ghana's Progress Report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS*, p. 48.

184 UNICEF, "Scaling-Up Early Infant Diagnosis and Linkages to Care and Treatment," Briefing Paper, January 2009, p. 4.; www.unicef.org/aids/files/EIDWorkingPaperJune02.pdf.

185 MoWAC and UNICEF, *Children in Ghana*, p. 157.

186 GDHS data cited in UNICEF Ghana, *Annual Report 2009*.

revealed that 76.4 per cent of the children in junior secondary schools had information and skills to reduce their risks and vulnerability to HIV/AIDS.¹⁸⁷ ASM has now been expanded nationwide, and other donor-supported awareness programmes are also being expanded.¹⁸⁸ Among these, a Know Your Status campaign has expanded HIV testing and counselling to people at the community level.¹⁸⁹

In all regions of Ghana, interviews with young people showed that high levels of “*risk behaviour*” were continuing to take place – even among young people who had some knowledge of HIV/AIDS and how it is transmitted. Eight per cent of women and 4 per cent of males 15-24 years had their first sexual debut before the age of 15.¹⁹⁰ Stigma and discrimination against people living with HIV/AIDS is also quite high, together with misconceptions about the disease. Among adolescents, the main challenges consist of closing the gap between knowledge and behaviour, halting the cycle of infection, and overcoming the sense of fatalism or helplessness, which has led to reckless behaviour and thus contributed to new cycles of infection.¹⁹¹ Gender issues are vital in tackling the epidemic, especially in cases where women are powerless in relation to their counterparts due to poor economic empowerment and negative social norms that subject them to the will of their partners.¹⁹² Data from the 2008 GDHS reveal that only 29 per cent of unmarried women aged 15-24 years used condoms during their last sexual intercourse.



¹⁸⁷ UNICEF Knowledge, Attitude, Practice, and Behaviour (KAPB) study, 2010.

¹⁸⁸ UNICEF Ghana, Realising the Rights of Children.

¹⁸⁹ NDPC and UNDP, 2008 Ghana MDG Report, p. 40.

¹⁹⁰ GDHS, 2008, p. 267.

¹⁹¹ MoWAC and UNICEF, Children in Ghana, p. 157.

¹⁹² Ibid., p. 40.



CHAPTER FOUR: Conclusions about maternal and child survival and development

A. THE UNDERLYING CAUSES OF CHILD MORBIDITY AND MORTALITY

There are four underlying causes of child morbidity and mortality: lack of access to services, poor quality services, poverty, and improper care practices. Each of these causes is interrelated and is further exacerbated by disparities and inequities. Not surprisingly, the poorest areas of the country have the highest burden of disease and the lowest doctor-to-patient ratios. Poor families, likely to have the lowest education levels and the smallest disposable incomes, often demonstrate the most detrimental care practices– such as not giving birth in a health facility due to lack of funds for transport or not washing hands properly because they cannot afford soap. In essence, household poverty compounds inequities in service distribution. Only a conscious reallocation of resources to the poorest families and the most underserved areas will break the cycle that currently condemns Ghana's most vulnerable families and regions to high rates of sickness and death.

Equitable distribution of resources

Progress in reducing morbidity and mortality is also important to note. First and foremost, morbidity and mortality have fallen in regions where the government and its partners have undertaken concerted efforts to serve the poorest and hardest to reach families. Mortality fell between 2005 and 2008 in the Upper East region, one of the most deprived in the country, in part due to the High Impact Rapid Delivery method pioneered by the Ghana Health Service, with support from UNICEF.

Second, universal coverage of schedulable interventions, such as immunization, have successfully reached the poorest regions and lowest wealth quintiles. There is also little difference in access of boys and girls to such services. Consequently, Ghana has had no measles deaths in recent years.

B. POLICIES AND RESOURCES TO ENSURE EQUITABLE ACCESS TO QUALITY HEALTH CARE

In the Ghana Shared Growth and Development Agenda (GSGDA) 2010–2013 the Government of Ghana lists its priorities for improving access to quality health care as follows:

- bridge equity gaps in access to healthcare and nutrition services
- improve governance and strengthen efficiency in health service delivery, including medical services improve access to quality maternal and child health services
- intensify prevention and control of non-communicable and communicable diseases, including malaria, HIV/AIDS, STIs, and tuberculosis
- promote healthy lifestyles, strengthen mental health service delivery, and make health services “youth friendly” at all levels¹⁹³

An independent review by the Ministry of Health issued in April 2010 questioned whether the sector-wide approach adopted in 1998, with a unified budget jointly supported by government and donor resources, might be giving way to fragmentation in healthcare service delivery. This was reflected, it observed, “in several dynamics in the sector, but mainly:

- an increasing number of health (related) agencies without effective communication between agencies and without performance based/results-based financing;
- a greater complexity/variety in health financing mechanisms, with an increasing tendency to earmarking financial and programme resources, and more emphasis on clinical/curative care through a (relatively new) health insurance financing; and
- a loss of focus in the respective (programmes of work), moving from a theme-based to an agency-based focus.”¹⁹⁴

Such a situation could indicate capacity gaps in programming that could have a negative effect on the healthcare system available to children and women in Ghana.

Decentralization and equity

Ghana’s public health care is currently de-concentrated, meaning that the Ghana Health Service (GHS) has employees at the regional and district level. District staff report to the regional teams, who in turn report to headquarters in Accra. Budgets and personnel appointments are determined at the headquarters level. While District Assemblies theoretically are responsible for integrating health services into a composite budget and for coordinating health services with water and sanitation, education, etc., their lack of control over health resources reduces their ability to direct services to the neediest communities. The government’s plan to place health, education, and other civil servants under the authority of the District Assembly will facilitate improved coordination across the sectors. However, it will be important for government to ensure that, if resources are no longer channelled through the GHS, they are still distributed equitably.

193 NDPC, Medium-Term National Development Policy Framework, p. 99.

194 MoH, Independent Review, p. 7.

Targeting primary care for the poorest

Approximately 49 per cent of health sector expenditure went to primary health care, and this was in line with planned expenditure. The amount budgeted for 2009 was 58.47 per cent, far above the planned expenditure of 48.86 per cent in 2008, but far below the 2006 estimate of 66.28 per cent. Of the overall national budget, the health sector budget increased from 14.6 per cent in 2009 to about 15 per cent in 2010,¹⁹⁵ which is within the Abuja commitment of 15 per cent for national budgets. The per capita spending level increased from \$25.60 in 2009 to \$28.40 in 2010. This is still short of WHO recommendations (\$35–\$50) and the estimated \$28 required for a minimum health care package,¹⁹⁶ and this was despite the fact that most Ghanaian households identified health-related problems as the most important factor negatively influencing their well-being.¹⁹⁷

In order to implement its health policies, the Ghana Macroeconomics and Health Initiative has estimated that about \$620 million is needed as investment towards achieving the national under-five mortality targets. This compares with health expenditures equivalent to roughly \$378.6 million in 2006 and \$486.7 million in 2008, of which just under half was allocated to primary health care.¹⁹⁸ For the period 2002–2005, around \$790 million was needed to achieve MDG 5, and \$788 million to achieve MDG 6.¹⁹⁹



195 MoH, Preview of findings by the Health Sector Independent Review Team, 2011, presented during the 2011 Health Summit in April.

196 2008 Annual Report on the Implementation of the Fiveyear Programme of Work, 2008.

197 GSS, Ghana Living Standards Survey, 2005–2006, GSS, 2008.

198 NDPC and UNDP, 2008 Ghana MDG Report, p. 32.

199 Ibid.

PART THREE: WATER, SANITATION, AND HYGIENE



“ 19.4 million Ghanaians have access to improved drinking water, while 4 million do not ”





WATER, SANITATION, AND HYGIENE

INTRODUCTION

Access to clean, safe water and adequate sanitation, are vital for the survival and healthy development of children under the age of five years, reducing sickness and death due to diarrhoeal diseases and other major causes of child mortality. Use of safe water and sanitation lowers the risk of water-borne diseases among children – who are not only more susceptible to diseases related to poor water, sanitation, and hygiene compared to adults but who, once infected, are also more likely to die as a result. In addition, improved management of water resources reduces the transmission of malaria. In Ghana, poor water and sanitation services and hygiene practices are directly responsible for regular outbreaks of cholera. Lack of access to safe water and sanitation also infringes upon other rights. For example, children, particularly girls, may drop out of school to collect water and may have to travel long distances, which places them at greater risk of abuse.

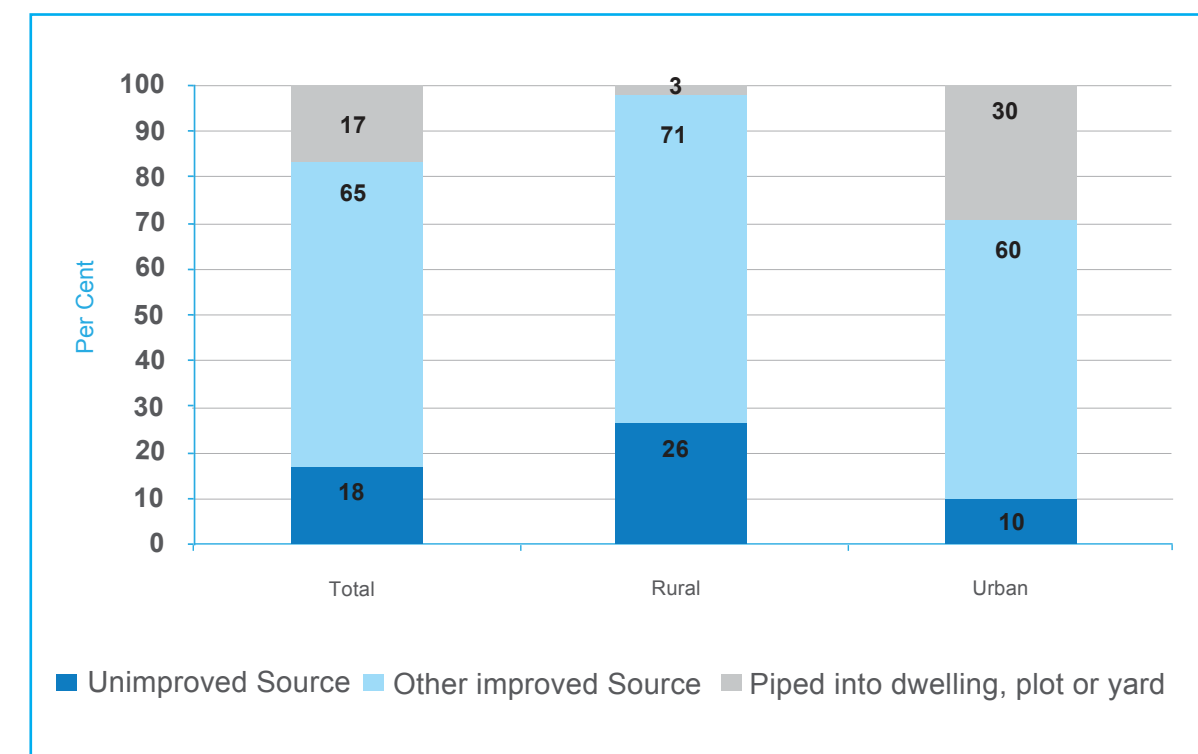
MDG 7: Ensuring environmental sustainability

According to the 2008 GDHS, 84 per cent of Ghanaians have access to improved water sources – 94 per cent in urban settings and 78 per cent in rural settings – which means that Ghana has already achieved the 2015 target of 78 per cent using improved drinking water under MDG 7.²⁰⁰ In terms of population, this would mean that 19.4 million Ghanaians have access to improved drinking water, while 4 million do not.²⁰¹ However, data given by local water service providers differ dramatically from the figures above, which come from the WHO/UNICEF Joint Monitoring Programme (JMP), which is the UN officially mandated mechanism to monitor global progress in drinking water and sanitation (toilet facility). Data from the Ghana Water Company Limited and Community Water Sanitation Agency reports indicate coverage for urban dwellers is currently 59 per cent while that for rural dwellers is just over 57 per cent.²⁰² Furthermore, UNICEF field experience suggests that some rural communities are far behind the national rate, and that there are even disparities within rural districts that statistics may not reveal.²⁰³

The provision of water to urban areas has not matched the rapid rate of urbanization in Ghana. Some urban areas do not have access to potable water, while others have erratic supplies. Performance in the water sector is difficult to gauge as it is often linked with supplies of electricity

and gas. Children and women are most affected in areas where water supplies are inadequate: the time they must spend searching for and fetching water detracts from time available for other household activities, and often makes children late or absent from school.²⁰⁴

Figure 22: Drinking water coverage, 2008



Source: WHO/UNICEF Joint Monitoring Programme, 2010.

