2009

The State of Human Rights in Ghana
ACKNOWLEDGEMENT

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ABBREVIATIONS AND ACRONYMS

ACHPRA - African Charter on Human People’s Rights Article

ACHPR- African Charter on Human and People’s Rights

AMA – Accra Metropolitan Assembly

AME ZION- African Methodist Episcopal Zion

CEDAW- UN Convention on the Elimination of all forms of Discrimination against Women

CFIS- Country Food Initiative Security

CHPS- Community Health Planning Service

CHRAJ- Commission on Human Rights and Administrative Justice

CRC – Convention on the Rights of the Child

CSO- Civil Society Organization

DA-District Assembly

DANIDA-Danish International Development Agency

DOVVSU- Domestic Violence and Victims Support Unit

DV- Domestic Violence

ESC Rights – Economic Social and Cultural Rights

FCUBE- Free Compulsory Universal Basic Education

FGM – Female Genital Mutilation

FGM/C - Female Genital Mutilation/Cutting

FIDA-International Federation of Women Lawyers

GES- Ghana Education Service

GETFUND-Ghana Education Trust Fund

HIV/AIDS – Human Immune Virus /Acquired Immune Deficiency Syndrome

ICCPR- International Covenant on Civil and Political Rights
ICESCR - International Convention on Economic Social and Cultural Rights
JHS - Junior High School
KG - Kindergarten
KVIP - Kumasi Ventilated Improved Pit
MA - Municipal Assembly
MCEs - Municipal Chief Executives
MCDs - Municipal Chief Directorates
MDGs - Millennium Development Goals
MHO - Mutual Health Organization
MICS - Multiple Cluster Indicator Surveys
MOFA - Ministry of Food and Agriculture
MOU - Memoranda of Understanding
MOWAC - Ministry of Women and Children
NCCE - National Commission on Civic Education
NDC - National Democratic Congress
NGO - Non-Governmental Organization
NHIS - National Health Insurance Scheme
PWD - Persons with Disabilities
SDA - Seventh Day Adventist
SPIP - School Performance Improvement Plan
STD's - Sexually Transmitted Diseases
TLMs - Teaching and Learning Materials
TMA - Tema Metropolitan Assembly
UDHR - Universal Declaration on Human Rights
UNICEF - United Nations International Children Emergency Fund
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EXECUTIVE SUMMARY

Introduction

The Commission on Human Rights and Administrative Justice (CHRAJ) has a constitutional mandate to promote, protect and enforce fundamental human rights and freedoms and administrative justice for all persons in Ghana. Over the years, it has been monitoring and assessing the general human rights situation in the country.

Objectives

The general objective of the 2009 nationwide monitoring exercise is to unearth the state of human rights, assess progress made so far, and identify existing gaps.

Methodology

The exercise used in-depth interviews and focus group discussions to gather information from participants including opinion leaders, community members, officials of government institutions, NGOs and CSOs.

Scope

In all, 295 public schools, 87 health institutions, 81 prayer camps, 3 witch camps and 6 slum communities were monitored. In addition, an average of 200 communities was monitored.

The monitoring covered the right to education, right to health, child rights, women’s rights, harmful cultural practices, extremely deprived communities (slums), suspected witch camps and prayer camps.

The Right to Education

The enjoyment of the right to education continues to have some setbacks.

The Free Compulsory Universal Basic Education (FCUBE) policy which mandates all children of school going age to be in school is not being fulfilled completely as some pupils continue to absent themselves from school to work. Most parents are also reluctant to contribute towards their children’s education because of the misconception that education is totally free with reference to the FCUBE.

The School Feeding Programme which began in 2002 is still limited to some selected schools across the country. Although the programme has improved enrolment and retention rates at beneficiary schools, funds for the project is inadequate and not disbursed on time.

The Capitation Grant is inadequate and also not released on time though government has increase it from GH¢ 3.00 to GH¢4.50 per child. Some schools as a result charge levies not approved by the Ghana Education Service increasing financial burden on parents.

A number of schools monitored did not have adequate teaching and learning materials as well as infrastructure such as classrooms, desk and toilets.
Sixty percent of schools monitored had structures not easily accessible to Persons with Disabilities (PWDs) and some school authorities remain ignorant of the right of PWDs in the schools. Again, PWDs in the schools do not benefit from the 2% of the district assemblies common fund meant for PWDs.

In 67.2% of the schools interviewed, corporal punishment persists with students sustaining injuries. The exercise also revealed cases of bullying in schools with pupils generally not aware of policy on bullying.

Right to Health
Health facilities and personnel continue to be inadequate in the country. The doctor-to-patient ratio and the nurse to patient ratio in 2008 were 1: 29606 and 1: 2859 respectively. Access to health centres is still a challenge for a number of communities due to distance of the nearest health facility and poor roads. Most of the health institutions are without specialized resources or services for persons living with disability.

Programmes and activities towards the promotion of sexual and reproductive health rights in most of the health institutions have improved. Maternal deaths have decreased on the average, from 5.2 per institution in 2008 to 2.2 in 2009 as a result of public health education and availability of pre-natal and post-natal care in most communities.

Infant deaths on the contrary have increased from 22.0 in 2007 to 25.6 by mid-2009. Ignorance, poor nutrition, delay and irregular pre and post natal care continue to be the major cause of the phenomenon.

Knowledge about the National Health Insurance Scheme has increased with more Ghanaians registering under the scheme. The major challenges currently confronting the scheme is that drugs and treatments covered under the scheme are limited; the card cannot be used to access the scheme nationwide, discrimination in drug prescription, high premium payment and complexities in registering under the scheme.

The Patient’s Charter is highly unknown among Ghanaians and awareness creation on the subject matter has been very minimal with the use of posters, fliers, etc at the various health centres.

Rights of Persons Living With HIV/AIDS
Stigmatization and discrimination against PLWHAs is still prevalent in our communities. Anti-retroviral drugs are also highly inadequate and unaffordable to some PLWHA.

Child Rights
Between 2006 and 2008, a total of 4,601 defilement cases were reported to government institutions located in 106 communities. Despite the high number of defilement cases recorded, community sensitization on defilement was low.
One hundred and sixty six (166) representing 84.7% of communities monitored had some form of recreational facilities but were still faced with the challenges of inadequate funds and personnel to handle sports.

Trafficking of children was recorded in all ten (10) regions of Ghana. Most of these trafficked children are found in the agricultural sector. The report revealed that major reasons children are trafficked include poverty, parental neglect and ignorance of the law.

80% of government institution’s anti-disability discrimination campaigns are funded by the government with 96% having positive results. However, 36% of PWD interviewed claimed they suffered various forms of discrimination which were perpetrated either by individuals or the State.

Children between ages 11-15years are still employed in various sectors of work such as farming, mining, prostitution and trade. Most of these children who have been working for an average of one to five years did so under very deplorable conditions.

The on-going campaigns funded by government, NGOs and CSOs have recorded positive results with more people being sensitized on child maintenance. As a result, there was a recorded decrease in cases of child neglect.

**Women’s Rights**

Despite the promotion of women’s rights as human rights, women continue to have unequal access to education; to be forced into marriage; denied reproductive health and sexual rights.

Domestic Violence against women still prevails in the various communities monitored. About 74% of the women interviewed have ever suffered some form of violence. They would however not report abuses due to cultural practices inherent in their communities, and also the desire to keep such matters private.

Reproductive health clinic with essential equipment are becoming more accessible to women throughout the country. Some women have also benefited from the free reproductive health services instituted by the government.

The Wills Act is quite known in the communities monitored. Only 8% of respondents from the communities monitored have actually made a will due to the fear of dying and the notion wills are made by the rich.

**Harmful Cultural Practices**

Widowhood rites are widely practiced in the country with some having negative health implications on the victims due to certain rituals performed during the rites. Some government institutions continue to undertake public education programmes to prevent such practices.

Tribal marks are made on the faces of children to serve as visible marks to identify tribesmen. Though it tends to strengthen the cohesion among members in the same tribe, it
also aids disunity in the nation, and makes a victim easily identifiable and a target for the opponents during strife.

Female Genital Mutilation (FGM) is done as part of puberty rites, with the aim to reduce promiscuity. The monitoring exercise revealed that the practice has reduced significantly. The last FGM report was recorded at the DOVVSU office in the Lawra district of the Upper West region in 2007.

Victims of FGM between 10 and 21 years interviewed indicated that though the practice was very painful, they could not resist.

Trokosi abolishing campaigns are still being conducted by NGOs. However, the effectiveness of their effort has not yielded much result because public awareness on Trokosi is still low.

**Extremely Deprived Communities (Slums)**
The communities were congested and not adequately protected against fire outbreak. Potable water, sanitation and sewage facilities although available, were found to be woefully inadequate. Health facilities were close to these communities and majority of community dwellers could pay for medical care with some registered under the National Health Insurance Scheme. Educational facilities were also available and sufficient.

**Suspected Witch Camps**
Memberships in the camps had increased slightly. Access to potable water was a problem and members had to resort to the use of rain water, rivers and streams. Toilet and bath facilities in all the settlement camps visited were poor. Basic education and adult literacy programmes are available and accessible in these camps.

**Prayer Camps**
Clients in prayer camps monitored indicated that no individual is subjected to any compulsory treatment in the camps. Camp operators suggested intensified human rights education programmes for operators of prayer camps to enhance their operations.
CHAPTER ONE

INTRODUCTION

The Commission on Human Rights and Administrative Justice since 2005 focused on educating and monitoring economic, social and cultural rights issues in Ghana. As part of the Commission’s mandate to promote and protect economic, social and cultural rights for all persons in Ghana, the 2009 state of human rights monitoring covered the following thematic areas:

- Right to Education
- Right to Health
- Child Rights
- Women’s Rights
- Harmful Cultural Practices
- Extremely Deprived Communities (Slums)
- Suspected Witch Camps
- Prayer camps

1.1 Objectives

The general objective of the 2009 nationwide monitoring exercise is to unearth the state of human rights; assess the progress made so far, as well as, identify human rights gaps.

The specific objectives are as follows:

1. To find out whether various rights are being fulfilled and to what extent.
2. Identify human rights abuses and the levels at which these violations are perpetuated on victims.
3. Ascertain the general challenges faced by implementers of human rights policies.
4. Verify if there has been any improvement in the services provided by monitored institutions over the years.

1.2 Methodology

In this year's monitoring exercise, several data collection techniques were employed in conducting the research. These include: qualitative and quantitative paradigm of data collection.
The exercise used an in-depth interview and focus group discussion to gather information from participants including, opinion leaders, community members, religious leaders, NGOs/CSOs as well as other groups and individuals to assess the situation at hand.

Data Collection Methods

Four methods were used by the monitoring officers in data collection. These are personal interviews, use of questionnaires, focus group discussions and observation.

Personal Interviews

Personal Interviews that were mainly informal were employed to elicit information from recognised targets. This provided vital insight and understanding during the monitoring exercise.

Questionnaires

Questionnaires and data tables covering the various thematic areas were administered by CHRAJ personnel.

Focus Group Discussions

A considerable number of Focus Group Discussions were held to solicit views from staffs of various institutions visited and community members in all the districts.

Observation

The officers adopted direct observation that provided them with valuable qualitative knowledge about the situation on the ground. Critical observations employed were to verify, or otherwise, data gathered during interviews or Focus Group Discussions. Direct interactions and transit walks were also conducted around the designated institutions for reinforcement.
CHAPTER TWO

RIGHT TO EDUCATION

2.1 INTRODUCTION

The right to education is recognized as a human right by the United Nations. This right is understood to establish an entitlement to free, compulsory primary education for all children, an obligation to develop secondary education accessible to all children, as well as equitable access to higher education, and a responsibility to provide basic education for individuals who have not completed primary education. In addition, the right to education encompasses the obligation to eliminate discrimination at all levels of the educational system and to improve quality. ¹

The purpose of this report is to find out whether the right to education is being fulfilled. It is also to inform the Commission to make commendations where due and propose appropriate recommendations.

For the year 2009, six themes were monitored namely,

- Education as a human right,
- Disbursement of Capitation Grant
- Corporal Punishment, Bullying and Harassment
- State of the School Feeding Programme
- Persons with Disabilities and the School Environment
- Availability and Affordability of Educational Facilities

In all, 295 public schools nation-wide were monitored. Table 1 shows the regional breakdown of the number of schools monitored.

Table 1: Regional Breakdown of the Number of Schools Monitored

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Public Schools Monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper East</td>
<td>18</td>
</tr>
<tr>
<td>Upper West</td>
<td>18</td>
</tr>
<tr>
<td>Northern</td>
<td>26</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>27</td>
</tr>
<tr>
<td>Ashanti</td>
<td>39</td>
</tr>
<tr>
<td>Western</td>
<td>54</td>
</tr>
</tbody>
</table>

¹ http://en.wikipedia.org/wiki/Right_to_education
<table>
<thead>
<tr>
<th>Region</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>21</td>
</tr>
<tr>
<td>Volta</td>
<td>31</td>
</tr>
<tr>
<td>Central</td>
<td>40</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>295</td>
</tr>
</tbody>
</table>

2.1.1 Education as A Human Right

This section attempts to find out the extent to which the right to education is being fulfilled as indicated by international and national instruments.

Article 28, 1(a) to (e) and 2 of the Convention of the Rights of the Child states:

1. States Parties recognize the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

   a. Make primary education compulsory, available and free to all;

   b. Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

   c. Make higher education accessible to all on the basis of capacity by every appropriate means;

   d. Make educational and vocational information and guidance available and accessible to all children;

   e. Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

Also, the 1992 Constitution of Ghana, Article 25(1) states: “All persons shall have the right to equal educational opportunities and facilities and with a view to achieving the full realization
of that right”. This also indicates that basic education must be free, compulsory and available to all.

On the question of what the government has done and is doing in;

(a) Making primary education compulsory, available and free for all, this study revealed that:

The government has enacted a policy that, all children of school going age must be in school and abolished all forms of fees at the basic level. More so, the Capitation Grant and the School Feeding Programme have ensured that more children are in school.

Government is also making preparations to provide uniforms to children in deprived communities. Clothes for the uniforms are being printed after which the dress makers would start sewing²

Even though, there is a policy that all children of school going age are mandated to attend school; there were reports that pupils in some communities absent themselves from school either because they are working to cater for themselves or are engaged by their parents to run market errands.

Some schools were found to be charging levies not approved by the Ghana Education Service, increasing the financial burdens on parents and making education not really free.

More so, there are challenges associated with the disbursement of the Capitation Grant. These include:

- Inadequacy of the grant;
- Untimely release of grants;
- High bank charges, rates and other deductions; and
- Payment of grant in tranches.

The School Feeding Programme is also saddled with challenges, such as:

- Limited funds;
- Untimely release of funds; and
- Allowances for the caterers are paid from the grant.

(c) Making secondary education available and accessible to all, it was found that:

- Through the policy of community day school with hostel facilities and upgrading of a secondary school in each district; model schools have been established in almost all districts. Existing schools have also been expanded.

² Daily Graphic, Friday, November 6, 2009, page 11
(d) Making guidance and counselling available and accessible to all children:

- There is a policy that all Senior High and Junior High Schools should have Guidance and Counselling coordinators. Some schools have already complied and have set up coordinators.

(e) Encouraging regular attendance at schools and the reduction in drop-out rates:

- Funds have been provided for girl-child co-ordination to encourage the girl child to stay in school.
- Introduction of Capitation Grant and School Feeding Programme has ensured that more children are in school.
- School registers are marked every day to monitor regular attendance.
- Free transportation is being offered by Metro Mass Transit to pupils.

(f) Ensuring that school discipline is administered in a manner consistent with the child's dignity:

- The Ghana Education Service (GES) has provided a blueprint on corporal punishment in schools and these are strictly adhered to by all heads. Currently, there is a stern warning for schools not to employ corporal punishment and if they do, strict laid down procedures ought to be followed, that is only heads of schools are allowed to administer punishment. They are to log it in a book stating thoroughly the reasons for his or her actions. Disciplinary committees have been also, set up in schools to handle indiscipline.

- The monitoring team however, found out that the GES policy on corporal punishment is not being followed. Pupils continue to be caned for not performing well in class and being late for school. Some get injured as a result.

The monitoring exercise in line with Article 28 of Convention on the Rights of the Child (CRC) also, sought to find out how education is directed at the development of the child’s:

**Personality:** Findings indicated that the nature of the GES curriculum is such that the personality is enhanced by teaching the pupil to be bold and develop the act of public speaking. At the kindergarten level, children are taken through plays and dance to prepare them for formal education. Teachers also monitor children to identify interest. At the primary level, teaching of literacy and innumeracy programmes help them identify their potentials.

**Talents:** The nature of the GES curriculum is such that the talents of the child is enhanced by the introduction of drama clubs and other forms of recreational activities aimed at unearthing talents.

Also, examinations are conducted periodically, taking into consideration various developments of the child’s mental ability. Subjects like mathematics, science, English etc which requires a lot of thinking builds the child’s mental abilities.
Physical abilities to its fullest potential: Physical education which is part of schools curriculum takes care of child’s physical abilities; some these programmes include interschool sporting activities.

Respect for human rights and fundamental freedoms: Human and civic rights clubs have been set up by the Commission on Human Rights and Administrative Justice (CHRAJ) and National Commission on Civic Education (NCCE) in most schools. Students are also taught human rights and freedoms through the learning of social studies. School authorities confirmed to the monitoring team that the school curriculum covers human rights and this includes the right to education.

Respect for parents: Children are taught culture and moral education including respect for the elderly.

2.1.2 Access to Information on the Right to Education in Schools

The monitoring exercise showed that majority (33.2%) of pupils interviewed got access to information on the right to education through their teachers, followed by radio / TV (23.5%). Teachers therefore need to be equipped with the necessary knowledge and skill to impart knowledge on the right to education.

Heads of schools in 65.4% of regions and districts monitored have benefited from seminars on the right to education organized by the Ministry of Education. These seminars and programmes were in three categories namely;
• Human rights being are integral part of other programmes; for instance human right modules, being part of training on new educational programmes and implementation of the free compulsory universal basic educational programme.
• Sponsored human rights educational programmes.
• Introductory course for newly trained and regular in-service training on topics such as right of the child and right to education.

Responses from school authorities (38.1%) confirmed that programmes on the right to education were held but were not regular. Majority of schools, with Brong Ahafo region being the most affected (76.2%), are yet to benefit from such training.

In all the schools monitored, even though 85.6% of pupils interviewed indicated that, they had been educated on the right to education which are part of human rights lessons in social studies. In spite of the education only 23.7% were very much informed on the issue.

School authorities numerated some of the challenges they face in accessing information on the right to education. These include:

• Limited learning and teaching materials on the subject matter.
• No specific reading materials on the right to education even though there are few on human rights issues in general.
• Lack of regular seminar for teachers.
• Unavailability of resource persons.

Apart from formal teachers, the monitoring exercise revealed that human rights clubs also contribute to the dissemination of human rights knowledge among school children despite the fact that only 33% of schools monitored had human rights clubs. On the average these clubs met once a month. Majority (34.8%) of the school authorities indicated that the performance and the activities of the clubs were generally good. Pupils (44.8%) of schools monitored did not fully grasp the concept of the right to education because such programmes are organized outside normal teaching hours and most pupils do not pay attention. Time allocated by the school authorities on seminars connected to human rights issues were inadequate which often affects enthusiasm.

Another significant collaborator to the dissemination of information on the right to education is stakeholder organizations. Quite a number of organizations actively collaborated with schools to educate the pupils on the right to education, some of which include CHRAJ and N.C.C.E. (see Table 2 for details)
<table>
<thead>
<tr>
<th>Organization</th>
<th>Type of Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission on Human rights and Administrative Justice (CHRAJ)</td>
<td>Public Education in the form of lectures quizzes and essay competitions.</td>
</tr>
<tr>
<td>National Commission for Civic Education (NCCE)</td>
<td>Public Education, sensitization</td>
</tr>
<tr>
<td>Ghana Education Service</td>
<td>Public Education</td>
</tr>
<tr>
<td>District Assemblies</td>
<td>Material support</td>
</tr>
<tr>
<td>Parent Teacher Associations (PTAs)</td>
<td>Material support, such as renovation of classrooms, provision of educational materials</td>
</tr>
<tr>
<td>World Vision International</td>
<td>Seminars, renovation of school building</td>
</tr>
<tr>
<td>Hanns Seidel foundation</td>
<td>Seminars</td>
</tr>
<tr>
<td>Ghana National Association of Teachers (GNAT)</td>
<td>Seminars</td>
</tr>
<tr>
<td>Three Town Youth Association</td>
<td>Provision of computers</td>
</tr>
<tr>
<td>Action Aid Ghana</td>
<td>Public Education</td>
</tr>
<tr>
<td>Danish International Development Agency (DANIDA)</td>
<td>Build school structures</td>
</tr>
<tr>
<td>Social Welfare</td>
<td>Public Education</td>
</tr>
</tbody>
</table>
Figure 1

Conclusion
The government has put in place various policies aimed at realising the right to education. However, the implementation of these policies has been weighed down by some challenges.

2.1.3 Disbursement of Capitation Grant
Article 38(2) of the Ghanaian constitution states: “the Government shall, within two years after Parliament first meets after the coming into force of this Constitution, draw up a programme for implementation within the following ten years, for the provision of free, compulsory and universal basic education”

In fulfilment of these provisions, the government of Ghana in 2005 introduced the Capitation Grant. Capitation Grant provides money to support education, teachers, provision of transport and school uniforms. Each pupil is entitled to an amount of GH¢3.00 annually. (The amount was increased to GH¢4.5 in 2009 as projected in the budget)

The introduction of the programme is also meant to achieve universal primary education where all children of both sexes will be able to complete a full course of primary education by 2015.

The Process of Disbursement
The monitoring exercise showed that the government continued its capitation grant programme, paying schools GH¢4.5 per child per school annually to cover sports, cultural and other school expenditure.

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3 The 1992 Constitution of Ghana

4 Ministry of Information and National Orientation publication (Copyright 2007)
Only 56% of schools monitored had their grant directly disbursed to their institution. The rest of the schools got their capitation grant through GES offices and majority (75.6%) received their grants by instalments.

According to schools monitored, the processes involved in accessing the grant are cumbersome:

First and foremost, information on the release of the grant is obtained from the locality’s education office. The school then prepares School Performance Improvement Plan (SPIP). In the SPIP, the various expenditure items showing how the grant is intended to be used are indicated. It is then sent to the locality’s education office and thoroughly scrutinized before the grant is released into school’s account. An advice form is then given to the school to enable it withdraw the money from the bank. It was also noted that accounting records of all previous transactions involving the use of capitation grant are audited by internal auditors from the local education office before a new grant is released.

In spite of all these processes to ensure fairness and transparency, 58.5% of schools indicated that the amount received was not the same as released by the Ministry of Finance. A fraction is deducted by the Ghana Education Service (GES) to assist sports and culture programmes. It was also revealed that some schools did not know the amount released by the Ministry of Finance.

A vast majority (93.9%) of school authorities said the grant was not adequate to sustain the running of the school. Activities such as buying sports equipment, teaching and learning materials, stationery, in-service training for new staff require much more money.

Set backs
A vast majority (93.9%) nation-wide did not receive their grants on time. This pattern runs through almost all the schools monitored across the country (Figure 2).
Figure 2

For instance, at the Whindo Methodist Primary School located at Assakae in the Western Region, the school’s capitation grant which should have been given in the first term of the 2008/2009 academic year was received in the third term of the same academic year. Droboso Methodist Primary located in the Brong Ahafo Region got grant for the following academic year. Also at the Kofi Nkrumakrom D/A Primary, located at Anyinasuso in the Brong Ahafo region, school authorities normally received their grant 3 to 6 months after the stipulated time. In the Volta region, the Philip Akpo Memorial R.C Model Junior High School normally receives their grants the following academic year.

Other challenges faced by the grant include:

- Inadequacy of the grant;
- High bank charges and other deductions;
- Payment of grant in tranches; and
- Parents’ reluctance to contribute towards the development of the child.

Conclusion

The capitation grant was disbursed through GES offices to various schools and in instalments. More so, amount received by schools was less than the amount released by the Ministry of Finance. On the other hand, some schools also did not know the amount released by the Ministry. Some amount of the grant is deducted by GES to fund sports and culture activities in the local area. Majority of schools, it was also noted did not receive their grants on time.
2.1.4 Corporal Punishment, Bullying and Harassment

Corporal Punishment and Human Rights
Corporal punishment is the intentional infliction of physical pain as a method of changing behaviour. It may include methods such as hitting, punching, kicking, pinching, shaking, use of various objects (paddles, belts, sticks, or others), or painful body postures. While some schools of thought believe that, corporal punishment helps to keep children away from wrong doings; this, over the years has not been proven. Most children get used to the kicking, slapping and other physical assault and do not bother about its outcome anymore.

Some of the negative effects of corporal punishments include:

- The pain it inflicts on children and injury it causes to some them which could take days and weeks to heal.
- The psychological trauma some children go through makes most of these children generally timid and scared.
- Children becoming hardened and used to this form of punishment. This may lead to some children engaging in more serious and dangerous social vices such as armed robbery.

Laws on Corporal Punishment
Section 13(1) of the Children’s Act, 1998(Act 560) states: “No person shall subject a child to torture or other cruel, inhuman or degrading treatment or punishment including any cultural practice which dehumanizes or is injurious to the physical & mental well-being of a child”.

In addition, the GES has provided a blue print on corporal punishment for schools and these are strictly adhered to by all heads. Currently, there is a stern warning for heads not to employ corporal punishment and if they should, then strict laid down procedures must to be followed. Only heads of schools are allowed to administer corporal punishment and they are expected to log it in a log book stating thoroughly reasons for his or her actions.

Corporal Punishment in Schools
The monitoring exercise showed that 67.2% of schools administer corporal punishment. In Ghanaian schools, it takes the form of caning/flogging, pinching and kneeling. In the Saint Andrews Practice Junior High school located in Ashanti Mampong for instance, students were caned when they did not perform well in the classroom. The prevalence of corporal punishment was high in the Brong Ahafo region; all schools interviewed administered corporal punishment.

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5 http://www.nospank.net/nasn.htm
Pupils confirmed that they have been victims of corporal punishment through canning, pinching and kneeling. Out of this number a few (13.6%) sustained injuries. The forms of injuries include:

- Bruises
- Cuts on body part such as hands, back and buttocks.
- Blisters and swellings

This research showed that 81.8% who sustained injury as a result of corporal punishment did not report the issue to the appropriate authorities.

**Penalties for Violators**

Majority (87.9%) of school authorities however, had laid down penalties for violators of the GES policy:

- “Violators are transferred from the school after consultation with the District Director of education”, says the headmaster of Ahenema Kokoen D/A junior High school located off the Obuasi road in Kumasi.
- First offenders are reprimanded, counselled or warned. They are then given query on repetition and when it persists GES is informed.
- Teachers who violate this policy are reported to circuit supervisors and advised. When it happens again, the district director is informed for the appropriate action to be taken against the said teacher.
But an interview with pupils indicated that the majority (54.6%) did not know whether their institution had a policy on corporal punishment or not; a case of lack of transparency.

