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人人有权享有可达到的最高水准身心健康问题特别报告员阿南德·格罗弗的报告

增编

对加纳的访问*

概要

人人有权享有可达到的最高水准身心健康问题特别报告员阿南德·格罗弗于 2011 年 5 月 23 日至 30 日访问了加纳。访问期间，他与政府代表、民间社会组织、卫生工作者、学术界人士，以及阿克拉、塔马利和库马西的当地代表举行了会晤。

特别报告员称赞加纳明确致力于为公民实现可达到的最高水准身心健康。不过，要充分实现健康权，还有许多严重问题需要处理。此外，加纳刚从低收入国家变成中低收入国家，这可能导致许多筹资问题，从而有可能威胁到该国在健康权方面的进展。

* 本概要以所有正式语文分发。报告本身载于概要附件，仅以原文分发。

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报告第一节和第二节涉及加纳的发展背景和法律义务。在第三节，特别报告员研究了“国家健康保险计划”对加纳健康权的影响。虽然制定该计划是一个值得称道的步骤，有助于确保所有人获得优质的保健，但是对成员资格和覆盖面，一些重要货物和服务被排除在外，以及该计划的长期可持续性存在严重担忧。第四节侧重加纳心理卫生部门资源严重短缺的问题。加纳在向公民提供优质的心理保健方面面临一些障碍，包括心理卫生设施不足、心理卫生工作者缺乏，语言不通和设施分布不够广。第五节探讨了妇女健康问题。加纳宣布孕产妇死亡率高为“国家紧急状况”。虽然政府已采取多项措施改善这一状况，包括让孕妇免费参加“国家健康保险计划”，但仍须采取更多措施。在第六节，特别报告员称赞加纳为缩小疟疾范围所做的努力，但是指出可以从有助于控制该疾病的健康的基本决定因素入手，在这方面取得更大进展。第七节探讨了与环境和职业健康有关的问题。加纳存在严重的职业健康和安全问题，尤其是采矿业，政府应立即处理这些问题。

最后一节载有关于加纳身心健康权利的结论和建议。

Annex

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, on his mission to Ghana

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I. Introduction

1. The Special Rapporteur visited Ghana at the invitation of the Government from 23 to 30 May 2011. The purpose of the mission was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health, as well as the measures taken for its successful realization and the obstacles encountered both at the national and international levels.

2. The mission focused on the health system in Ghana, including the National Health Insurance Scheme; mental health; maternal health, including maternal mortality; occupational and environmental health, including malaria. During the mission, the Special Rapporteur met with Government representatives, civil society organizations, health professionals, academics and representatives of local communities in Accra, Tamale and Kumasi.

3. Throughout the mission, Government officials and other relevant actors were open and constructive. The Special Rapporteur would like to thank all those who gave their time and extended cooperation to him.

II. Ghana and the right to health

A. Background

4. Ghana became the first country in Sub-Saharan Africa to gain independence from colonial rule in 1957. Between 1957 and 1981, Ghana experienced a period of political uncertainty. However, the country has since become a unitary republic with a multiparty democratic system, which vests executive power in the president. Despite this seemingly tumultuous recent political history, Ghana's independence and transitions between governments were largely peaceful. As a result, the country now enjoys a degree of political and economic stability.

5. While colonial rule and political uncertainty may have delayed Ghana's economic development, the country's gross domestic product (GDP) has grown at a robust 5.5 per cent per year since 2004. This economic growth has undoubtedly contributed to a significant decrease in poverty levels within Ghana, from 52 per cent in 1992 to 29 per cent in 2006.[1] Moreover, in July 2011, as a result of this sustained economic growth, Ghana transitioned from a low-income to a lower middle-income country.[2]

6. While keeping in mind Ghana's admirable economic growth and reduction in poverty, as at 2010, it ranked 130 out of 169 countries in the Human Development Index.[3] Though many health indicators in the country are still lagging, total expenditure on health in Ghana in 2009 was 8.1 per cent of the country's GDP.[4] This level of expenditure

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[1] World Health Organization (WHO), WHO Country cooperation strategy 2008-2011: Ghana (Brazzaville, Republic of Congo, 2009).

[2] World Bank, "Ghana Looks to Retool Its Economy as it Reaches Middle-Income Status," Washington D.C., 18 July 2011. Available from http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/GHANAEXTN/0,,contentMDK:22964653~menuPK:50003484~pagePK:2865066~piPK:2865079~theSitePK:351952,00.html

[3] United Nations Development Programme (UNDP), Human Development Report 2010: The Real Wealth of Nations: Pathways to Human Development (New York, 2010).