The proportion of the population with access to improved toilet facilities, according to the JMP, is the percentage of people using improved and sustainable toilet facilities. An improved toilet facility is considered one that hygienically separates human faeces from human contact. Whereas the MDG 7 target calls for 54 per cent of the population to have access to improved sanitation by 2015, overall only 13 per cent of the population use improved, not shared, toilet facilities, an increase from 6 per cent in 1990, according to the GDHS.²⁰⁵

There are marked differences in progress between urban and rural residence. Sixteen per cent of urban households and 7 per cent of rural households use improved toilet facilities that are not shared with other households. However, nationally nearly one in five households (18 per cent) has no toilet facilities, a situation that is more common in rural areas (30 per cent) than in urban areas (6 per cent). The vast majority of Ghanaians use shared facilities (60 per cent), and the rate of open defecation is still considered very high: 18 per cent nationally (down only slightly from 22 per cent in 1990), with variations of 6 per cent in urban areas and 30 per cent in rural communities as of 2010.²⁰⁶

200 UNICEF Ghana, Annual Report 2009.

201 UNICEF, et al., Country Status Overview on Water Supply and Sanitation for Ghana, internal report, 2010.

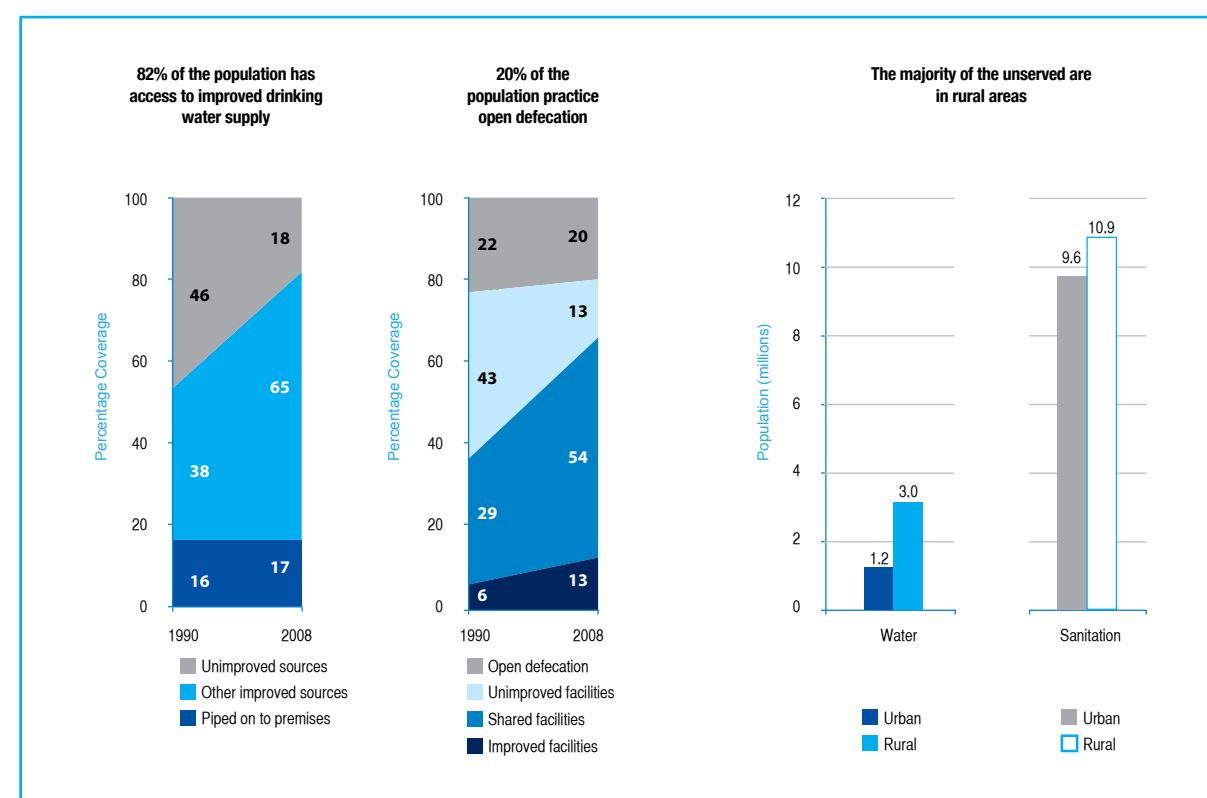
202 Quoted in "Report For the Compilation of Information/Data on Water and Sanitation Sector Investments in Ghana," by MAPLE Consult for the Water and Sanitation Monitoring Platform.

203 Discussion with UNICEF Ghana field staff, Tamale regional office, Northern region, 18 November 2010.

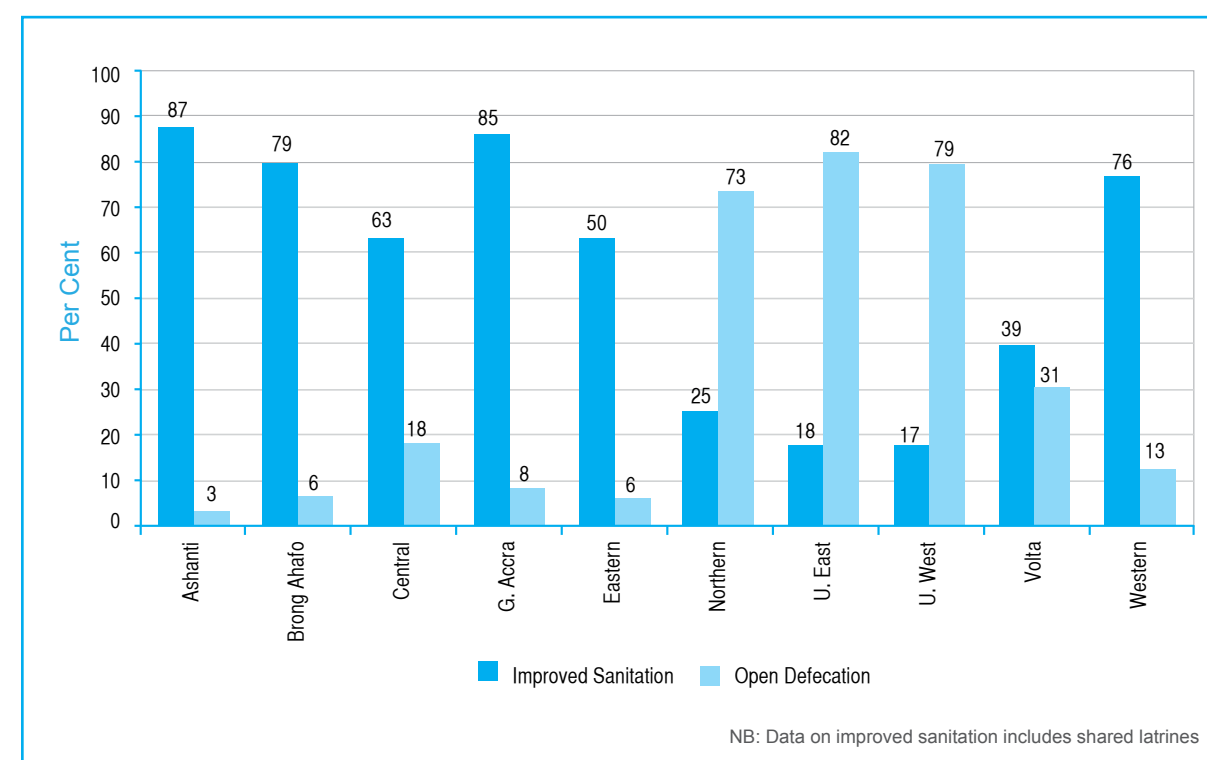
204 ISODEC and UNICEF, Budget Analysis, p. 52.

205 UNICEF Ghana, Annual Report 2009.

206 UNICEF et al., Country Status Overview on Water Supply and Sanitation for Ghana, internal report, 2010, and UNICEF Ghana, Annual Report 2009.

Figure 23: Water and sanitation coverage status and trends in Ghana, 1990 and 2008

Source: WHO/UNICEF Joint Monitoring Programme, 2010

Figure 24: Improved sanitation coverage and open defecation rates in Ghana, 2006

Source: MICS, 2006.

Access to improved toilet facilities also varies greatly by region. The improved sanitation coverage includes data on shared latrines which are usually separated in the WHO/UNICEF Joint Monitoring Program reports (see Figure 23 and 24). Open defecation rates are quite revealing and correspond to the access levels. Based on figure 24, the most disadvantaged regions are Upper East, Upper West, Northern, Volta, and Central regions in that order.

One persistent gap in sanitation coverage has been the lagging construction and maintenance of school toilet blocks. According to the Ministry of Education, in 2007–2008 only 48 per cent of primary schools had access to adequate toilet facilities and 63 per cent had access to portable water;²⁰⁷ during the same period, only 52 per cent of public junior high schools had toilet facilities and 64 per cent had access to potable water. Apart from presenting an obvious obstacle to good health and hygiene, and acting as a disincentive to school attendance in many communities, the lack of sanitation and water facilities in schools has also complicated efforts to deploy children as agents of sanitation and hygiene behaviour change in their communities.

Eradication of guinea worm

The eradication of guinea worm in the northern regions is a success story that demonstrates that concerted efforts to transfer substantial resources to deprived areas can dramatically improve the quality of life for poor children and families. Investments were made equitably – not equally – and impressive results have been seen.

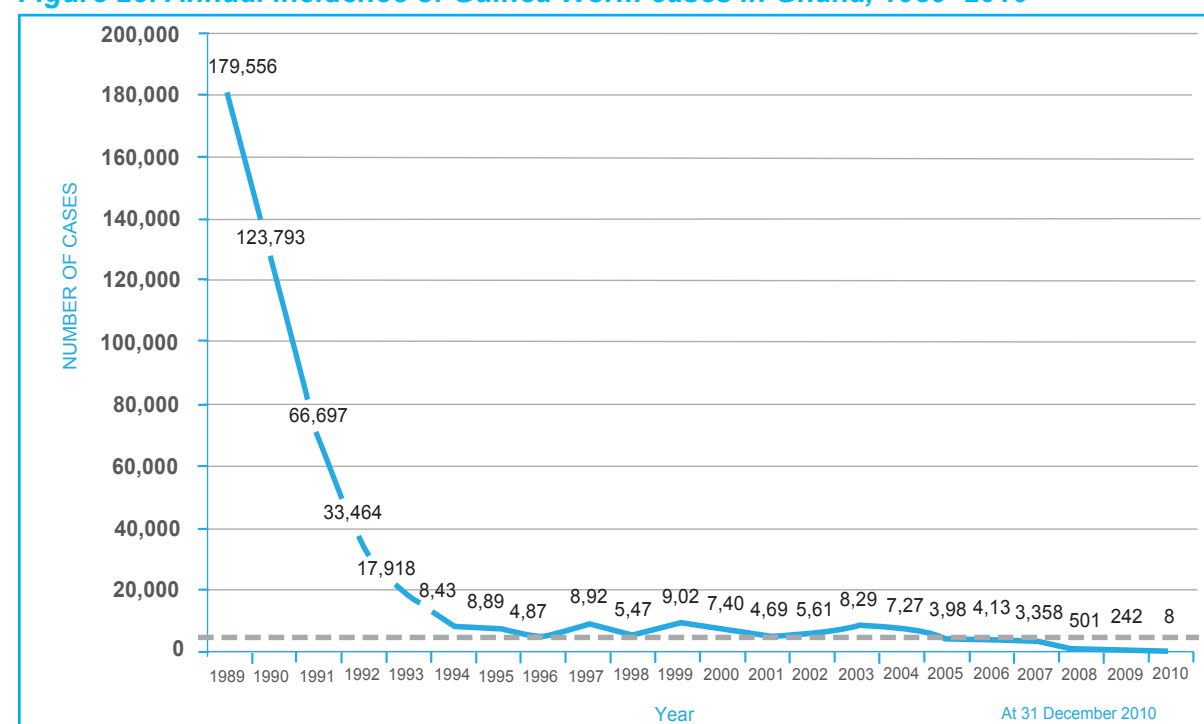
Until 2005 Ghana was for decades one of 20 endemic countries for Guinea worm disease, caused by drinking water from a pond infested with the Guinea worm cyclops. This debilitating parasitic disease had a devastating effect on livelihoods and school attendance in rural communities, whose only water sources were contaminated. Through the provision of safe water (particularly during the United Nations International Water Supply and Sanitation Decade in the 1980s), the prevalence of this disease began to decline.

In 2004, however, Ghana still reported more cases of Guinea Worm disease (7,275) than any other country worldwide (see Figure 25, below). In 2007, the EU/UNICEF funded “*Integrated Approach to Guinea Eradication through Water, Sanitation, and Hygiene in Northern region, Ghana*,” tagged the “*IWASH Project*,” began to make a major contribution to the country’s eradication efforts. Through strong partnership arrangements coupled with funding for water supply, behavioural change, and sanitation activities, the impact of the IWASH project began to be felt from 2008 onwards. Between 2007 and 2008 the number of cases plummeted by 85 per cent, and excellent progress continues to be made, with only 242 cases reported in 2009 and 8 cases in 2010²⁰⁸ – all in the Northern region, compared with nearly 180,000 cases in Ghana 20 years earlier.²⁰⁹ Since June 2010, Ghana has not reported a single case of Guinea worm and is well on course to eliminating transmission of the disease and for the certification of eradication. Thus, strong partnership, effective government leadership, and more focused eradication strategies and interventions have resulted in this important achievement.

207 Government of Ghana, Ministry of Education (MoE), Science, and Sports, Education Sector Performance Report 2008-2009, Accra, July 2008.

208 WHO, Dracunculiasis eradication – Global surveillance summary 2009.

209 MoH, Independent Review: Health Sector Programme of Work 2009, p. 3, and MoWAC and UNICEF, Children in Ghana, pp. 61-62.

Figure 25: Annual incidence of Guinea Worm cases in Ghana, 1989–2010

Source: National Guinea Worm Eradication Programme database, 2010.

Policies and resources to ensure equitable access to water and sanitation

In the Ghana Shared Growth and Development Agenda (GSGDA) 2010–2013 the Government of Ghana will pursue the following policy objectives to improve access to quality water and sanitation services:

- ensure efficient management of water resources; accelerating the provision of safe, portable, and affordable water
- improve environmental sanitation
- ensure implementation of health education programmes as a component of all water and sanitation programmes
- improve sector coordination through a sector-wide approach to water and environmental sanitation delivery
- improve sector institutional capacity
- ensure sustainable, predictable, and adequate financing to the sector

Ghana's National Water Policy, launched in 2007, provides a framework for the development of Ghana's water resources and encompasses issues related to water resources management, urban water, and rural/small town water and sanitation. The policy also recognises the various cross-sectoral issues related to water use and provides the links to other relevant sectoral policies, such as sanitation, agriculture, transport, and energy.²¹⁰

The implementation of the water and sanitation policies is overseen by several ministries and agencies, including the Ministry of Water Resources, Works, and Housing; Ministry of Local Government and Rural Development (for sanitation); the Community Water and Sanitation Agency; the Water Resources Commission; and the Ghana Water Company, Limited. In addition, District Assemblies are charged with some water and sanitation responsibilities. Districts' successful oversight of the near eradication of guinea worm demonstrates that tangible results can be seen when the District has control over staff and resources, and when all actors are able to converge around a single objective.

Financial resources needed to improve water and sanitation

In April 2010, the Government of Ghana, through three government ministries, signed the Ghana Compact on Sanitation and Water for All (SWA), pledging "to do more to improve sanitation and sustain gains in water delivery." Specifically, the government committed to spending \$200 million annually up to 2015 to achieve MDG 7; \$150 million annually towards the hygienic treatment and disposal of septage and faecal sludge and on storm water management; and 0.5 per cent of GDP to cover capacity building for hygiene education and country-wide outreach for the Community-Led Total Sanitation programme.²¹¹

The Ghana Compact shows a financing gap of \$119 million between what is required to meet the water targets of MDG 7 and the planned expenditure. Of the financing required, \$123 million was needed for rural communities or small towns, and \$115 million for urban areas; however, planned expenditures were only \$58 million and \$61 million, respectively. This recognition of greater financial need in areas with poorer sanitation is a positive example of equitable distribution of resources.