**Complaint Procedures**

In most (73.4%) of schools monitored, it was realized that there are established complaint procedures for students to report violations of the policy;

- Report is ultimately made to the head of school either directly through head prefects, house fathers/mothers, senior house fathers and mothers, teachers, assistant heads, guidance or counselling coordinators.

Some pupils do not report because of;

- Fear
- ignorance or,
- feel deserve it

Only (17.4%) of authorities intervened when pupils who sustained injuries reported to them. Majority however, did not intervene for instance, at the Dabanyin DA Primary in Gomoa West in the Central region some of the pupils from class 4 to 6 indicated to the monitoring team that they will be insulted by the headmaster if they reported injury.

**Bullying and harassment**

Bullying on the other hand is to hurt or frighten people, often forcing them to do something they do not want to.  

A greater number (72.9%) of schools monitored had policies on bullying and harassment. Generally, the policy was that no bullying is allowed and culprits are given appropriate punishment such as weeding, scrubbing, suspensions or dismissal depending on the gravity of the offence. However, majority (54.6%) of students did not know whether or not their school had a policy on bullying and harassment. Statistics on the number of school children bullied showed that only a few pupils (24.2%) were bullied, most of them were males.

**Complaint Procedures**

A vast number (78.2%) also indicated that they have established complaint procedures for victims of bullying and harassment. Students normally report to their prefects, housemasters/mistress, senior housemaster/mistress, form masters through to the disciplinary committee or directly to the headmaster if issue is not resolved. Some do not have documented complaint procedure policies but are against the practice.

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6 [www.nasn.org](http://www.nasn.org)
Recorded Instances of Bullying
There were just few instances (21.7%) of bullying recorded in 2009. Kneeling on the ground with hands raised, kicking and hitting with hand or an object were prevalent types of bullying found in schools.

The Western region recorded the highest occurrence of bullying (40.9% of schools in the Western region).

Few pupils (13.6%) got injured after bullying. Of all who got injured, (81.8%) failed to report to the appropriate authority because, they did not know whether there existed a policy on bullying and harassment. Others did not report because they see it as part of school life. Only (24.2%) reported cases were intervened by the authorities; culprits were punished.

Recorded Instances of Harassment
Few schools (28%) reported that forms of harassment such as teasing/name calling, sexual harassment and fondling occurred.

Sexual harassment and fondling of females by male colleges was reported in these schools: Akatsi Duwodom Basic School and Tefle PCG Primary School in the Volta region.

Only (44.4%) victims reported to the appropriate authority. However, majority (64.9%) of cases were intervened by persons reported to.

The mission schools were found to be better off when it comes to discipline and the exercise of keeping to rules. E.g. School discipline was high in the E.P primary/ Nkwanta and Kodibenum EP Primary School, Kadjebi, all in the Volta region.

Conclusion
Pupils confirmed that they have been victims of corporal punishment through canning and kneeling. As a result, some suffered various forms of injuries such as bruises, blisters and swellings and did not report to the appropriate authorities because of fear or felt they deserve it.

There were few instances of bullying and harassment. Punitive actions should be put in place in order to nib these practices in the bud.

2.1.5 School Feeding Programme
In 2002, the government of Ghana introduced the Ghana Poverty Reduction Strategy as an overall policy framework in support of development activities. Education was identified as a means to reduce poverty.
One major barrier to education was the inability of many parents to provide their children with money for feeding at school. A school feeding program was then designed to provide meals for pre-school and primary school children.\textsuperscript{7}

The government of Ghana has been able to realize its dream for the promotion of free and compulsory education tantamount to Article 38 Clause 2 of the Constitution. This states that, “within two years after parliament first meets, a program shall be drawn for implementation within 10 years for the provision of free compulsory and universal basic education”\textsuperscript{8}

\textbf{Disbursement of funds}

The Commission’s monitoring showed that money for the school feeding programme is initially lodged into the school feeding account with the Bank of Ghana by the government. The districts have also got secretariat accounts where funds are lodged into. Vouchers are then prepared by the school feeding secretariat making reference to the number of school children. Monies are paid to the private caterers in charge of the schools.

Before amount is paid to caterers, their estimate is first and foremost approved by the MCEs and MCDs. To check corruption, proper accounting procedures are undertaken before monies are released to caterers. All payments are receipted and where there are no receipts, certificates of honour are provided to cover funds released or spent. Internal as well external auditors were always around the clock performing their tasks.

\textbf{Concerns of the School feeding Programme Secretariat}

The majority (91.2\%) of school feeding secretariats said they do not get the funds on time. They also pointed out that the amount is inadequate. Secretariats were of the view that between 0.70 and 2.80 Ghana cedis per day would be sufficient for each child.

The school feeding programme secretariat was of the view that the programme should be sustained but said:

\begin{itemize}
  \item Quality of food should be improved by increasing the funds.
  \item There should be quick delivery of funds to enable the bulk purpose of food stuff at a reduced price.
  \item Government should also provide caterers with cooking utensils so that the funds provided are not used to buy utensils.
  \item An agency like GETFUND should be established so that monies would be available and released early.
\end{itemize}

\textsuperscript{7} www.alliancetoendhunger.com
\textsuperscript{8} The 1992 Constitution, Article 38,Clause 2
Challenges faced by the School Feeding Secretariat
Challenges they faced include;

- Untimely release of funds
- Limited funds
- Inadequate classrooms to house pupils due to increase in enrolment
- Allowances for the caterers are taken from the funds allocated for the programme.

Continuity of the School Feeding Programme
The programme in some schools had not run continuously. At the AME Zion ‘A’ Primary School in Bekwai of the Ashanti region, the programme had been temporarily suspended since the new government came into power.

Food Preparation and the Environment
Approximately 60% of caterers indicated that they procure supplies for themselves from sources such as contractors and from the market. Only 33.9% thought that monies provided were adequate or very adequate.

One challenge facing caterers is the unavailability of storage facilities. 33.6% of all caterers complained, with Upper West region being the most affected (66.7% caterers complained of storage facilities). Firewood (67.8%) was most used as fuel for food preparation.

There was regular flow of pipe borne water which was the major source of water for food preparation. In addition to pipe borne water, boreholes were also widely used in the Ashanti, Brong Ahafo and the Northern regions.

Approximately (50.8%) of the schools had canteens where foods were prepared for and eaten by pupils. The majority (88%) had hygienic environment for cooking. For instance, Atwima Takyiman Presby Primary in the Ashanti region had a very clean environment.

Some cooking environments were not found to be hygienic,

- Some were exposed to leaves and other contaminants (Odumase Basic School, Nkwanta in the Volta region.
- The cooking area was not cemented and the food was always served on the floor for pupils. (Atonsuagyga M/A Primary School), Mampong Ashanti.
- The kitchen was not enclosed; as a result goats and other animals had access to the kitchen after the close of school. (English/Arabic Primary in the Western region.)
- The kitchen staff fetched water from a stream located in a muddy environment near the school for cooking. (DA Primary School in the Western Region)
- Some cooked in the open (Mampamhwe KG/Primary School located in Mampamhwe in Obuasi, Kumasi, Abudukrom Basic Schools located in Abudukrom in the Central region.)
Food preparation environment at Nkwakom in the Nkawie district in the Ashanti Region

Provision of Cutlery and Bowls
According to the pupils, the provision of cutlery and bowls are;

- Provided for by themselves, others by the caterers. For instance, at the Boundary Road Methodist Primary School, Sekondi in the Western Region, classes 4-6 provide their own bowls and cutlery whereas; caterers provide bowls for classes 1-3.
- All provided by the pupils themselves (Bepoa DA Primary School)
- Brought alongside with food by the caterers.

Pupils at Alavanyo in the Volta region with their own bowls waiting to be served
Challenges encountered by Caterers
Challenges encountered by caterers include:

- Delay in releasing funds.
- A permanent place for food preparation. Sometimes, food is prepared some distance away from the school due to lack of kitchen; conveying the food to the school is a problem. (Jasico Basic Demonstration School, Jasikan, Volta region)
- Storage facilities: “No refrigerator to store perishable items”, says Diana Sakyi, caterer for English/Arabic Primary, Tepa in the Ashanti region.
- Limited funds: The money given her is only worth ten days expenditure, yet it is meant for the whole term. I do procure on hire purchase and also pay cooks employed by the District assembly says Gertrude Osei, Catholic Primary school, Half Assini in the Western region)

Food quantity and quality
Up to 65.6% pupils said the quantity was adequate, fairly adequate or highly adequate. However, a higher percentage of males saw the quantity as inadequate as compared to the females. For the nutritious nature, more males were satisfied than females.

Effect on the financial responsibilities
The introduction of the school feeding programme however, had some considerable effect on the financial responsibilities of parents in that, pocket money reduced after the introduction of the school feeding programme. On the average, pupils were being given 50 Ghana pesewas
before the introduction of the school feeding programme. After the introduction of the school feeding programme however, it reduced to 30 Ghana pesewas on the average.

**Partner Organizations**
Organizations including DANIDA, Catholic Relief Services, and World Food Programme must be commended for supporting the school feeding programme.

**Conclusion**
The school feeding programme though beneficial comes with challenges; challenges such as untimely release of funds, increase in school enrolment and limited funds.

The introduction of the school feeding programme however, had some considerable effect on the financial responsibilities of parents in that, pocket money reduced after the introduction of the school feeding programme.

The programme should be sustained despite the mounting challenges.

**2.1.6 Persons with Disability and the School Environment**
Human rights are those basic claims or entitlements that enable or protect our ability to satisfy our basic needs with dignity and respect. The basis of human rights is that “all human beings are born free and equal in dignity and respect.” (UDHR Art.1)

Human Rights are fundamental because they do not have to be earned, bought or inherited. They are for all persons irrespective of their health or other status.

Persons with disabilities are entitled to exercise their civil, political, social, economic and cultural rights on equal basis with others. Disability “summarizes a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions and mental illness. Such impairment, conditions or ailment may be permanent or temporary in nature”.

**National Human Rights Instruments on Persons with Disability (PWDs)**
- 1992 Republican Constitution of Ghana, Article 15(1) “the dignity of all persons shall be inviolable”.
- 1992 Republican Constitution of Ghana, Article 17(2) “A person shall not be discriminated against on grounds of gender, race, colour, ethnic origin, religion, creed or social or economic status”.

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9 www.hrea.org
10 The 1992 Constitution of Ghana
Ghana Education Service (GES) Policy on the Disabled in Schools

The research revealed that about half (50.9%) of schools had physically challenged persons, pupils and staff alike. Also there exists a GES policy on the physically disabled, 57.1 % of school authorities indicated.

According to school authorities, the policy supports inclusive education; however, those who need special attention are to be made known to the nearest education service for reposting to special schools.

The monitoring team also found that 14.8% of school authorities nationwide indicated that they were not aware of the rights available to persons with disability. Approximately 20% of all school authorities in Western region said they were not aware of the rights available to persons with disability.

Schools without Disability Friendly Structures

Irrespective of school authorities’ awareness or otherwise of the rights of the disabled, majority (59.5%) did not have disability friendly environment. The persons with disability found it difficult to climb stairs, because the staircase had not been designed to cater for physically disabled persons. For instance, at the Agona D /A JHS School B, two (2) physical disabled found it difficult climbing the stairs.
Minority (28.6%) of the physically disabled interviewed indicated that they encountered problems because of unfriendly nature of school structures; stair cases, school lavatory, and dual desks. The remaining (71.4%) had no problem accessing school facilities, because some such as the lame climb stairs with relative ease.

**Schools with Disability Friendly Structures**

Some schools (40.5%) had disability friendly structures. This includes all inclusive as well as special schools. The S.D.A J.H.S, Agona in the Sekyere South district of the Ashanti region is an all-inclusive school which had friendly structures. The Centre for the disabled; Jackie Pramso Senior High School also in the Ashanti region is a special school that had disability friendly structures.

**Inclusive Education**

Inclusive education is a system of education in which all the pupils with special educational needs are enrolled in ordinary classes in their district schools. They are provided with support services and an education based on their forces and needs. Inclusive schools are based on the basic principle that all school children in a given community should learn together, so far as it is practicable, regardless of their handicaps or difficulties.  

When schools were asked whether or not they support the idea of inclusive education, the larger number (84.2%) supported the idea. Some reasons given include:

- The 1992 constitution frowns upon any form of discrimination
- To enhance socialization
- Will make such pupils feel part of the society they belong to
- Parents in the rural areas do not have the means to send their wards in special schools. (Head teacher of Kodibenum E.P Primary School, Kadjebi Volta region)

Some said no rightly because:

- The visually and hearing impaired cannot sit together with their able bodied fellows in class. (for instance at the King’s Presbyterian Basic schools - Jasikan, Volta region, a hearing impaired pupil finds it difficult to get what the teacher says)
- It will enable them learn at their own pace.

**Relationship with peers**

Students with different disabilities were interviewed including the physically challenged, mentally disabled, hearing and visually impaired.

- The majority (88.3%) said they were treated well; treated with respect by both peers and teachers. A few however had challenges interacting with their peers:

Some are sidelined in almost all activities in the school.

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• Others are also teased by peers

A visually impaired pupil in the same class with her abled colleagues

Disabled Awareness of their Rights
Approximately half (48.3%) of disabled children said, they were aware of rights available to people with disabilities. Some of which include the rights to education, health, expression, recreation, non-discrimination, work after completion of school and the rights to entertainment. This percentage indicates that much work is needed in terms of teaching all children irrespective of their ability and rights.

District Assemblies Common Fund
Some schools complained to the monitoring team that disabled children in their schools do not benefit from the 2% of the district assemblies common fund meant for the disabled persons.

Conclusion
Apart from the special schools, school structures were generally not disability friendly. Even though all inclusive schools were generally supported by school authorities, it is necessary that pupils with severe disabilities are given the chance to learn at their own pace in special schools.

2.1.7 Availability and Affordability of Educational Facility
General comment 13.6a of the International Covenant on Economic, Social and Cultural Rights expect that functioning educational institutions and programmes have to be available in sufficient quantity within the jurisdiction of the State party. What they require to function depends upon numerous factors, including the developmental context within which they operate; for example, all institutions and programmes are likely to require buildings or other protection from the elements, sanitation facilities for both sexes, safe drinking water, trained
teachers on domestically competitive salaries, teaching materials, and so on; while some will also require facilities such as a library, computer laboratory and information technology.

Two hundred and forty two (242) public schools monitored aimed at finding out the availability of educational facilities. The breakdown is found in Table 3

### Table 3: Type of Institutions monitored

<table>
<thead>
<tr>
<th>Level of Institution</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crèche</td>
<td>4</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>62</td>
</tr>
<tr>
<td>Primary</td>
<td>65</td>
</tr>
<tr>
<td>Junior High School</td>
<td>80</td>
</tr>
<tr>
<td>Senior High School</td>
<td>28</td>
</tr>
<tr>
<td>Other (Special School)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>242</strong></td>
</tr>
</tbody>
</table>

### Availability and Sufficiency of Educational Institutions

Schools monitored generally served five and more communities. Approximately 35% of institutions monitored had more pupils than the expected number in 2008/2009 academic year. Also, 21.8% institutions did not have classrooms for each class.

The introduction of the school feeding programme partly has contributed to the blotted number of pupils and this is because;

(a) Two classes were grouped in one. Such instances occurred in
   - *The Tefle RCG Primary School in the South Tongu district of the Volta region and*
   - *The Moryi Primary School in Akatsi in the Volta region had classes 5 and 4 combined*
   - *The Obuasi Anglican Primary School in new Nsuta in the Ashanti region had nine instead of twelve classrooms*

(b) Some school children sat under trees. Such instances occurred in
   - *Mampong S.D.A Primary I Mampong in Ashanti*
   - *Kofi Nkrumakrom D/A in Ashanti where KG1 and KG2 had no classrooms and sat under trees.*

### Proximity to Educational Facility


The monitoring team revealed that 68.2% of school children had their schools closer to their residence. Majority of pupils get to school from their homes within 30 minutes. Pupils who stayed far of preferred their school due to the fact that;

- The school had enough learning materials and good teachers.
- Fees are comparatively cheaper.

**Seating Arrangement**
The dominant type of seating arrangement used was the desk (73.8%), table and chair (15.1%). Approximately, 43% of the responses indicated that seats were not available for all pupils. For instance;

- Three (3) pupils sit on a desk designed to accommodate 2 pupils (St. Peter’s Anglican Primary School)
- Three(3) to four (4) children have to share a desk as most of them had been stolen by some community members. (Abrofoa D/A Basic School located in Ajumako in the Central region)

**Lighting Condition**
Only 9.6% had poor lighting for reading and writing. Poor lighting was caused by:

- No electricity; At the Dodowa Newtown Basic J.H.S in Dodowa in the Greater Accra region, there was no electricity, windows were also small
- Bad architecture; At the Moryi Primary School, Akatsi in the Volta region, enough space had not been provided for the window
- A lot of trees and vegetation around the compound made lightening very poor; At the Bonsua M/A J.H.S in Offinso in the Ashanti region, trees and vegetation around the compound made lightening very poor.

**Ventilation**
Ventilation was generally adequate for each classroom. A few schools monitored (5.4%) however had poor ventilation.

- At the Whindo /Assakae STMA JHS in Takoradi in the Western region for instance windows were made of honeycombs (many small holes) and the classrooms were so hot in the afternoons that teachers were reluctant to teach.

**Teaching and Learning Materials**
General comment 13.27 of the International Covenant on Economic, Social and Cultural Rights states...."the material conditions of teaching staff shall be continuously improved,"

Majority of schools (62.5%) had learning materials provided by the government of Ghana. However, other institutions and philanthropists provided some learning materials. For instance, Action Aid an NGO provided learning materials to many schools including Kodibenum E.P Primary School, Kadjebi in the Volta region.
The research however, revealed approximately half (53.8%) of all schools in the Northern region had not got adequate teaching and learning materials.

Three categories of challenges associated with teaching and learning materials were enumerated by school authorities.

1. **Not supplied regularly**
   - Some are not regularly supplied by the Ghana Education Service. *(L.A Primary School, Tanyigbe-Anyigbe, Ho in the Volta region)*
   - Specialized materials for special schools are often not supplied. *(Shalom Special School Nkoranza in the Brong Ahafo region.)*

2. **Not supplied at all**
   - Not all are provided, teaching aids such as compasses and wall charts *(Abudukrom Basic Schools in the Central Region)*
   - No Ghanaian language textbooks, no religious and moral education *(Ekow Nketsia AME Zion Primary School, Sekondi in the Western region).*
   - No textbook on Physical Education is provided *(Mpintsim AME Zion Primary School, Sekondi, Western region)*
   - No material for learning technical and vocational subjects *(Tebrebe M/A Basic School, Tarkwa in the Western region)*

3. **Inadequate materials**
   - The number of materials is inadequate because the number of school children enrolled is more than the expected number. *(Salvation Army JHS, Apam in the Central region, Duawodome Basic Schools in Akatsi in the Volta)*

**Affordability**

General comment 13.6b of the International Covenant on Economic, Social and Cultural Rights expects “…..Education has to be affordable to all…”

The monitoring team revealed that no fees were charged by basic schools but some (57%) continue to pay levies. The monitoring team found out that levies on examination printing was the only approved levy by the Ghana Education Service. However, some schools charged levies on other items. For instance, at Atwima Takyiman Presby Primary and Obuasi Methodist School, all in the Ashanti region, charged levies on extra classes and watchman fee are still taken.

Presently, parents are required to provide uniforms for their children since, all pupils are required to wear uniforms. About 60% of pupils who pay levies indicated that, additional cost
including levies on printing fees, provision of uniforms and learning materials pose a financial burden on their families.

In fact, some parents have refused to pay any fees because they claim education is free.

**Toilet Facilities**
Majority, (59.8%) of schools had Ventilated Improved Pit Latrine (KVIP). However, as much as 45 schools representing (17.9%) had no toilet facility. The Western region had the highest percentage of schools with no toilet facility; 29% of schools monitored had no toilet facility.

School authorities (60.8%) indicated that toilet facility availability was not adequate for the number of pupils. Sanitary conditions were generally good.

Few schools (4.4%) had flush toilets with excellent sanitary conditions.

- The Boundary Road Methodist Primary school in Takoradi and
- St Peters Anglican Primary school, Sekondi both in the Western region are commended for the excellent sanitary conditions

**Potable water**
Main source of water is pipe borne (53.1%) which is generally regular in flow.

**Health**
Most institutions had no health facilities; only 7.2% had health facility in their schools, all functioning well. Barely, 7.9% had health assistants.
The majority (79.6%) had first aid box in their institution. Out of this 25.6% were poorly stocked.

**Freedom of Religion**
Whereas some schools endorse the beliefs of a particular religion, 73.3% of institutions visited, do not endorse beliefs of a particular religion.

**Conclusion**
The monitoring exercise showed that an appreciable number of schools did not have enough teaching and learning materials because of the blotted number of pupils, there were no TLMs on physical education, vocational studies, ICT, religious and moral studies in some schools. Specialized materials for special schools are often not supplied.

The continuous pressure on existing facilities such as desks and toilet facilities need much attention from the state.
3.1 INTRODUCTION

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous complementary approaches such as, the formulation of health policies or the implementation of health programmes developed by the World Health Organization (WHO) or the adoption of specific legal instruments (General comment 14.1 of the CESC). This covenant is also supported by article 25 (1) of the UDHR which states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing, medical care and necessary social services.

Furthermore, article 34(2) of the 1992 constitution of Ghana recognizes health as a human right and mandates a sitting President to ensure the realization of basic human rights; the right to good health care of every citizen. In recognition of this, the Commission continue its monitoring exercise in the areas of:

- Awareness of Health as a human right issue
- State of maternal and infant mortality
- NHIS
- Patient’s Charter
- The right to facilities

3.1.1. Health as a Human Right

Awareness of health as a human right issue
Knowledge about the right to health is an essential requirement to its full enjoyment. This assertion is based on the premise that people will, and can only demand their rights when they are aware of what the said right, entails.

Views of Community members
Information gathered from Focus groups discussions with community members comprising male and female of varying age revealed a high level of awareness of the right to health among the community members. Out of one hundred and eighty five (185) focus group discussions held nationwide, 153 of them forming 82.7% had majority of the participants confirming this statement.
The major responses given were:

- The right to a healthy life.
- The right to attend one’s preferred hospital.
- The right to health care without discrimination.

However, majority of them perceived the right to health as simply the presence of health centres and attending hospital when sick, and without much knowledge of the various rights listed in the patient’s charter. The few focus group discussions (17.3%) that revealed a higher proportion of participants being ignorant of the issue were found in the Northern (40.0%), Upper East (42.9%) and Central (36.4%) regions respectively. Activities for the promotion of the right to health in the various communities by NGOs, CSOs, and state institutions were found to be very minimal. State institutions like CHRAJ, NCCE and the Ghana Health Service were cited by majority of participants in only a few (59 or 32%) of the focus group discussions held.

The situation raises questions about the level of impact of the activities or the role of state institutions like the National Commission for Civic Education (NCCE). For instance, it is mandated under article 233(d) of the 1992 Constitution to “formulate, implement and oversee programmes intended to inculcate in the citizens of Ghana awareness of their civic responsibilities and an appreciation of their rights and obligations as free people”
3.1.2 Availability of Medical Facilities

The provision of health facilities and quality health services by the government that are easily accessible and affordable constitutes a major component for the enjoyment of the right to health. These conditions are emphasized in general comment 14.36 of the ICESCR, where states are enjoined to “ensure the provision of a sufficient number of hospitals, clinics and other health related facilities with due regard to equitable distribution throughout the country”.

It is clear therefore that, it is the responsibility of government to make health facilities readily available/accessible to all persons. A careful analysis of the responses from the exercise indicates that, majority of the community members (75.4%) perceive Government as having put in a lot of effort into making sure that the right to health is enjoyed. This view, according to them, was because of their awareness of the introduction of the NHIS and its related programmes such as free services for expectant mothers and the national immunization programme.

Majority of the participants who held an opposing view mentioned that, there are inadequate numbers of health facilities in their communities.

Health centres and facilities were found to be available in more than half of the communities visited. However, majority of the participants in 126 (68.9%) focus group discussions held said that, they have such facilities (hospital or clinic) in their communities. The remaining communities without health centres and facilities were almost evenly distributed across all the regions with the Western region, surprisingly emerging as the region with the least health facilities. 80% of the focus group discussions held in the Western region had majority of the participants indicating unavailability of health facilities.

Health related NGOs and CSOs

The number of NGOs and CSOs in the communities with the focus on promoting the right to health was found to be few. Only 45 (23.7%) of the communities visited had associations or organizations that engage in health-related issues. A summary of the focus of these organizations are listed below:

- sexual and reproductive health issues, HIV/AIDS stigmatization campaign
- education on health rights, women’s development and empowerment
- improving the health status of the rural people and empowering the marginalised
- maternal and infant health

In contribution to the realization of the right to health in the district or region, the following were the major activities mentioned by contacted NGOs or CSOs:
• Advocacy and education in communities about Health issues and formation of Para-legal committees to monitor advocacy programs.
• free health screening and health workshop to sensitize people on the status of health, collaborating with health insurance schemes to better services.
• malaria and HIV awareness campaign, elephantiasis eradication, training volunteers to help community health nurses, as well as the supply of drugs and equipment.
• promoting preventive health care, and services in reproductive health and provision of treated mosquito nets to pregnant women and children.

Among the major achievements made by the established organizations are;
• formation of para-legal, and advocacy groups.
• the conducting a number of eye screening checks and sight prevention interventions.
• provision of KVIP and potable water in the communities.
• have been in the fore front in combating or eradicating elephantiasis and guinea worm in the communities
• contributed towards acceptance of family planning, reduction in abortion cases and hence reduction in the HIV rate
• increased the extent of awareness on reproductive health rights and behavioural change toward health issues
• encouraged more community members to register for the NHIS scheme
• partnered with GHS to supply drugs to patients
• formation of support groups for persons living with HIV, offered microfinance and assistance for PWD and PLWA
• Developed a clinic that is complementing the regional hospitals.

Judging the status of health facilities, about 52.5% of the visited NGOs stated that, the health conditions in their operating districts were in a bad state. Table 4 gives a summary of the responses of the assessment of health conditions in the various regions.

<table>
<thead>
<tr>
<th>REGION</th>
<th>Assessment of health status</th>
<th>Count</th>
<th>% within region</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASHANTI</td>
<td>good</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td>BRONG AHAFO</td>
<td>good</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CENTRAL</td>
<td>good</td>
<td>4</td>
<td>44.4%</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>5</td>
<td>55.6%</td>
</tr>
<tr>
<td>EASTERN</td>
<td>good</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>2</td>
<td>66.7%</td>
</tr>
<tr>
<td>GREATER</td>
<td>good</td>
<td>1</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Bad</td>
<td>1</td>
<td>66.7%</td>
</tr>
<tr>
<td>Region</td>
<td>Count</td>
<td>% within region</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>ACCRA</td>
<td></td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>NORTHERN</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>UPPER EAST</td>
<td>1</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>VOLTA</td>
<td>6</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>WESTERN</td>
<td>1</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>47.5%</td>
<td></td>
</tr>
</tbody>
</table>

Most of the NGOs with a positive opinion attributed it to an increase in hospital attendance as a result of the NHIS and its associated programmes, availability of health post in the communities and some other government health policies such as the national immunization programme. The other organizations complained that, although such policies or programmes are available, they are highly ineffective and inaccessible to the community members.