[4] WHO, Ghana Country Profile 2011. Available from http://www.who.int/countries/gha/en/.

demonstrates the Government's commitment to improving the health and lives of its population. The Special Rapporteur also commends Ghana on the great strides it has made towards meeting Millennium Development Goal 4 of reducing child mortality. Unfortunately, similar gains have not yet been realized with respect to Goal 5 to improve maternal health. While maternal deaths are declining, a drastic reduction in deaths over the next few years is needed in order for Ghana to meet its target by 2015.[5]

7. The challenge for Ghana, like other countries transitioning into middle-income status, is to manage its new resources appropriately, particularly with respect to health expenditure. Although an increase in income may immediately translate into better population health outcomes, these gains will only be sustained with good strategic planning based on the right to health approach. Ghana's transition from a least developed country to a lower middle-income country status may limit the funding it is eligible to receive from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank, and other international donors. The resulting shortfalls in funding will likely result in a lack of availability of affordable health goods and services. In order to ensure full realization of the right to health, the Government will need to increase health spending to make up for anticipated deficits, particularly when these shortfalls will substantially affect the most vulnerable populations.

B. Legal framework

8. Ghana has ratified several international treaties recognizing the right to health. These include the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Ghana has signed but not ratified the Convention on the Rights of Persons with Disabilities.

9. Ghana is also a party to the African Charter on Human and Peoples' Rights. The right to the best attainable standard of physical and mental health is recognized in Article 16 of the African Charter, which requires States to take "necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick".

10. The Constitution, adopted in 1992, establishes several health-related rights including care for mothers after childbirth, care of children and protection of the rights of the disabled and sick. However, there is no explicit provision concerning the right to health in the Constitution. Articles 24(1) concerning right to work under satisfactory, safe and healthy conditions; 27(1) concerning special care accorded to mothers during a reasonable period before and after childbirth; 28(2) concerning protecting children from unhealthy work; 28(4) concerning non-discrimination against children with respect to health care; 29(4) concerning the treatment of disabled persons; 36(10) concerning health and system standards in employment; 37(2)(b) concerning the ensuring all basic human rights for vulnerable groups; 39(2) concerning the abolishment of traditional practices injurious to health; and 190(1) concerning the public health services of Ghana all provide for various health-related protections.

[5] UNDP and Ghana, National Development Planning Commission (NDPC), *2008 Ghana Millennium Development Goals Report*, April 2010. Available from http://www.undp-gha.org/site/docs/Ghana Ghana MDGReport-2010.pdf.

III. Health system

11. The Special Rapporteur commends the Government on its clear commitment to provide health care to all and its willingness to explore equitable methods to do so. This is especially important in Ghana, as in many other developing economies, in light of the fact that it remains an economically unequal society.[6] From independence to 1985, the Government provided free health care through a tax-based health financing system. However, economic crises in the 1970s and 1980s led to sizeable revenue shortages and resulted in the introduction of a "cash and carry" scheme, which imposed user fees in 1985.[7] The introduction of this system of payment significantly reduced health service utilization by creating sizeable financial barriers to access, especially for the poor.[8] The Government recognized this problem and attempted to create user fee exemptions for vulnerable populations, such as pregnant women, older persons, children, the poor and others. However, in practice, the exemption system was not successful in providing access to health care for exempted groups, for a variety of reasons.[9]

12. As an alternative to this system of health-care provision, in the 1990s, various insurance schemes such as Community-Based Health Insurance (CBHI) and Ministry of Health insurance schemes were trialled. While there was significant growth in the number of CBHI schemes, they were again unable to provide health-care funding for more than a small minority of Ghanaians.[10]

13. The right to health obliges States to ensure that health systems are designed to ensure sufficient availability, accessibility, and quality of health goods and services in a non-discriminatory manner. In that respect, the National Health Insurance Scheme (NHIS) was developed in 2004 to expand and improve access to health goods and services across the country. It has to been noted that the effectiveness and equity of the scheme has recently been questioned and should be critically examined in order to make the necessary improvements.

14. The NHIS is administered through District Mutual Health Insurance Schemes (DMHIS) and provides for both private commercial health insurance and private mutual health insurance. Official government figures suggest that scheme membership was as high as 59.5 per cent of the population in June 2010,[11] while critical reports indicate that membership stands at just 18 per cent.[12] While there is disagreement over the actual percentage of coverage offered by the NHIS, Government officials indicated to the Special Rapporteur that the true number was likely somewhere between the two figures presented

6 UNDP, International Human Development Indicators, Income Gini Coefficient (World Bank, 2011).

7 Varatharajan Durairaj, Selassi D'Almeida, Joses Kirigia, "Obstacles in the process of establishing s sustainable National Health Insurance Scheme: insights from Ghana," Technical brief for policy-makers (WHO, 2010). Available from http://www.who.int/health_financing/pb_e_10_01-ghana-nhis.pdf.