²¹⁰ Water Sector Monitoring Platform, "Report for the Compilation of Information/Data on the Water and Sanitation Sector Investments in Ghana," November 2009, p. 12.

²¹¹ Government of Ghana, Ministries of Local Government and Rural Development, Water Resources, Works and Housing, and Finance and Economic Planning, The Ghana Compact: Sanitation and Water for ALL: a Global Framework for Action – SWA, April 2010.

For environmental sanitation services, the gap was much wider, with about \$325.5 million needed by 2015.²¹² In 2009 the Ministry of Water Resources, Works, and Housing and its development partners produced a roadmap for a sector-wide approach to water, sanitation, and hygiene programming to ensure effective donor coordination and to streamline funding.²¹³

Despite the pledge of substantial government resources, resources for the water and sanitation sector are predominantly from donors. Although the 2011 budget brings a significant increase in the allocations for the Ministry of Water Resources, Works, and Housing (from \$119 million in 2010 to about \$373 million in 2011)²¹⁴, the additional funds are solely due to large contributions from donors. In fact, government allocations have actually decreased from \$8.9 million in 2010 to \$4.5 million in 2011. At the same time, donor funding is anticipated to increase from \$92.6 million in 2010 to \$353.3 million in 2011. In light of the government's recent commitment to allocate \$350 million to water and sanitation over the next five years, it will be important to track actual releases and expenditures in the water sector.

Allocations to pro-poor expenditures, such as rural water, should be prioritized within national water budgets. Expenditure on rural water was \$14.3 million out of a total of \$42.2 million spent in the works and housing sector in 2009. Less than half of the 2008 planned estimate on rural water was actually spent, and this reduction is likely to affect children and women in the rural areas who walk long distances to fetch water, potentially affecting their education and adding to their household burdens. Despite the low performance in 2008, the 2009 budget allocated about 71 per cent of total expenditure for the water, works, and housing sector to rural water.²¹⁵



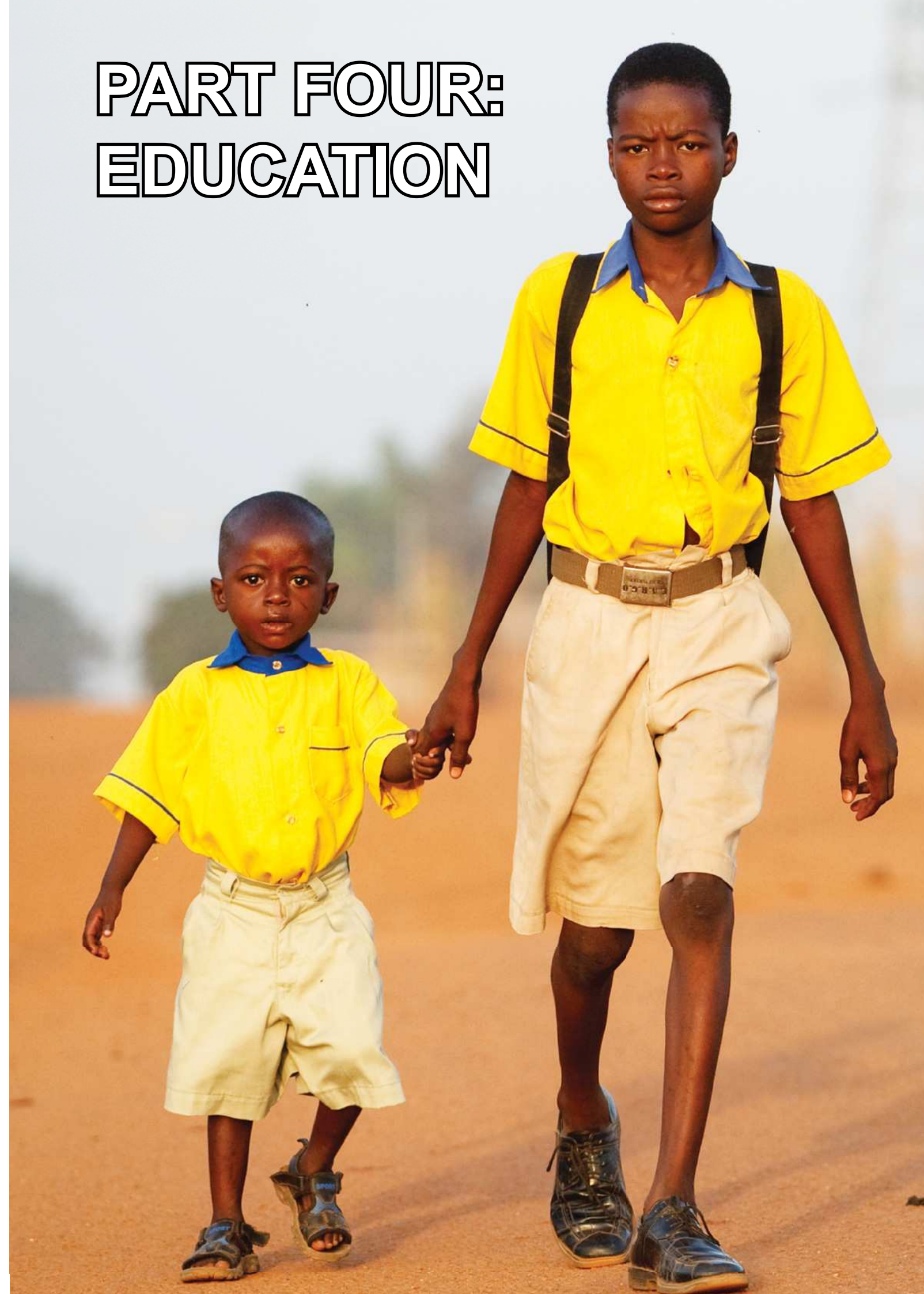
²¹² Ibid.

²¹³ UNICEF Ghana, Realising the Rights of Children in Ghana, Accra, February 2010.

²¹⁴ ISODEC and UNICEF Ghana, 2011 Budget and Issues Relating to Women and Children Welfare, report, March 2011.

²¹⁵ ISODEC and UNICEF, 2009 Budget and Issues Relating to Women and Children Welfare, pp. 19–20.

PART FOUR: EDUCATION



“ Education is one of the most powerful instruments for reducing childhood poverty and inequality ”



Education

INTRODUCTION

Ghana's 1992 Constitution provides for education to be “free, compulsory, and available to all”; and the 1996 reform measures known as “F-CUBE” (Free Compulsory Universal Basic Education) were meant to advance that goal, increasing, in two phases, mandatory education from six to nine years (through junior high school level) and then in 2002 to 11 years, with the addition of two years of pre-primary schooling.²¹⁶ In addition, Ghana is a signatory to the Education for All (EFA) goals adopted in Dakar in 2000 and the subsequent Fast Track initiative aimed at expediting EFA.²¹⁷ Education is one of the most powerful instruments for reducing childhood poverty and inequality, and consequently features prominently in international child rights conventions. The importance of education, particularly primary education, in advancing economic and social development and in reducing poverty is well documented.

As noted in the previous chapters, education plays an essential role for child survival and development. This is especially the case for girls' education, which is highly correlated with reduced child mortality and improved health and nutrition for subsequent generations of children. People with the lowest levels of education are largely found in the poorest segments of the population, and children growing up in households whose members have low education levels are themselves among the most excluded from education.

Ghana deserves praise for many of its achievements in the area of education. Since 2005 the abolition of school fees and the provision of assistance to schools through the “capitation grant” have had a great impact on boosting school enrolment and narrowing the gender gap between girls and boys in schools. More recently, Ghana has also expanded its formal education system to include early childhood education for children aged 4–5 years. With these successes have come new challenges that will need to be addressed as Ghana continues to improve and strengthen its education system. The biggest challenges are improving and sustaining the quality of education and addressing persistent disparities, especially between regions and socio-economic groups, in the provision of basic education.

²¹⁶ World Bank, Africa Region, Education in Ghana: Improving Equity, Efficiency and Accountability of Education Service Delivery, September 2010.

²¹⁷ ISODEC and UNICEF Ghana, 2009 Budget and Issues Relating to Women and Children Welfare.

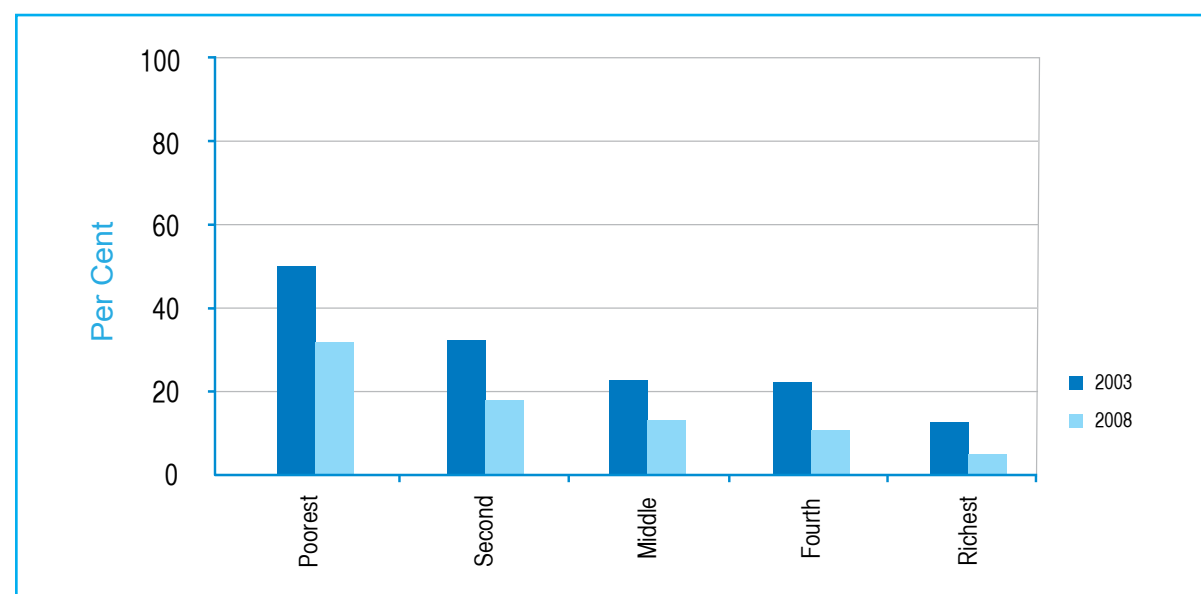
A. BASIC EDUCATION: ACCESS, RETENTION, AND COMPLETION

Enrolment increases and disparities

Today, more than 80 per cent of Ghana's children are enrolled and staying in school, a rate far ahead of most other countries in sub-Saharan Africa. The gross enrolment ratio (GER)²¹⁸ has increased at all levels of basic education in Ghana over the past 20 years. At the kindergarten level, the GER increased from 50.6 per cent in 2003–2004 to 92.9 per cent in 2008–2009, and the net enrolment ratio (NER) increased from 34.4 per cent to 63.6 per cent during the same period. At the primary level, the GER increased from 78.4 per cent in 2003–2004 to 94.9 per cent in 2009–2010 and the NER increased from 55.6 per cent to 83.6 per cent. At the junior secondary school level, the increase in GER was a bit less dramatic, from 65.6 per cent to 80.6 per cent during the same period, while the NER increased from 29.5 per cent to 47.8 per cent.²¹⁹

However, increased enrolment masks stark disparities – by region, gender, and income group. The likelihood of a child from the poorest quintile never having gone to school is about six times greater than for a child from the wealthiest quintile. The chances that a child from a rural area has not attended school are more than twice as high as for a child from an urban area. A child in the Northern region is four times more likely not to have attended school than a child in the Ashanti region. In 2008 girls from the poorest households in the Northern region are nearly three times more likely to be out of school compared with the national average.²²⁰

Figure 26: Percentage of children 6–14 years who have never attended school, 2003 and 2008



Source: Analysis of out-of-school children in Ghana, using GDHS 2003 and GDHS 2008.

²¹⁸ This section includes references to gross and net data for school enrolment. These are defined as follows: The gross enrolment rate or ratio (GER) represents the number of pupils enrolled in a given level of education, regardless of age, expressed as a percentage of the population in the theoretical age group for the same level of education. The net enrolment rate (NER) is the number of pupils in the theoretical age group for a given level of education enrolled in that level, expressed as a percentage of the total population in that age group. (Source: UNICEF, ChildInfo: www.childinfo.org/education_methodology.html.)

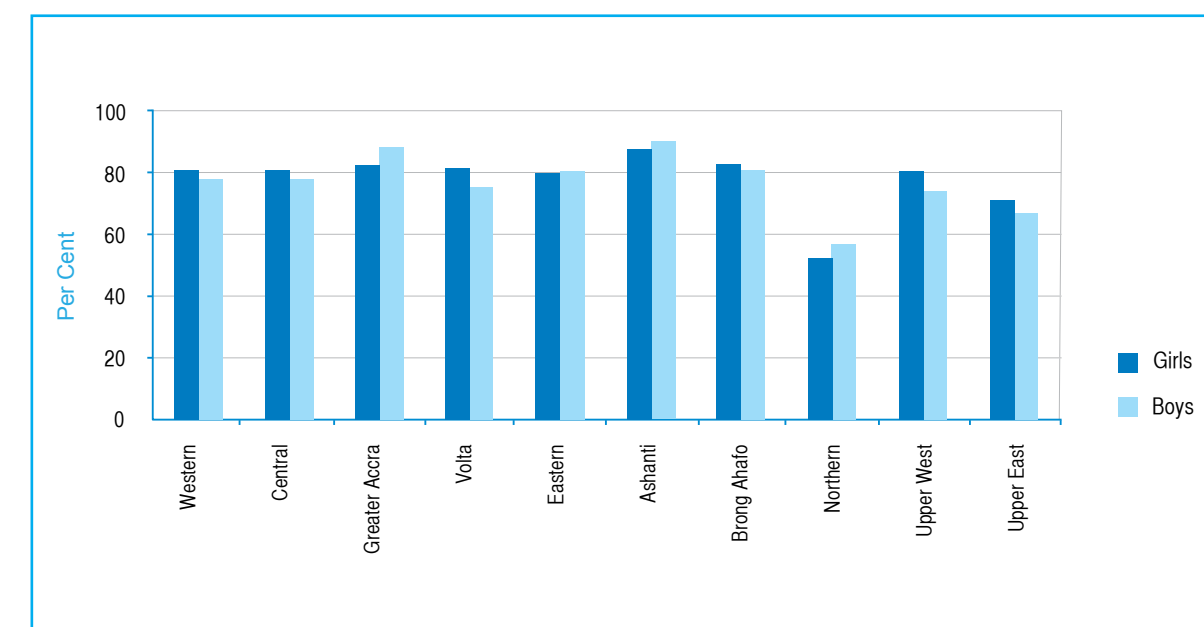
²¹⁹ MoE, Education Sector Performance Report 2008–2009.