**Conclusion**
There is a broad-spectrum of awareness on the right to health in Ghanaian communities. However, the content of the right and conscientiousness to the enjoyment of health is highly unfamiliar in almost every community in Ghana.

With the introduction of the NHIS, the government has been on the threshold of creating the awareness and opportunity to good healthcare. However, from the gathered data, it is evident that most communities in all regions of the country have not realised the dream or goal of the assessment of good healthcare. Most communities lack affordability and accessibility to good healthcare. Apparently, there are NGOs, CSOs, as well as, some religious bodies who are actively involved in the conscious campaign of good healthcare.

**3.1.3 Maternal Mortality**
The right to life is a fundamental human right which needs to be enjoyed by all persons. This right is enshrined in *Article 3 of the UDHR which states that “Everyone has the right to life, liberty and security of person”*. Article 13 of the 1992 Constitution also safeguards the right to life.

Maternal mortality refers to the death of an expectant woman during or shortly after a pregnancy. This is a human right issue because it involves human life and curtails the right to life.
Maternal Mortality and Reproductive Health

Results from the monitoring exercise revealed that, maternal deaths have gradually reduced in the various communities for the year 2008 and 2009. Majority of the participants in the focus group discussions (70.5%) affirmed this. The responses are summarized in table 5

Table 5: Prevalence of Maternal Mortality within Community

<table>
<thead>
<tr>
<th>Responses</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>28</td>
<td>29.5</td>
</tr>
<tr>
<td>NO</td>
<td>67</td>
<td>70.5</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>100.0</td>
</tr>
</tbody>
</table>

29.5% of participants of focus group discussions asserted that, the phenomenon was rampant in their areas. This category of respondents lamented that the phenomenon could be attributed to; a lack of ante-natal health care facility and refusal or delay in attending ante-natal services were mentioned as the major challenges leading to the extent of mortality in the communities.

Information was further obtained from the families of victims of maternal death; the snowball method of sampling was used to locate them. Responses indicate that, most of the maternal deaths occurred during birth and after birth in 33.0% and 48.9% of cases respectively. In most cases, deaths were said to have occurred at home while a few mentioned the hospital.
All the respondents were found to be aware of the medical services available for expectant mothers and majority also stated that they availed themselves to the services. Ante-natal and post-natal care constitutes the main maternal health services offered.

The monitoring exercise also examined some major factors which could contribute to the occurrence of maternal death. Table 6 gives a summary of the responses obtained from the community members about such factors.

Table 6: Influencing Factors of Maternal Mortality

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating of factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very important</td>
</tr>
<tr>
<td>Exodus of medical personnel</td>
<td>39(49.4%)</td>
</tr>
<tr>
<td>Adequate sanitation facilities in the communities</td>
<td>56(61.5%)</td>
</tr>
<tr>
<td>Health and quality of life of mother</td>
<td>74(82.2%)</td>
</tr>
<tr>
<td>Stress/hardship on mother due to poverty/lack of food</td>
<td>65(72.2%)</td>
</tr>
<tr>
<td>Stress/hardship on mother due to need to work hard/long hours during pregnancy</td>
<td>54(58.7%)</td>
</tr>
</tbody>
</table>
Stress/hardship on mother due to domestic problems | 45(48.4%) | 37(39.8%) | 11(11.8%)
---|---|---|---
Number of previous births by mother | 39(44.8%) | 23(26.4%) | 25(28.7)
Young or old age of mother | 38(50.7%) | 28(37.3%) | 8(10.7%)
Other factors | 10(43.5%) | 9(39.1%) | 4(17.4%)

Clearly, adequate sanitation in the communities’ healthy lifestyle of expectant mothers, poverty and stress on the mother due to the need to work during pregnancy were perceived to be dominant factors in the occurrence of maternal mortality. Additionally, every factor under consideration had at least 40% of participants suggesting that it influences the occurrence of maternal death.

Religion and cultural practices were also cited as one of the causes of maternal mortality by majority of participants in about 44% of the focus group discussions held. Among the common explanations given were that, some religious bodies prevent women from receiving ante-natal care and other health services such as blood transfusion. Again, actions of some pastors and traditionalists to cure ailments mostly results in complications and eventual death.
A section of the participants however, commented on some positive aspect of religion and cultural activities on maternal health. The few mentioned were preaching against unwanted pregnancy, organizing a health talk for the congregations and encouraging women to take their reproductive health issues seriously, this most of them did through the various internal associations they had formed.

Activities of NGOs, CSOs and state organizations engaged in educating the public and campaigning against maternal mortality were found to be low in the communities. Only 20 (18.3%) had majority of participants who claimed to know of the existence of institutions that focus on such issues.

**Views of NGOs and CSOs**

Organizations involved in public education, monitoring programs and campaigns to ensure a reduction in the incidence of maternal mortality were found to be few. Only 46 constituting 42.2% of the communities visited had such organizations. A significant number of the existing organizations (71.8%) confirmed that, there has been a decrease in the rate of maternal mortality as compared to previous years. The result is summarized in figure 8.

Almost 70% of the contacted organizations said to be engaged in monitoring and campaigning against maternal mortality, with activities being conducted on regular basis. A cumulative of 84.8% was found to have been to their communities for public education in the past three to six months.
Government Institutions (Health Facilities)

The recognition of health as a human right, hence maternal mortality is highly appreciated by most of the health authorities. Almost all the institutions visited agreed that maternal mortality is a human rights issue. Respondents explained that, pregnant women have the right to life, to enjoy quality health care which includes having safe deliveries.

Majority of the health authorities adjudged a decrease in maternal mortality in their institutions.

Data were also retrieved from records of the various health institutions for the year 2008 and up to August 2009. A summary of the descriptive statistics computed are shown in table 7.

Table 7: Descriptive Statistics on Maternal Mortality for the Year 2008 and Up to August 2009

<table>
<thead>
<tr>
<th>Statistic</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total maternal death</td>
<td>38</td>
<td>1.0</td>
<td>33.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Death during delivery</td>
<td>14</td>
<td>1.0</td>
<td>4.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Death before delivery</td>
<td>17</td>
<td>1.0</td>
<td>12.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Death after delivery</td>
<td>24</td>
<td>1.0</td>
<td>19.0</td>
<td>3.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statistic</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total maternal death</td>
<td>32</td>
<td>1.0</td>
<td>8.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Death during delivery</td>
<td>11</td>
<td>1.0</td>
<td>2.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Death before delivery</td>
<td>10</td>
<td>1.0</td>
<td>3.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Death after delivery</td>
<td>16</td>
<td>1.0</td>
<td>2.0</td>
<td>1.3</td>
</tr>
</tbody>
</table>

It can be seen that, figures of maternal death for the year 2008 tends to be higher than that of 2009 for similar statistics (means and the maximum figures). This confirms the reduction in the maternal death in most of the institutions. Another confirmation is that, majority of the maternal death occurs during and after delivery.

Institutions with a reduction in the number of maternal deaths mentioned the availability and accessibility to health facilities such as ambulance and the free delivery services for expectant mothers as reasons for the reduction.

Ante-natal care, neonatal care and post-natal care services were being rendered in almost all the institutions visited.
Table 8: Availability of Maternal Services

<table>
<thead>
<tr>
<th>Type of services</th>
<th>Responses</th>
<th>Number of institutions with such facilities</th>
<th>Percentage of institutions with these facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante Natal Care</td>
<td></td>
<td>78</td>
<td>95.1%</td>
</tr>
<tr>
<td>Neo Natal Care</td>
<td></td>
<td>74</td>
<td>90.2%</td>
</tr>
<tr>
<td>Post Natal Care</td>
<td></td>
<td>76</td>
<td>92.7%</td>
</tr>
</tbody>
</table>

Although there has been a reduction, the occurrence of maternal death still prevails in a number of health institutions. Major challenges inhibiting attaining a zero or minimal maternal mortality in the various health institutions are:

- Shortage of midwives and equipment for obstetric care as well as shortage of blood at the blood bank
- Late arrival of pregnant women to health facilities due to bad roads and long distances.
- Negative cultural and religious beliefs, illiteracy and irregular attendance of ante-natal and post-natal clinics.
- Lack of adequate staff, ambulances and fund for staff re-training
- Low level of commitment by members towards the terms of the M.O.U.
- Lack of adequate personnel, equipment and the need to train personnel on life saving skills.
- Bad roads and difficulty in getting to the communities during the rainy season.
- Aging of midwives and doctors.

All institutions visited reported that, they had been conducting public education programmes on the importance of maternal health in various forms. In most cases, health personnel explained that, they give general health promotion talks during ante-natal and post-natal care and hold community durbars. They also organise health related outreach programmes in nearby communities to educate expectant mothers on the right diet and other activities for healthy living. A few of the institutions also mentioned programmes via the radio and by posters.

Health authorities in most of the health institutions strongly believe that, the Ghanaian religious beliefs and cultural practices have great impact on maternal mortality in the country.
Health authorities in 87.5% of the health institutions monitored confirmed this statement. It was explained that, over-reliance on traditional medicines and religion/faith based solutions mostly results in complications which becomes difficult to treat at the local level.

Table 9: Maternal Mortality and Its linkage to religious and cultural beliefs – Views of Health Authorities

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>77</td>
<td>87.5</td>
</tr>
<tr>
<td>NO</td>
<td>11</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The monitoring exercise also examined government policies and programmes towards the attainment of the millennium development goals of ensuring 75% reduction in maternal mortality in the African region and hence Ghana within the next decade (from 2000 to 2015). The major programmes mentioned by majority of the health authorities were:

- Training of more midwives, traditional birth attendants and provision of basic equipment for maternity wards;
- A Memorandum of Understanding (M.O.U) between the Ghana Health Services and transportation unions;
- Strengthening of district health clinics through the provision of more nurses, ambulance services and basic emergency system;
- Free maternal care, immunisation and education on proper nutritional care;
- Provision of theatre equipment like beds for surgery, lights and machines for anaesthesia;
- Introduction of free delivery and maternal health education;
- Establishment of more midwifery schools;
- Establishment a fund to improve and promote maternal health and infant health services;
- Capacity building for all staff and provision of needed equipment and logistics.

Conclusion

The problem of maternal mortality appears to be on a gradual decline. The introduction of the Free Delivery Program and a general improvement in ante-natal and post-natal services were mentioned as the main reasons behind the current decrease in cases of maternal mortality. It is however important to intensify efforts at alleviating the incidence of maternal mortality, if possible to a point where Ghana will become known as one of the few places in sub-Saharan Africa where the problem is virtually non-existent.
3.1.4 Infant Mortality

Infant mortality refers to the total number of deaths of babies under the age of one year for every thousand (1,000) live births. A better health delivery system must encompass facilitating effective and safe deliveries, resulting in a minimal or no incidence of maternal mortality. This requires measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information. This is in line with article 12.2 (a) of ICESCRs which requires, the provision for the reduction of infant mortality and for the healthy development of the child”.

Focus Group of Adults in Communities

Community members perceive the occurrence of infant death to be low in their communities as declared by majority of the participants in 57 (83.8%) of the focus group discussions held. These participants believed that, the introduction of the NHIS, its related free delivery services for expectant mothers, the national immunization programme and patronage of health services during and after pregnancy have contributed to the low occurrence. It was however stated that, infant death occurs usually at home and during delivery.

![Figure 9](image_url)

Established organizations (state institutions, NGOs, CSOs) have played significant roles in the fight against infant mortality though, only a few of such institutions exist in the communities (only 31.6% of the communities visited had a similar organization). Activities of such organizations were known by majority of the participants in about 80.0% of the focus
group discussions held. Among the activities carried out in the communities were regular visits to educate expectant mothers on the need for medical check-ups during pregnancy.

The implementation of the Exclusive Breastfeeding Promotion Programme was introduced with the aim of building a child’s immune system through breastfeeding during the first six months of the child. Majority of the participants in almost all the focus group discussions (95.4%) knew of the programme. In expressing their views as to the possible causes of infant mortality in the communities, participants believed that, poverty, lack of adequate medical facilities (ante-natal and post-natal) and ignorance of the need for health care are the leading causes of the phenomenon.

Health Authorities

Information was retrieved from records on infant death covering the year 2007, 2008 and up to March 2009. The descriptive statistics summarizing the figures are as shown in table 10.

Table 10: Descriptive Statistics On infant Mortality for the Year 2007 to Mid-2009

<table>
<thead>
<tr>
<th>year</th>
<th>Minimum Statistic</th>
<th>Maximum Statistic</th>
<th>Mean Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>11</td>
<td>61.0</td>
<td>22.0</td>
</tr>
<tr>
<td>2008</td>
<td>20</td>
<td>139.0</td>
<td>27.2</td>
</tr>
<tr>
<td>January to June 2009</td>
<td>9</td>
<td>175.0</td>
<td>25.6</td>
</tr>
</tbody>
</table>

Contrary to the perception of the community members, a comparison of the mean and the maximum figures indicate that, there has been an increase in the number of infant death in the communities from 2007 to 2009. Higher recorded figures for the years under review were found in the Northern region of Ghana. Such health institutions are shown in table 11.

Table 11: Health Institutions with Higher Infant Death

<table>
<thead>
<tr>
<th>Region</th>
<th>Heath Institution</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Bimbilla hospital</td>
<td>139</td>
<td>175</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GHS Savelugu hospital</td>
<td>61</td>
<td>65</td>
<td>.</td>
</tr>
<tr>
<td></td>
<td>Salaga District hospital</td>
<td>.</td>
<td>50</td>
<td>24</td>
</tr>
</tbody>
</table>
Commenting on the situation, health authorities attributed the cause to a number of factors as such as:

- Poor nutrition and not using mosquito nets;
- Delay and irregularities in seeking medical care;
- Lack of motorable roads and experts to handle neo-natal severe cases;
- Ignorance of the need for ante-natal and post-natal health care.

It was also said that, some traditional beliefs and practices negatively contribute to infant deaths. Giving birth at home usually exposes the child to sunlight and other hazardous conditions which could lead to severe sickness.

**Conclusion**

The study revealed that contrary to the perception of community members, hospital records provided by health authorities indicated that, infant mortality is on the rise especially in the Northern region from 2007 to 2009. Health authorities attributed this to poor nutrition, delay and irregularities in seeking medical care and ignorance on the need to seek adequate care during and after pregnancy.

They also thought that certain traditional beliefs and practices and also exposure of children to hazardous conditions during birth at home are factors that contribute to infant mortality.

Community members on the other hand felt poverty and lack of medical facilities are contributory factors to infant mortality. The findings of the study go to explain why more strategies should be employed in the fight against infant mortality.

**3.1.5 National Health Insurance Scheme**

**Introduction**

The NHIS was established after the Government of Ghana passed the National Health Insurance Act in 2003 to set up Mutual Health Organizations (MHO) in every district in the country. The object of the Bill was to “put in place a mechanism that will ensure equitable access to an acceptable package of essential health services without out-of-pocket payment at the point of service delivery for all Ghanaians”.

<table>
<thead>
<tr>
<th>Region</th>
<th>Hospital Name</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta</td>
<td>Ho Municipal hospital</td>
<td>49</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keta municipal hospital</td>
<td>27</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Upper west</td>
<td>Regional hospital, Wa</td>
<td></td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>
In order to ensure a well-regulated and designed system, the bill sought to provide a regulatory framework in the country for health insurance and a mechanism for the establishment of district mutual health insurance scheme in every geographical area of a district.

The introduction of the National Insurance Scheme is therefore very important taking into consideration the General comments number 14.36 of the ICESCR which recommends states to “give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation and to adopt a national health policy with a detailed plan for realizing the right to health”.

The main laws regulating the National Health Insurance Scheme are:

i) the 1992 Constitution of Ghana  
ii) the National Health Insurance Act, 2003 (Act 650)  
iii) National Health Insurance Regulations (L.I 1809)  
iv) Insurance Act, 2006 (Act 724)

Contributions are to be payable in line with one’s ability to pay. For the informal sector, community health insurance committees are to identify and categorize residents into social groups to enable individuals in each group pay in line with ability to pay.

Since the socio-economic condition of all residents in Ghana is not the same and contributions must be affordable to all, the contribution payable by non-contributors to the social security scheme is as shown in the table 12.

Table 12: Classification and Minimum Premium Payable Annually

<table>
<thead>
<tr>
<th>Name of Group</th>
<th>Category</th>
<th>Who They Are</th>
<th>Minimum Contributions Payable Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Poor</td>
<td>A</td>
<td>Adults who are unemployed and do not receive any identifiable and constant support from elsewhere for survival</td>
<td>free</td>
</tr>
<tr>
<td>Very Poor</td>
<td>B</td>
<td>Adults who are unemployed but receive identifiable and consistent financial support from sources of low income</td>
<td>₢72,000</td>
</tr>
<tr>
<td>Poor</td>
<td>C</td>
<td>Adults who are employed but receive low returns for their efforts and are unable to meet their basic needs</td>
<td></td>
</tr>
</tbody>
</table>
needs | ₡72,000
---|---
Middle Income | D | Adults who are employed and able to meet their basic needs | ₡180,000
Rich | E | Adults who are able to meet their basic needs and some of their wants | ₡480,000
Very rich | F | Same |

Residents who pay their contributions in full will have to wait for at most six months before their Health Insurance Identification and Health Facility attendance card are issued to them to enable them attend any public health facility in Ghana for both inpatient and outpatient care in line with the scheme’s benefit package.

This year’s monitoring obtained information from community members, patients and the hospital authorities in the various districts in the regions about the awareness level of the National Health Insurance Scheme.

**Views of Community Members and Patients**

Every adult and patient contacted in the various communities testified to be aware of the NHIS and its importance. Community members understood the NHIS as a policy to ensure free health care for all Ghanaians. However, the detail of the scheme such as the types of diseases and drugs it covers, the classes of people and the amount to be paid for the insurance were highly unknown among most of the respondents.

All contacted members expressed optimism in the health scheme and perceived it as a major policy towards the realization of their rights to health. Respondents also believed that, it would bring quality health care to the vulnerable in the society. It was also said by a section of the respondents that, it would increase hospital attendance and reduce sicknesses resulting in complications and death of patients. Observation from the monitoring indicates that, the level of patronage of the scheme has increased significantly. This is confirmed by the 80.0% of the patients contacted who were found to have registered under the scheme. The distribution of premium payment is as shown in figure10.
Satisfaction of the Service under the Scheme

Premium payment was found to be affordable to majority of community members as confirmed by 75.7% of the patients interviewed, although a sizeable number of them (49.4%) claimed their colleagues do complain about the amount. A summary of the responses also revealed that, there is a cordial relationship between NHIS holders and health workers. Preferential treatment by health authorities towards patients (with and without NHIS card) was also affirmed to be low. A total of up to 85% of the participants were of this view.

The few respondents who disagreed explained that, in most cases, NHIS holders spent more time in the hospital than those with cash payment and are also not given quality drugs.

Soliciting information on major challenges confronting an NHIS card holder, respondents mentioned the following:

- Low coverage of NHIS on drugs and other ailments forces one to seek treatment and drugs outside the hospital and are usually expensive;
- Prolonged delays at the hospital due to increase in attendance of NHIS holders;
- Poor doctor-patient attention and delay in services provided;
- Difficulty and delay in registering for the card and renewals;
- Inability to use the NHIS cards nationwide;
- Most drugs provided by NHIS is of poor quality;
- High hospital attendance and shortage of health personnel and inadequate facilities;
• Healthcare authorities frown on parents who seek healthcare for more than one child at a time.

**Information from hospital authorities**

All hospital institutions visited were found to be accredited to provide services under the NHIS. Thirty seven (37) of these institutions forming 61.9% testified that, all their services were not covered under the scheme.

Major services excluded from the scheme include:

• ambulance services and some laboratory services ;
• buruli ulcer, dental care;
• Family planning , fixing of artificial teeth ;
• fertility treatment, medical examination, HIV/AIDS retroviral drug ;
• optical services ;
• prostate cancer .

Services relating to persons living with mental disabilities were also not covered under the scheme in 34(40.0%) of the institutions.

Figure 11 illustrates the trend in general hospital attendance and NHIS holders’ attendance and that of non-NHIS attendance for the year 2008.
A review of the attendance records of the visited hospitals indicated an increase in hospital attendance for the year 2008 in most of the hospitals. As indicated in figure 1, hospital attendance rose gradually in March to July but, steady between August to September. It then declined marginally. The proportion of hospital attendants with NHIS card also increased from January to December but, was at its peak between March and July while the non-NHIS holders took opposite trend. On the average, the proportion of hospital attendants with NHIS card lies between 70% and 85%. Common diseases gathered to be treated under the scheme were malaria, hypertension, acute respiratory infections, diarrhoea, rheumatism and skin diseases.

Assessing the sustainability of the scheme, health authorities were optimistic and hope that, the various challenges of the scheme could be addressed appropriately. Delay in the payment of insurance claims and prone of NHIS to fraudulent activities were confirmed by the authorities.

**Conclusion**

The NHIS has come to stay as a feasible means of providing highly subsidized healthcare to all citizens. The gaps identified should be promptly attended to by the responsible agencies to ensure the continuous equitable access to health for all as affirmed in article 21(2) of the Universal Declaration of Human Rights which says that, “Everyone has the right to equal access to public service in his country”. 

![Trend Analysis of Hospital Attendance Among NHIS Holders and Non-NHIS Holders](image-url)
3.1.6 Ghana Health Service Patients’ Charter

Introduction

“The Ghana Health Service is for all people living in Ghana irrespective of age, sex, ethnic background or religion. The service requires collaboration between health workers, patients/clients and society. Thus, the attainment of optimal health care is dependent on Team Work” (The Ghana Health Service Patients Charter: 2002).

In February 2002, The Ghana Health Service Patients’ Charter was therefore introduced with the main aim of promoting open and positive relationship between and amongst health workers and patients which is expected to subsequently lead to a better health-care delivery and an effective health care process. It addresses the following:

The right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country. In explaining ‘quality health care’, general comments number 14.12(d) of the ICESCR indicates that “as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality”. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation”.

- Respect for the patient as an individual with a right of choice in the decision of his/her health care plans.
- The right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability
- The responsibility of patients/clients and health personnel towards the full enjoyment of right to health.

The charter therefore seeks to ensure good health care by making clear the rights and responsibilities of patients, their families and health workers. The introduction of the patient’s charter represents Ghana’s effort to recognise the right to health by way of a legislative implementation as clearly indicated in general comments number 14.36 of the ICESCR.

This year’s monitoring continues to assess the extent of awareness of the patient’s charter among Ghanaians and the health workers as well as the effectiveness of its implementation. A number of hospitals in the various districts were visited and the patients and health workers there were interviewed.

Patients’ Awareness of the Charter

A general observation from the exercise suggests that, many Ghanaians/patients continue to be ignorant of the charter. A summary of responses revealed that, only 35% of the respondents testified to have heard of the charter. Almost all of them (65%) mentioned the hospital as their source of the information. These findings are clearly illustrated in figure 12.
The hospitals have been the most dominant avenue for the creation of the awareness of the charter followed by other means such as NGOs and the media as confirmed by 53.6% and 26.8% of the respondents respectively. However, about 84.4% of the respondents, representing the majority, said that the hospital did not take any measures to inform patients of their rights as stated in the patient’s charter. This suggests that, other means in the hospital such as posters, billboards, fliers etc have been the contributing factor in the awareness creation.

Although majority claimed to be unaware of the patient’s charter, about 76.4% of the respondents confirmed to know their rights as patients. Assessment was based on other issues such as, right to access one’s own personal health records, right to confidentiality of personal information, right to be treated in privacy and the right to seek second opinion from another qualified health professional if unsure about initial treatment yielded similar percentage range of about 45% to 85%.

Health authorities
All health workers interviewed in the institutions visited were found to be aware of the patient’s charter. About 95.1% of them also responded positively that, the charter allows patients to access high quality service in any part of the country. In assessing the perception of hospital authorities about the impact of the charter, 88.2% of them felt the charter really
measures fairness and transparency within the health sector. They explained that, the charter has succeeded in:

- ensuring that confidentiality/privacy is adhered to;
- helping patients know and demand for their rights;
- allowing patients to fully enjoy the right to good healthcare;
- fighting discrimination against patients and
- making known to patients their rights and responsibilities.

In another examination, almost all the respondents (91.5%) agreed that the patient’s charter encourages a better relationship between a doctor/health worker and a client, and 75.5% also felt that the charter allows the individual/client to be involved in decisions about his/her health. Authorities were of the view that the charter allows patients and health workers to know their rights and responsibilities and also made access to information about patients’ health care easier. They however expressed an observation that the Charter makes no mention of accountability.

A major right stipulated in the Charter is that, procedures for complaints, disputes and conflict resolution shall be explained to patients or their accredited representatives. A higher proportion of the institutions visited (73.5%) affirmed to have measures in ensuring these rights. Among the measures in place are: posters of the charter on walls, suggestion boxes, complaint desks, health talks, and workshops for staff.

**Conclusion**
The patient’s charter was introduced with the main aim of empowering parties involved in health care delivery by adequately ensuring accountability. The study revealed that many Ghanaians are still ignorant of the existence of the charter though majority still claim they know their rights as patients. On the part of health authorities, about 95.1% of them also responded that the charter allows patients to access high quality service in any part of the country. In assessing the perception of hospital authorities about the impact of the charter, 88.2% of them felt the charter really measures fairness and transparency within the health sector.

More effort should therefore be exerted in educating patients about the charter and hence their rights and responsibilities especially, in the Eastern region where awareness is low.

**3.1.7 Persons Living with HIV/AIDS**

**Introduction**
“No single world body, government, health agency or nongovernmental organization can respond to the AIDS epidemic on its own”, (UNAIDS, 2007). If this assertion is anything to go by, then we have to as a nation recognize and work-out the necessary partnerships/collaborations and linkages required to effectively deal with the threat HIV/AIDS
poses. There have been numerous campaigns, monitoring programs and education towards
the reduction of HIV/AIDS by our NGOs, CSOs and health institutions among others.
The UNDP, 2007 Human Development report on Ghana also asserts that there has been
considerable commitment on the part of Government, as evidenced in the operation of the
National Strategic Framework for HIV/AIDS and the establishment of the Ghana AIDS
Commission (GAC) to provide leadership and to coordinate a national response to the
menace. The same report however notes that, whilst a lot of work is being done at the policy
and operational level to deal with the health concerns of PLWHAs, very little is being done to
ensure their political and legal inclusion.

It is quite unfortunate as a nation we have not fully incorporated the special needs of
PLWHA into the existing legal framework. The plight of PLWHA is similar to that Persons
living with Disability, but in a more intense way. PLWHA as we know constitute a vulnerable
group in society, “In Ghana, as in almost all countries, the disease is associated with stigma,
repression, discrimination and exclusion, as individuals affected (or believed to be affected)
by HIV have been rejected by their families, their loved ones and their communities” (UNDP,
2007). It is common to find PLWHA being thrown out of their jobs by their employers due to
the mere fact that, they have tested HIV positive. Article 17 of the 1992 Constitution of
Ghana frowns heavily upon any form of Discrimination and considers all persons equal
before the law, Article 15(1) categorically states that “The dignity of all persons shall be
inviolable”.