8 Catriona Waddington and K.E. Enyimayew, "A price to pay: The impact of user charges in Ashanti-Akim district, Ghana," International Journal of Health Planning and Management, vol. 4, No. 1 (1989), pp. 17-47.

9 M. Aikins, S. J. Anie, P. Apoya, S. Grey, *A survey of health financing schemes in Ghana* (Dakar, PHRplus, 2001).

10 Oxfam International, *Achieving a Shared Goal: Free Universal Health Care in Ghana* (March 2011), p. 18. Available from http://www.oxfam.org/sites/www.oxfam.org/files/rr-achieving-shared-goal-healthcare-ghana-090311-en.pdf.

11 Ghana, National Health Insurance Scheme, Summary statistics (as of June 2010). Available from http://www.nhis.gov.gh/?CategoryID=309.

12 Oxfam International, *Achieving a Shared Goal: Free Universal Health Care in Ghana* (March 2011).

above. Coverage within this range falls far below that which is required to ensure the full realization of the right to health. The Government should do much more to expand coverage, especially to those areas in which physical infrastructure is lacking. Further, it is regrettable that reliable data regarding insurance coverage is not accessible. Better data collection, including additional disaggregation, is necessary to assess the effectiveness of the scheme.

15. Aside from concerns about coverage, certain other aspects of the insurance scheme may be lacking or in need of refinement to ensure accessibility for the poor and marginalized groups. Although, as of 2009, approximately 45 per cent of Ghanaians were insurance cardholders[13], a number of problems related to cardholding and registration remain. The initial NHIS registration process itself can take up to six months, and a fee must be paid for the mandatory annual re-registration. Such fees create a barrier to access, in particular since the most vulnerable populations will not be able to afford them, especially if there is a registration fee at the outset. While provisions have been made for temporary cards, it is unclear how many Ghanaians receive or utilize such cards. A valid registration card is necessary to access all non-emergency health care; lack of a card or an expired card will most likely lead to denial of service. Again, without better data collection, it is difficult to further analyse the effectiveness of the registration system.

16. There have been reports of discrimination within the system against insured persons, which has an obvious impact on accessibility of health-care services. Some of the discrimination is due in part to delays in provider reimbursement, which creates an incentive for providers to treat uninsured persons who can pay immediately out-of-pocket, as opposed to treating insured persons for whom payment will not be immediate. In addition to restrictions on the accessibility of health goods and services, the Special Rapporteur was also informed that in many cases services provided were of inferior quality. Patients with insurance faced discrimination with regard to service, including long waiting lists, and were more likely to be seen by a physician's assistant, nurse or other health-care professional less qualified than a doctor.

17. Though many important goods and services are included under the NHIS, it is of great concern to the Special Rapporteur that some vital goods and services are excluded from the scheme. For example, HIV anti-retroviral treatment (ART), cancer treatment (other than for breast and cervical cancers), rehabilitation other than physiotherapy, organ transplants, cardiovascular and neurological surgery (except such surgery resulting from accidents), echocardiography, angiography, appliances (such as optical and auditory aids) and orthopaedics, are among the essential goods and services that do not fall within the scheme.[14]

18. The Special Rapporteur was informed that the provision of immunoglobulin to newborn infants to prevent transmission of hepatitis B from infected mothers was not covered under the insurance scheme, even though a one-off payment of around 500 USD for treatment would prevent transmission in nearly 100 per cent of cases, and thereby save significant costs associated with lifetime management of the illness. The Special Rapporteur was also informed that family-planning services (except counselling) and contraceptives were not included in the scheme. Given their importance in controlling the fertility rate and reducing maternal mortality rates, and equally importantly, enabling women to make choices concerning their sexual and reproductive health, a wide range of

[13] Ghana, Ministry of Health, "Pulling together, achieving more," Independent review, Health sector programme of work 2008 (Accra, 2009).

[14] Ghana, National Health Insurance Authority, *Annual Report 2010*, (2011). Available from http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/8(1).pdf.

contraceptives and family-planning services should be included in the insurance scheme free of cost, as a matter of priority. The Special Rapporteur urges the Government to reconsider all of the exclusions and ensure that they are included in the NHIS.

19. Broader concerns about the overall sustainability of the scheme relate to its ability to generate adequate revenue to make up for outlays.[15] Value-added tax (VAT) is currently the primary revenue source for NHIS and in 2008, accounted for 69.5 per cent of revenues.[16] The remainder of revenues come from premiums and other payments made by users of the system and some international funds. Government reports suggest that at the current level of VAT and premium collection, the scheme will not be sustainable. Ghana's transition to a lower middle-income country will further impact on its eligibility to receive funding from some sources, such as the GFATM, that it currently relies on for critical areas, including HIV/AIDS treatment. During the mission, Government officials reported that they would be experiencing reductions in international assistance, similar to other countries undergoing such an economic transition. However, there was no indication by the Government as to how it would tackle these sustainability issues in the medium or long term.