²²⁰ UNICEF Ghana, Education Section, An analysis of out of school children in Ghana: Ghana Demographic and Health Surveys (GDHS) 2003–2008, Accra, September 2010

A more positive trend is seen in the gender parity index (GPI), which shows that Ghana is very close to achieving the target of complete gender equality in primary school enrolment. At the national level, the primary GPI was 0.96 in 2009–2010, meaning there were 96 girls for every 100 boys. Thus, MDG 3 (eliminating gender disparity in primary and secondary education by 2005 and in all levels of education by 2015) will almost certainly be attained, at least for the primary level and the national aggregate level. Junior secondary schools, with a GPI of 0.92 for the same period, still lag a bit behind. Active implementation of activities to promote girls' education has helped to eliminate barriers to enrolment and encouraged participation and attendance.²²¹

While at the national level the rate of gender parity for primary schools appears stable and is seen as encouraging, not all regions are sharing this success equally. For example, in the Northern region the GPI was only 0.87 in the 2008–2009 school year, whereas there was virtually no difference in the ratios for primary school enrolment in the urban centres of Greater Accra (0.98) and Ashanti (0.97). At the same time, at the junior secondary level the respective GPI of 0.91 and 0.90 for those two metros shows that urban girls continue to be disadvantaged compared to urban boys.²²²

Figure 27: Primary school attendance by gender and region, 2008



Source: Analysis of out-of-school children in Ghana, using GDHS 2003 and GDHS 2008.

²²¹ NDPC and UNDP, 2008 Ghana MDG Report, 2010, p. 25.

²²² Ibid., pp. 25–26.

Meeting MDG 2 targets

Based on the indicators of net enrolment in primary education, Ghana is on track to meet the MDG 2 target of universal access to primary education by 2015.²²³ However, the target for school completion is unlikely to be met, thus in all likelihood preventing Ghana from fulfilling the overall MDG 2 targets for achieving universal basic education by 2015. Completion rates for the primary level were 87.1 per cent in 2009–2010, an 8.4 per cent increase over 2003–2004 and higher than in most countries in sub-Saharan Africa. Nonetheless, this is probably not high enough to ensure achievement of the MDG 2 target of a 100 per cent completion rate. At the junior secondary school level, the completion rate increased from 58.0 per cent to 75.0 per cent over the same period, but this too appears insufficient for Ghana to achieve universal basic education.²²⁴

Completion rates among female pupils are lower than for males at both the primary and junior-secondary level. At the primary level, completion rates for male pupils increased from 81.7 per cent in 2003–2004 to 89.3 per cent in 2008–2009, but went up only from 74.0 per cent to 83.2 per cent among female pupils over the same period. At the junior-secondary level, the male completion rate increased from 61.9 per cent to 79.7 per cent, while for female pupils it increased from 53.8 per cent to 70.1 per cent.²²⁵

Removal of financial barriers

The striking increases in basic education admission and enrolment rates over the past decade can be attributed to a great extent to the elimination of school fees and the introduction of the “*capitation grant*” in 2005 to make up for the loss of those fees by providing schools with direct funding from the central treasury.²²⁶ The increase in kindergarten enrolment, up 60 per cent between 2005 and 2008, reflected the change of government policy, making early childhood education a part of the basic education cycle.

Attendance rates and enrolment rates

Between 2003 and 2008 the net primary school attendance rate (as opposed to enrolment rate)²²⁷ increased from 60 per cent to almost 75 per cent.²²⁸ However, one factor in high attendance rates is the presence of children in schools – particularly those from households in the poorest quintile and who are concentrated in such disadvantaged areas as the three northern regions – who are around three years older than the official age for their respective grades. There are several causes of this tendency, including the need for older children to care for younger siblings or to work during harvest times. It is a phenomenon that is found generally in rural areas of Ghana, and it is a problem that could be mitigated by offering families – particularly the poorer ones – incentives for ensuring that their children enter school at the right age.²²⁹

²²³ Ibid., pp. 19–24, and table, p. 89.

²²⁴ Ibid., p. 21.

²²⁵ MoE, Education Sector Performance Report 2008–2009.

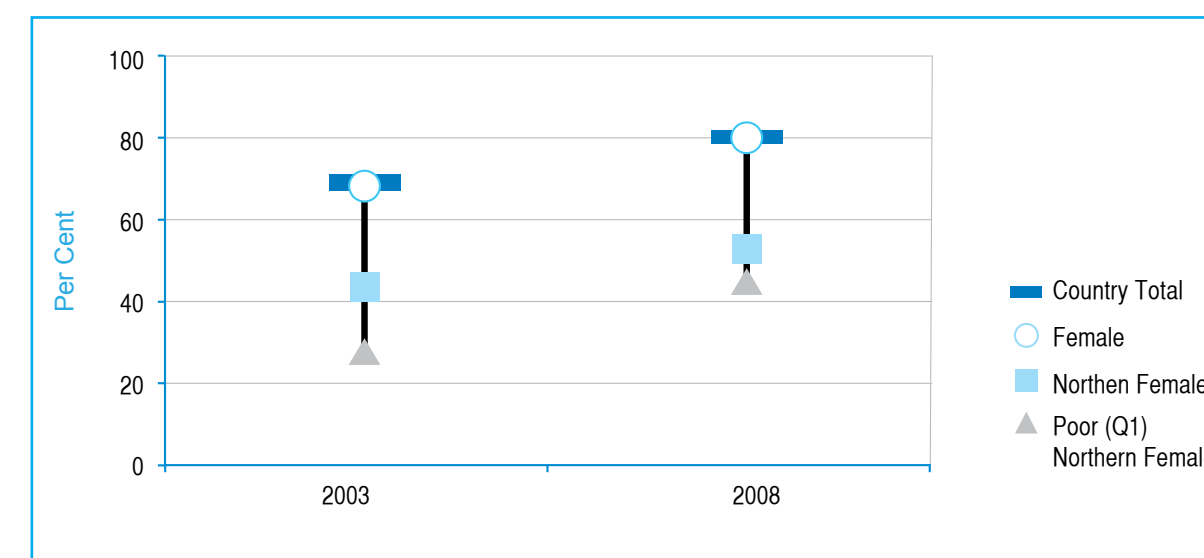
²²⁶ World Bank and UNICEF, *Abolishing School Fees in Africa: Lessons from Ethiopia, Ghana, Kenya, Malawi, and Mozambique*, Washington, D.C., 2009.

²²⁷ It is important to note that school attendance and enrolment are not always the same. For example, it is possible for children to formally enrol in a school but never actually attend. This distinction is important when using different survey sources (e.g., administrative data and household survey data).

²²⁸ UNICEF Ghana, Education Section, *An analysis of out of school children in Ghana*, p. 38.

²²⁹ Ibid.

Figure 28: Attendance rates for children 6–14 years by poverty, gender, and region, 2003 and 2008



Source: Analysis of out-of-school children in Ghana, using GDHS 2003 and GDHS 2008.

At the secondary-school level, net attendance rates are 39 per cent for girls and 37 per cent for boys. Family income appears to be the most significant factor determining school attendance, with rates rising from 12 per cent for girls and 14 per cent for boys in the poorest quintile to 62 per cent for girls and 65 per cent for boys in the wealthiest quintile. The urban/rural divide at the secondary level is also slightly wider than at the primary level, with 49 per cent of urban secondary-age children in school, compared with 30 per cent of rural children.²³⁰

Different factors often interact to create magnifying layers of disadvantage that restrict a child's participation in education. A recent UNICEF study indicates that girls from the poorest households in the Northern region are nearly three times more likely to be out of school compared with the sample average in 2008.²³¹

While enrolment rates have gone up nationally, there remains a significant disparity in enrolment rates between the poorer and the better endowed regions of Ghana. Data from the Ministry of Education indicate that about 450,000 Ghanaian children aged 6–11 years were not enrolled in primary school in the 2008–2009 school year. Further, children from deprived households not only have fewer chances than their better-off counterparts to be enrolled, but those from deprived households who are enrolled have an even smaller probability of completing a given cycle of schooling.²³²

Dropout rates

School dropout rates nearly doubled between 2003 and 2008. In 2003 only 2.3 per cent of children aged 6–14 were no longer in school after having attended at some point. In the 2008 GDHS, the rate was 4.1 per cent (3.7 per cent in the rural areas, 4.7 per cent in the urban areas). It is believed that this statistical increase was partly explained by the increase in the

²³⁰ ODI and UNICEF, *Study on Social Protection*, p. 12.

²³¹ UNICEF Ghana, Education Section, *An analysis of out of school children in Ghana*, p. 48.

²³² MoE, Education Sector Performance Report 2008–2009.

number of children entering school during this period. But it was considered likely that the rise in dropouts reflected the quality concerns that accompanied such an expansion of the education system – for example, the new demands put on teachers and the potential for new entrants to become discouraged with the conditions and learning environment that they encounter in the classroom.²³³

Children may drop out of school for various reasons, including:

- poverty, especially when compounded by the death of a parent
- access difficulties, e.g., long distances to school can discourage children and families.
- discrimination against disabled children
- pressure on adolescent girls to marry
- teen pregnancy
- frequent interruption of studies to support one's family with labour
- peer pressure, e.g., to join peers in labour or street trade
- poor use of instruction time in schools: frequent teacher absence or disregard can demotivate children and make them question the value of education;
- pervasive and severe corporal punishment;
- recurrent low performance precipitated by de-motivated teachers or poor school facilities;
- seeming irrelevance of formal schooling when children and families perceive that it does not lead to advancement or “success” in life.²³⁴

B. QUALITY OF BASIC EDUCATION

The quality of education currently being received by Ghanaian children who are in school is a source of major, and increasing, concern. In overcrowded classrooms, often instructed by teachers who have had little or no pedagogical training, many Ghanaian children complete primary education without attaining functional literacy. According to the Ministry of Education's National Education Assessment (NEA) tests of 2009, only a third of grade six students reach proficiency levels in English, and fewer than 14 per cent achieve proficiency in mathematics.²³⁵ A recent World Bank report points out that “the districts with the poorest performance on NEA were in the northern regions.”²³⁶

Government statistics for primary school achievement show wide variations in pupil performance among regions. In English language study, for example, primary three-level pupils scored highest (a mean score of 50.9 per cent) in the Greater Accra region and lowest (32.9 per cent) in the Upper East region. Interestingly, the disparities in results for the same level pupils within a single region were widest (standard deviation: 20.9) within the Greater Accra region and lowest (12.6) within the Upper East region, suggesting a great variance in the socio-economic levels of pupils in Greater Accra region and a very small variance among pupils in Upper East.²³⁷

²³³ UNICEF Ghana, Education Section, An analysis of out of school children in Ghana.

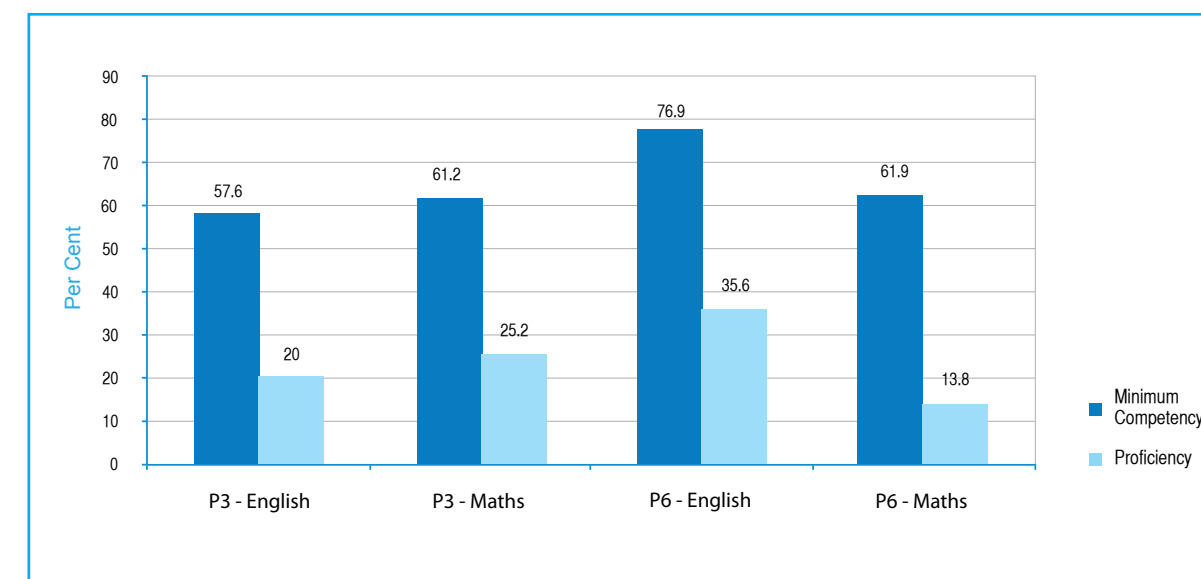
²³⁴ Government of Ghana, DFID, UNICEF, and World Bank, Participatory Poverty and Vulnerability Assessment, Briefing Note.

²³⁵ MoE, Education Sector Performance Report 2008–2009.

²³⁶ World Bank, Improving Equity, Efficiency and Accountability of Education Service Delivery,” February 23, 2011, p. v.

²³⁷ MoE, Basic Education Comprehensive Assessment System (BECAS), Report Summary: 2009 National Education Assessment, Primary 3 and Primary 6, English and Mathematics, June 2010.

Figure 29: Percentage of pupils with minimum competency/proficiency in primary schools, 2009



Source: Ministry of Education sector performance report, 2008–2009.

Main causes of poor quality education

Large number of untrained teachers and insufficient time on task: Fewer than 60 per cent of primary-level teachers have had proper professional training.²³⁸ This trend is particularly stark in the deprived districts, since many trained teachers will prefer to teach in more endowed districts.