The Commission on Human Rights and Administrative Justice has in its own way, through its
Public Education Department embarked on a number of educational campaigns and Human
rights monitoring programs with regards to the Rights of PLWHA.

Views of Community Members on HIV/AIDS

Awareness creation (which takes various forms) appears to have had some positive impact
on the community members, as almost all the participants in the focus group discussions
(89%) stated that, AIDS is real and can result in breakdown of the human immune system.
Whereas all participants agreed that AIDS is not curable, majority (67.6%) said it is treatable.

Participants who felt the condition is treatable explained that, with the help of ante-retroviral
drugs, better nutrition and a more health conscious lifestyle, PLWHA could reduce their virus
count, thereby prolonging their lives. Most of the participants in about 60% of focus group
discussions indicated that, they have more trust in orthodox modes of treatment than
traditional (traditional or herbal medicine) modes, whilsts 10% of them asserted that they
have more trust in traditional modes of treatment. However, participants in 30% of the focus
group discussions stated that both orthodox and traditional modes of treatment are
trustworthy in the treatment of PLWHA.

Almost all the participants claimed that, they are aware of the means through which the virus
is transmitted. Respondents explained that unprotected sex, sharing contaminated sharp
objects, transfusion of un-screened blood and deep kissing are the commonest modes of
transmission they are aware of. Views on the use of condoms as an effective means of
protection were almost divided as majority of participants in 52.9% focus group discussions agreed condoms are effective. This is shown in Table 13.

**Table 13: Is Condom an Effective Means of Protecting against STIs and STD’s, Including HIV/AIDS**

<table>
<thead>
<tr>
<th>Responses</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46</td>
<td>52.9</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>47.1</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Participants who were of the view that condom use is not an effective means of protection against STIs and STDs like HIV/AIDS stated that, the susceptibility of condoms to tearing or bursting during sexual intercourse as the main reason they felt condoms are unreliable forms of protection. 79.5% of respondents who had witnessed the funerals of PLWHA said that normal funeral rites were accorded the deceased PLWHA. Some of them however noted that, the funerals of PLWHA were not well patronized even though, normal funeral rites were accorded. This might be due to the stigma attached to HIV/AIDS and PLWHA in general; Zastrow and Kirst-Ashman (1990) for instance, assert that there are cases where morticians refuse to prepare corpses of PLWHA’s for burial.

The stigma attached to the condition sometimes seems to be more of a problem than the virus itself. Globally stigma and discrimination are considered key drivers of the HIV/AIDS epidemic. Ban Ki-Moon (2008) maintained that, the absence of stigma and discrimination is very vital in the process of preventing and controlling the global epidemic.

Out of 86 participants who stated that, they had ever come across PLWHA, 65 of them constituting 75.6%, said they felt frightened at the sight of PLWHA, whiles 21 participants, constituting 24.4% said they felt normal upon seeing PLWHA. Those with expression of fear at the sight of PLWHA might be due to the negative notions/perceptions people have towards HIV/AIDs or the physical state of PLWA with full blown AIDS.
Human Rights Dimension

Furthermore, in considering the Human Rights dimension of HIV/AIDS, several questions were posed to respondents and they in-turn aired quite a number of views for instance, 94.3% of respondents were of the view that PLWHA must be accorded all human rights and must be treated as normal human beings. Some of the reasons they cited for the above view include the notion that PLWHAs are human beings like any of us and since all human beings have their rights protected, it is then proper to safeguard the rights of all PLWHA, this is in consistence with article 2 of the Universal Declaration of Human Rights(UN,1948) which proclaims that all persons are entitled to their rights without discrimination, and Article 15 (1) of the 1992 constitution of the Republic of Ghana that also states that, “The dignity of all persons shall be inviolable”. If rights are to be understood as those conditions necessary for the realization of human dignity, then it is both necessary and sufficient that all persons be accorded the right as prescribed by law.

They also added that HIV/AIDS is a health issue and the health rights of all persons ought to be protected. Even though 94.3% of respondents agreed that PLWHA must be accorded their human rights, as many as 25.9% of respondents felt PLWHAs right to confidentiality with respect to their status ought to be disregarded in other to prevent them (PLWHA) from spreading the virus to unsuspecting people. It must however be stated at this point that, the Patients Charter of the Ghana Health Service, safeguards patients’ right to confidentiality.
Health Authorities

Health authorities from a number of Health facilities across all the 10 regions of the country were interviewed; they expressed their views on the current state of HIV/AIDS, rights of PLWHA and what their facilities/institutions have done or are doing to better the lot PLWHA.

Respondents attributed as reasons for the seeming upsurge of HIV/AIDS cases to the increasing number of people who now avail themselves to Voluntary Counselling and Testing (VCT). This in a way confirms the assertion of 80.8% respondents who asserted that, public education has impacted positively on the fight against HIV/AIDS. This is because with more people knowing their status at the early stages of infection, they would be able to better manage the situation, especially with the use of ante-retroviral drugs and taking better care of themselves.

31.5% of health authorities stated that their facilities do not have enough ante-retroviral drugs. This means that access to these drugs will be limited in such facilities, thereby worsening the plight of PLWHA living within areas where such facilities are sited. To check stigmatization against PLWHA respondents stated that, they encourage members of their various communities to accept PLWHA, educating them on how to relate with PLWHA, making them know that is safe to live with PLWHA. They also added that, they adhere strictly to a policy of non-Discrimination and non-stigmatization and as such have taken measures like cautioning staff to keep all client information confidential.

Efforts Made to Deal with the Problem

74.7% of health authorities interviewed stated that, their institution undertake public education programmes on the prevention of HIV/AIDS. 83.3% of them claim that their public education programmes have had a positive impact on the prevalence of HIV within their areas of operation.

Table 14: Education on HIV/AIDS Prevention by Institution.

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Valid Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>62</td>
<td>74.7</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>25.3</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Views of NGO or CSO’s Involved in HIV/AIDS Campaigns

Some of the organizations contacted in the research include World Vision-Ghana, Afrikids-Ghana, Bawku East Women Development Association (BE-LIMWASA), Concern Universal, Victory Health Foundation, CODESULT Network, PRO-LINK, Manya Krobo Queen Mothers Association among others.

HIV/AIDS Campaign

As many as 90.3% of respondent stated that their organizations actively monitor the general situation of HIV/AIDS within the localities they operate in. Some of them stated that, their organizations visit their focal areas on a daily basis, others on a weekly basis, others on a monthly basis, others on a quarterly basis, while others stated that they conducted such visits, as and when they had the funds to do so.

76.5% of the respondents stated that, their organisations have ongoing HIV/AIDS prevention campaigns, commenting on the effectiveness of such campaigns, they said more people have become well informed on HIV/AIDS prevention and so are now more careful with their sexual behaviour and the way they share sharp objects, they also added that condom use has increased significantly whiles stigmatization of PLWHA is on the decrease.

Conclusion

The extent to which PLWHA enjoy their rights largely depends on interplay of personal, family, community and governmental forces. To be able to address the special needs of PLWHA, serious attention has to be paid to studying and understanding the roles all the above forces play.

3.1.8 Right to Health Facilities, Goods and Services

“The highest attainable standard of health” as found in the general comment number 14.9 of ICESCRs is explained to include the right to enjoyment of a variety of facilities, goods and services.

According to general comment 14.12 of ICESCR, “The right to health” in all its forms and at all levels contains the following interrelated and essential elements:

(a) Availability: Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party and such provisions shall take in safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;¹²

(b) **Accessibility**: Health facilities, goods and services\(^\text{13}\) have to be accessible to everyone with emphasis on:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;\(^\text{14}\)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that, medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas\(^\text{15}\) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

(c) **Acceptability**: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;

(d) **Quality**: As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation.

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\(^{13}\) Unless expressly provided otherwise, any reference in this general comment to health facilities, goods and services includes the underlying determinants of health outlined in paragraphs 11 and 12 (a) of this general comment.

\(^{14}\) See paragraphs 18 and 19 of this General Comment.

\(^{15}\) See article 19(2) of the International Covenant on Civil and Political Rights. This general comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.
The General Comment 14(17) of IESCR also asserts that, “the creation of conditions which would assure to all medical service and medical attention in the event of sickness both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.

Community Members
Health centres and facilities were found to be available in more than half of the communities visited. Majority of participants in 126 (70.4%) of the focus group discussions held testified to have such facilities in their communities which were either hospital or clinic as shown in table 15.

<table>
<thead>
<tr>
<th>Availability of health facilities</th>
<th>Number of focus group discussions with majority of participants testifying availability of health facilities</th>
<th>Percent of focus group discussions with majority of participants testifying availability of health facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>63</td>
<td>50.4%</td>
</tr>
<tr>
<td>Clinic</td>
<td>71</td>
<td>56.2%</td>
</tr>
<tr>
<td>Infirmary</td>
<td>3</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

Such health centres were found to be at most one in the communities with the exception of about 26% having two to four health centres. Traditional birth attendance was also mentioned in some communities as their main form of health facility.

The remaining communities without health centres and facilities were found to have been distributed in all the regions but surprisingly dominated in the Western Region. As large as 80% of the focus group discussions held in Western Region had majority of the participants stating unavailability of health facilities.

Whilst responses indicated the presence of health centres in most of the communities, most of them complained of inadequate doctors and nurses in relation to the population of their community (this is confirmed by the average doctor to patient’s ratio in the report). Distance of health facility from some community members continues to be a major challenge to health accessibility. A total of 82 (46%) of the focus group discussions had majority of the participants stating that the nearby health institutions is more than 5km from their residence.
Means of transportation to health centres were mainly by automobile (57.1%) and trekking (36.8%). About 17.5% of the focus group discussions had most of the participants mentioning motorcycle and bicycle as the major means of accessing the available health centres. Long distance and bad roads, lack of specialized medical officers (mental doctors, dentists, ophthalmologists) and long queue at the health centres were mentioned in most areas as the major challenge in accessing health care.

**Hospital Administration**

Statistics gathered from the various health institutions visited indicated that, health personnel are inadequate for the communities they serve. Table 16 gives a summary of the health persons to patients’ ratio figures obtained for the year 2008.
Table 16: Descriptive Statistics on Health Personnel to Patients’ Ratio

<table>
<thead>
<tr>
<th></th>
<th>Minimum Statistic</th>
<th>Maximum Statistic</th>
<th>Mean Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-to-patient Ratio</td>
<td>79</td>
<td>220000</td>
<td>29606</td>
</tr>
<tr>
<td>Nurse To Patient Ratio</td>
<td>78</td>
<td>34368</td>
<td>2859</td>
</tr>
<tr>
<td>Lab Technician To Patient Ratio</td>
<td>70</td>
<td>220000</td>
<td>31053</td>
</tr>
</tbody>
</table>

According to the UN standard, doctor-to-patient ratio should not exceed 1:3000 (that is one doctor to 3000 patients). However, as indicated in table 16, the recorded doctor-to-patient ratio as well as the other related ratios’ average for the inspected health institutions far exceeds the standard ratio.

Furthermore, most of the health institutions’ ratio exceeded the recorded average and that confirms a worse situation in the health institutions. Comparison of the maximum figures (worse ratios) with the previous year’s indicates that, staff strength in the health sector is worsening. In the Upper East region, for instance, the doctor-to-patient ratio for 2006 and 2007 were 1: 109,069 and 1:79,000, respectively. For the year 2008, the maximum recorded doctor-to-patient ratio was found to be 1:220,000 as indicated in table 16.

Health institutions with figures closer to the recorded maximum doctor and nurse-to-patient ratios are summarized in table 17 and 18.

Table 17: Institutions with Worse Doctor-to-patient Ratio

<table>
<thead>
<tr>
<th>Region</th>
<th>Name of Health Institutions</th>
<th>Doctor to Patients Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Salaga District Hospital</td>
<td>220000</td>
</tr>
<tr>
<td></td>
<td>Savelugu District Hospital</td>
<td>112320</td>
</tr>
<tr>
<td></td>
<td>Bole District Hospital</td>
<td>68735</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Mankranso District Hospital</td>
<td>178113</td>
</tr>
<tr>
<td></td>
<td>Ejura District Hospital</td>
<td>105990</td>
</tr>
<tr>
<td></td>
<td>Effiduase District Hospital</td>
<td>60000</td>
</tr>
<tr>
<td></td>
<td>St. Martin’s Catholic Hospital</td>
<td>72462</td>
</tr>
<tr>
<td>Volta</td>
<td>Akatsi District Hospital</td>
<td>106000</td>
</tr>
<tr>
<td></td>
<td>Hohoe Government Hospital</td>
<td>88500</td>
</tr>
<tr>
<td>Brong-Ahafo</td>
<td>Sene District Hospital</td>
<td>102615</td>
</tr>
<tr>
<td></td>
<td>Atebubu District Hospital</td>
<td>100689</td>
</tr>
<tr>
<td></td>
<td>Kintampo Municipal Hospital</td>
<td>50000</td>
</tr>
<tr>
<td>Upper East</td>
<td>Sandema Hospital</td>
<td>83174</td>
</tr>
</tbody>
</table>
### Table 18: Health Institutions with Maximum Nurse to Patient Ratio

<table>
<thead>
<tr>
<th>Region</th>
<th>Name of Health Institution</th>
<th>Nurse to Patients Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Bole District Hospital</td>
<td>34368</td>
</tr>
<tr>
<td></td>
<td>Salaga District Hospital</td>
<td>9166</td>
</tr>
<tr>
<td></td>
<td>Zabzugu Tatale District Health Directorate</td>
<td>10000</td>
</tr>
<tr>
<td></td>
<td>Gushegu District Hospital</td>
<td>7474</td>
</tr>
<tr>
<td></td>
<td>Savelugu District Hospital</td>
<td>5106</td>
</tr>
<tr>
<td></td>
<td>Yendi Municipal Hospital</td>
<td>5000</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Tepa Government Hospital</td>
<td>30846</td>
</tr>
<tr>
<td></td>
<td>Mankranso District Hospital</td>
<td>8906</td>
</tr>
<tr>
<td></td>
<td>Effiduase District Hospital</td>
<td>4000</td>
</tr>
<tr>
<td>Western</td>
<td>Dixcove Hospital</td>
<td>14625</td>
</tr>
<tr>
<td>Upper West</td>
<td>Dorimon Health Centre</td>
<td>9356</td>
</tr>
<tr>
<td>Brong-Ahafo</td>
<td>Atebubu District Hospital</td>
<td>5034</td>
</tr>
<tr>
<td>Volta</td>
<td>Mary Theresa Hospital</td>
<td>4158</td>
</tr>
</tbody>
</table>

Availability of expatriate doctors to support the staff strength of the health workers were found in only 40 (40.8%) of the institutions visited. Majority of such institutions have 2 to 4 of the expatriates.

### Health Facilities

An effective health delivery system encompasses the availability of adequate health facilities and or equipment for the treatment of all kinds of sicknesses. The absence of ambulance services for emergency cases remains prevalent in the country and that poses a threat to sick people in emergency situations. About 41.0% of the institutions visited did not have ambulance and emergency services. Patients and health institutions had to make private arrangement during such situations. Referrals to the appropriate health institutions were also mentioned as an approach in such instances.
Additionally, provision for the enjoyment of the rights to privacy and confidential services during consultation, examination and treatment was not available in 24.0% of the health institutions visited.

Potable water was available and accessible to majority of the health institutions (90.5%) with about 74.5% relying on pipe borne water. The remaining institutions were depending mostly on borehole and well. These sources of water supply were regular in about 78.6% of the institutions visited.

3.1.6 Persons Living with Disabilities

The right to health for persons living with disabilities is also enshrined in International Conventions and the 1992 Constitution of Ghana. The General Comment 5 Section 34 of the ICESCR states that, “States should ensure that persons with disabilities are provided with the same level of medical care within the same system as other members of society” and also implies the right to have access to, and to benefit from, those medical and social services - including orthopaedic devices - which enable persons with disabilities to become independent, prevent further disabilities and support their social integration. Article 29 (6) of the 1992 Constitution also states that, “As far as practicable, every place to which the public have access shall have appropriate”

Health centres were said to be accessible to persons with physical disability in almost every health institutions’ visited with (90%) majority of them having wheelchairs. Physical therapy,
orthopaedic devices and prosthetics which constitute major services for the physically
disabled were only available in less than 30% of the institutions visited.

### Table 19: Services Available for Persons Living with Disabilities

<table>
<thead>
<tr>
<th>Kind of services</th>
<th>Number of health institutions with such services</th>
<th>Percent of health institutions with such services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td>21</td>
<td>24.7%</td>
</tr>
<tr>
<td>Orthopedic Devices</td>
<td>27</td>
<td>31.8%</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>80</td>
<td>94.1%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>29</td>
<td>34.1%</td>
</tr>
<tr>
<td>Others</td>
<td>14</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Services to persons with intellectual, sensory or mental disability were confirmed to be available in only 58.3% of health institutions. Common services mentioned were availability of Psychiatry Unit with a nurse in charge, a visiting psychiatric doctor, an orthopaedic unit and an Ophthalmologist. Common activities engaged in by institutions without any specific services for such people were general consulting and referral of cases to major health centres.

In a number of institutions services pertaining to persons with disability (physical, sensory, mental and intellectual) were not covered by the NHIS per existing NHIS policy of the institutions.

### 3.1.7 The Right to Maternal, Sexual and Reproductive Health

Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as, the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

The promotion and awareness creation of the right to sexual and reproductive health tends to have improved. Almost every institution visited (92.9%) confirmed to have some institutional measures to inform patients (especially youth and women) on their sexual and reproductive rights.

Majority of the institutions have reproductive and family planning units instituted purposely for counselling and educating patients or the public on such issues. Contraceptives for distribution were also available in most of the hospitals visited (83.7%) and 91% of them confirmed their affordability. Common contraceptives mentioned by these institutions were
condoms, pills, injectables, jadel and norplant. Services of prenatal care, neonatal care and postnatal care were also available in most of the institutions visited.

**Availability of Immunization and Drugs**
Immunization programmes have been on the increase for the year 2009 in most of the health institutions in the various districts. As indicated in table 20, yellow fever, tuberculosis, polio and measles are the common diseases covered under the immunization programmes in almost every health institution. Typhoid fever and hepatitis were not covered in the programme in about 30% to 40% of the health institutions. Authorities in institutions without these diseases on their immunization programmes explained that, they are very expensive and are not covered under the NHIS policy.

<table>
<thead>
<tr>
<th>Diseases under the immunization programme</th>
<th>Number of health institutions</th>
<th>Percentage of health institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow Fever</td>
<td>86</td>
<td>90.5%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>92</td>
<td>96.8%</td>
</tr>
<tr>
<td>Polio</td>
<td>91</td>
<td>95.8%</td>
</tr>
<tr>
<td>Typhoid</td>
<td>55</td>
<td>57.9%</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>48</td>
<td>50.5%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>65</td>
<td>68.4%</td>
</tr>
<tr>
<td>Measles</td>
<td>90</td>
<td>94.7%</td>
</tr>
<tr>
<td>Others</td>
<td>44</td>
<td>46.3%</td>
</tr>
</tbody>
</table>

**Conclusion**
Health facilities are available in most communities but, inadequate for the community population and a number of communities are distanced from their nearby health centres thereby, making accessibility a challenge due to poor route. The right to sexual and reproductive health is highly promoted in the country by the health institutions through the provision of reproductive and family planning units within the centre. However, facilities and services for emergency cases continue to be highly inadequate in the various health institutions. Similarly, health institutions lack specialized facilities for persons living with disabilities.

The implementation of the National Immunization Programme has also taken a wider scope in the country as almost every institution is embarking on it. However, some deadly diseases (hepatitis A and B, typhoid) are not covered in all.
CHAPTER FOUR

WOMEN’S RIGHTS

4.1 INTRODUCTION

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) and the article 19 of the protocol to the African Charter on Human and Peoples’ Rights (ACHPR) states that,

“All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.”

In line with this, all state parties are required to provide systems to ensure equality of rights for both men and women. These rights of women as enshrined in the Millennium Development Goals (MDGs) adopted by Ghana in 2000 include; eradicate extreme poverty and hunger, promote gender equality and empowerment of women, ensure the rights of women to their reproductive rights and improve maternal healthcare.

This section of the report makes a situational analysis of the fundamental rights of women, domestic violence against women, womens’ reproductive health rights, marriage in the Ghanaian context, inheritance, wills and the Wills Act.

4.1.1 Women’s Rights as Human Rights

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) defines discrimination against women in the following terms:

“All 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 Convention further establishes an agenda of action to put an end to sex-based discrimination: States ratifying the Convention are required to enshrine gender equality into their domestic legislation, repeal all discriminatory provisions in their laws, and enact new provisions to guard against discrimination against women.

Communities in Ghana understand women’s rights to be the basic entitlements of women under the law. They spell out the rights and freedoms that every woman is supposed to enjoy. Currently, the human rights enjoyed by women in their communities include freedom of association, right to own property, right to life, right to health care, right to maternity leave
with pay for government workers, right to vote and to be voted for, right to shelter and the right to work and earn a living.

On equality of rights, Ghanaian women like their counterpart males continue to enjoy equal work for equal pay. Women are also gaining roots in the area of decision process but are however restricted in certain areas for instance, men continue to dominate political leaderships.

**Instance of Abuse of Womens’ Rights as Human Rights**

About seventy three percent (73%) of the women engaged in focus group discussions at the various communities indicated that there is continuous abuse in the various communities, citing common abuses against women to be freedom of expression, freedom of making decisions and association. Non maintenance, denial of pregnancies, widowhood rites, forced marriages, betrothal, not given equal access to education, denial of women’s control over their own bodies (in terms of reproductive choices and sexuality).

About 68% of the 2191 respondents indicated that they know where to seek redress. 36% of these respondents have ever patronized the services of such institutions out of which 34% were satisfied with the services rendered to them. The services rendered also helped 33.7% to obtain the relief they were seeking for, whilst 33.2% women were actually satisfied with the outcome of the redress.

**Availability of Human Rights Institutions in the Communities**

The respondents are aware of human rights organizations operational in their communities, such as CHRAJ, Social Welfare and the Police Service, through the programmes they organized. There are also a number of human rights based NGOs, FIDA, ARK foundation, NCCE, Department of Social Welfare, Department of Community Development among other local NGOs engaged in human rights educations, advocacy on respect of women’s rights, socio-economic development and counselling across the country to augment the work of CHRAJ in the communities. These are however unevenly distributed in the regions with the majority in Greater Accra, Central and Ashanti region.

According to the NGOs and CSOs interviewed, government policies on women’s rights are not felt on the ground. There is the need to improve empowerment through education on women’s rights. The Government should ratify Conventions on rights protection as this would aid the legal and human rights institutions to protect the rights of women in the light of both culture and religion.

**Organized Community Based Educational Programme on Women’s Rights**

A number of community based educational programmes are periodically organized by CHRAJ, NGOs, CSOs across the country. Nine hundred and thirty-six (936) out of 1514 forming 38% of the women interviewed have attended or head at least one educational programme on human rights issues. A summary of the programmes organized include
fundamental human rights, violence, reproductive health rights, forced marriages and the empowerment of women.

The programmes have benefited its participants greatly by creating awareness on issues that were unknown to the women. This is realized from 95% of the beneficiaries of these programmes. Notable among the impacts are the awareness of women’s rights and violations that constitute abuse and fair distribution of properties jointly acquired in marriage in the case of divorce.

Cultural Practices that Perpetuate Violence against Women

A number of cultural practices were identified by the women to be violating their rights. Widowhood rites cut across the rites mentioned for the various regions. Other cultural practices mentioned were Dipo (puberty rites) from the Eastern region, Female Genital Mutilation (FGM) from the Upper East and Trokosi for the Volta region. The right to live in a deceased husband’s house and the right to polyandry are among the cultural practices.

4.1.2 Domestic Violence against Women
Introduction

Domestic violence is described under the Domestic Violence Act, Act 732 as any physical abuse, namely physical assault or use of physical force against another person including the forcible confinement or detention of another person, and the deprivation of another person of access to adequate food, water, clothing, shelter, rest, or subjecting another person to torture or other cruel, inhuman or degrading treatment or punishment; sexual abuse, namely the forceful engagement of another person in a sexual contact which includes sexual conduct that abuses, humiliates or degrades the other person or otherwise violates another person’s sexual integrity.

It also includes economic abuse, namely the deprivation or threatened deprivation of economic or financial resources which a person is entitled to by law. Emotional, verbal or psychological abuse, harassment including sexual harassment and intimidation by inducing, fear in another person; and behaviour or conduct that in any way harms or may harm another person, endangers the safety, health or well-being of another person, undermines another person’s privacy, integrity or security, or detracts or is likely to detract from another person’s dignity and worth as a human being.

Knowledge of Communities on Domestic Violence

The introduction of the Domestic Violence Act is helping to restrain the abuse of the rights of women in the communities. These notwithstanding people continue to infringe violence on women. From the research, 84% respondents know domestic violence to be any physical or psychological harm inflicted on an individual in the domestic setting. 76% are also aware of acts that constitute domestic violence ie. to be restricted movements, insult, physical and
sexual assault, harassment (sexual), deprivation of responsibilities, child molestation, unlawful detention of children or a woman, denial of food, sex, womanizing habit of husbands, not giving housekeeping money, beating, rejecting, denial of food.

Abuse against women is assuming an alarming proportion, most of which are not reported to police for reasons which includes:

- It was the first time and it was not too serious;
- Taught it was part of family issues that should not come out;
- Action taken by the police may disrupt the relationship;
- Desire not to expose the family
- Action taken by the police may disrupt the relationship;
- To sustain their marriages.

Fifty six percent (56%) of the women interviewed have ever been domestic violence victims out of which 42.8% reported the abuse to either a relative, the perpetrator’s relative, the Chief, Social Welfare or Police. Incidence of domestic violence is normally reported to the Police, DOVVSU, when the victim is referred by a clinic or hospital. The perpetrators of the domestic violence acts are predominantly reported to be the stepmothers, guardians, husbands and boyfriends. Wives and brothers are however also noted for such abuses. Frequently suffered domestic violence are battery, psychological violence, non-maintenance of wife and children, beating and denial of food.

Out of these victims, 44.4% obtained various injuries of which only 18.7% sustained serious injuries and sought medical attention. About 28.4% have never patronized the services of any redress institution even though, they are aware of their existence. Out of the 623 who patronized the services of a redress institution, 24.9% were satisfied with the services rendered to them by helping to obtain the required redress. They were also satisfied with the outcome of the redress.

A respondent explained that:

“Though domestic violence is very prevalent in the Lawra and Dormaa West, the victims are reluctant to report to appropriate agencies. Some women in the Tolon district are suffering from domestic violence acts but are forbidden by tradition to report their husbands to any institution including the chief. Any woman who makes the attempt to report the husband is either divorced by the husband or made to pay a fine. Women in the West Gonja who sustain injuries from an abuse cannot seek medical treatment since the clinics would refer them to the police which would then lead to the arrest of the perpetrator (husband)”.

Educational Programmes on Domestic Violence

Both Government, CSOs and NGOs continue to sensitize the communities in their catchment areas on the Domestic Violence Act. They also offer counselling to victims and seek justice for victims.
About 58.7% of the women interviewed have at least attended or listened to a domestic violence programme. These agencies however complain of resource constraints which goes to limit the number of programmes and communities they can reach. The community members who have benefitted from these programmes praise its importance and the awareness it has generated in their lives. The comment of a participant reads, “Domestic violence constitutes offence and no longer a family issue. I am able to know the effects of domestic violence. My husband cannot force me to make more babies when I know we can’t take care of them. Now I know what constitutes domestic violence and where to report such acts. The programme has increased my knowledge on the rights of women and children”.

**Views of the Police Service on Domestic Violence Act.**


According to the Police Service, the Domestic Violence Act would check domestic violence but wished it is specific on issues relating to gender as majority of people assume it is to keep men from violating women.

Currently, the operations of the police on the protection of women include investigating complaints bordering women, education on women rights, counselling aggrieved parties and prosecuting culprits.

Table 21 shows an overview of incidence of domestic violence from the various regions since 2008. It is obvious from the table 21 that female victims outnumber male victims. Western region also recorded the highest number of cases over the period.

**Table 21: Regional breakdown of Domestic Violence Cases by Sex**

<table>
<thead>
<tr>
<th>Region</th>
<th>Type of Violence</th>
<th>Number of Female Victims</th>
<th>Number of Male Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta</td>
<td>Assault</td>
<td>137</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Unlawful harm</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Threat of death</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Threat of harm</td>
<td>32</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>187</strong></td>
<td><strong>13</strong></td>
</tr>
<tr>
<td>Upper East</td>
<td>Assault</td>
<td>121</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Central</td>
<td>Ashanti</td>
<td>Obuasi</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>Compulsory marriage</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat of harm</td>
<td>7</td>
<td>30</td>
<td>41</td>
</tr>
<tr>
<td>Defilement</td>
<td>4</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Rape</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Abduction</td>
<td>4</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Offensive conduct</td>
<td>25</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>173</strong></td>
<td><strong>640</strong></td>
<td><strong>68</strong></td>
</tr>
<tr>
<td>Central</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>30</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>Child abuse</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-maintenance</td>
<td>462</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat of harm</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murder</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defilement</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abduction</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offensive conduct</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>640</strong></td>
<td></td>
<td><strong>68</strong></td>
</tr>
<tr>
<td>Obuasi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>41</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Defilement</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat of death</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
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<td><strong>2</strong></td>
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<tr>
<td>Ashanti</td>
<td></td>
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</tr>
<tr>
<td>Rape</td>
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<td></td>
</tr>
<tr>
<td>Defilement</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td>223</td>
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<td>1</td>
</tr>
<tr>
<td>Abduction</td>
<td>23</td>
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<td></td>
</tr>
<tr>
<td>parental neglect</td>
<td>609</td>
<td></td>
<td>81</td>
</tr>
<tr>
<td>Region</td>
<td>Crime</td>
<td>Brong Ahafo</td>
<td>Eastern</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>Stealing</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Threat</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>896</strong></td>
<td><strong>82</strong></td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>Rape</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Offensive conduct</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Abduction</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assault</td>
<td>48</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Stealing</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Threat of death</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Exposing child to</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non,maintenance</td>
<td>87</td>
<td>6</td>
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<tr>
<td></td>
<td>Defilement</td>
<td>5</td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>173</strong></td>
<td><strong>17</strong></td>
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<tr>
<td>Western</td>
<td>Assault</td>
<td>695</td>
<td>32</td>
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<tr>
<td></td>
<td>Defilement</td>
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</tr>
<tr>
<td></td>
<td>Rape</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Threat of harm</td>
<td>50</td>
<td>6</td>
</tr>
<tr>
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<td>Threat of death</td>
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<td>9</td>
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<tr>
<td></td>
<td>Harassment</td>
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<td><strong>Total</strong></td>
<td></td>
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<tr>
<td>Eastern</td>
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</tr>
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<td>Defilement</td>
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<td>Indecent assault</td>
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<td>Assault</td>
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<td>Sexual harrassment</td>
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<td></td>
<td>Threat of harm</td>
<td>Non,maintenance</td>
<td>Total</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
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</tr>
<tr>
<td>Greater Accra</td>
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<td>17</td>
<td>735</td>
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<td>Sexual Harrasment</td>
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</tr>
<tr>
<td>Assault</td>
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<tr>
<td>Defilement</td>
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<tr>
<td>Rape</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threat of harm</td>
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<td></td>
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</tr>
<tr>
<td>Incest</td>
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<td></td>
</tr>
<tr>
<td>Threat</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>915</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper West</td>
<td></td>
<td></td>
<td>485</td>
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<tr>
<td>Defilement</td>
<td>55</td>
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</tr>
<tr>
<td>Assault</td>
<td>153</td>
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<tr>
<td>Non,maintenance</td>
<td>115</td>
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<td></td>
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<tr>
<td>Abduction</td>
<td>78</td>
<td></td>
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<tr>
<td>Ofensive conduct</td>
<td>57</td>
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<tr>
<td>Stealing</td>
<td>13</td>
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<td></td>
</tr>
<tr>
<td>Rape</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child trafficking</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>485</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Why Victims of Domestic Violence Abandon Cases**

A number of cases of domestic violence reported to the police are abandoned due to reasons which include: victims cannot afford court filing fees and hospital charges, family intervenes, intimidation by family members, loss of interest by complainant, lengthy and rigid court procedures amidst drain on complainants’ finances. Table 22 shows the breakdown of domestic violence cases reported (green) in some communities and those abandoned (wine).
Table 22: Regional Breakdown of Domestic Violence Cases

<table>
<thead>
<tr>
<th>Region</th>
<th>Community</th>
<th>No. Of Cases Received</th>
<th>No. Of Cases Successfully Settled</th>
<th>No. of Cases Prosecuted</th>
<th>No. of Cases Abandoned By Complainants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta</td>
<td>Jasikan</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Whuti</td>
<td>54</td>
<td>23</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Bowiri Amanfrom</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dzelukope</td>
<td>45</td>
<td>19</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Upper East</td>
<td>Zongo Nogenia</td>
<td>17</td>
<td>5</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Bolga</td>
<td>275</td>
<td>9</td>
<td>19</td>
<td>29</td>
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<tr>
<td>Central</td>
<td>Kasoa</td>
<td>647</td>
<td>-</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>Obuasi</td>
<td>Obuasi</td>
<td>35</td>
<td>7</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Kokote</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patriensa</td>
<td>211</td>
<td>67</td>
<td>24</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Agona palace area</td>
<td>24</td>
<td>14</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Juaso</td>
<td>211</td>
<td>59</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>kentinkrono</td>
<td>122</td>
<td>81</td>
<td>17</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Ayeduase</td>
<td>170</td>
<td>118</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>Amaasu</td>
<td>36</td>
<td>29</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bonsua</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Berekum</td>
<td>223</td>
<td>126</td>
<td>59</td>
<td>42</td>
</tr>
<tr>
<td>Western</td>
<td>Assakae</td>
<td>630</td>
<td>118</td>
<td>24</td>
<td>326</td>
</tr>
<tr>
<td>Eastern</td>
<td>Nsawam</td>
<td>249</td>
<td>21</td>
<td>64</td>
<td>164</td>
</tr>
<tr>
<td></td>
<td>Koforidua</td>
<td>4031</td>
<td>1277</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Akosombo</td>
<td>51</td>
<td>42</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>
4.1.3 Women’s Reproductive Health Rights

Introduction

World Health Organization (WHO) acknowledges women’s reproductive rights as the right of all women to make decisions concerning reproduction free of discrimination, coercion and violence. The United Nation's International Conference on Human Rights (UNICHRs) also describes reproductive rights as the right that entitles women to attain the highest standard of sexual and reproductive health. Reproductive rights include the following; the right to legal or safe abortion, control one's reproductive functions, the right to quality reproductive healthcare, the right to education and access in order to make reproductive choices free from coercion, discrimination, and violence. Reproductive rights may also be understood to include education about contraception and sexually transmitted infections.

Right to Education on Reproductive Health Care

In line with Article 14(b) of CEDAW women have the right to access information, counselling and services in family planning. All clinics and hospitals are to provide general information and counselling to women on their reproductive health. Information collated from focus group discussions indicated that, women are provided information on their reproductive health and about 76.3% respondents accessed this information for free.

Right to Quality Reproductive Healthcare Services

On Ghanaian women’s access to quality reproductive healthcare, reference is made of facilities available for providing the health services, affordability of the healthcare services, availability of drugs and equipment, distribution and attitude of health professionals, quality of reproductive healthcare services rendered, relevance of service delivery in reference to antenatal and postnatal care.
Available Reproductive Healthcare Facilities

Reproductive health care can only be acquired when women have physical access to health centres. With the exception of respondents from Obuasi; all respondents indicated the presence of a clinic or hospital within their reach. The women interviewed indicated that, the clinics or hospitals are accessible in terms of distance. Majority of the health centres are located in the regional capitals and their surrounding towns. This poses a challenge to women living in the small towns and villages which are however addressed by the Community Health Planning Services (CHPS). Only 16% indicated that the health centres they access healthcare from have an ambulance.

The general services provided by clinics on women’s reproductive healthcare across the country include, vaccination of pregnant women and immunization of children, health education, family planning and counselling. The clinics also provide counselling and testing of STIs and STDs.

Affordability of Reproductive Health Care Services

Regarding affordability of reproductive services, pregnant women with NHIS cards are entitled to free healthcare up to 90 days after delivery. This facility is however not available in all health centres across the country. For example, pregnant and lactating mothers without NHIS cards are turned back at the clinic in Yorogo, a community in the Upper West region. Generally, women continue to enjoy antenatal services which are categorised into free and paid for services. Table 23 indicates the services that fall under the categories.

Table 23: Free and Paid for Services under Reproductive Health Care

<table>
<thead>
<tr>
<th>Free services</th>
<th>Paid for services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighing, antenatal, during birth, neo-natal, postnatal, counselling on family planning, health education, HIV/AIDS tests</td>
<td>Family planning, abortion</td>
</tr>
</tbody>
</table>

The NHIS card bearers also go through unduly long processes to access services at health centres. This makes the use of the card stressful.

Availability of Drugs and Equipment

It is sometimes not possible for a patient to obtain all prescribed drugs from the clinic since prescribed drugs could run out of stock. A range of 78% to 93% of the total health authorities interviewed indicated the availability of all essential drugs and equipment necessary for family planning, before, during and after delivery services at the various hospitals and clinics.
Some quotes from respondents are as follows:

“The Avenui Clinic needs rehabilitation, adequate supply of medicines and relevant equipment. Kpenoe community does not have a clinic”.

“The clinic in Jasikan needs facilities such as the scan, xray, palpation and incubation machines. Some delivery drugs are free but not available and all referrals are made to Ho municipal hospital”.

“The clinic is not adequately stocked with antenatal medicines and facilities are not adequate. Winkongo community also obtain prescribed drugs from Bolgatanga”.

**Distribution and Attitude of Health Professionals**

The women interviewed indicated that, there is always someone to attend to them at the health centre each working day of the week. In some areas there are no doctors, nurses or health assistants. A patient’s time of reporting at the health centre normally determines when she is likely to leave. A second factor is the total number of patients that had reported sick at the time. The number of health personnel available also counts. On the attitude of health providers 8.1% respondents ranked them excellent, 39.7% very good, 46.3% good and 5.9% poor.

**Relevance of Reproductive Health Service Delivery to Antenatal and Postnatal Care**

Article 12(2) on CEDAW again indicates states parties to ensure that women have appropriate services in connection with pregnancy, postnatal period, granting free services where necessary as well as adequate nutrition during pregnancy and lactation.

About 95% of respondents interviewed revealed that women are provided adequate antenatal information at the clinic as it adequately prepares them for delivery as well as postnatal care. Eighty seven percent (87%) of the women interviewed received these services and drugs for free. The general attitude of health professionals is also good. Fifty percent (50) of women said they were able to pay for the drugs that were not free. Though most women in the communities are aware of antenatal service some would not access it due to cultural and religious beliefs.

Some quotes from respondents are as follows:

“Pregnant women from Whuti in the Volta region would normally not go for antenatal because they believe their ancestors would grant a safe delivery. This is due to the fact that services at the health centres are not fast and discriminatory”.

“In Nanga community in the Northern Region more women now attend clinic due to the introduction of free food and oil”.
“In sections of the Upper East, un-motorable roads makes it difficult for expectant mothers to attend antenatal care.”

During delivery 95% respondents indicated that they are provided adequate information on the delivery procedure. This service was free and the attitude of the staff was also good. All the drugs required during delivery were also provided for free to 80.3% respondents. For those who had to pay for the drugs 82.3% were able to afford. This is likely to have contributed to the low incidence of maternal mortality as indicated in the table 24.

Table 24: Maternal Mortality from January 2008 to May 2009

<table>
<thead>
<tr>
<th>REGION</th>
<th>Community</th>
<th>Number of Maternal Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta</td>
<td>Whuti</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Dzelukope</td>
<td>5</td>
</tr>
<tr>
<td>Upper East</td>
<td>Zongo nogsenia</td>
<td>7</td>
</tr>
<tr>
<td>Central</td>
<td>Winneba</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Assin foso</td>
<td>16</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Tepa</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Konongo</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Offuman</td>
<td>3</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>Amaasu</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mo-line</td>
<td>12</td>
</tr>
<tr>
<td>Eastern</td>
<td>Koforidua</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Manya krobo</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Kade</td>
<td>21</td>
</tr>
<tr>
<td>Upper West</td>
<td>Nandom</td>
<td>8</td>
</tr>
</tbody>
</table>

Right to Family Planning and Safe Abortion
As part of women’s reproductive rights, every woman is entitled to family planning and safe abortion. This is in line with the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. According to 76.3% respondents, health centres offer
them counselling services on family planning. They are also exposed to the various family planning options. On the right to safe abortion, only 35% of respondents indicated health centres provide them with information on the availability of abortion services. Respondents from Greater Accra did not indicate they are provided any information on the availability of abortion services.

4. 1.4. Marriage in the Ghanaian Context

Introduction

Article 6 of the Optional Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (2003) reiterates provisions under International Conventions by aiming among others, to enhance the right to equality of men and women in marriage. Marriages are sacred and treasured traditions in Ghana and notwithstanding modernity, culture continues to play a key role and dictates the roles and duties of the couples in the three forms of marriage, ordinance, mohammadan and customary. The legal age for marriage in Ghana is eighteen years and above and this should be with the full consent of the parties involved.

Women continue to enjoy the following rights: right to marriage, work and bear children. It was indicated that in the Builsa district, women’s rights are not respected and their rights are those that are sanctioned by their husbands. The rights of women in marriage is also restricted in the following; taking decisions in marriage, liberty of the wife to travel at will, attend meetings or join any association should be at the acceptance of the husband.

**Customary, Mohammadan and Ordinance Marriage Rites**

A practical customary rite would involve, some payments and provision of some drinks. The bride and her parents are aware of the payments made at every level of the process.

The mohammadan form of marriage pre-dominantly for moslems. It includes greetings with empty hands first, followed by visit with cola, tobacco and guinea fowl with the consent of ones parents. The bride’s parents also consult with the groom’s family. An agreement is reached after which the bride is sent to the groom followed by a marriage feast. The groom then pays the bride’s dowry to end the marriage rites.

The ordinance however, involves the registration of the marriage in a competent court of jurisdiction by the couple.

Not all women however go through marriage rites since, some women move in to live with their boyfriends without the necessary rites and start making babies. Some men also complain of the expensive cost of dowry. Cohabitational marriages therefore, continue to persist in some communities.
Table 25 shows statistics on the type and number of marriages registered for the period between January 2008 to May 2009. Mohammadan marriages are normally not registered since the emphasis is on the payment of dowry which seals the marriage.

Table 25: Type and Number of Marriages Registered

<table>
<thead>
<tr>
<th>Region</th>
<th>Type Of Marriage (i.e Customary, Mohammadan and Ordinance Marriage)</th>
<th>Number of Marriages Registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta</td>
<td>Customary</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Customary</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>30</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Customary</td>
<td>1390</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>2143</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>Customary</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>2145</td>
</tr>
<tr>
<td>Western</td>
<td>Customary</td>
<td>327</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>515</td>
</tr>
<tr>
<td>Eastern</td>
<td>Customary</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>170</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>Customary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mohammadan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ordinance</td>
<td>1930</td>
</tr>
<tr>
<td>Tema</td>
<td>Customary</td>
<td>208</td>
</tr>
<tr>
<td>Mohammedan</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Ordinance</td>
<td>2685</td>
<td></td>
</tr>
</tbody>
</table>

**Public Education Programme on Marriage**

About 30% respondents have ever attended or heard of any educational programme on marriage. They indicated that the programmes organized by Government agencies, NGOs and CSOs have increased their knowledge on marriage. They are aware of the legal age at which a female can be married. They are also aware of the proper marriage procedures and have identified several marriages that were not contracted properly.

**4.1.5 Inheritance, Wills and the Wills Act**

**Introduction**

A Will is the legal document that determines how a deceased relative would like his or her property to be shared. Anyone who owns a property can make a will to cover it. Wills are prepared by seeking the advice of a lawyer who then proceeds to draft it in the presence of a witness. After which a copy is deposited in court. Wills are revoked any time by the testator and takes effect one year after the death of the testator. It can as well be revoked on the death of a beneficiary or upon divorce or when the owner of the will decides to change its content.

Though 75% of community members interviewed across the country know what a will is, who can make a will and where to keep a will, only 8% have actually made a will. This is attributed to the fact that, respondents assume they do not have any property which may bring litigation in future or have no child yet to bequeath properties to. There is also the erroneous impression that anyone who prepares a will is close to dying, as well as, the idea that only the rich prepare a will.

About 79.6% respondents do not have any knowledge of the procedures one goes through to make a will nor the fact that a will can be revoked.

The right to inheritance also continues to be an issue nationwide since the intestate succession law is not widely known. Illegitimate people continue to have more access to farmlands and other properties in the communities. Girls are not allowed to inherit deceased fathers because it is assumed she will get married and leave the father’s compound. Girls are allowed in extreme cases to inherit partially depending on the family however, they can inherit their deceased mothers.

Respondents indicated that, in the event where a woman loses her husband the table 26 indicates the section of his properties she can inherit.
Table 26: Properties Women Can and Cannot Inherit

<table>
<thead>
<tr>
<th>Properties women can inherit</th>
<th>Properties women cannot inherit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animals, clothing, Household chattels, House, foodstuff, money, Jointly acquired properties</td>
<td>Gun, clothes of deceased, Land(inherited farms owned by the dead spouse), properties held in trust for the family</td>
</tr>
</tbody>
</table>

A respondent said:

*People in the rural areas of Sekyere South Agona in the Ashanti Region are not aware of the PNDC law and so their women are suffering, the widows are being maltreated. In Mampong municipality, properties of deceased husbands are shared according to the customary practices which exclude the widow. She is only given a portion on humanitarian grounds.*

The intestate succession law seeks the proper inheritance of a deceased relative who died intestate. It is primarily to protect the right to inheritance of a surviving spouse and children. About 62% of men and women interviewed across various communities in Ghana are aware of the intestate succession law. However, 55% are unaware that the property of a relative who dies intestate is to be shared according to the law, 9/16 portion goes to the children, 3/16 to the spouse, 1/8 to surviving parents and 1/8 to the successor. Another respondent said:

*Though community members of Ada in the Dangbe East district of the Eastern Region are aware of the intestate succession law, they become adamant to it when sharing the properties of people who die intestate.*

**Redress Institutions on Inheritance and Wills**

Thirty two percent (32%) of those interviewed are aware of CHRAJ and the courts as redress institutions for issues on inheritance out of which 19% have ever patronized their services and were satisfied with the services rendered to them. According to 74% of Government institutions, NGOs and CSOs working in the various communities, the intestate succession law is steadily addressing discrimination when it comes to who can inherit who and what. However, more education is required in the villages.
CHAPTER FIVE

HARMFUL CULTURAL PRACTICES

5.1 Widowhood Rites

Introduction

The protection of women’s rights is reflected in major international and national instruments. The Convention on the Elimination of all forms of Discrimination against Women (CEDAW), Article 5 (a) and Chapter 6 of the 1992 Constitution of the Republic of Ghana article 39 (2) all allude to the need for modification and if possible abolishing of traditional practices which are injurious to the health and wellbeing of the person.

Ghana is one of the countries that have steadily endeavoured to fulfil its State obligations toward fulfilling women’s human rights. However, societal norms and perceptions of women in Ghana still remain negative and discriminatory. Some of the norms and traditional cultural practices are in direct contradiction with women’s rights, perpetuating gender discrimination and the subordination of women in all stages of life. It is on this basis that the commission as part of monitoring the general human rights situation in Ghana, monitored widowhood rites.

Widowhood rites involve rituals ranging from seclusion and general isolation from the wider community to causing physical harm to the widow. Of the 27 respondents from various government institutions, 89.2% agreed that widowhood rites go with certain negative health implications. Some of these included psychological trauma and transmission of sexual diseases.

. Fighting against widowhood rights may not necessarily mean calling for its abolition entirely but rather calling for the abolition of certain dehumanizing aspects of it. Some amount of importance, however little, could be attributed to the cultural practice since 61.7% of the community members who were interviewed declared that widowhood rites as a cultural practice is necessary. These respondents claim that the rite separates the spirit of the man from the widow; gets them identified as widows; gives the widows spiritual protection and also prevents them from committing suicide.

Respondents

A total of 50 people from various communities of seven regions of Ghana were interviewed to get their take on the pressing issues of widowhood rites practice. Of this 10%, 18%, 6%, 2%, 28%, 6% and 30% were from Brong Ahafo, Central, Greater Accra, Upper East, Volta, Northern and Western region respectively. Most (80.4%) of these respondents, were above 40 years. Government institutions such as the Department of Community Development, Department of Social Welfare, MOWAC and National Commission on Civic Education working in the various communities were interviewed. Women in Law and Management, CENSUDI, Kids Foundation and Action Aid among others are non-governmental organizations working in the communities. Some religious bodies, widows and widowers
were interviewed in the Commission’s bid to monitor the state of human rights with respect to widowhood rites.

**Prevalence of Widowhood Rites**

Widowhood rites are widely practiced in Ghana, though they are of various forms and procedures 95.8% of the community members alluded to that. Widowhood rites take forms such as; dressing differently (usually black in the Volta region), accepting no donation from anyone, being bathed in the sea by other people sometimes with herbs as in the Brong Ahafo and other times it takes the form of depriving the widow of food for some time.

**Violation of Human Rights through Widowhood Rites**

Of the 46 community members who answered the questions, only 23.9% thought that widowhood rites do not violate human rights in their communities whilst 69.6%, said that it does violate the human rights. 6.5% have no idea as to whether widowhood rites violate human rights or not.

**Health Implications**

On the issue of health implications of widowhood rites, 89.2% of these institutions agreed that certain aspect of widowhood rites have some negative health implications. Some of these included psychological trauma, transmission of sexual diseases etc. They therefore suggested the abolishing of the dehumanizing aspect of the practice such as bathing very chilled water, deprivation of food and also sleeping in the same room with the corpse.

**Consequences of refusing to Undergo Widowhood Rites**

Women who refused to undergo widowhood rites suffer many abuses. According to some respondents in the Brong Ahafo and Central regions, these women are accused of being responsible for the death of their spouse while others are verbally abused and denied some of the property of their deceased spouse. Other respondents claim that such women can be banished whilst some say that the community does not physically inflict pain on the woman but believes that the spirit of the man haunts such women.

**Support for the Abolishing of Widowhood Rites**

Though some might be mealy-mouthed about the abolition of certain cultural practices because of the fear or belief in certain consequences, others remain resolute and eloquent about its abolition. Support for the abolishing of widowhood rites were divided among community members interviewed- 51% were in support of abolishing these rites while 49% were against it. Some explained that widowhood rites are necessary because it is one of the cultural practices of the community. 73% of government institutions indicated their readiness to support the abolishing of the rite. Despite the implications it may pose, some 27% of the respondents from these governmental institutions maintained that the practice should not be abolished. CSOs interviewed generally stressed the need for something to be done about
widowhood practice. They however appeared skeptical by adding that, not all aspects of the practice are wrong or should be abolished.

57% of religious organizations interviewed declared that the cultural practice should be outlawed. About 42.9% of the respondents from various religious bodies however revealed that their sects support certain practices of widowhood rites. 49% of widows interviewed thought widowhood rites should be modified while 49% said it should be outlawed. 95.7% of the widows indicated that they have not received any form of assistance from any organization.

**Campaigns against Harmful Widowhood Practices**

In the light of the high prevalence of inhuman widowhood rites, the expectation would be that, many organizations would get seriously engaged in Anti-Widowhood rites campaign in various parts of the country. The CHRAJ revealed otherwise; not many organizations are involved in the fight against inhuman widowhood rites. 50% of the community members said no organization exists to campaign against the inhuman practice in their communities.

According to the respondents, the few organizations involved usually focus on advocacy and public education. Sometimes they do well by going to churches to preach against the rites and hence advise the public to desist from the practice. Some of the organizations that campaign against widowhood rites are the Upper East Region namely; Widows and Orphans Ministry, World Vision Ghana, CRS, Catholic Church, Deeper life and the Presbyterian Church. Others in the Volta Region include PACODEP which focuses on education and also WILDAF which monitors, counsels and educate the people on their rights. Organizations that were also mentioned included God’s Glory Global Outreach Centre, NCCE, CHRAJ and Social Welfare Department in the Brong Ahafo, Central and Western Regions respectively.

87.5% of government institutions said that their institutions undertake programs which are often done to stop the cultural practice. Working effectively in the area of widowhood rites requires enough empowerment. This is the view shared by about 94.6% of the respondents.

Non-Governmental Organizations in 84.4% communities noted that their organisations undertake community-based anti-widowhood rites campaigns. According to the interviewees, their organizations mainly monitor, advocate and educate the public on widowhood rites.

**Conclusion**

Whilst majority of all respondents supported the abolition of widowhood rites, some community members thought that the practice is still necessary as they claimed that the rite separates the spirit of the man from the widow; gets them identified as widows; gives the widows spiritual protection and also prevents them from committing suicide. This goes to explain the observations of some respondents that only the harmful aspects of the practice should be abolished. The interview of victims of harmful widowhood rites also revealed that both governmental and non-governmental institutions do not support them during their times of pain.
5.2 Tribal Marks

Introduction

Tribal marks are marks intentionally or purposely made on the face and other parts of the human body. This could be done for beautification (tattooing). Tribal marks are also done as a form of sacrifice for traditional treatment of children suffering from convulsion, measles and pneumonia among others. It is also used to identify the individual with his or her clan or ethnic group. This practice is part of the African belief system and used as a means of tracing tribesmen and women who have migrated to other lands. For example, one vertical mark on the face of a Dagomba identifies him as having grand-fathers in Nigeria. Tribal marks are common to the Akans, Gas and the following tribes from the three northern regions; Gonja, Nanumba, Frafra, Mamprusi and Dagomba.