Table 4: Percentage of trained teachers, nationally and by deprived districts, 2003–2008

	2003/04	2004/05	2005/06	2006/07	2007/08
Kindergarten				35.3%	42.9%
Primary National	73.9%	72.4%	70.8%	62.1%	59.4%
Primary Deprived	55.3%	53.2%	55.9%	42.8%	37.2%
Junior High National	84.2%	83.5%	85.5%	77.2%	76.4%
Junior High Deprived	75.9%	73.9%	77.7%	64.2%	62.9%

Source: Ministry of Education sector performance report, 2008–2009.

Other major quality issues are high teacher absenteeism (more common in rural schools) and the insufficient time students spend on actual learning tasks. Taken together, teacher absenteeism, poor “time-on-task,” and the short duration of the school year can result in as much as 50 to 60 per cent of teaching time being lost – clearly a key constraint to proper learning.²³⁹

²³⁸ MoE, Education Sector Performance Report 2008–2009.

²³⁹ A World Bank study shows that schools are open and teachers are available in the classroom for only 55.1 per cent of the year, compared with 89.9 per cent in Tunisia, 87.4 per cent in Brazil, and 86.1 per cent in Morocco. Another finding was that in Ghana only 39 per cent of school time was spent in learning tasks, as opposed to 77.9 per cent in Tunisia, 71.1 per cent in Morocco and 63 per cent in Brazil. Source: World Bank, Absenteeism and Beyond: Instructional Time Loss and Consequences. Washington D.C., October 2007.

Lack of basic teaching and learning materials: Schools generally lack basic learning materials, including textbooks. At the primary level, each student is expected to have at least three core textbooks (English, math, and science), which implies a ratio of core textbooks per pupil of 3:1. However, in the 2008–2009 school year the actual ratio was only 1.6:1. Further, there exists significant regional disparities in terms of the availability of textbooks, with the ratio of core textbooks ranging from 0.8:1 (Tonlon-Kumbungu District, Northern region) to 2.7:1 (South Tongu District, Volta region).²⁴⁰

Overcrowded classrooms in rural and urban areas: Contrary to the tendency among other indicators to show the greatest disparities between the deprived northern region and the better-endowed south of the country, the prevalence of high pupil-teacher ratios (PTRs) applies to schools in both north and south. The Education Sector Performance reports for 2008–2009 showed that the highest PTRs at primary level were found in schools in the Upper East region (48 pupils per teacher), Upper West (42), and Greater Accra (40), while the national average PTR was 34. The lowest rates were found in the Eastern and Volta regions (30 each).²⁴¹ This may be explained by the influx of large numbers of rural families into the Greater Accra region.²⁴² (Pupil-teacher ratios of 60:1 are not unknown in some rural districts, where classroom construction and improvement lags more than in other areas.)

Unhealthy school environment: High pupil-teacher ratios are particularly challenging because they are found to a great extent in the very parts of Ghana where other disparities in education are also prevalent and where a high proportion of primary schools already lack basic facilities. For example, on average, only 57 per cent of primary schools have a dedicated water supply, only 48 per cent have latrines, and 25 per cent of classrooms are already in need of major repair. Most of the worst examples of these shortages can be found in deprived areas, such as the three northern regions. This is not only a practical quality issue but an equity challenge that Ghana must quickly address.²⁴³

Safety concerns: Many schools do not adhere to child-friendly standards. A recent study on corporal punishment finds that 94 per cent of surveyed school children either experienced or witnessed corporal punishment;²⁴⁴ and there is significant evidence that sexual abuse is a problem in Ghanaian schools. A recent report by Plan Ghana shows that 14 per cent of school children have been sexually abused – primarily in senior high schools and junior high schools – manifesting itself in both contact and non-contact forms.²⁴⁵



²⁴⁰ MoE, Education Sector Performance Report 2008–2009.

²⁴¹ SODEC and UNICEF Ghana, 2009 Budget and Issues Relating to Women and Children Welfare.

²⁴² MoE, Education Sector Performance Report 2008–2009.

²⁴³ UNICEF Ghana, Education Department, briefing paper, 2010.

²⁴⁴ Department of Children and Children and Youth in Broadcasting (CURIOUS MINDS), The Use of Corporal Punishment in Ghana: Voices of Ghanaian Children, Accra, 2008

²⁴⁵ Plan Ghana, Report on the Study of Child Sexual Abuse in School, Accra, 2009

C. EQUITY IN BASIC EDUCATION

Ghana's Education Strategic Plan (ESP), covering the period 2010–2020, seeks to ensure that all children enter primary education by age six; to provide basic education to over-aged, out-of-school children; and to improve all aspects of education quality.²⁴⁶ The government's spending on education has reached unprecedented levels (around 5–6 per cent of GDP since 1990 but rising to 11 per cent of GDP in 2008), proportionally double the average for Africa and other developing regions.²⁴⁷

Priorities for the government and other stakeholders in the education sector can be summarized as:

- inclusion of the most vulnerable and marginalized children in education
- student retention in and completion of basic education
- improvement of the quality of all aspects of education
- Bolstering of accountability in school management through better monitoring²⁴⁸

In line with this, the Ghana Shared Growth and Development Agenda (2010–2013) spells out strategies for “*increasing equitable access to and participation in quality education at all levels*,” starting with “ensuring the availability of teachers in classrooms” through upgrading and expanding teacher training and “*improving and expanding*” educational facilities in “*poorly endowed*” areas to bridge equity gaps.²⁴⁹

Achieving full education coverage for all children in Ghana will require targeted efforts to reach the remaining excluded children from the most disadvantaged households and marginalized districts and regions. Further, this must be done while also addressing the challenges implied by expansion, such as overcrowded classrooms; shortages of trained teachers; increased costs of the building, repair, and maintenance of school buildings; increased demand for materials, etc. Ensuring “*meaningful access*” – and success rates – beyond the initial primary grades will bring another set of challenges, the addressing of which will require targeted and innovative interventions. This in turn highlights the need for continuous monitoring of educational outcomes, together with research into the underlying causes of school participation and exclusion.²⁵⁰

Reducing inequity and improving quality

The Education Strategic Plan (2010–2020) already includes provisions for making schools more inclusive; for improving the learning environment and level of pedagogy in the classroom; for making schools healthier, safer, and more protective for children; for enhancing gender equality; and for further engaging communities in the education of their children. This holistic intervention is seen as the most effective way of making schools more “*child-friendly*,”²⁵¹ and the Ghana Education Service drafted the National Child-friendly School Standards to translate this plan into concrete actions.

²⁴⁶ MoE, Education Strategic Plan 2010–2020, Accra, 2010

²⁴⁷ MoE, Education Sector Performance Report 2008–2009.

²⁴⁸ UNCT, Ghana Country Analysis.

²⁴⁹ NDPC, Medium-Term National Development Policy Framework, pp. 94–95. 248

²⁵⁰ UNICEF, An analysis of out of school children in Ghana.

²⁵¹ Interview with chief of UNICEF Education Section, 27 October 2010.

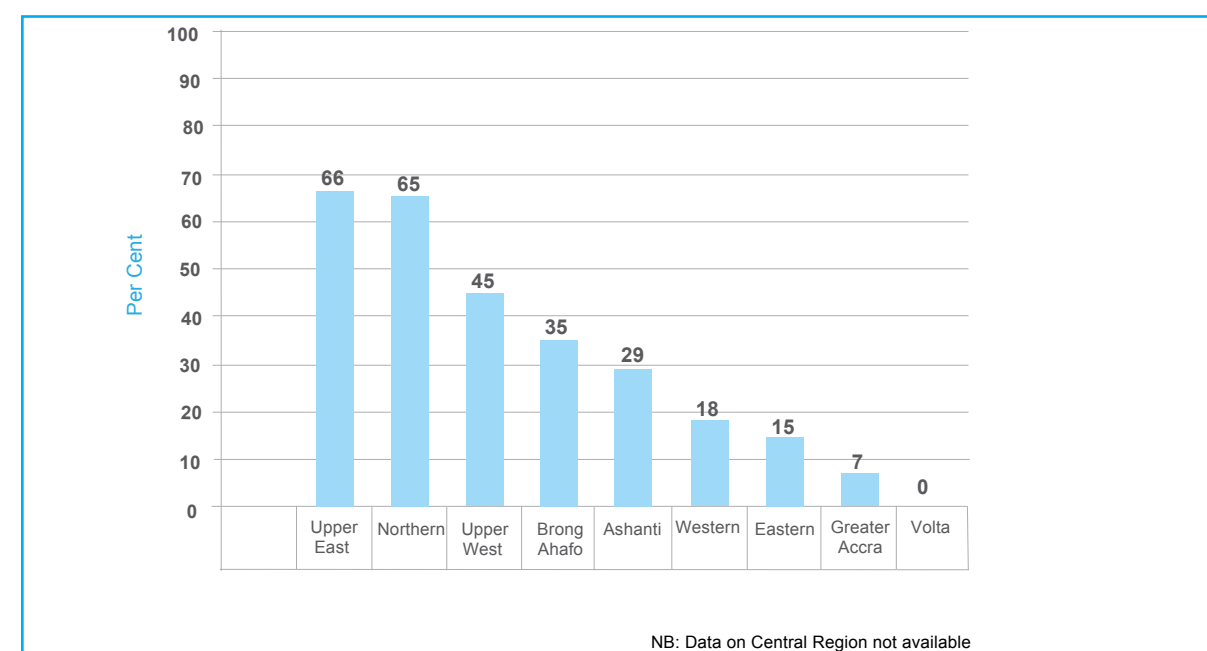
On a positive note, there are currently policies in place that could alleviate some of the quality issues, if properly implemented. One plan would provide teachers in rural areas with an allowance (an additional 20 per cent of their salaries) for teaching in rural districts; similarly, dedicated accommodations for rural teachers have been built in some locations. Under a programme known as Untrained Teachers' Diploma in Basic Education, teachers can be fast-tracked to certification so that they can remain where they are from and teach the children of their own communities.²⁵²

Funds for the neediest districts and children

Overall, the education sector received the largest allocation of the total budget (roughly 18 per cent of the budget in 2008 and 2010, with an intermediate spike to 20.9 per cent in 2009), the bulk of which was allocated to primary education.²⁵³ Since the bulk of government spending on education goes to staff costs, a rechanneling of resources into infrastructure and teacher training could have a direct impact on equity issues – principally by making attending and working in schools in deprived areas, particularly in rural districts, more attractive to students and teachers alike.

According to the Ghana Education Service, additional annual spending of some \$260.1 million would be required to attain the MDG 2 targets, although this low figure would not seem to take into account the major investment needs across Ghana to ensure real improvements in access to education for all children of school-going age, equity in the distribution of classrooms

Figure 30: Percentage of children in districts with substandard per capita expenditure at primary level, 2008



Source: World Bank, *Improving Equity, Efficiency and Accountability of Education Service Delivery*, 2011.

²⁵² Ibid.

²⁵³ ISODEC and UNICEF Ghana, Analysis of the 2010 National Budget and Economic Policy Statement of the Government of Ghana to Determine Gaps and Opportunities for Women and Children, draft report, March 2010, p. 14, and ISODEC and UNICEF, 2009 Budget and Issues Relating to Women and Children Welfare, pp. 19–20.

and teachers to the most disadvantaged districts, and, above all, closing the quality gap in education. The new ESP estimates that over the 10-year period the Plan will require additional resources in the amount of \$4.8 billion. In 2008, total government education expenditure was about \$1.288 billion, 48 per cent of which was allocated to basic education.²⁵⁴

Contrary to current practice, this expenditure needs to be allocated equitably. At present, inequitable investment across regions is a primary cause of low enrolment and poor quality. Per capita expenditure at the basic level is much lower in the poorer regions than in the more endowed regions, as seen in the following table from a recent World Bank study.²⁵⁵

The distribution of teachers, and especially trained teachers, among the geographical regions of Ghana is both unequal and inequitable. Teachers generally prefer to work in better-endowed urban areas, rather than being deployed to schools in remote, impoverished areas. Even greater disparities are found in the distribution of untrained teachers, who are heavily concentrated in the more deprived areas, especially the northern regions. At the national level, the proportion of trained teachers in 2007–2008 was 59.4 per cent on average. But in the most deprived districts the proportion was 37.2 per cent. Even within individual districts, qualified teachers prefer to stay in urban areas, meaning that rural schools get even fewer qualified teachers. This inequitable distribution of qualified teachers is one of the main causes of the fiscal inequity in terms of per-capita expenditure. As is stated in the new ESP, aggressive and persistent measures need to be taken to improve the deployment of qualified teachers in the most disadvantaged areas.