A tribal mark for identification is made following the naming ceremony of the child. The mother is requested to breastfeed the baby and in the process a sharp knife or blade is used to cut the face or the particular section of the baby's body. Contrary to this practice, Article 28(3) of the Children's Act 560 however states,

“No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.”

This implies that, no one has the legal right to create tribal marks on children since it cruel and a form of torture.

In the other tribes aside the three northern regions, a mother who looses any child she delivers before the child is a year old is made to give a tribal mark to the next child. This is to ward off evil spirits believed to have caused the deaths of the previous children. The surviving child is then given a name such as Donkor, Kaya, and Begyina.

A form of tribal mark depends on the tools and techniques used, factors related to skin healing, and the types of substances introduced to the wound. Various sharp objects are employed in the cutting process to produce different scar effects. The tools include:

- A triangular-shaped razor called *ugelle* or *uche*;
- Nails turned into knives by forging their sharp ends to form blades;
- Knives;
- Sharp glass;
- Pen knives or butcher's knives;
- Semi-circular blade.

Scars can be raised or indented, globular or linear, depending on the tool used. To make raised, globular scars, a hook is used to pierce the skin and pull it upwards so that it can be cut across with a blade. As the skin heals a round, raised scar is produced. Indented scars are often made using nails or blades to cut into the skin and sometimes cut a thin strip out of the skin. These are usually linear scars.
To produce a raised scar as opposed to a flat or sunken scar, raised cuts are made by “making the lines of cuts on the body or face, then stretching them open and inserting pads of palm leaf or other padding beneath the skin. Soot or oil is rubbed in and the treatment is repeated until the keloids or ‘beauty berries’ have attained the desired size and protrusion.

**Effects of the tribal marks**

Tribal marks are often made against the wish of the victims who are mostly children and the injury to the skin such as “the prick of a pin or a trifling cut or burn of the number of marks repeatedly made on a person at a time is so painful and unbearable. The whole process can be described as torture and barbaric. Severe pain is felt after the operation is carried out until the wound heals.

There is also evidence of very pronounced scars resulting from the introduction of foreign materials into the skin. This is the deliberate reaction that results from adding foreign substances after cuts are made on the skin, and this might lead to serious functional and cosmetic problems for the patient.

The use of unsterilized instrument on a number of people can cause the spread of HIV/AIDS, hepatitis B and Tetanus or sepsis (bacterial infection).

The marks produce permanent damage to the facial skin beauty which is potentially irreversible.

**Relevance of Tribal Marks**

Tribal marks have outlawed their usefulness. According to 82.8% of respondents, though they are relevant to serving as a visible mark to identify a tribesman, it has also contributed to war factions easily identifying their opponents and killing them in the event of strife. The practice should rather be abolished to promote a culture of unity among the tribes and eliminate favoritism and nepotism. Respondents with tribal marks indicated that, tribal marks inflicted for healing purposes is good but that for identification of a sort has two sides, the one with a small mark which does not disfigure the face can continue to help in easily tracing a tribesman who has relocated. The second with long marks disfigures the face and the healing process is also painful so should be abolished. This notwithstanding, others however believe tribal marks for identification purpose is also good because, it is easy to identify a tribesman. Despite the fact that it deforms the face, it also protects the children against certain diseases later in life as it is believed.

**Campaign against Practice**

At least within every six months an NGO embarks on a campaign against tribal marks in the three Northern regions. Government agencies also advice practitioners to seek the consent of the victims prior to the act. These initiatives have reduced the practice according to 87.5% respondents.
5.3 Female Genital Mutilation

Introduction

Traditional practices constitute a major aspect of the Ghanaian culture and play a significant role, one of which is a sense of belongingness. These practices define the culture and values of the individual and to a large extent contribute to the various tribes/ethnic groups existing in the country and also form part of the Ghanaian history. Although the significance of these practices cannot be underestimated, some are also inhuman and discriminatory to the human existence and hence the need to abolish them.

The term Female Genital Mutilation/Cutting (FGM/C) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other reasons that are not medical necessities. From the statistics derived from the Multiple Cluster Indicator Surveys (MICS), published by UNICEF, it revealed that in the year 2005, an estimated prevalence of female genital mutilation in girls and women between the ages of 15-49 years was 3.8%.

FGM as a Human Rights Violation

A human rights perspective sets FGM/C in the context of women’s social and economic powerlessness. Recognizing that civil, political, social, economic, and cultural rights are indivisible and interdependent is a crucial starting point for addressing the range of factors that perpetuate FGM/C. A human rights framework affirms that, the rights of women to physical and mental integrity, to freedom from discrimination and to the highest standard of health are universal. Violations of these rights can never be justified.\(^1\)

FGM/C and International Law

*General Recommendation No.19 of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* asserts, "gender-based violence... is... violence that is directed against a woman because she is a woman or affects women disproportionately..." States are obligated under international law to prevent, investigate and punish violence against women.\(^1\)

*The UN Declaration on the Elimination of Violence Against Women* recognizes that, violence against women not only deprives them of their civil and political rights, but also their social and economic rights, saying that, "the underlying structural consequences of these forms of gender-based violence help to maintain women in their subordinate roles, contribute to their low level of participation and to their lower level of education, skills, and work opportunities." The Declaration provides that, states should not invoke any custom, tradition, or religious consideration to avoid their obligation to eliminate violence against women, and that they


must exhibit due diligence in investigating and imposing penalties for violence, and establishing effective protective measures.

Five communities where the practise took place were monitored, these are;

- **Pindaa Community in the Upper East Region**
- **Karni Community in the Upper West Region**
- **Guli community in the Upper East Region**
- **Dimajan Community in the Upper West Region**
- **Zambo community in the West Region**

**Pindaa Community**

The Pindaa community is found in the Kassena –Nankana district of the Upper East region of Ghana.

**Form of FGM**

The type of Female Genital Mutilation which existed in this community was the removal of the female genital organs i.e. cutting of the prepuce, the clitoris and part or whole of the labia minora (small lips) leaving the vagina opened. The community had not gone through the practise for the past ten years.

**Reasons for the Practise**

The practice is done to acknowledge the fact that, they have attained the age of marriage. Refusal to go through the practice will mean that, if one dies she would be treated as a man.

According to community members, it is an age old practice handed over time, but for now it has outlived its usefulness and must be discouraged, for it results in the death of women i.e. through excessive bleeding.

Community members felt very bad about the behaviour of families who subject their children to this act and are trying to dissuade families from this act.

**Processes Involved**

Young girls who attain the age of marriage at the community are gathered and a practitioner invited either from Burkina Faso (Chebell) of the Gurune speaking areas of the region. The tools used are usually knives made from local materials known as “pongo” with herbs. A lot of women get infected and die.
Views from victims of FGM

According to them, the practice is a very painful ordeal. Some women bleed profusely and are affected by sickness and infections.

They were informed that, refusal to go through is tantamount to being treated as a man when one dies.

Some resisted the practise and the victims supported their action; they had lived ever since and nothing happened to them.

All the victims said, it is a bad practice and must be stopped because, it had resulted in the suffering and deaths of many women. Moreover, a lot of men refuse marrying women who went through the FGM.

Campaign against the Practice

In this community, health workers of the Pindaa Community Health Compound are the major campaigners against the practise. This they do, by educating the community on general health issues. The practise has reduced drastically due to the campaign.

Religious bodies are also involved in the campaign against the practise. These are Anglican Diocesan Development Ballet Organization and the Federation of Muslim Women Association of Ghana. The first focuses on the negative cultural practices that are dehumanizing and degrading whereas, the latter focuses on the campaign against dehumanizing treatments against women.

In summary, responses showed that, the practice has almost died off or decreased significantly in the community but sensitization is still needed.

Karni Community

The Karni community is found in the Karni Lambussie district of the Upper West region of Ghana.

Form of FGM

This involves the removal of the clitoris of the female genital organ.

Reasons for the Practice

It was practised for easy penetration of the penis. According to community members, they were made to believe that it makes the woman sexier.

Processes Involved

An old woman would put the child on the labs open the legs and would cut the clitoris with a razor blade. Tools used are not sterilised and this could lead to HIV/AIDS.
Views from victims of FGM

According to them, it was painful but as a child there was no option once your parents wants it carried it out, you cannot resist. They were told the practise reduced immorality among women that is what our parents in the olden days used to say. The practice used to be performed at a very early stage so there was no resistance.

Campaign against the Practice

Responses showed that no respondent is aware of the presence of any organisation in the district focused on campaigns against FGM.

Trend of FGM

The responses evidently agree that, the trend of FGM in the communities or locality where these organisations work has decreased significantly.

To conclude, most communities indicated that, it is no longer practiced in their communities and that it should be abolished because it is an inhuman, outmoded and bad practice.

Guli Community

The Guli community is found in the Wa Municipality of the Upper East region of Ghana.

Form of FGM

The type of Female Genital Mutilation is cutting of the clitoris.

Reasons for the Practice

The main reason put up was that it reduces promiscuity.

Processes Involved

Blade is used in cutting the clitoris and this is done seven days after birth. Black powder is then used to stop the bleeding.

Views from Victims of FGM

According to them, formerly they considered it a good practice. But presently, it is an outmoded practise and therefore not good.

Dimajan Community

The Dimajan community is found in the Sisala district in the Upper West Region.

Form of FGM

Respondents did not know the form.
Reasons for the Practice
The purpose is to reduce the sexual desires of the girls. Some also said it is done to remove dirt.

Processes Involved
A U-like shaped hook is used to pierce the clitoris to hold it so a blade can be used to cut it off. A mixture of locally made concoction is then used to stop the bleeding.

Views from Victims of FGM
According to them, FGM is a bad practice. “We used to insult and curse whoever came around to resist the practice but now they know FGM is bad”. Some said they do not enjoy sex.

FGM according to them is bad, could make a girl barren and could lead to death through bleeding.

Campaign against the Practice
Responses showed that no respondent is aware of the presence of any organisation in the district focused on campaigns against FGM.

To conclude, respondents indicated that it is no longer practiced in their communities.

Zambo Community
Zambo is a community found in the Lawra district of the Upper West Region of Ghana.

Form of FGM
Female Genital Mutilation (FGM) in this community takes the form of cutting the clitoris after which sheabutter is smeared on to dress the wound.

Reasons for the Practice
FGM is done to avoid promiscuity. It is also believed a woman cannot get pregnant with her clitoris on. Even if she gets pregnant, her clitoris can cause an abortion.

Processes Involved
After FGM excision, herbs are boiled and the wound is massaged. After which Sheabutter is applied. The tools used for the FGM are never sterilised. There is a possibility of contaminating others, if the apparatus used are not sterilised.

Views from Victims of FGM
Victims indicated that they are now aware that the practise is wrong, and would readily report to the appropriate authority; police, chief or CHRAJ, if anyone is seen engaging in it.
Campaign against the Practice

The Information Service uses Mobile Van to inform the community about the legal instrument prohibiting the practice of FGM. Also CHRAJ uses its Public Education programmes to sensitize communities.

Views from Victims of FGM

According to them, when giving birth tears and scars are produced. The scars easily break into fresh wounds and cause excessive bleeding which can lead to death. The scars are treated by sitting on hot-sit-baths. According to them it is very traumatic.

They also said that, those who have not had the FGM are lucky because, they do not experience tears like they do when giving birth .They are also informed by some men that, they enjoy sex with those who resisted the practice.

In their opinion, FGM is bad, due to the excessive bleeding, the pain and the tears that they experience during child birth. It can also lead to contamination or transmission of STDs.

Focus Group of NGOs or CSOs - Campaign against FGM

The Information Service and CHRAJ are organizations that are involved in the regular education of the community on the ills of FGM.

Trend of FGM

The responses evidently agree that, the trend of FGM in the communities or locality where these organizations work has decreased significantly. The last record of FGM was in 2007. This was reported at the DOVVSU office in the Lawra district.

In brief, the practise has decreased significantly. Continuous sensitization would bring about a complete end to the practise.

5.4. Trokosi

Introduction

“Trokosi” has its name from a combination of two mutually exclusive Ewe (one of Ghana’s major languages) words, tro and kosi. Tro means deity and kosi is a slave which when combined means a slave of deity.

It is a practice whereby women and girls are held as captives, ‘sacrificial lambs’, for the pacification of deities and ancestral spirits. Societies that practice Trokosi believe that when the deities are wronged by a member of a family or a clan, the repercussions are visited on the family till a member of that family atones for the wrong by relinquishing a girl child or woman preferably a virgin to serve in the slave camp.
This practice is most prevalent among two patrilineal groups: the Ewes of southern and northern Tongu and Anlo, and the Dangmes of Greater Accra Region. Among the Dangmes, such groups are known as woryokoe.

Chapter 5 of the 1992 Constitution of the Republic of Ghana spells out the Fundamental Human Rights and Freedoms of all persons. Specifically, the practice violates Articles 15, 16 (1) (2), 17, 21, 25, 26 and 28 of the 1992 Constitution, which is inviolability of the human person, slavery, forced labour and confinement of any form.

In this year’s report, aspects of rights issues investigated include:

- The right to adequate housing;
- The right to health and sanitation;
- The right to education;
- Freedom of religion;
- The campaign against the practice and
- Re-integration.

Background Information on Trokosis

Available statistics from the monitoring of 17 shrines in the Volta region indicated that from 2007 to date, a total of nine (9) females have been admitted and yet to be liberated in the Torgbi Gatu Badza, Nyigbaledzi and Torgbi Nigbla shrines. (See table 27). The occupation of these females include petty trading, farming, fish mongering and mat weaving. Some family members also provide support in cash and in kind.

Table 27: Statistics on the Number of Trokosis Admitted and Liberated from 2007 to 2009

<table>
<thead>
<tr>
<th>Shrine</th>
<th>District</th>
<th>Physical Location of Shrine</th>
<th>Year</th>
<th>Number admitted</th>
<th>Number Liberated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nana and Kunde</td>
<td>Keta</td>
<td>Anyako-Woeta. From Abor move southwards toward Keta Lagoon</td>
<td>2007</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2008</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2009</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Torgbi Gatu</td>
<td>Ketu-North</td>
<td>Afife</td>
<td>2007</td>
<td>1</td>
<td>nil</td>
</tr>
<tr>
<td>Badza</td>
<td></td>
<td></td>
<td>2008</td>
<td>nil</td>
<td>Nil</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2009</td>
<td>nil</td>
<td>Nil</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2007</td>
<td>1</td>
<td>Nil</td>
</tr>
</tbody>
</table>
Despite the criminality of the practice, five shrines are still admitting Trokosis these are:

**Table 28: Shrines admitting Trokosis**

<table>
<thead>
<tr>
<th>Shrine</th>
<th>District</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nana and Kunde Shrines</td>
<td>Keta</td>
<td>Anyako-Woeta. From Abor move southwards toward Keta Lagoon</td>
</tr>
<tr>
<td>Bekli Shrine</td>
<td>South Tongu</td>
<td>Avegagorme</td>
</tr>
<tr>
<td>Torgbi Nigbla and Mama Ziorpe</td>
<td>Ketu-North</td>
<td>Alakple</td>
</tr>
<tr>
<td>Nyigbaledzi</td>
<td>Ketu-North</td>
<td>Afife</td>
</tr>
<tr>
<td>Torgbi Gatu Badza</td>
<td>Ketu-North</td>
<td>Afife</td>
</tr>
</tbody>
</table>

Notwithstanding, the continuous admission of Trokosis to some shrines, coupled with the human rights violation, the present number of Trokosis admitted into various shrines has decreased significantly over the past year.

**The Right to Adequate Housing**

General comment 4.8d states “…. Adequate housing must be habitable, in terms of providing the inhabitants with adequate space and protecting them from cold, damp, heat, rain, wind or other threats to health, structural hazards and disease vectors.” From the above provision on housing, our focus was therefore centered not only on the type of materials used for housing, but its safety for the occupants.

This research revealed that 56.7% of Trokosis live in mud huts whereas, 43.2% are in sandcrete. Majority (68.8%) of settlements of Trokosis had natural roofing materials and 25% in iron sheets. One abode however was tiled.

Despite that all the houses for residence were found to have been roofed with thatch, the leave coverings had dried up and lacked frequent maintenance. Consequently, the supposed
roofs had lost their protective abilities. Typical of this problem were, Nyigbaledzi, Torgbi Gatu Badza, Shiorbor, Adzemu and Torgbi Nigbla shrines. Trokosis interviewed from the Torgbi Nigbla and Shiorbor shrines indicated to the monitoring team that, their rooms are not in the best of shapes.

The forms of energy used varied from firewood (55%) to charcoal (31%). The Nana and Kunde Shrines alone used charcoal, firewood, electricity and gas as forms of energy.

To conclude, even though, Trokosis used firewood and charcoal as their main source of fuel, their homes had serious roofing problems leading to leakage that calls for immediate attention.

The Right to Health and Sanitation

The most common ailment suffered by Trokosis was malaria. No one prevented any Trokosi from seeking medical attention; they sought medical attention whenever they fall sick. In majority (57.1%) of the cases, the priest is responsible for paying medical bills of Trokosis. Relatives and friends (28.6%) also foot medical bills. Only 14.3% accessed the National Health Insurance Scheme.

Though pipe borne water was the main source of water for most of the shrines that were monitored, four shrines namely, the Koleh, Shiorbor, Torgbi Nigbla and Torgbi Gatu Badza shrines had no potable water. However, those shrines with the facility had regular flow of water.

All shrines had very neat environments. Trokosis and other shrine settlers dispose refuse at public dump sites found at the outskirts of town.

Predominant among the toilet facility in the shrines were traditional pit and Ventilated Improved Pit latrines (KVIP). The sanitary conditions of the toilet facilities were good; the toilet facility is tidied up every morning. Apart from the Bekli shrine, all other shrines had adequate toilet facility for settlers. However, four shrines, including Shiorbor, Nyigbaledzi, Torgbi Nigbla and Torgbi Gatu Badza had no toilet facility.

In summary, Trokosis access medical facilities for attention whenever they fall sick. Priests, relatives and friends paid for the medical bills. Most shrines had potable water, and those without water in their shrines could easily access it from close by, without much difficulty. Sanitary conditions of toilet facilities were generally good. The overall shrine environment was found to be neat.

The Right to Education

Primary, Junior High and Senior High Schools were accessible to Trokosis. Responses showed that 50% accessed primary education.

All but the Bekli shrine enrolled Trokosis at various government schools. At the Adzemu shrine, the priest indicated that, he has released land for the construction of a community
school which was underway. However, response from the Bekli shrine indicated that, the issue of schooling was not the concern of the priest, but the parents of Trokosis.

Non formal education division of the Ministry of Education organizes adult literacy programs for some Trokosis. Approximately 40% of shrines monitored had not benefited from the adult educational programmes for Trokosis.

In fact, Trokosis had access to both formal and non-formal education with majority accessing primary education. However, only sixty percent (60%) of shrines monitored had access to adult educational programmes.

Freedom of Religion

Almost half of the shrines monitored were not allowed to engage or practice any other form of religion. Torgbi Nigbla, Tomife, Koleh, Danso Tovor, Torgui Ganadzi, Torgbi Gatu Badza, Torgbui Adzema shrines refrained from the enjoyment of their freedom to practice any religion of choice.

The Campaign against the Practice

In the South Tongu district, IN-Network, CHRAJ, and MOFA are organizations engaged in campaigns against the practice. Their campaign programs are in the form of advocacy.
Traditional rulers, opinion leaders, community members and the priests are targets of campaign programs organized by the above mentioned organizations.

IN-Network monitors the situation at settlements every quarter. Their last visit was done in July 2009.

According to 73.3% of District Assembly representatives interviewed, the campaign against the practice of Trokosis is non-existent. For those who indicated that, there is an ongoing campaign, they lamented about its effectiveness because public awareness is low. Some assemblies also complained about the non-enforcement of the law on Trokosi.

Some liberated Trokosis advised organizations in the campaign against the practice to intensify their educational campaigns in their communities, focusing on the harmful and discriminatory aspect of the practice, reiterating on the enforcement of the law.

**Experiences of Liberated Trokosis**

Some liberated Trokosis were interviewed as part of this exercise. These supposed liberated Trokosis had stayed in the shrine between less than a year and more than five years.

On whether the Trokosi practice is necessary, only 37.5% answered in the affirmative. The reason given was that, the practice never failed in arresting culprits of heinous crimes. The only concern was the use of human beings for reparation purposes; modification of the practice was recommended.

However, 62.5% were of the view that, the practice is not necessary because it perpetuates inhuman treatment and there are alternate places of redress.

Some described their experience in the shrine as bad in that they were not allowed to do anything on their own. As custom demands, they were not expected to complain. The practice according to them has reduced their dignity as human beings.

In contrast, one liberated Trokosi said she was not against the practice since it is a custom of their fathers. She explained that, the practice will reduce crime in the community and bring about harmony in the community.

**Re-integration**

Re-integration into the community had been very problematic; the members of the community refuse to accept the liberated or freed ones. Their businesses are not patronized and those who are able to sustain theirs have low clientele. This unfortunate situation, sometimes result in relocation. Men in their community refuse to marry them because of fear and the stigma attached to the liberated Trokosis.

Some of the liberated Trokosis claim that, an NGO involved in campaign against the practice, International Needs, promised various forms of training after liberation but have failed to deliver on their promises.
Conclusion

This report has revealed that, some shrines are still admitting Trokosis. The law that bans the practice seems to be mere paper work which is not been enforced. This observation is based on the fact that, since the passage of the law, nobody has been arrested and prosecuted for admitting and harbouring Trokosis. Concrete steps must be taken to stop the practice entirely.
CHAPTER SIX

SUSPECTED WITCH CAMPS

6.1 Introduction

“Witchcraft accusations” are allegations levelled against persons suspected of possessing evil powers meant to harm people and bring misfortune upon the society. They are claimed to exercise or invoke alleged supernatural powers to control people or events, practices typically involving sorcery. It is the power in a person’s domain to do harm or influence nature through occult means. Witchcraft is practiced by both men and women, although statistics have shown that, elderly women above 60 years are more often accused of this practice than their male counterparts.

In respect to the above, men and women who are suspected to be witches and wizards suffer the fury of the community members who may end up lynching them.

To escape from the angry mob, the suspected witches and wizards seek refuge in these settlements to save their lives and spare themselves from excessive discrimination.

6.1.1 The Kukuo Settlement

Background Information

The Kukuo Witch Camp is located in the Nanumba south district of the Northern Region. The present total number of dwellers in the settlement is two hundred and ninety eight (298) persons. Out of this number, twenty (20) males and one hundred and fifty one (151) females are children (below the age of eighteen as defined by the 1992 Constitution of Ghana). However, a male and one hundred and twenty six (126) female settlers are aged (above 60). It was revealed in the monitoring that, the longest period served by a suspected witch at the time of visit was about thirty nine years (39).

The Kukuo settlement that has over the years been a hub for witches has reduced its number of settlers from 535 in 2005, 314 in 2006, 114 in 2007 to 113 in 2008. The number which gradually reduced slightly shot up this very year to 127. It is quite fascinating to note that, the current number of settlers in the camp this time includes a single suspected wizard.

The Right to Adequate Housing

The settlers of the camp live in thatched buildings roofed with natural materials. These roofs are old and of inferior quality thus not protective enough. The dwellers had access to radio as their main source of information. The main form of energy available in the settlement is firewood and dwellers disposed off refuse at the incinerator. This notwithstanding, the settlement was infested with excessive household pests like rodents and insects, due to the insanitary conditions the poor alleged witches live in.
Rights to Health and Sanitation

Alleged witches of the Kukuo Camp had no access to potable water. Their main sources of water are the river, stream and rain of which supply was irregular. The rain normally ceases and the others may dry up during the harmattan. There were no toilet facilities therefore, settlers eased themselves in the nearby bushes thus, worsening the insanitary condition in the camp. The bathhouses are made of wood and old mats and are also in very poor conditions in terms of sanitation. The commonest ailments affecting the inhabitants of the camp are convulsion, malaria and hernia. A health post is available to them, but patients paid whenever they accessed their services. Though the occupants had registered with National Health Insurance Scheme (NHIS) their cards however were not ready.

Nutrition

Generally friends and relatives provide financial support and food stuffs to dwellers of the camp. While others engaged in income generating activities such as petty trade and soap making to support them; though their level of nutritional intake is poor.

Right to Education

There is a primary school accessible to dwellers of Kukuo camp. This educational facility however, is not enough to cater for all the children in the settlement. Adults in the camp benefit from the adult literacy programme. However, there is no library.

Activities

Out of a total number of settlers fifty (50) of them are into petty trading whiles, two (2) are involved in soap making. The alleged witches are allowed to enjoy their rights to religion. Some are Christians whereas, others are Muslims.

Monitoring

The general situation at this settlement is monitored regularly by CHRAJ, SONGTABA, GRAMEEN and Action Aid on quarterly basis. CHRAJ officials were informed that, the settlement was monitored within the last three (3) months. Unfortunately, suspected witches and wizards are still being banished into this settlement and the number has significantly increased as compared to last year. The total number of suspected witches and wizards in 2008 was one hundred and thirteen (113). This number had short up to two hundred and ninety eight (298) at the time of visit; an upshot of over a hundred percent (100%)

Campaign against Discrimination of Suspected Witches and Wizards

Information gathered by CHRAJ officers revealed that, upon all the campaigns and advocacy programmes by CHRAJ and SONGTABA to disabuse native’s minds on negative perceptions of witchcraft allegations, it has not yielded much result. The suspected witches and wizards are refused patronage in any form of business they engage in. Two (2) suspected witches were admitted into the settlement in 2008 and two (2) were successfully
discharged back into the society. Between January and March 2009, nineteen (19) suspected witches and one (1) suspected wizard had been admitted into the settlement, but no release had been made during the period under consideration.

On the average, women are mostly the victims of witchcraft allegation. These women are stigmatized and their children and grandchildren are discriminated against in schools especially and other circles, resulting in high school dropout in their families. Presently, hundred and seventy one (171) children are with their grandmothers in the settlement, but only sixty four (64) are in the primary school. These children may even drop out of school as they are not able to cope or withstand the stigmatization.

Civil Society Organization

Monitoring of Suspected Witch and Wizards Settlement

The SONGTABA organization monitors the Kukuo settlement on quarterly basis with their last visit dated in June 2009. The organization admits that, suspected witches and wizards are still being banished into this settlement. The number as compared to last years has increased significantly.

Campaign against Discrimination of Suspected Witch and Wizards Settlement

SONGTABA has been able to campaign against this unacceptable allegation in the camp itself and the neighbouring communities. They confirmed that, Action Aid Ghana is also involved in this campaign. Their campaign programmes focus on nutrition, inhuman treatment meted out to suspected witches and reintegration.

Conclusion

The conditions under which settlers of the Kukuo camp survive are generally not the best. Inhabitants need both financial, health and educational support and perpetuators of this violent act against other persons suspected to be witches and wizards should be brought to book.

6.1.2 Tindaan Shayili-Kpatinga Settlement

Background Information

The Tindaan Shayili- Kpatinga camp is located at the Gushegu District in the Northern Region. The camp which has only aged females has since 2004 held forty-five witches as its maximum number of settlers. This same number of witches was held in the camp till 2007 when it was reduced to thirty-two. These thirty-two suspected witches have been exiled till present day. At the time of visit, these thirty-two female inhabitants who are aged sixty and above, in addition to 8 grandchildren were in the camp. Four of these children are boys with the four others being girls. It worth noting that, these children are neither alleged witches nor wizards, but have joined their grandparents due to various reasons.
This year’s monitoring revealed that, the longest serving suspected witch has been at this settlement for about thirteen years.

**Right to Adequate Housing**

Interestingly, this camp has block housing for inhabitants with each occupying a room. The buildings are roofed with corrugated iron built by World Vision Ghana to provide adequate protection for the individuals.

Their main source of energy is firewood which they fetch from nearby bushes for the preparation of food. Dwellers disposed off refuse at designated refuse-dumps. Nonetheless, the settlement is infested with a lot of mosquitoes, tsetse flies, and sometimes snakes especially, during the raining season.

**Right to Health and Sanitation**

The inhabitants of Tindaan Shayili- Kpatinga settlement have access to potable water from bore-holes which provides them with regular source of water. The settlers use a five-seater Kumasi Ventilated Improved Pit-latrine (KVIP), which is in a good sanitary condition. Though they enjoy adequate toilet facilities, no bathing houses are provided for them. The settlers have managed to construct just a few with “zanamat” a traditionally unacceptable structure for bathing purposes. There is no health facility available at the settlement; the dwellers mentioned that after the initial NHIS registration, it could not be renewed in the subsequent years. For this reason, the dwellers pay for their medical bills whenever they visited health facilities with some common illnesses including malaria, chest pains, and stomach problems among others.

**Nutrition**

All thirty two settlers of the Tindaan Shayili- Kpatinga camp receive from friends and relatives food items. They also engage in farming activities to supplement what is received, though they still do not get adequate nutritional supplies in terms of quantity and quality.

**The Right to Education**

Though the settlers of the camp had no library, they had access to a Kindergarten and basic school (primary and JHS). This educational facility is however not adequate in the provision of the basic educational needs. However, the adult dwellers did no benefit from any form of adult education.

**Activities**

The monitoring exercise revealed that no income generating activity is pursued by any settler of this camp.

All of the present dwellers at the camp are Christians and attend a church close by.
Monitoring of Suspected Witches and Wizards Settlement

Apart from CHRAJ that undertakes a regular monitoring of the settlement, National Commission on Civic Education (NCCE), Social Welfare, World Vision Ghana and Project Shere, an NGO in the Gushegu district occasionally pay monitoring visits. According to information gathered, this settlers camp benefited from such a visit last year.

It was also indicated that, there has been a stop in the practice of banishing suspected witches and wizards into the Tindaan Shayili- Kpatinga settlement resulting in a slight reduction in their number of settlers.

Campaign against Discrimination of Suspected Witches and Wizards

The above mentioned organizations in addition to monitoring, engage in campaign against discrimination, the practice in totality and general human rights. The success of their campaigns have resulted in no admission of any suspected witch or wizard into the camp since 2008.

Sources of Funding

The dwellers in this camp presently do not receive any financial support from any organization, but they were appreciative to World Vision Ghana for providing them with a descent accommodation.

As aged people, the settlers pleaded with CHRAJ officers that, they needed support in terms of health, food, clothing, and beddings.

Civil Society Organization

Other organizations apart from CHRAJ, World Vision Ghana officials said they monitor the settlement four times a year on quarterly basis. They confirmed no admissions of suspected witches and wizards into the settlement. They mentioned that, the slight decrease in the number of settlers is due to their effective monitoring activities.

Campaign against Discrimination of Suspected Witch and Wizards

Information received by CHRAJ officials at the time of visit, confirmed that CHRAJ, NCCE, Social Welfare and SONGTABA carry out effective campaign in this settlement. Their main campaign activities border on discrimination against women, women’s rights and human rights.

An officer from World Vision congratulated the efforts of other organizations that are in the campaign business so far. He however did not hesitate to urge other concerned organizations to get on board to provide regular assistance to the aged women. “The health of these women is weaning and there is an urgent need for a health facility to meet their health needs” he added.
6.1.3 Gnani Settlement

Background Information

The Gnani witch and wizard camp can be sited in the Yendi district of the Northern Region. Statistics gathered from this camp since 2004 reveals the following:

Table 29: Number of Suspected Witches and Wizards camped from 2004 to 2009

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Witches</th>
<th>No. of Wizards</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>15</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>2005</td>
<td>21</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>2006</td>
<td>18</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>2007</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>2008</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>2009</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
</tbody>
</table>

At the time of visit, the 25 suspected witches and wizards that had been camped in 2008 were still in camp.

The Right to Adequate Housing

Presently, the dwellers of the Gnani camp live in huts built with natural materials with inadequate protective roofing. The roofs of these huts were made of dried thatch that was in a serious state of disrepair. Moreover, the huts in which they lived had no windows to allow ventilation. The inhabitants had no access to modern communication gadgets like telephones, radio, television or refrigerator. The main source of fuel in this camp is charcoal and firewood which the dwellers fetched from nearby bushes. The settlers had no proper means of disposing off refuse; they did so in the bushes. This unhealthy behaviour has resulted in serious infestation of rodents and insects in the settlements. There are lots of mosquitoes, tsetse flies and other reptiles including snakes. This is as a result of the bushy surroundings.

The Rights to Health and Sanitation

At the Gnani camp, settlers have no portable water. The main source of water is either stream or river. Either of these however has no regular flow as they normally dry up during the dry season.
The toilet facility available to the settlers is the Kumasi Ventilated Improved Pit-latrine (KVIP). This facility is not only inadequate for the settlers but also in a dilapidated state. Considering the bathing facility available to this community, a small area has been enclosed with mats as bathrooms for the inhabitants. This bathroom was also found to be in a poor sanitary condition.

Despite the availability of hospitals or clinics, patients paid themselves whenever they accessed the facility. Common ailments suffered by the inhabitants include malaria and joint pains. It is interesting to note that, the assembly registered the dwellers with NHIS but expired cards had not been renewed yet. Owing to the above reasons, settlers who had no money on them during the period of ailment are refused treatments. It was made known that without the valid NHIS cards the health facility operates on cash and carry system.

Nutrition

The inhabitants have since 2008 been receiving some nutritional support from two NGOs and philanthropists. Other relatives and friends also provided about 24 of them support nutritionally in 2008. This number of benefactors has unfortunately reduced to 20 in 2009. About 6 of the dwellers are engaged in farming in 2008. However, this number has also been reduced to half at the time of visit. Admittedly, the distribution of food supplies to the settlers of this camp in terms of portion or nutrition is inadequate.

The Right to Education

The dwellers in this settlement have Primary and Junior High School level of education accessible to them. Conversely, the educational facilities are not adequate to cater for the needs for all children in the settlement.

In addition to the adverse situation above, the adult education programme they used to benefit from has ceased functioning.

Activities

The monitoring visits to the camps revealed that all suspected witches were into farming activities. Besides farming, about thirteen (13) of the inhabitants are in thread weaving whilst twenty-four (24) others were into shea-butter extraction.

Though the monitoring team were told that the settlement offer religious opportunities, the type of religion was not specified.

Monitoring of Suspected Witches and Wizards Settlement

There is an ongoing monitoring on half year and yearly basis by Country Food Initiative Security (CFIS) and Management Aid respectively. Unfortunately, suspected witches and wizards are still being banished into this settlement, though the number has not increased those that were successfully released have been replaced.
Campaign against Discrimination of Suspected Witches and Wizards

Currently, there is no organization that is engaged in any form of campaign against discrimination of such persons. It is a fact that a suspected witch and two suspected wizards were successfully released from the Gnani Camp in 2008; surprisingly however, between January and March 2009, these same numbers that were released have been replaced.

Source of Funding

The settlers receive no financial support from any organization or philanthropist but the aged dwellers are so malnourished that, they really need some form of nutritional supplement and support. This notwithstanding, inhabitants need to be provided with adequate housing and portable water that could be more regular in supply and reliable.

Civil Society Organization

Information gathered from an interview held between Officials from Management Aid and CHRAJ revealed that the former have been monitoring the settlement on yearly basis. In spite of their effort, suspected witches are still being banished from these settlements which corroborates the information received from the settlers during the interview sessions.

Monitoring of Suspected Witches and Wizards Settlement

On this issue, there was no organization mentioned to be campaigning against this discriminatory practice. They however, appealed to government and other organization to work together in re-integrating suspected witches and wizards into their respective communities.

Conclusion

Presently, the settlers of the Gnani camp need to be provided with some forms of nutritional, housing and health support to improve their lot.

Witchcraft Accusation as a Human Right Issue

The practice violates certain provisions in the international and national legal documents.

UDHR, Article 1 “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood”

UDHR, Article 2 “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.

Article 25 (1) of the UDHR states that, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.
International Covenant on Civil and Political Rights (ICCPR) Article 17(1) “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence or to unlawful attacks on his honor and reputation.”

ICCPR Article 7 “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment…”

Convention on the Rights of the Child (CRC)

Some provisions of the CRC which have relevance to the issue of witchcraft accusation are:

*Article 2*: Freedom from discrimination on any grounds, including sex, religion, ethnic or social origin, birth or other status.

*Article 6*: Maximum support for survival and development.

*Article 19*: The right to protection from all forms of physical or mental violence, injury or abuse, maltreatment or exploitation, including sexual abuse, while in the care of parents, guardian, or any other person.

*Article 24*: The right to health and to access to health services; and to be protected from harmful traditional practices.

The 1992 Constitution of the Republic of Ghana

- Denial of the right to practice one's belief. Article 21(1c).
- The practice is discriminatory. Article 17(2).
- Denial of the right to fair trial, violation of article 19 (1).
- Denial of the right to life. Article 13 (1&2)
- Denial of the right to human dignity. Article15 (1)
- Arbitrary arrest, detention torture, or other cruel, inhuman or degrading treatment or punishment. Article 15(2).
- Violation of their rights to freedom of movement. Article 21 (1g)
- Deprivation of the right to work under satisfactory, safe and healthy conditions. Article 24 (1)
- Denial of their right to health.
- Deprivation of their children’s right to education, article 25(1)
CHAPTER SEVEN

CHILD RIGHTS

7.1 Introduction

In practical terms, child rights refer to all the needs of a child, the provision of care and protection which a child must have in order to ensure his/her wholesome development. The needs of children for care and protection are basic and constitute the rights of the child provided by law under both international and national laws such as the Universal Declaration on Human Rights, UN Convention on the Rights of the Child, 1992 Republican Constitution of Ghana and the Children’s Act (Act 560, 1998).

The UN Conventions on the Rights of the Child states that:

“State Parties must undertake to ensure the child such protection and care as is necessary for his or her wellbeing, taking into account the rights and duties of his or her parents, legal guardians or any other individuals legally responsible for him or her and, to his end, shall take all appropriate legislative and administrative measures”.

The CRC also proclaims that, states parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform to the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff as well as competent supervision. It is in this light that, the Commission on Human Rights and Administrative Justice as part of monitoring the state of human rights in Ghana monitored the rights of children in the following areas: child defilement; children’s right to recreation; child trafficking; rights of persons with disability; child maintenance and child labour.

7.1.1 Child Defilement

The Commission monitored a total of 194 communities on issues of child defilement across the country. Some of the questions asked bordered on the existence of child defilement cases in the community, knowledge of institutions that handle these cases by the community members and the existence of anti-child defilement campaigns in the community among others.

Out of 190 that answered questions on reports of defilement cases in their communities, inhabitants in 53.7% communities have heard of such cases, while 88 representing 46.3% have not; 54 representing 54% of these communities indicated that, it was not common. However, 66% of communities that indicated defilement is common said there has not been any sensitization on defilement in their community. The low level of community sensitization was further emphasised with 96 (51.3%) out of 187 communities, who answered the
question on the awareness of legal instruments against child defilement, indicating that, they had no knowledge of any of such instrument.

With regards to government institutions that handle child defilement cases, interviewees in 90% of the communities monitored said, they knew of such institutions and mentioned CHRAJ, DOVVSU-Ghana Police Service, Department of Social Welfare as some of such institutions.

With respect to government institutions that monitor child defilement, the Ghana Police Service was present in 146 (94%) out 156 communities monitored. Government institutions in 126 (81%) out of 155 communities were monitored on the receipt of reports of defilement cases across the country indicating that, defilement cases are reported to their institutions.

Between 2006 and 2008, a total of 4,601 defilement cases were reported to government institutions located in 106 communities. With regards to the presence of a clearly defined procedure for a child to lodge defilement complaints 105 representing 71% of the government institutions said they had clearly defined procedures, while 27% indicated there were none.

Ninety-six (96) government institutions out of 138 indicated that, they use various means to educate the public on the various legal provisions on child defilement. These institutions used either community, group or organization based campaigns or individual, household interaction. The most effective anti-child defilement campaign with positive response according to government institutions is the one done at the community level. Sixty-three (63) of these institutions interviewed indicated that community based educational campaigns have been successful. Funding for anti-child defilement campaigns for government institutions in 36 communities were provided by the government while 29 were either supported by NGOs or philanthropists. Thirty-one (31) receive funding from other sources like individual officers, personal contributions, donation from churches, etc for their anti-child defilement campaigns.

A total of 96 NGOs and CSOs working on children’s rights were interviewed across the country. Out of these, 64% had ongoing child defilement campaigns while 36% did not. These NGOs and CSOs collaborate in various ways with each other as well as with government institutions such as NCCE, CHRAJ, and DSW in the effort at reducing or eliminating the incidence of defilement in their communities.

NGOs and CSOs in 87% of the communities regularly monitored the general situation of children in the community. Last year, these organizations monitored child defilement cases in 57 communities. Knowledge of legal provisions on defilement according to the NGOs and CSOs has increased in 86% of communities monitored.

The Commission interviewed a total of 909 children aged 15 and below in 91 communities monitored across the country. Children in 91% of the communities noted that defilement is a crime and 95% of these children indicated that it should be reported to the appropriate institution. According to the children interviewed in about 37 communities, victims of
defilement are not treated well by their family and community members. These children are often times blamed for the incidence, beaten up or sometimes teased by the friends.

Out of 86 communities who answered questions on the provision of assistance to victims of defilement, 70% did not know of any assistance given to victims of defilement by government institutions, NGOs or CSOs. Some of the institutions mentioned by these children that provide support for victims of child defilement included the Ghana Police Service (DOVVSU), Department of Social Welfare and MOWAC.

**Conclusion**

Government institutions and various NGOs and CSOs are doing their best to ensure that the rights of children are recognized. Through education, campaigns and various forms of sensitization they have been able to make people realize the importance of these rights. Most of the laws against the abuse of the rights of children are not enforced and adhered to making it impossible to punish perpetrators. Therefore the continuous effort of the Commission and other institutions may help reduce and eventually eradicate the problem.

### 7.1.2 Children's Rights to Recreation

The Commission, in accordance with Children’s Act (Act 560 1998) Section 9 which states that, “no person shall deprive a child the right to participate in sports, or in positive cultural and artistic activities or other leisure activities”, monitored children’s right to recreation. Some of the areas monitored included the existence of recreational facilities for children, government obligations towards the provision of these facilities and civil societies’ views on government fulfilment of its obligations.

Out of a total of 201 communities monitored across the country, 30 did not have any of such facilities, 166(84.7%) had some form of recreational facilities. Some of these include football fields, community centres, sports academy, school and children parks, netball field, volleyball court, keep fit clubs, table tennis court, social centre, handball court and basketball court. About 15% of the communities did not have any recreational facilities even though community members interviewed are aware that, children have the right to recreation. They agreed that recreational facilities are necessary and would benefit children in the community.

Sixteen (16) different categories of government institutions were interviewed across the country. All government institutions in 143 communities who answered questions on the benefit of recreational facilities agreed that recreational facilities will not only develop general health of the child but also develop their economic and social lives. Some of the challenges numerated by these state institutions included lack of funds and inadequate personnel to handle sports in the schools.

NGOs and CSOs in 115 (84%) communities were interviewed. Sixty four percent (64%) of these organizations noted that, government and other stakeholders were not doing enough to realize children’s right to recreation. They suggested that, the communities should provide such facilities if government has failed in its obligations. In order to do that, these communities may face some challenges. Some of these challenges include; inability to
secure funds and lack of human resource to manage these facilities. Only 50% of these NGOs regularly monitor these rights.

7.1.3 Child Trafficking

According to the Children's Act 560 (Act 560 1998) Section 5, a child must not be denied the right to live with his parents and family and grow up in a caring and peaceful environment. To ensure the fulfilment of this provision among others, the Commission monitored 200 communities on child trafficking across the country. Trafficking of children existed in 136 communities monitored; children are either trafficked in or out, or sent both ways in these communities. In 64 of these communities, children were brought in, while in 72 of these communities children were sent out to work. On the other hand, 96 communities did not have any incidence on child trafficking. Volta Region had the highest number of communities, 20 in all, where children are trafficked in and out to work.

According to those interviewed poverty, parental neglect and ignorance are the major reasons why children are trafficked. Community members in 115 communities representing 82% monitored are aware that child trafficking is an offence.

Table 30 shows a breakdown of regions and some sectors in which children predominately work.

Table 30: Sectors of Work by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Sector of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Accra</td>
<td>Hawking, Fishing, Domestic Service, Prostitution, Truck Pushing, Agriculture</td>
</tr>
<tr>
<td>Western</td>
<td>Agriculture, Trading, Domestic Servants, Prostitution, Truck Pushing, Quarry</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Agriculture, Prostitution, Quarry, Domestic Service, Porterage, Weaving</td>
</tr>
<tr>
<td>Eastern</td>
<td>Agriculture, Quarry, Prostitution, Trading, Domestic Service</td>
</tr>
<tr>
<td>Volta</td>
<td>Agriculture, Hawking, Prostitution, Quarry, Domestic Service, fishing mongering, Porterage, Truck pushing</td>
</tr>
<tr>
<td>Central</td>
<td>Agriculture, Prostitution, Quarry, Trading</td>
</tr>
<tr>
<td>Upper East</td>
<td>Agriculture, Prostitution, Domestic Service, Porterage</td>
</tr>
<tr>
<td>Upper West</td>
<td>Agriculture, Trading, Domestic Service, Prostitution, Quarry, Pito Brewing,</td>
</tr>
<tr>
<td></td>
<td>Porterage</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>Agriculture, Quarry, Prostitution, Trading, Domestic Service, Store Keeping</td>
</tr>
<tr>
<td>Northern</td>
<td>Agriculture, Hawking, Fishing, Quarry, Chop bar services, porterage, Prostitution.</td>
</tr>
</tbody>
</table>

Members in 76% of the communities indicated that trafficking can be avoided, 24% on the other hand noted that, trafficking is unavoidable in their communities because the laws are not strictly enforced.

Ten (10) different categories of government institutions were interviewed in 138 communities while monitoring child trafficking and 65% indicated that the phenomenon existed in their communities. Between 2006 and 2009 a total of 1,775 children are reported to have either been trafficked in or out of 36 communities. Collaborating reasons why parents give out their wards numerated by community members and government institutions noted that informal fosterage, ignorance of the law and poverty are the main causes of trafficking. Even though these children are given out to households, traders, fishermen, farmers etc. most of these children are found in the agricultural sector.

Government institutions interviewed have rescued, rehabilitated and reintegrated trafficked children in these communities. These institutions indicated that they have either carried out one, two or all of these activities in 160 communities. Some of the measures that these institutions have put in place to prevent rescued children from being re-trafficked include; sensitization of victims and parents on the legal and social consequences of trafficking, formation of watchdog committees and provision of micro credit for parents of the victims among others.

On the question as to whether parents/guardians were justified in giving out their children, government institutions in 146 (92%) communities said they were not, while 13 responded in the affirmative. They explained that some parents are poor, do not have lucrative jobs and unable to take care of the family. They are therefore forced to send out their children to work.

Ten (10) different categories of government institutions in 138 communities monitored undertook anti-child trafficking campaigns in various forms. These campaigns were community, group or organizational based, some were household campaigns and through individual interactions. Government institutions in (16) communities said they used all the four forms of campaigns and 12 indicated positive results of their campaign activities while only one (1) institution reported that the campaign result was indifferent. Government and NGOs have been the main sources of funding for these institutions for anti-child trafficking campaigns. Most of the government institutions monitored collaborated with NGOs and other state institutions in their effort at eliminating child trafficking in the various communities monitored.
NGOs and CSOs working on child trafficking issues were present in 70% of communities monitored. Eighty-six (86) representing 74% organizations noted that child trafficking existed in the communities they worked in and 67.1% had received complaints on trafficked children. 71% of these organizations had an ongoing campaign to eliminate child trafficking in the communities. These campaigns were carried out in various forms such as community sensitization, rescue and reintegration as well as providing support for trafficked children. NGOs and CSOs in 74(69%) out of 107 communities regularly monitored the general situation of child trafficking and 80% noted that, the situation had decreased.

A total of 393 trafficked children below 16 years were interviewed in 42 communities across the country. Most of these children had an average working year of one (1) to five (5). Narrating the conditions under which they worked, some of them indicated that they are sometimes not given enough food to eat, they wear dirty and torn clothes, they suffer different types of abuses such as beating, insults and sleep outside while some are abused sexually. Out of 41 communities that answered questions on the assistance given to victims of child trafficking, 76% had not received any form of assistance, 24% on the other hand have received various forms of assistance from both some private and state institutions in the form of school materials, feeding fees, provision of microfinance for parents and legal advice among others.

7.1.4 Rights of Persons with Disability

The Commission as part of its mandate to promote and protect the rights of all persons in Ghana particularly the vulnerable monitored the rights of persons with disability. A total of 200 communities were monitored across the country; persons with disability lived in 191 of these communities. 36% of these people are unemployed, 29% were self-employed while 4.3% were government workers. Most persons with disability (54%) interviewed work in the informal sector that is self-employed, artisans or work in the agricultural sector. Members in 181 (93%) communities monitored indicated that, PWD do not face any challenges while only 7% indicated that they do. Some of these challenges included inability to take part in developmental programmes in the community; lack of support from family members; discrimination; difficult access to buildings; inability to work; exclusion from decision making etc.

On the question of organisations that work on issues relating to persons with disability, members in 66% of these communities could not easily identify organizations working to promote the welfare of persons with disability, only 34% could. Some of these organizations included notable NGOs like World Vision International Ghana, Ghana Society of the Physically Disabled, action and state 7.institutions such as the District Assembly, Department of Social Welfare, National Commission for Civic Education and Ghana Education Service. Some of these organisations promote the welfare of PWD by providing advisory services, financial support, advocacy, empowering them through social education, counselling, vocational training, training workshops. Some have also received complaints of discrimination and inability to access between 2 and 5% of the district assembly common fund meant for PWD. These institutions have collaborated in the area of sensitization;
provision of logistics and funds with other state institutions and NGOs to further enhance the wellbeing of PWD.

With respect to anti-disability discrimination campaigns, government institutions in 126 communities representing 82% embarked on various forms of campaigns. They carried out these campaigns in the communities, with groups or organizations, individuals and households. Government institutions in 43 communities who have embarked on anti-disability discrimination campaigns at regular intervals have all reported that, these campaigns had positive impacts. Campaigns of 80% of these government institutions are funded by the government with 96% indicating that their campaigns have been positive.

Non-Governmental Organisations (NGOs) and CSOs were present in 96 communities out of 123 who answered questions as to whether NGOs and CSOs working with PWDs existed in the community. 69% of these had an ongoing anti-discrimination campaign. 81% of the NGOs and CSOs have in the last year monitored the general situation of discrimination against PWDs and noted a decrease in the level of discrimination.

A total of 1,470 PWDs between less than 10 and above 41 years in 45 communities were interviewed across the country. On the question of whether they suffer from any form of discrimination, 36% responded in the affirmative while 64% said no. Some of the discrimination numerated is perpetrated by both the individuals and the state. Some of discriminations by individuals included exclusion from community meetings, decision making, inability to seek audience of prominent people such as chiefs. With regards to discrimination perpetuated by the state, PWDs noted that public buildings and transports are inaccessible, their share of the common fund is not given to them, and the NYEP modules created did not take into consideration PWDs. Only 18% of those PWDs interviewed who have suffered discrimination had reported the case, 82% did not report. Out of this number 71% indicated that they were satisfied with the outcome while 29% were not. PWDs in 45% communities interviewed had not received any form of assistance while 55% had received some assistance in the form of apprenticeship, training and provision of free equipment.

7.1.5 Child Maintenance
The children’s Act (560, 1998) section 47(1) states that,

“A parent or any other person who is legally liable to maintain a child or contribute towards the maintenance of the child is under a duty to supply the necessaries of health, life, education and reasonable shelter for the child.”

The phenomenon of child neglect is very high in Ghana and constitutes the highest number of cases CHRAJ receives every year.

The Commission deem it appropriate to monitor issues relating to child maintenance as part of monitoring the general state of human rights in Ghana. In all, 855 parents and guardians were interviewed in 203 communities monitored across the country. While 49% knew of
international or national legal provisions on child maintenance, 51% did not. 50.3% of those interviewed have never attended a program on child maintenance, 49.2% indicated that the programs were organized by DOVVSU, Department of Women and Children, CHRAJ among several other institutions.

91% of community members interviewed indicated that, they knew institutions that handle cases of child neglect in the communities. Ninety-Six (96) representing 56% knew about institutions that handle these cases but have neither witnessed nor reported child neglect cases. Out of 75 communities whose members had been taken to child neglect institutions, 91% were satisfied with the services and the outcome of the case while 9% were not. Members in 118 out of 180 communities representing 65.6% were not aware of NGOs and CSOs that promote children’s right to maintenance in their communities.

With respect to government institutions that handle child maintenance cases, the Commission interviewed 6(six) different categories of such institutions in 137 communities across the country. One hundred and fifty (150) that or 97% of these institutions carry out sensitization programmes in the communities which are done through the media, meeting with community members and identifiable groups. Government institutions interviewed in 95% of the communities receive maintenance cases.

88% of government institutions have used various means to campaign against child neglect in the communities among groups, in household and with individuals. 91% of the institutions that embark on anti-child neglect campaigns reported a positive response. It is interesting to note that, 81% of the institutions whose campaign response were positive were funded by the government while 3.6% and 11.9% were funded by NGOs and philanthropists respectively.

NGOs and CSOs working on child maintenance issues were present in 101 out of 141 communities interviewed on the issue of children’s right to maintenance. Out of this, 83% have ever received complaints or helped a child claim his/her right to maintenance. With regards to ongoing campaigns against child neglect, 67% of these institutions have done that in collaboration with other NGOs and state institutions while 33% do not have any ongoing campaign.

Regular monitoring was carried out by 76% of NGOs and CSOs on the general situation of issues of child maintenance. In the last year, 65(76.5%) of these organizations reported a decrease in child neglect.