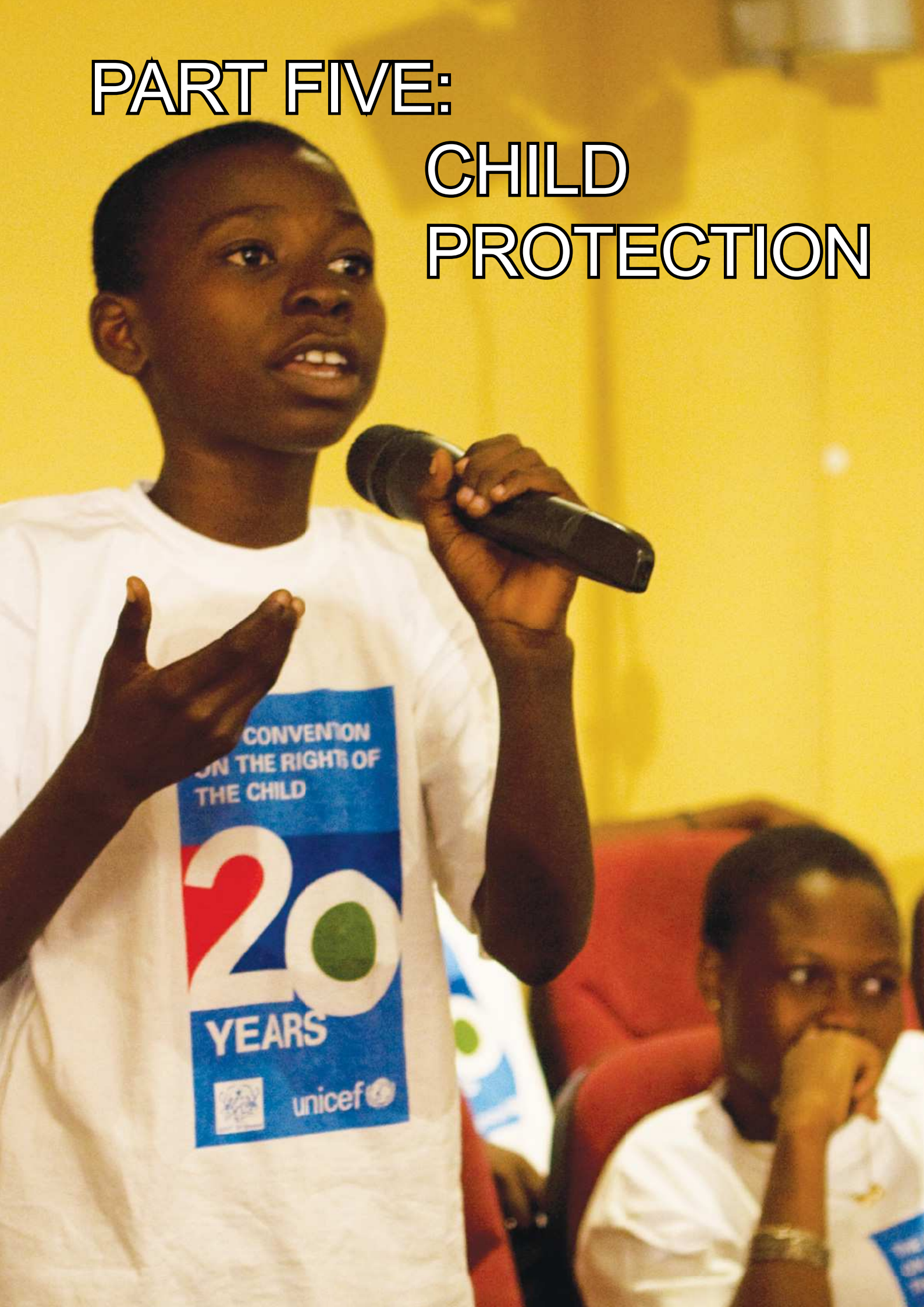


²⁵⁴ NDPC and UNDP, 2008 Ghana MDG Report, p. 24.

²⁵⁵ World Bank, "Improving Equity, Efficiency and Accountability of Education Service Delivery," p. 131.

PART FIVE: CHILD PROTECTION

“Legislation to protect children and women is progressive but is not fully put into practice”





Child protection

INTRODUCTION

Child protection addresses the same vulnerabilities of children that can deny them their rights to human development, well-being, and full and equitable participation in a safe and child-friendly world. The abuse and exploitation of Ghanaian children – be they working on the cocoa farms, forced into domestic servitude, left to their own devices on city streets, or victimized by sexual abuse or trafficking – constitute Ghana's major child protection challenge. Domestic violence and child abuse are underreported but growing trends. Legislation to protect children and women is progressive but is not fully put into practice. A lack of comprehensive statistical data and the low capacity and poor coordination of implementing partners compromise the effectiveness of the country's child protection system.²⁵⁶

By definition, many but certainly not all child protection issues affect poor children disproportionately more than better-off children. The exception to this observation is domestic abuse, which can affect children from any region or wealth quintile. Phenomena such as child labour, trafficking, and street children mostly affect poor children for the simple reason that their parents either permit or do not actively prevent these conditions because the family needs the income or will benefit from having one less mouth to feed. In addition, harmful traditional practices are more likely to be practiced by less educated families, which often suffer from poverty; and we also see regional disparities in certain practices such as female genital mutilation/cutting because they are related to particular ethnic groups.

A. DOMESTIC VIOLENCE AGAINST CHILDREN

Children, especially girls, are vulnerable to violence, exploitation, and abuse from people they tend to know and trust. In the period 2004–2008, half of all abuse cases reported to the Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service were child-related.²⁵⁷ Abuses against children continue to be an issue of concern and according to the 2010 figures obtained from DOVVSU, of the more than 13,000 abuse cases reported, child abuse cases had risen from the previous year, with 85 per cent of victims being girls. These cases covered such abuses as defilement (from 851 in 2009 to 982 in 2010, all against girls), rape (286), abduction (238), and forced marriage (21).²⁵⁸ The number of cases reported indicates not only an increase in the actual cases but also a greater awareness and confidence in the justice system. The challenge remains the slow pace at which criminal-related cases are tried in court.²⁵⁹

²⁵⁶ UNICEF, UNICEF in Ghana: A Summary, information kit, Accra 2009.

²⁵⁷ UNICEF Ghana, Annual Report 2009.

²⁵⁸ Domestic Violence and Victim Support Unit (DOVVSU), All Regional Child Related Cases Reported, as at first-third quarter (January–September 2010), figures provided to UNICEF, Accra, November 2010.

²⁵⁹ UNICEF Ghana, Annual Report 2009.

B. CHILD LABOUR

Household poverty and dire living conditions are overwhelmingly what propels children into work. Traditional practices and socio-economic norms are also a factor. Children may also opt to work rather than attend rural schools, where teachers are often absent or inattentive, facilities are lacking, and the journey to and from class is arduous and time-consuming. While some children may choose to work out of ignorance, peer pressure, or poor parental guidance, there are clearly many instances where adult influence, even exploitation (particularly of girl children) is a major factor.²⁶⁰

The majority of working children (71 per cent) are found in the agriculture sector (including fishing and forestry), followed by services (22.6 per cent) and manufacturing (5.8 per cent). Rural boys mostly work in agriculture (77 per cent), while rural girls also work mostly in agriculture (58 per cent) but with a significant proportion in sales/retail (26 per cent). Urban children were more likely engaged in selling (52 per cent). Overall, 90 per cent of working children are unpaid family workers, although in urban areas 15 per cent are employed or self-employed.²⁶¹

By far the biggest employer of child labour in Ghana is the cocoa industry, the country's main economic activity. Two surveys on labour practices on the cocoa farms, conducted in 2006–2007 and 2007–2008, found that about 186,000 children in the cocoa-growing areas of Ghana (about 10 per cent of the child population in those areas) were engaged in at least one hazardous cocoa-specific activity.²⁶² The studies also indicated that over 92 per cent of children in cocoa-growing communities attended school regularly, although 54 per cent of that group were illiterate.

The National Programme for the Elimination of Worst Forms of Child Labour in Cocoa (NPECLC) was established in 2006 with the goal of eliminating such labour by 2011. With technical support from ILO and UNICEF, the NPECLC has led Ghana's efforts to comply with the Harkin-Engel



²⁶⁰ CRRECENT/PlanGhana, Child Rights Situational Analysis, citing Ghana Statistical Service, Ghana Child Labour Survey, Accra, 2003.

²⁶¹ ODI, Study on Social Protection and Children in West and Central Africa: Case Study Ghana, p. 13.

²⁶² The hazardous activities associated with cocoa farming include strenuous work that can lead to illness and injuries, and the use of sharp tools and pesticides. Children working in cocoa harvesting are exposed to physical and chemical hazards without proper training or protective equipment. Source: Mull, L. Diane and Kirkhorn, Steven R., MD, "Child Labor in Ghana Cocoa Production: Focus upon Agricultural Tasks, Ergonomic Exposures, and Associated Illnesses and Injuries," Public Health Reports, vol. 120, no. 6, November–December 2005, www.ncbi.nlm.nih.gov/pmc/articles/PMC1497785/.

Protocol (a multilateral commitment by the cocoa industry to comply with ILO Convention 182 on the worst forms of child labour), and was able to meet a 2008 deadline for establishing a regime for certifying progress in this effort.²⁶³

Perhaps the most hazardous work activities in which children can be found to be engaged in Ghana are stone-quarrying and mining. Apart from the large-scale mining of Ghana's rich resources of minerals, such as gold, diamonds, and manganese, there are also small-scale (and illegal) artisanal mining operations in which mineral-bearing soil or rocks are extracted manually (and, in the case of gold, extracted with the use of mercury). Many operators of these illegal mines (known as *galamsey*) engage large numbers of children between the ages of 10 and 18 years (including girls) and pay them daily wages to work in this dangerous business. One estimate counted more than 3,000 children engaged in *galamsey* in the Western region alone. Children working in Ghana's mines and quarries include those who have never been to school, those who dropped out of school to find work or to help their families, and those who go to school but also work to raise money for their families and for their own survival.²⁶⁴

Children sent to live with members of their extended families are often exploited by being forced into economic activity. Indeed, in some cases families in deprived areas give up their children for "*fostering*" by distant relatives, who may be unable or unwilling to care for them properly or to see to their education, and may be more inclined to exploit their labour. There is evidence that some parents are sending their children to unfamiliar towns to work for strangers or to sell their labour to intermediaries. In a sense, the practice of "*fostering*" highlights the multiple vulnerabilities and deprivation of rights that children can sometimes face in Ghana.²⁶⁵

C. STREET CHILDREN

There are estimated to be as many as 50,000 children living and/or working in the streets in Ghana. According to studies by MoWAC and the Ghana National Commission on Children conducted in 2004 (the most recent data available), nearly half of all street children in the country were found in the Greater Accra region, with another 25 per cent in the second largest city, Kumasi (more than 60 per cent of the latter being females). Also, 71 per cent of street children were illiterate.²⁶⁶

More girls than boys are found among child migrants, and girls are migrating at ever-younger ages. Most end up in menial jobs and suffer indignities and dangers, but the remittances they may be able to send back to their families are invaluable during the "hunger seasons" experienced by subsistence farming families. Child migrants often end up mortgaging their future wellbeing for short-term relief in urban marketplaces, where they endure numerous hazards, including homelessness, eviction, and sexual exploitation.²⁶⁷

Many street children are either victimized by sexual predators (including, in the case of girls and boys alike, other street children) or turn to commercial sex as a way to make a living. This

263 Mull and Kirkhorn, "Child Labor in Ghana Cocoa Production"; "US Department of Labor launches initiative to combat child labor in cocoa growing regions of Ghana and Cote d'Ivoire," Press Release, U.S. Department of Labor, ILAB, 13 September 2010 (www.dol.gov/ilab/); and "Cocoa: Giant strides in the elimination of child labour," Francis Asenso-oakyee, Ghana News, news.myjoyonline.com/features/201010/53976.asp.

264 MoWAC and UNICEF, *Children in Ghana*, p. 127.

265 Ibid., p. 140.

266 MoWAC data of 2004, cited in *Children in Ghana*, p. 11.

267 Drawn from Government of Ghana, DFID, UNICEF and World Bank, *Participatory Poverty and Vulnerability Assessment (PPVA)*, conducted between July 2009 and March 2010, Briefing Note.

exposes them to great risks, including violence, serious physical and psychological harm, and sexually transmitted diseases, including HIV. Studies found that many children in such situations were unfamiliar with the concept of sexual exploitation, seeing sexual activity as a practical necessity or part of the life of the street.²⁶⁸

D. CHILD AND WOMEN TRAFFICKING

Ghana is a source, transit, and destination country for the trafficking of children and women for commercial sexual exploitation and forced labour. Ghanaian children are particularly trafficked to Côte d'Ivoire, Togo, Nigeria, and The Gambia for domestic service and exploitative labour. There are also reports of girls being trafficked to countries even further away for employment in domestic service or the commercial sex trade.²⁶⁹ Children are also trafficked within Ghana to work in cocoa farming, domestic service, street vending, head portering, fishing, and the commercial sex trade.²⁷⁰ Typically, boys aged 10–17 are trafficked from the northern regions to Lake Volta for fishing or to the Western region for mining, while girls come from the north and east and are trafficked to Accra and Kumasi for work in portering, domestic service, and trading.²⁷¹

In 2005, Ghana passed the Human Trafficking Act (Act 694), which not only criminalized trafficking but also established a fund and mechanisms to rehabilitate child victims through non-formal education and skills training. A human trafficking management board under MoWAC has oversight on all aspects of the law, especially as it relates to children and women, and there also is in place a National Action Plan on Human Trafficking, which provides a framework for implementing Act 694. As with other such frameworks in Ghana, the challenge is the capacity – especially at the district level – to combat trafficking on the ground; there are also challenges regarding the training of law-enforcement and judicial officers, the provision of shelters and resettlement of victims, and coordination among all the relevant agencies.²⁷²

E. CHILDREN AFFECTED BY TRADITIONAL AND HARMFUL PRACTICES

Ghanaian children are often caught in the gap between modern law and traditional attitudes and practices. For example, there have been limited prosecutions of parents or others who engage in certain harmful practices against children, such as child marriage and female genital mutilation/cutting. Such practices may be considered acceptable in a given cultural setting, but are nevertheless in violation both of the CRC and of Ghanaian laws protecting child rights.

According to the 2006 MICS, about a quarter (25.9 per cent) of women aged 15–49 were married before the age of 18, and 4.4 per cent of women in the same age group had been married before the age of 15.²⁷³ Child betrothal is most frequently found among a number of ethnic groups in the three northern regions, as well as among some groups in the Volta and Greater Accra regions.

268 Study by Adomako Ampofo, et al., 2004, cited in MoWAC/UNICEF, *Children in Ghana*, pp. 119–120.

269 U.S. Department of State, *Trafficking in Persons Report – 2006*, Washington, DC, June 2006, and U.S. Embassy – Accra, Ghana: *Update on Worst Forms of Child Labor*, December 2006.

270 Ibid., U.S. Department of State.

271 U.S. Department of State, *Country Reports – 2006: Ghana*. See also CRRECENT/PlanGhana, *Child Rights Situational Analysis*, 2010, p. 51.

272 MoWAC and UNICEF, *Children in Ghana*, pp. 132–133.

273 ODI and UNICEF, *Social Protection and Children: Opportunities and Challenges in Ghana*, p. 38.

Child betrothal and early marriage rob girls of their childhoods and invariably have negative effects on their physical, educational, and social well-being. Early sexual activity exposes child brides to possible physical harm and to such health risks as premature pregnancy or abortion, obstetric fistula, and sexually transmitted infections, including HIV. Accordingly, girls under 15 are five times more likely to die in childbirth than women in their twenties. Apart from the physical damage, the most lasting harm of early marriage is to deprive a girl of her education. In some regions, parents planning for their daughter to marry early will keep her out of school. Some girls from these regions leave home on their own to escape an early marriage and join the ranks of street children in Ghana.

The Children's Act of 1998, in its Section 14, specifies that "no person shall force a child to be betrothed, or to be the subject of a dowry transaction, or to be married," and it provides for penalties of fines or imprisonment. Ghanaian law establishes 18 years as the minimum legal age for marriage for both girls and boys, but much sensitization remains to be done on this issue to alter traditions, customs, and behaviour that have accepted this practice for centuries.²⁷⁴

While it is not as common in Ghana as in some other African countries, female genital mutilation (FGM) is practised among some ethnic groups in northern Ghana. About 9 to 15 per cent of Ghana's population belong to groups who practise FGM, mostly concentrated in the Northern, Upper East, and Upper West regions (but also found in parts of Brong Ahafo region and among migrants from the north who have relocated to southern Ghana).²⁷⁵ FGM is outlawed under both the 1992 Constitution and by amendment of the Criminal Offences Act of 2007; legislation calls for sentences of three years for those found committing the practice. Some traditional leaders have banned the practice; and in recent years a growing number of FGM practitioners in the Upper East and Upper West regions have been jailed, and some communities have abandoned the practice.²⁷⁶

F. CHILDREN IN CONFLICT WITH THE LAW

The Juvenile Justice Act (Act 653) adopted in 2003 and covering persons under 18 years who come into conflict with the law, was premised on international standards and good practices and seeks to apply the principle of the best interests of the child.²⁷⁷ The law empowers the Chief Justice to designate a district court as a juvenile court, with powers to hear and determine civil or criminal cases involving persons under the age of 18 years.²⁷⁸

Juveniles convicted under the law are remanded to detention centres – including those for children between 13 and 15 years of age – which are supposed to provide vocational training. However, many juvenile detention centres are lacking in such facilities, thus depriving children of access to education, skills training, and other psychosocial services essential to their development.²⁷⁹ There are also insufficient juvenile courts – some districts have no such courts at all – and the ones that do exist do not convene often enough to address the case load adequately, meaning that juveniles spend excessive time in police detention awaiting trial.²⁸⁰

274 MoWAC and UNICEF, *Children in Ghana*, pp. 116–117.

275 CRRECENT/PlanGhana, *Child Rights Situational Analysis*, p. 51.

276 Ibid.

277 MoWAC and UNICEF, *Children in Ghana*, pp. 133–134.

278 Ibid.

279 UNCT, *Ghana Country Analysis*, p. 8.

280 MoWAC and UNICEF, *Children in Ghana*, p. 136.

An analysis of children in one juvenile detention centre in Accra found that of the 153 children there (males and females), nearly half were either orphans or had been abandoned; of the 83 whose parents were alive, 65 came from broken homes. The vast majority came from families living at or below the poverty level, and only 11 (7 per cent) had parents who had completed either secondary or tertiary education.²⁸¹

G. BIRTH REGISTRATION

The Convention on the Rights of the Child specifies that every child has the right to a name and a nationality and the right to protection from being deprived of her/his identity. Birth registration is the fundamental means of securing those rights. In 2000 only 31 per cent of children born in Ghana were registered by their first birthday. After a campaign by the government and development partners, the rate rose to 63 per cent in 2007, with the urban registration rate (72 per cent) greatly outpacing the rural rate (48 per cent). By 2009, however, the registration rate for children under 12 months nationally had fallen back to 61.4 per cent,²⁸² but rebounded to 65 per cent in 2010.

Lack of parental awareness is the apparent primary cause of the low birth registration rate, as well as a lack of need for registration, since birth registration is not linked to the provision of basic services such as health and education. In surveys, parents also indicated that they did not know where to go to register their children's births. The cost of registration was another reason given.²⁸³ Thus it is not surprising that children in poorer families are less likely to be registered than those in richer families. According to the 2008 GDHS, about 60 per cent of children under five years in the poorest quintile had their births registered, compared to 88 per cent of children in the wealthiest quintile. Additionally, children in the wealthiest quintile were twice as likely to have a birth certificate compared to children in the poorest quintile.²⁸⁴



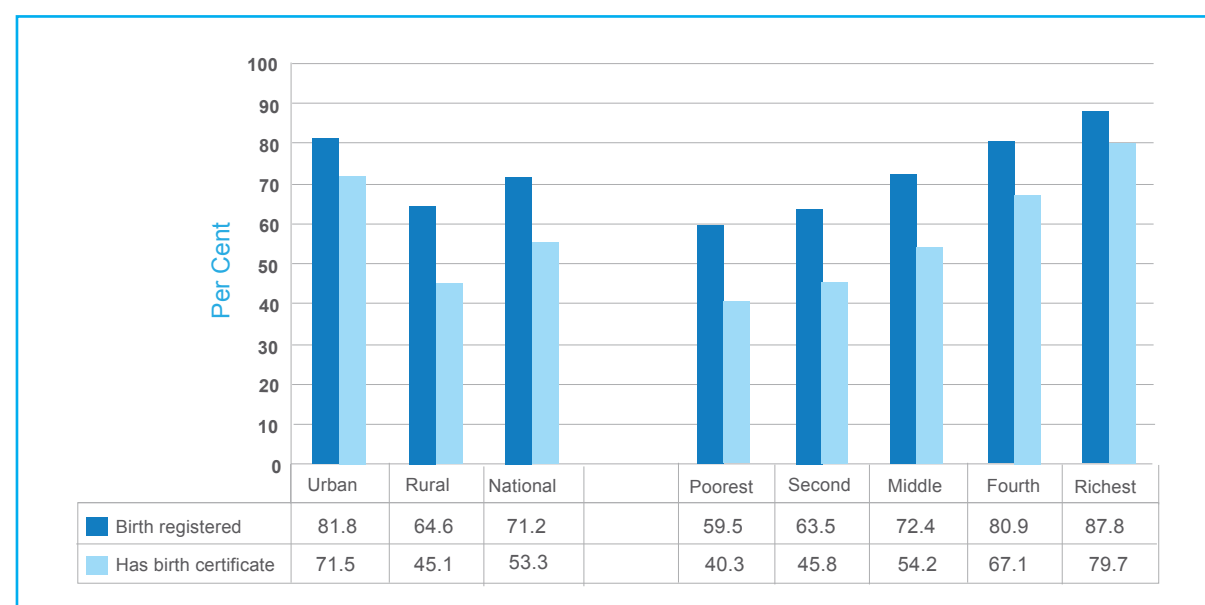
281 Ibid.

282 CRRECENT/PlanGhana, *Child Rights Situational Analysis*. See also ODI/UNICEF, *Study on Social Protection*, p.

283 Ibid., CRRECENT/PlanGhana, p. 49.

284 GDHS 2008, cited in UNICEF, *The State of the World's Children 2011*, UNICEF, New York, February 2011, p. 135.

Figure 31: Birth registration for children under-5 years, 2008



Source: GDHS 2008.

H. CORPORAL PUNISHMENT

Corporal punishment is an all too common phenomenon in Ghanaian households and schools. Ghanaian law does permit corporal punishment, “*provided it is justifiable, reasonable in kind or in degree according to the age, physical and mental condition of the child.*”²⁸⁵ The Ministry of Education’s code of conduct for teachers also permits caning, further blurring the human rights dimension of violence against children in Ghana.

A corporal punishment evaluation²⁸⁶ conducted in primary and junior high schools revealed contradictory results: about half of all students interviewed advocated for the ban of corporal punishment while the other half opposed the ban. During focus group interviews, the dominant view expressed by the pupils was that corporal punishment had value and that it should therefore not be abolished – an opinion consistent with the position of teachers, head teachers, parents, and Ghana Education Service officials.²⁸⁷

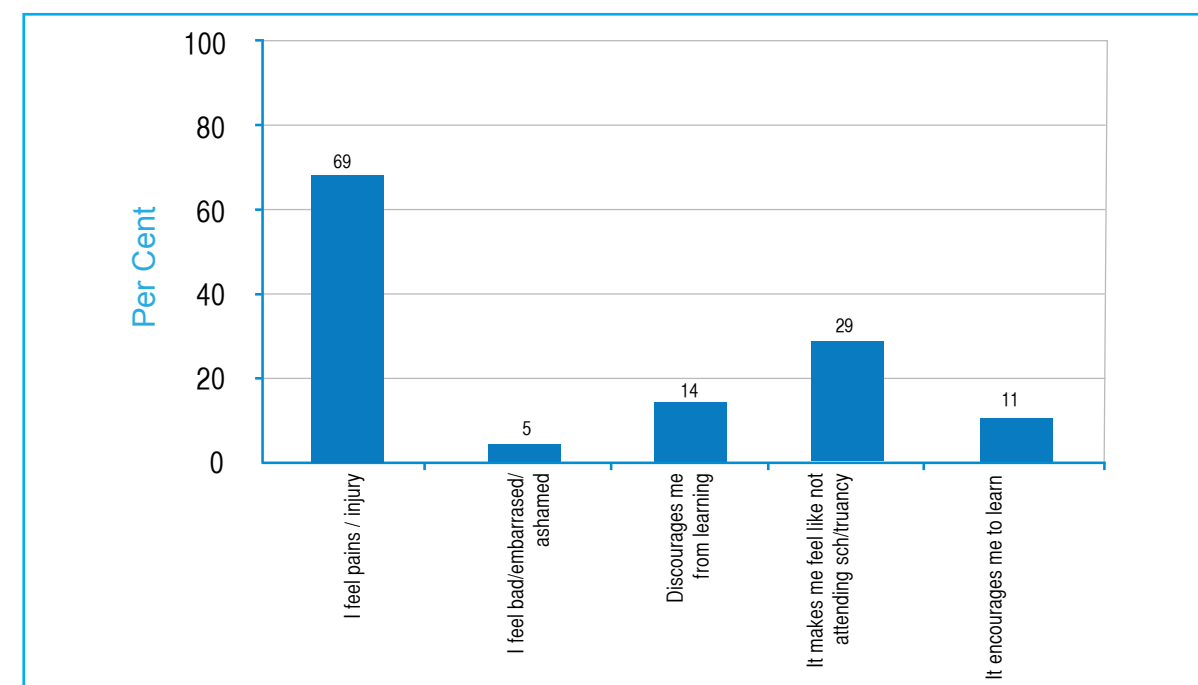
In respect to the effects of corporal punishment, the findings showed that nearly 70 per cent of pupils interviewed claimed corporal punishment inflicted pain and sometimes injuries on them. Thirty per cent claimed that it made them feel like dropping out of school. Some students indicated that corporal punishment discouraged them from learning, while others said it made them embarrassed and ashamed of themselves. Only a few reported that it encouraged them to learn (11 per cent).

285 MpWAC and UNICEF, Children in Ghana, p. 134.

286 UNICEF/GES/NCRIBE, The State of Corporal Punishment in Ghanaian Basic Schools: Towards Abolition, March, 2011.

287 Ibid.

Figure 32: Effects of corporal punishment on pupils, 2011



Source: UNICEF/GES/NCRIBE, Corporal Punishment Evaluation, 2011.

As the above reactions from children indicate, there is clearly some confusion in Ghana regarding the respective roles of rights holders and duty bearers as far as corporal punishment and other child-abuse issues are concerned. A large proportion of children from 6 to 17 clearly see occasions when physical punishment is warranted; and in the context of school, most children believe that caning or other punishment by teachers is a suitable means of correction. Similarly, there is evidence to suggest that adults, particularly parents, believe that physical punishment of children is a critical component of child-rearing. In focus group discussions reported in the local media, parents and children alike said physical punishment was a necessary means of correction (“*A child who insults an adult needs to be beaten,*” said one parent), and many cited religious teachings, quoting verses from the Bible, as justifying it.²⁸⁸

The findings from the evaluation conclude that stake holders in education are not ready for the ban of corporal punishment in schools, and recommends the sensitization of all stake holders on the negative impact that corporal punishment has in schools.²⁸⁹

I. POLICES AND RESOURCES FOR CHILD PROTECTION

Ghana has made significant progress in establishing an enabling national legislative and policy environment for the protection of children, in line with the CRC and other international human rights standards. Ghana is party to the following frameworks covering the protection of children from violence, abuse, and neglect:

288 “Scope of physical punishment of Ghanaian children,” Daily Graphic, Accra, 28 October 2010.

289 Ibid.

International conventions:

- UN Convention on the Rights of the Child (but it has not yet ratified the CRC's two Optional Protocols, on the sale of children, child prostitution, and child pornography; and on the involvement of children in armed conflict)
- ILO Conventions 182 on the Worst Forms of Child Labour and 138 on the Minimum Age for Employment
- African Charter on the Rights and Welfare of the Child

Domestic law:

- Constitution of 1992 (specifically, Article 28, on the rights of children)
- Children's Act (Act 560) of 1998 and its legislative instrument
- Juvenile Justice Act (Act 653) of 2003
- Human Trafficking Act (Act 694) of 2005
- Persons with Disability Act (Act 715), 2006
- Domestic Violence Act (Act 732), 2007
- National Health Insurance Act (Act 484), 2003
- Registration of Births and Deaths Act (Act 301), 1965

Many of Ghana's laws have incorporated key principles of the CRC. While the 1998 Children's Act regulates such matters as child maintenance, adoption, and child labour, the 2003 Juvenile Justice Act sets out the procedures to be followed when a person under 18 is arrested and/or imprisoned. The principle underpinning the law is that *"the best interest of the child shall be the paramount consideration by any court, person, institution, or other body in any matter concerned with a child."* In most matters, the laws guarantee the rights of children as specified in the CRC. They also set the age of criminal responsibility at 12, which is seen as a great improvement over the previously set age of seven, but still low by international standards.²⁹⁰

In addition, National Action Plans for Orphans and Vulnerable Children and for the Elimination of the Worst Forms of Child Labour have been developed; also, as noted above, Children's Panels have been established in all 10 regions (but not yet in all districts, as mandated) for discussing child protection-related issues.²⁹¹ Child Rights Regulations adopted in 2002 provide further interpretation and procedures to support the Children's Act.²⁹² A Commission on Human Rights and Administrative Justice, established in 1993, provides support for vulnerable children and women in the specific Ghanaian cultural context – for example, ensuring that children receive medical attention despite opposition based on religious or cultural beliefs, and undertaking public education on FGM.²⁹³

A multitude of ministries, departments, and agencies are mandated or involved in various aspects of child protection in Ghana. At the top, these include:

- Department of Children of the Ministry of Women and Children's Affairs
- Department of Social Welfare and the Child Labour Unit in the Ministry of Employment and Social Welfare
- Domestic Violence and Victim Support Unit, a unit of the Ghana Police Service
- Anti-Human Trafficking Unit of the Ghana Police²⁹⁴

²⁹⁰ Ibid.

²⁹¹ MoWAC and UNICEF, *Children in Ghana*, pp. 133–134.