To solicit the views of children on the rights of children to maintenance, the Commission interviewed a total of 1,435 children below 18 years in 112 communities across the country. The highest percentage r (35%) of children interviewed was between ages 11-15 years followed by a 6-11 years age category representing 30%. Children in 107 communities representing 90% knew about child neglect while those in 12 (11%) had no idea what it is. In 94% communities, children who knew what child maintenance is also knew institutions that handle child maintenance cases, 6% on the other hand answered negative to both questions. Even though children in 93 communities knew institutions that work to curb child neglect, only 40% said they had received some form of assistance from them.
7.1.6 Child Labour and Its Worst Forms

Ghana, apart from being the first to ratify the UN Convention on the Rights of the Child has a wide range of national instruments that seek to protect children from economic exploitation. These international and national instruments also seek to protect children from performing work that is hazardous or interferes with their education or harmful to their health or physical, mental, spiritual, moral or social development. To assess the labour situation with respect to children’s rights, the Commission monitored the general child labour situation in 215 communities across the country.

A total of 1,778 people were interviewed in 201 communities, 72% of these communities indicated that, child labour exists in their communities. Children between ages 11-15 according to the community members interviewed, form majority of children (54%) found in labour. Only 3% of children below 6 years are engaged in labour in these communities. These children are employed in various sectors of work such as farming, mining, prostitution and trade. However, majority of these children were engaged in the agriculture sector. Poverty accounts mostly for reasons why children engage in labour. These children often have to work for long hours without food, harassed and exposed to various types of danger. They also added that, these children are often not paid, threatened and most often the girls are sexually harassed or assaulted.

On the question of whether child labour is avoidable in their community, 51% of community members think it is while, 49% said it was not because the laws are not being strictly enforced. Child labour must be outlawed, according to 62% of those interviewed, because it’s a crime. However, 9% think that, child labour should not change because; it is the only way by which some families are able to make ends meet. Even though 142 communities indicated that child labour existed, 57% did not know about the existence of anti-child labour campaigns by NGOs and government institutions in these communities.

In 148 communities monitored on the health implication of labour on the child, officials of 11 different categories of government institutions in 92% of the community said, labour has adverse health implications for working children. Labour according to them could affect the psychological and emotional wellbeing of these children. These institutions are involved in protecting children against labour in 139 (90 %) communities monitored Some of the activities carried out by these institutions with respect to child labour included sensitization on the effect of child labour, inspection of work place and advising employers to stop engaging children.

Government institutions in 138 communities representing 87% think guardians/ parents are not justified in putting their wards/children into labour. On the other hand, 13% think they are. They explained that, such parents/guardians are very poor; they therefore do not have any other alternatives, but to send their children out to work. Child labour due to its harmful effect on the child should be outlawed according to 63.4% of the institutions interviewed because, the practice is entrenched and only the enforcement of legal sanctions can stop its practice.
Anti-child labour campaigns are being carried out in the communities, with groups or organizations, through individual and household interactions in 109 communities. These campaigns are carried out at least once a year by 61.7% of these institutions. Funds for child labour campaigns by government institutions are mainly provided by government, this is evident by 53% responses affirming the above when the question was posed. 88% of the government funded campaigns have recorded positive results as more people being sensitized on child labour and such cases are being reported.

The Commission interviewed some civil society groups as part of monitoring child labour. NGOs and CSOs were interviewed in 107(69%) communities across the country. These institutions have done various works on issues relating to child labour. Children according to these institutions can be found in various sectors engaging in worst forms of labour. Some of these sectors include fishing, farming, prostitution and petty trading. Supplementing household income, children desiring to earn living, broken homes are some of the reasons these children work.

Conditions under which these children work according to NGOs and CSOs interviewed are very deplorable. These children, for instance work for long hours and are not paid for work done. Children in labour suffer many abuses such as beatings, verbal and physical abuse, the girls are sexually harassed or assaulted.

On the issue of anti-child labour campaign, NGOs and CSOs in 80% of the communities had ongoing campaigns in the form of educational programmes, provision of educational materials and basic needs, paying of medical bills and vocational training. These are often done in collaboration with state institutions like CHRAJ, DSW, Department of Labour and, District Assemblies. Apart from campaigning, NGOs and CSOs have carried out yearly monitoring of child labour in 78% of communities monitored and according to 73% of these organizations; the level of child labour had decreased. A total of 1,546 child labour victims below 15 years were interviewed in 119 communities across the country.

Find below a tabular representation of regions and the predominant sectors that children work.

Table 31: Predominant Sectors of Work by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Sector Of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper East</td>
<td>Agriculture, truck pushing, trading, porter</td>
</tr>
<tr>
<td>Upper West</td>
<td>Agriculture, mining, cattle rearing, porter, car washing, water fetching, trading, chop bar</td>
</tr>
<tr>
<td>Northern</td>
<td>waiter, trading, agriculture</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>Activities</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Ashanti</td>
<td>Kente weaving, transport, mining, agriculture, trading,</td>
</tr>
<tr>
<td>Eastern</td>
<td>Porter, trading, hired labour, agriculture</td>
</tr>
<tr>
<td>Volta</td>
<td>Agriculture, mining, cattle herding, fishing</td>
</tr>
<tr>
<td>Western</td>
<td>Scrap collectors, fishing, quarrying, agriculture, mining, trading, spraying,</td>
</tr>
<tr>
<td>Central</td>
<td>Agriculture, trading, fishing, porter,</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>Fishing, stone quarry, agriculture, domestic servant, trading, sand weaning, truck pushing, car washing</td>
</tr>
</tbody>
</table>

Majority (69%) of working children interviewed were between 11 - 15 years followed by 6- 10 years with 28%. 68% of these children have worked for between 1 and 5 years and 21% have worked for less than a year. 37% of these children indicated that, the work does not violate their rights because, they need to work in order to support their families and finance their education. On the other hand, 63% indicated it does with the explanation that, it denies them of the right to education and the right to be a child. According to these children they are forced to work in dangerous environments, which affect their health. Even though they are not well paid, they have to work in order to survive.

In 81% communities monitored, working children interviewed stated that, they have not received any form of assistance as victims of child labour. Only 19% have received some forms of assistance from organisations like World Vision, CHRAJ among others in the form of provision of school materials; vocational training; training on child development; payment of medical bills, rescue and reintegration of victims.
CHAPTER EIGHT

EXTREMELY DEPRIVED COMMUNITIES (SLUMS)

8.1 Introduction

According to the Oxford Advance Learners Dictionary, a slum is a street or district of old buildings in a poor dirty condition often crowded with people and whose social level is very low.

Article 25(1) of the UDHR states: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.  

Article 24 of the African Charter on Human and Peoples Rights also states: All peoples shall have the right to a general satisfactory environment favorable to their development.

Based on the above conventions, the monitoring exercise sought to find out the state of human rights in slum communities.

Household Demographics

Six communities were monitored in order to establish the living conditions of residents. These communities are:

- James Town community in the Greater Accra Region
- Ziavi Bamefedoe in the Volta region
- Abonkor in the Greater Accra region
- Tema Manhean U Compound in the Greater Accra Region
- Aboabo No.1 in the Ashanti region
- Sodom and Gomorrah in the Greater Accra region

The highest number of household members for this research was fifty-one (51) from the Aboabo No1 community in the Kumasi Metropolis of the Ashanti Region. Whereas, the lowest number of household members was eight (8) in Tema Manhean community of the Tema Metropolis.

The Commission’s monitoring exercise revealed that, there were more females than males in various houses. In one particular household in Aboabo No1 community in the Ashanti region, the total household number was 51; 18 males and 33 females.

The bulk of the ages for all households ranged from thirty-one (31) to forty (40) and there was an open distribution of members of all households. In that, the allocation was cut across physically disabled, mentally disabled, pregnant women, widowed, single parents and others.

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18 UDHR, Article 25
such as orphans. The widowed and single parents were the commonest form of household members.

Majority (50%) of the residents were engaged in one form of business or another with an average monthly income of (GH ¢ 201-250). About 16.7% earned (GH ¢ 151-200) on the average whilst about 33.3% earned more than GH ¢ 300.

Most of them were into petty trading and agricultural activities such as fishing and fish mongering with just a few were in the Civil Service such as, teaching.

Close to half (42.7%) dwellers lived in rented houses whereas, just a few claimed ownership of the houses they inhabit. Rental fees ranged between eight (8) and fifteen (15) cedis per month. However, some admitted that, they have rented the land and have built their own structure.

8.1.1 Availability and Habitability

According to the General Comments adopted by the Committee on ESC rights, the right to adequate housing contains not only one form of shelter or another, but provides a broad explanation of adequate shelter as adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities, all at a reasonable cost.

Housing

The monitoring exercise revealed that, the type of houses used by slum dwellers run through wooden kiosks, thatched, steel containers, sandcrete and wooden structures. However, it was very evident that, the bulk of the population lived in wooden structures.

According to dwellers their roofing were mainly made of corrugated iron. The type of roofing was sufficient for their security; in protecting their houses from elements such as rain, wind, and fire. In Sodom and Gomorrah however, most houses were roofed with tarpaulins and carpets. This is because; they are not sure when a demolishing exercise is likely to be conducted. Their choice of roofing is informed by the adverse nature of the weather and the cool temperature the tarpaulin and carpet create in the rooms since ventilation is very low.
A section of Old Fadama (Sodom and Gomorrah) a slum community in the Greater Accra region with wooden structures which are used as houses

Potable Water
The mainstream of respondents acknowledged that, their households enjoyed easy access to potable water. Sources of water include well, river, pond and rain water. However, majority (85.7%) said pipe borne was the main source of drinking water that flowed regularly.

Toilet Facilities
Half of the slum dwellers had no toilet facility. Also, a sizeable number utilize public toilet facilities. The sanitary conditions were generally good in public toilets.

Bathing Facilities
Most slum dwellers used public bath houses made of concrete. For the few who had bathing facility, they were made of wood and iron sheets. It was discovered that, most bathing facilities were in poor sanitary conditions.

Appliances Used in Households
Appliances include radio and television which were the most used. These were followed by cooking stoves, refrigerators as well as, telephone respectively.

Forms of Energy
Most households had electricity as the form of energy they use. Others include gas, charcoal and kerosene.

Disposal of Refuse
Various responses were given concerning where refuse was disposed in these extremely deprived communities. With regards to the responses, the percentage was shared between the dumping sites provided by the District Assemblies, the Zoomlion Company, the lagoon and the sea shore respectively.
Excessive Infestation in Households

Responses from households indicated that, households had to put up with various kinds of infestation of rodents, insects and other living creatures such as mice, mosquitoes and house flies.

Domestication of Animals

The greater number of the residents (85.7%) domesticated animals such as poultry, cats, goats, sheep and dogs in their houses.

8.1.2 Availability of and Accessibility to Healthcare

The African Charter on Human and People’s Rights Article 17 says; every individual shall have the right to enjoy the best attainable state of physical and mental health.

This section of the research seeks to examine the availability of and accessibility to good healthcare facility by residents of extremely deprived communities.

Presence of Hospitals in Community

All but one slum, Ziavi Bamefedoe in the Ho Municipality of the Volta Region had at least a healthcare center in the community. For those communities that had healthcare centers, accessing the facility was easy. On the average it took just 15 minutes to access those facilities.

Majority (71.4%) also said, seeking professional medical care and treatment was within their finances.
Plange Memorial Clinic (a private clinic) which serves the Sodom and Gomorrah Community

Registration with the National Health Insurance Scheme

A little above half (57.1%) of the respondents were registered with the National Health Insurance Scheme. Unregistered household members explained that, their inability to register was mainly due to reasons such as lack of funds and cumbersome nature of the registration process. A few however, considered the registration important and necessary.

Common Ailments in Community

Malaria (46.7%) was the most widespread ailment followed by diarrhoea (20%) and cholera (13.3%) respectively.

8.1.3 Availability and Access to Educational Facilities

Article 17 of the African Charter on Human and Peoples Rights also states that, “everyone has a right to education and to participate freely in the cultural life of his or her community.

This part of the research is to assess the availability of and access to educational facilities in extremely deprived communities.

Education should also be made adaptable. In that, education should be made to have the ability to change or adapt to the social changes occurring in society. Article 25 of the African Charter states that, “state parties shall have the duty to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that, these freedoms and rights as well as corresponding obligations and duties are understood”.

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From the constitution of the Republic of Ghana, educational rights are part of the general fundamental freedoms of the individual citizens. It states that, “all persons shall have the right to equal educational opportunities and facilities and with a view to achieving the full realization of that, basic education shall be free, compulsory and available to all; secondary education in its different forms including technical and vocational education, shall be made generally available and accessible to all by every appropriate means and in particular by the progressive introduction of free education; functional literacy shall be encouraged or intensified as far as possible; the development of a system of schools with adequate facilities at all level shall be actively pursued.”

Types of Schools Available in Community

There was the availability of crèche, kindergarten, primary, and junior high schools. However, there was no senior high school in all communities monitored.

Sufficiency of Schools

Educational facilities were available and sufficient. On the average, pupils spent up to 15 minutes to get to school.

Monetary Commitment to Educate Children within Family Means

A little above half (57.1%) of the responses actually affirmed that, the monetary commitment was not within their means.

Some had uncommitted monetary means to educate children due to the fact that, school fees were expensive. Also, parents and guardians in these communities are mostly self-employed and hence are assured of a fluctuating income which becomes really frustrating.

8.1.4. Child Labour

Article 5 of the African Charter on Human and People’s Rights specifically forbids any form of slavery, and states that, no one may be “pawned” or sold into bondage. Article 16 of the Constitution of the Republic of Ghana and Children’s Act 560 states that, no person (child) shall be held in slavery or servitude.

Existence of Child Labour

The existence of child labour is real in most slum areas. The study proved that, some children in these areas were involved in some form of child labour. These forms of child labour included fishing, selling or trading, household works as well as physical labour (carrying loads).
Education of Children

Almost all children who engaged in one form of labour or another were still schooling. Others were found loitering around during school hours.

Reasons for Child Labour

The main reason for child labour was poverty. They had to engage in various forms of labour to support themselves and pay for school fees.

Educating Citizens

Article 25 of the African Charter states that, “state parties shall have the duty to promote and ensure through teaching, education and publication, the respect of the rights and freedoms contained in the present Charter and to see to it that, these freedoms and rights as well as, corresponding obligations and duties are understood.

Responses indicated that, most communities did not have any form of education on child labour. This tends to confirm the fact that, residents living in slum areas have no form of education on child labour.

8.1.5. Level of Crime

Crime is an offence for which one may be punished by law. The African Charter on Human and People’s Rights states that, all people have the right to national and international peace and security.

The level of crime in these extremely deprived communities according to most 50% of respondents is either high or very high.
Common crimes ranged from petty theft, physical assault, sexual assault, robbery, domestic violence to drug related incidents.

Crime cases are sometimes reported to traditional leaders who sit on the cases and the culprit is fined. Other crimes are reported to various heads of tribes and committees. Cases beyond their jurisdictions are however forwarded to the police officers stationed in the community. At other times, the police fail to make any arrest and even when these cases are reported, the offenders are not tried.

It was revealed that, the Abonkor community in Tema of the Greater Accra Region, the Aboabo No1, in Kumasi of Ashanti Region and the Ziavi Bamefedoe in Ho of the Volta Region had no police station where cases could be reported.

Children’s Involvement in Crime

The responses proved that, children’s involvement in crime was low in extremely deprived communities. According to the study, even though children’s involvement in crime was low, there were situations where some children were involved in one crime or the other. Most common of these crimes engaged in by these children were petty theft, drug related incidents, robbery and physical assault.

Community Education

Extremely deprived communities were monitored as to whether there were any programmes organized to educate inhabitants on crime related issues. It is interesting to note that, these communities answered in the affirmative. That is, programmes were organized to educate the community on crime related issues.

Programmes organized to educate their communities took the form of durbars. Also, during occasions such as marriage ceremonies and funerals, opportunity was taken to educate the communities about the wrongs of crimes.

Responses showed that, there were no formal organizations responsible for the education, instead; Muslim preachers, the chiefs and elders of the communities provided the education. Programme themes used include morality of the youth, domestic violence, human rights and other crime related issues.

Commission on Human Rights and Administrative Justice and Non-Governmental Organizations

Only two communities indicated that the Commission on Human Rights and Administrative Justice or any other Non-Governmental Organizations had organized programmes on the education of crime related issues in their communities.

Conclusion

The study revealed that, a bulk of the population lived in wooden structures with the roofing made up of corrugated iron which according to them was informed by the adverse nature of the weather. It is worth mentioning that, the level of crime in these extremely deprived
communities according to about 50% of respondents is either high or very high. Interesting however is the fact that, children’s involvement in such crimes was very low.

The study also proved that, some children despite the fact that they are in school also engage in child labour with poverty as the main reason. One of the major findings of the study was also that, apart from Senior High School, there was the availability of Crèche Kindergarten, Primary, Junior High Schools.
CHAPTER NINE

PRAYER CAMPS

9.1 Introduction

Prayer camps are faith based facilities run by self-professed ‘prophets’ and healers where people with certain health disorders or others who exhibit some ‘abnormal’ and unfriendly behaviours suspected to have been caused by evil powers are sent, apparently to seek spiritual healing and cure. Many Ghanaian cultures and beliefs consider certain ailments, including mental disorders, barrenness etc. to be caused by evil spirits and can only be healed or cured by spiritual powers. Examples of such evil spirits include witchcraft.

Such ailments are often times not beyond medical cure. However, relatives and or friends lead clients to such places without recourse to medical treatment. These prayer camps became very common in the 1920’s and have existed, recording so many instances of inhuman treatments meted out to clients. Ghana as a religious nation has quite a number of these camps with the Central Region recording the largest number.

As part of its efforts to promote and protect the fundamental human rights and freedoms of all persons including the sick, the Commission monitored 81 prayer camps across the country. The scope of the monitoring bordered on the length of the existence of the camps, the nature of ailments reported, views on prayer camps and alleged human rights violations in the camps.

The United Twelve Apostles prayer camp in Bibiani in the Western Region, found to be the oldest prayer camp during the monitoring, has been in existence for 80 years. Precious Chapel in the Eastern Region is the most recent and has existed for only 1 year.

Registration Status of Camps

With regards to registration, 61 out of the 81 prayer camps monitored were registered with the Registrar Generals’ Department.

Category of People Who Visit the Camps

Among the category of people who patronise the services of these camps are;

- People with mental problems
- People with spiritual problems
- Suspected witches and wizards
- Sick people

Table 32 shows the frequency distribution of the category of people who visit the camps.
Table 32 : Category of People Who Visit Prayer Camps

<table>
<thead>
<tr>
<th>Category of People</th>
<th>Responses</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>People With Mental Problem</td>
<td>70</td>
<td>24.1</td>
</tr>
<tr>
<td>People With Spiritual Problems</td>
<td>77</td>
<td>26.5</td>
</tr>
<tr>
<td>Suspected Witches And Wizards</td>
<td>51</td>
<td>17.5</td>
</tr>
<tr>
<td>Sick People</td>
<td>72</td>
<td>24.7</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>7.2</td>
</tr>
<tr>
<td>Total</td>
<td>291</td>
<td>100</td>
</tr>
</tbody>
</table>

People with mental problems are often chained to keep them confined and incapable of resisting treatment. The chaining also prevents them from running away from the camp whilst in the custody of the camp practitioner. Article 5, of the Universal Declaration on Human Rights however states,

“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”.

This implies no prayer camp has the right to chain people who are brought to the camp. Table 32 indicates that 26.5 % of people who patronise the services of the camps have spiritual problems. Other categories of people who visit the prayer camps are people with the problem of barrenness, marriage and finance.

Pictures showing the arms and legs of a client chained over a period
Who sends Clients to the Camps?
It was evidenced that 72.2% of the people who visit the camps come on their own whilst 27.8 are normally sent by relatives and friends. In 55 out of the total number of camps visited, clients can leave the camps at will.

Reasons why Clients visit the Camps
There are different reasons for which clients visit the camps. Prominent among these reasons are:

- Satisfactory healing
- Believe in the power of God

Maximum Period of Stay
The longest period a client stayed in a camp was 2 years. This was recorded in “The Blood of Jesus” prayer camp in the Bosomtwe district of the Ashanti Region.

Accommodation
The type of accommodation varies from camp to camp. Shed accommodation is provided in 49% of the camps while others live in rooms and open air.

Source of Energy
The major source of energy used in these camps is charcoal and firewood.

Relationship with people outside
Inmates in 65 camps have contacts with people outside the camps. They also receive visitors occasionally.

Clients’ Daily Activities
Clients normally engage in personal prayers and the preparation of their own domestic chores.

Average Period of Stay
On the average, people stay between 6 months and 2 years.

Status of Healing
The exercise also indicate that majority of the people who visit the camps get completely healed after the period of stay. This was the case in 76.9% of the camps visited.
Source of Water

87.5% of the total number of camps monitored has potable water. Pipe borne water and well are the main sources of water at the camps visited. 38 camps have pipe borne water. Water supply is regular in most of the camps.

Toilet Facilities

It was also established that a large number of camps monitored use Ventilated Improved Pit (KVIP) and traditional pit latrine. Meanwhile, a few camps do not have toilet facilities; hence inmates use the “free range”. Sanitary conditions are said to be good in majority of the camps. 76.8% of the camps have adequate toilet facilities for inmates.

Bathing Facilities

The commonly used bathing facility is the concrete type with good sanitary conditions. In a few instances however, palm fronts are used to create bath houses. Sanitary condition is however unacceptable in one of the camps.

Common Ailments in the Camps

The common ailments clients normally suffer from in the camps are malaria and typhoid.

Availability of Refuse Dumps

A greater number of camps have refuse dumps where refuse is disposed off.

Monitoring of General Situation in Camps

It was gathered that 64% of the camps visited have not been monitored by other organisations except CHRAJ.

Advocacy Campaigns

Among the government institutions interviewed, only 40.4% embark on advocacy campaigns against prayer camps and human rights violations at these camps.

Views on Prayer Camps

Seeking the views of various religious bodies on whether prayer camps are necessary, It came out that 75% of Christians said it is necessary, while 20% of Moslems said it is unnecessary. In a related development, 81% of Christians interviewed support the continued existence of prayer camps. Notable among the reasons for the continued existence of prayer camps are;

- The belief that certain illnesses are spiritual and can only be cured through divine intervention.
- Prayer camps provide solutions to spiritual and psychological needs of people.
To regulate the activities of prayer camps, 96.8% of respondents suggested that they should be monitored regularly. They also expressed dissatisfaction about government institutions in the campaign against human rights violations in prayer camps.

**Clients’ Views about Prayer Camps**

In focused group discussions with clients, it was upheld that prayer camps are necessary evils in our society because they provide quick solutions to their spiritual and psychological problems. Clients also affirmed that apart from a few instances, including dry fasting and prayers, no mistreatments are meted out to them. They however suggested intensified human rights education programmes for operators of prayer camps to enhance their operations.

**Conclusion**

The operations of prayer camps are being monitored against the backdrop of reported human right abuses meted out to people who patronize their services. There is the continuous effort by the Commission is to sensitize the camp practitioners to operate, being mindful of the rights of persons brought to them.
### Recommendation

**Indicators**

<table>
<thead>
<tr>
<th>Implementation Agency</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Education</td>
<td>Ban payment of levies in basic schools.</td>
</tr>
<tr>
<td>Ghana Education Service</td>
<td>Increase amount for capitation grant and school feeding programmes to correspond with the increasing number of school children</td>
</tr>
<tr>
<td>Ministry of Finance</td>
<td>Monitor schools in the administration of corporal punishment.</td>
</tr>
<tr>
<td>Ghana Education Service</td>
<td>Include human rights education in the school curriculum for primary, JHS, SHS and teachers training college</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>Sensitize pupils on GES Policies on corporal punishment, bullying and harassment</td>
</tr>
<tr>
<td>Ghana Education Service</td>
<td>Re-introduction of religious, moral and civic education into schools</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>Extend school feeding</td>
</tr>
</tbody>
</table>
Ministry of Finance
Metropolitan, Municipal, District Assemblies (MMDA)

- Student's with disability should benefit from district assembly common fund
- School structures should be made accessible to persons with disability.
- Provision of learning materials and equipment for students with disability
- Provision of equipment for school workshops, computer laboratories

Ministry of Education
Ghana Education Service
MMDA

- The Ghana Police Service
- Judicial service
- Attorney General’s Department

MOWAC
The Ghana Police Service
Ministry of Health
Ghana Health Service

- Enforce Domestic Violence laws
- Establish shelters and counselling units for victims of domestic violence.
MOWAC

Translate Domestic Violence Acts into the major local languages

Ministry of Health
Ghana Health Service

Provide free medical care for victims of domestic violence

Enforce government’s policy of free health care for pregnant women

NCCE
CHRAJ
Information Service Department
Faith Based Organisations
Ministry of Women and Children’s Affairs
MMDA

Educate public on harmful cultural practices like tribal marks, FGM, trokosi, harmful widowhood rites

Gear sensitization programmes towards the reintegration of suspected witches into communities

Harmful Cultural practices
Right to Health and Education in Deprived Communities (Slums)

- NCCE
- CHRAJ
- Information Service Department
- Faith Based Organisations

- Educate slum dwellers on their rights and responsibilities

Right to Health

- Ministry of Health
- Ghana Health Services

- Educate slum dwellers on child labour and its worst forms
- Increase access to healthcare services across the country especially in the Western Region.

- Post more mid-wives, doctors, nurses, and other health personnel to regional, districts and community health post

- Provide at least one ambulance for each regional, districts and community health post across the country.

- Ministry of Health
- Ghana Health Services
- Ghana Ambulance Services

- Provide health facilities for communities at the country sides

- Train more health professionals
- **Ministry of Health**
- **Ghana Health Services**

- **Ministry of Health**
- **Ghana Health Services**

- **National Health Insurance Authority**

- **MMDAs**
  - The Ghana Police Service
  - NGOs
  - Head Councils of Faith Based Organisations

- **Rights of Persons in Prayer Camps**

- Improve the general conditions under which health workers operate in terms of availability of infrastructure and equipment

- Sensitization of the general public on general health on maternal health, patients charter, HIV/AIDS

- Improve NHIS to ensure prompt issuance of card

- Increase drugs lists of the scheme

- Create a national uniform cards for patients to enable them access healthcare everywhere

- Make legislations to regulate the operations of prayer camps

- Monitor regularly
Children’s Rights

- CHRAJ
- NCCE
- MOWAC,
- Ministry of Youth and Sports,
- Sports council
- MMDAs

- NCCE
- CHRAJ
- Information Service Department
- Faith Based Organisations

- MOWAC
- CHRAJ
- DSW
- Ghana Police Service
- Attorney general’s department
- Judicial Service

- Ministry of Health
- Ghana Health Services

- MOWAC
- DSW
- Ghana Police Service

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- Sensitize operators of prayer camps on human rights
- Provide recreational facilities in each community
- Increase public education on general children’s rights issues
- Enforce laws on protecting children’s rights
- Free medical care for victims defilement
Rights of Persons in Detention

- The Ghana Police Service
- Judiciary
- Attorney-General’s Department
- Ghana Police Service
- Ghana Prison Service
- Department of Social Welfare
- MOWAC

- Establish rehabilitation centres for trafficked children
- Decongest the prisons
- Hasten the process of prosecution in the Courts.
- Make provision for detained nursing mothers

\textsuperscript{i} Prenatal denotes existing or occurring before birth; perinatal refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); neonatal, by contrast, covers the period pertaining to the first four weeks after birth; while post-natal denotes occurrence after birth. In this general comment, the more generic terms pre- and post-natal are exclusively employed.