²⁹² ODI and UNICEF, *Study on Social Protection*, p. 52.

²⁹³ MESW and UNICEF, *National Plan of Action for Orphans and Vulnerable Children*, Ghana, p. 21.

²⁹⁴ MoWAC and UNICEF, *Children in Ghana*, p. xxi.

In addition to national structures, regional child protection networks have been established in the three northern regions and the Western region.

Data on child protection issues are becoming increasingly available. There is still, however, a dearth of reliable information on child trafficking and commercial sexual exploitation, on HIV/AIDS orphans (and on street children generally), and on the prevalence of harmful sociocultural practices.²⁹⁵ Coordination and referral mechanisms are important parts of a child protection system, and these are still not functioning as well as they could be. The Multisectoral Committee on Child Protection, set up in 2001 and formerly chaired by the Chief Justice of Ghana, is no longer functioning, leaving a gap in the coordination of child protection services and response. In the absence of a single coordination mechanism for protection, referrals are based on ad hoc initiatives.²⁹⁶

Resources for child protection

In 2011, the Ministry of Employment and Social Welfare was allocated GH¢34.9 million (\$23.26 million) for the implementation of its programmes, including Child Labour, LEAP, and Disability programme. This figure represents a 6.37 per cent increase in the allocation for 2010 and a 6.09 per cent increase over 2009.²⁹⁷ The Department of Social Welfare (DSW) was allocated more than GH¢1,000,000 for salaries in 2011 but only around GH¢70,000 (\$47,000) to operate all social welfare services, including orphanages, assistance for the disabled, and more in the entire country. Such inadequate sums for service delivery result in DSW staff spending their own money to care for deprived children. They also eliminate any incentive for proper budgeting because DSW staff see no hope that accurate and comprehensive budget requests will be rewarded with higher allocations.

Such hot topics as child labour and cocoa generate higher allocations from development partners but, in part because of these high external contributions, domestic allocations remain low.



²⁹⁵ Ibid.

²⁹⁶ Information from Child Protection Section, UNICEF Ghana, December 2010.

²⁹⁷ ISODEC and UNICEF Ghana, *2011 Budget and Issues Relating to Women and Children Welfare*.

PART SIX: CONCLUSIONS



“ Ghana is likely to meet some of the MDGs, due to the right investment choices, policies and priorities ”





Conclusions

GHANA'S impressive achievements in economic growth and democratic governance now present it with very real challenges and a unique opportunity as to how to use those gains to improve the lives of Ghanaian children and women. The challenge is to fulfil the promise spelled out in the government's newest development plan to deploy its resources in an equitable and pro-poor manner, meeting the needs of the most deprived and marginalized communities. The opportunity is to be among the first developing countries to prove that, by channelling resources first to those areas and groups whose needs are greatest, the benefits of equity and empowerment will spread in such a way that the country's growth and equitable development will be felt by the population as a whole, with children and women as the primary beneficiaries.

Among the key findings of this analysis:

- Ghana is likely to achieve MDG targets for poverty reduction, primary school enrolment, retention, and gender parity; and access to improved water sources. But it is off track on under-five and maternal mortality, skilled birth attendance, and sanitation.
- Nearly half the population still lives below the poverty line. Poverty – resulting not from a lack of available resources but from a lack of formal employment opportunities, from economic stagnation, from poor land use, and from marginalization – is the basis of all the challenges to child survival, development, protection, and participation now confronting Ghana.
- Ghana's prospective flow of oil resources, its sustained rate of GDP growth, and its accession to middle-income country status all highlight the need to bring benefits and services to communities that historically have been marginalized, deprived, and under-served. These disparities are based mainly on the “three Gs”: geography, gender, and (socio-economic) group.
- Children and women are those hit hardest by poverty, and by inequities or inefficiencies in the distribution of resources (notably for schools and health centres).
- The lack of opportunity and family resources leads many children (girls and boys alike) to migrate; to seek work in farming, mining, and street trades; and exposes them to hazards related to child labour, migration, the commercial sex trade, and other abuses.
- Families scratching out subsistence livelihoods are exposed to the debilitating impact of “seasonal hunger” and the caprices of climate change and natural disasters, such as flooding.

- Ghana has in place the legislative and policy framework for pro-poor and child-friendly policies and has enacted the strategies, at the national and sector level, to put them into practice. Major constraints – in human capacities and budgeting priorities, processes, and implementation mechanisms – remain, and need both attention and assistance from stakeholders and development partners.
- The Government of Ghana is strongly committed (in GPRS II and its successor strategy) to “eliminate the worst manifestations of poverty, social deprivation, and economic injustice.” Vigilance is required to translate this commitment into action through transparent linkages from the central government to the district level and, at the district level, among the District Assemblies, area councils, and communities.
- District-level governance requires specific attention in order to realize gains in fulfilling the rights of children and women, particularly in “deprived” areas. Numerous NGOs and other actors are already engaged in empowering women and vulnerable communities at the district level, and this is an area that can be greatly strengthened in keeping with an equity-focused approach. Children's issues – including child protection – must be given the same priority at the district level as nominally at the national level; at the moment, this is not happening.
- The government has adopted pro-poor policies aimed at achieving the MDGs and has put in place National Plans of Action (including “A Ghana Fit for Children”) in the five key focus areas. There is a profusion of actors on the stage – national ministries, departments, and agencies; non-governmental organizations; UN agencies; civil society organizations; community-based organizations; and faith-based organizations – that would benefit from sharpened coordination mechanisms.
- Despite the government's commitment to pro-poor policies, many services are inequitably distributed. Attention is required to ensure that both personnel and funds are distributed equitably. In many cases, this may require extra funding for the poorest regions or districts, or special efforts may need to be taken to reach the poorest families who live in better-off districts.
- In addition to capacity gaps in administrative linkages and human resources, particularly at the district level, there are numerous gaps in data gathering (and disaggregation) and monitoring and evaluation processes needed to rationalize and strengthen programming priorities and practices.



Annex 1: International treaties

Ratification of international human rights treaties and conventions by Ghana

International Bill of Human Rights	Signature	Ratification	Accession	Succession
International Covenant on Economic, Social, and Cultural Rights	7 Sept 2000	7 Sept 2000		
International Covenant on Civil and Political Rights (ICCPR)	7 Sept 2000	7 Sept 2000		
Optional Protocol to the ICCPR	7 Sept 2000	7 Sept 2000		
Second Optional Protocol to the ICCPR Aiming at Abolition of Death Penalty	7 Sept 2000	7 Sept 2000		
Prevention of discrimination on the basis of race, religion, or belief, and protection of minorities				
International Convention on the Elimination of all Forms of Discrimination	8 Sept 1966	8 Sept 1966		
United Nations Convention on Persons with Disabilities (PWD)	3 Dec 2010	3 Dec 2010		
Women's human rights				
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	17 Jul 1980	2 Jan 1986		
Optional Protocol to the CEDAW	24 Feb 000	2009*		
United Nations Convention against Transnational Organized Crime	Not signed			
Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Children and Women		2009*		
Slavery and slavery-like practices				
Protocol Against the Smuggling of Migrants by Land, Sea, and Air		2009*		
Convention for the Suppression of Traffic in Persons, and of the Exploitation of Prostitution by Others	24 Sept 2003			
Protection from torture, ill treatment, and disappearance				
Convention against Torture and Other Cruel, Inhuman, and Degrading Treatment or Punishment	7 Sept 2000	7 Sept 2000		

Rights of the child				
Convention on the Rights of the Child (CRC)	29 Jan 1990	5 Feb 1990		
Optional Protocol to the CRC on the Involvement of Children in Armed Conflict	24 Sept 2003			
Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour	Not signed	13 Jun 2000		
Freedom of association				
Convention on Freedom of Association and the Right to Organize		2 Jun 1965		
Convention on the Right to Organize and Collective Bargaining		2 Jul 1959		
Employment and forced labour				
Employment Policy Convention	Not signed			
Convention Concerning Occupational Safety, Health, and the Working Environment	Not signed			
Convention on the Protection of all Migrant Workers and Their Families	7 Sept 2000	7 Sept 2000		
Education				
Convention Against Discrimination in Education	Not signed			
African regional conventions				
African Charter on Human and People's Rights (ACHPR)			24 Jan 1989	
Convention Governing the Specific Aspects of Refugees in Africa	10 Sept 1969	19 Jun 1975		
Protocol to the ACHPR on the Rights of Women in Africa	Not signed			
Protocol to the ACHPR on the Establishment of an African Court on Human and People's Rights	9 Jun 1998			
African Charter on the Rights and Welfare of the Child	Aug 1997			

Source: Adopted from www.umn.edu/humanrts/research/ratification-ghana.html

Notes: *Ghana ratified these three protocols in 2009, according to the Ghana Government Budget Statement and Economic Policy of 2010.

Annex 2: Status of MDGs in Ghana

Status of the Millennium Development Goals (MDGs) in Ghana ¹						
Goals		Indicators	Baseline data	Most recent data	2015 MDG Target	Will goal be reached? Probably/Likely/Achieved
MDG 1 Eradicate extreme poverty and hunger						
MDG 1a	Halve, between 1990 and 2015, the proportion of people below the poverty line	Proportion below extreme poverty line %	36.5 (1991/92)	18.0 (2006)		Achieved
		Proportion below poverty line (%)	51.7 (1992)	28.5 (2006)		
MDG 1b	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Proportion of children who are malnourished (%)				Likely Unlikely Probably
		Underweight				
		Stunting	27.0 (1993)	14.0 (2008)	15.5	
		Wasting	26.0 (1993)	28.0 (2008)	15.0	
			11.0 (1993)	9.0 (2008)	3.8	
MDG 2 Achieve Universal primary education						
	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	Gross Enrolment rate (%)	75.7 (2002)	94.9 (2009/10)	100	Likely
		Net Primary Enrolment ratio (%)	55.9 (2002)	83.6 (2009/10)	100	Probably
		Primary completion rate (%)	85.5 (2007/08)	87.1 (2009/10)	100	Unlikely
MDG 3 Promote Gender equality and empower women						
MDG 3a	Eliminate gender disparity in primary secondary education, preferably by 2005, and in all levels of education by 2015	Ratio of females to males in primary schools (%)	0.92 (2002)	0.96 (2009/10)	1.0	Likely
		Ratio of females to males in junior secondary school (%)	0.85 (2002)	0.92 (2009/10)	1.0	Likely
		Ratio of females to males in senior secondary school (%)	0.73 (2005/06)	0.80 (2009/10)	1.0	Unlikely
MDG 4 Under-five Mortality						
	Reduce by two-thirds, between 1990 and 2015, the under-five mortality	Under-five mortality rate (per 1000 live births) ²	122 (1990)	80 (2008)	41	Probably
		Infant mortality rate (per 1000 live births) ³	77 (1990)	50 (2008)	22	
		Proportion of 1 year old children immunized against measles		90.2 (2008)	100	
		Immunization coverage (%)	55.0 (1993)	79.0 (2008)		
MDG 5 Maternal Mortality						
	Reduce maternal mortality ration by three-quarters by 2015	Maternal mortality per 100,000 live births (survey) ⁴	740 (1990)	451 (2007)	185	Unlikely
		Births attended by skilled health personnel (%)	43.8 (1993)	55.0 (2007)	100	

1 Some of the MDG indicators are not currently included in the Ghana report, and the targets in some cases are those defined during the GPRSI, II and GSSDA processes.
2 Calculations by the Inter-agency Group for Child Mortality calculations reveal that Ghana's Under-5 mortality is 74 deaths per 1,000 live births in 2010.
3 Calculations by the Inter-agency Group for Child Mortality calculations reveal that Ghana's Infant mortality rate is 50 deaths per 1,000 live births in 2010.
4 Calculations by the Inter-agency Group for Maternal Mortality calculations reveal that Ghana's MMR is 350 deaths per 100,000 live births in 2009.

MDG 6 Combat HIV/AIDS and Malaria						
MDG 6a	Halt and reverse the spread of HIV/AIDS by 2015	National HIV prevalence rate (%)	1.5 (1999)	1.5 (2010)	<1.5%	Likely
MDG 6b	Halt and reverse the incidence of malaria	Under Five Malaria case fatality (institutional) (%)	2.9 (2002)	2.1 (2006)	-	Probably
MDG 7 Ensure Environmental Sustainability						
MDG 7a	Integrate the principles of sustainable development into the country policies and programmes and reverse the loss of environmental resources	Proportion of land area covered by forest (ha/annum)	6,229,400 (27.4% of total land area) (1999)	5,517,000 (24.3% of land areal) (2005)	>7,448,000	Unlikely
		Annual rate of deforestation (%)	1.82 (1999)	1.7 (2005)	<1.82	Unlikely
MDG 7b	Half the proportion of people without access to safe drinking water	Proportion of population without access to safe drinking water (%)	56.0 (1990)	83.8 (2008)	78.0	Achieved
		Urban	86.0 (1990)	93.8 (2008)	93.0	
		Rural	39.0 (1990)	78.0 (2008)	69.5	
		Proportion of population without access to improved sanitation (%)	6.0 (1993)	13.0 (2008)	54.0	Unlikely
		Urban	10.0 (1993)	16.0 (2008)	55.0	
		Rural	1.0 (1993)	7.0 (2008)	50.5	
		Population without access to secure housing (%)	11.0 (2005)	12.5 (2008)	18.5 (2020)	Unlikely
Population living in slums	27.2 (1990)	19.6 (2008)	<13	Unlikely		
MDG 8 Global Partnership for development						
	Deal comprehensively with debt and make debt sustainable in the long term	Public Debt Ratio (% of GDP)				Likely
		External	152.8 (2000)	27.7 (2008)	-	
		Domestic	20.0 (2000)	27.5 (2008)	-	
		Total	181.65 (2000)	55.2 (2008)	-	
		External Debt service as a percentage of exports of goods and services (%)	7.8 (1990)	4.3 (2008)	-	
		ODA Inflows (% of GDP)				
	Total	6.0 (1999)	8.6 (2008)	-		
	Programme Aid	30.0 (1999)	37.0 (2008)	-		

Sources: 2008 Ghana Millennium Development Goals Report, April 2010, Ghana Demographic Health Survey (GDHS), 2005/06 Ghana Living standard Survey 5(GLSS), 2007 Ghana Maternal Health Survey (GMHS), Ministry of Education (MoE-EMIS – various years), UNAIDS (various years), World Bank (WB), UNICEF/WHO/WB/UNDESA, Levels & Trends in Child Mortality, September 2011.

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