HIV/AIDS under NHIS

20. HIV prevalence in Ghana is among the lowest in West Africa at 1.9 per cent of the population aged 14 to 49.[17] While the epidemic remains generalized, seroprevalence has dropped over the past five years. Nonetheless, recent gains cannot be taken for granted, especially in light of the potential funding obstacles described above, many of which particularly affect HIV.

21. Although knowledge of HIV/AIDS in Ghana is high, this broad awareness has not translated into knowledge of HIV/AIDS prevention. While 98 per cent of women and 99 per cent of men have heard of HIV/AIDS, only 25 per cent of women and 33 per cent of men possess comprehensive knowledge of prevention strategies.[18] This awareness has more importantly failed to reduce the still potent stigma directed against people living with HIV (PLHIV). This stigmatization is reinforced through criminalization of the conduct of some of the most at risk populations, namely female sex workers and men who have sex with men. Criminalization of the conduct of these groups is a serious concern in light of discrimination experienced by men who have sex with men.[19] The impact of criminalization, aside from the generation of stigma, includes reduced access to goods and services for PLHIV who are afraid to seek out such services for fear of sanction.[20] As a result, HIV prevalence rates among female sex workers (25.1 per cent) and men who have sex with men (25 per cent) remain far and unacceptably higher than in the general population.

22. The realization of the right to health requires that greater efforts be made to ensure adequate access to ART for PLHIV. As mentioned earlier, anti-retroviral drugs are

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[15] Oxfam International, *Achieving a Shared Goal: Free Universal Health Care in Ghana* (March 2011), p. 45.

[16] Ibid., p. 46

[17] World Bank, HIV/AIDS in Africa – Ghana. Available from http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0,,contentMDK:20450329~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html.

[18] Ghana Statistical Service and Ghana Health Service, *Ghana: Demographic and Health Survey 2008* (September 2009). Available from http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf.

[19] UNAIDS/PCB(26)/10.3 pp. 2-3, 10; *See also*, http://www.bbc.co.uk/news/world-africa-14250170

[20] See A/HRC/14/20.

currently excluded from the NHIS.[21] Even with treatment subsidies provided by GFATM, users must pay five Ghanaian cedis a month to access ART – a significant amount of money for the poor and most-at-risk. Such fees prevent affected individuals from receiving treatment and therefore constitute financial or economic obstacles to accessing goods and services. Furthermore, these financial barriers may result in interruptions to otherwise rigid treatment cycles, even for people who can afford the fees. Interruptions to ART may in turn promote resistance to first-line medicines, which would necessitate the use of more expensive second- or third-line drugs in order to continue treatment, thereby further burdening the finances of the health system.

23. The sustainability of health financing may be further negatively affected by reductions in funding and support from international donors such as GFATM, which have begun to reduce assistance to Ghana in light of the country's recent economic growth. If the cost of treatment programmes such as ART rises, and international funding diminishes, severe funding shortfalls and drops in coverage are bound to result. While this raises concerns from a right to health standpoint, it is also a matter of great concern for the NHIS; the scheme is already operating at a loss and would have to make up for the increases in HIV-related expenditure stemming from more expensive treatment regimes and reductions in international assistance.

IV. Mental health

24. Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes that enjoyment of the highest attainable standard of mental health, alongside physical health, is central to the realization of the right to health. This, in turn, requires the creation of conditions assuring equal and timely access to appropriate mental health treatment and care.[22] Although the provision of mental health care in Ghana is among the best in the region, its scale of implementation remains substantially inadequate to address the population's burden of mental illness. And even where these services are available, the quality of service is often poor, due in part to a de-prioritization of mental health concerns within the overall health system.

25. The Special Rapporteur was concerned to learn of the many issues regarding the provision of mental health-care services in Ghana. The major issues leading to deficiencies in the treatment of those with mental illness include grossly inadequate physical and human resources for service provision; lack of institutions that provide training for aspiring psychiatrists; high levels of stigma concerning both mental health-care workers and patients; and lack of a comprehensive legislative framework to address mental health care.

26. The Special Rapporteur was informed that mental health facilities in Ghana are understaffed and ill-equipped, both in terms of physical outfitting and financial resources to cope with their patient load. This was confirmed by observations in a facility, where a number of inmates had to sleep side by side on the floor in a room without toilet facilities – in some instances, up to 70 or 80 people – because dormitory accommodation had already been utilized to capacity. However, it is encouraging that steps have been taken to reduce overcrowding in these facilities by relocating eligible patients to the community. The Special Rapporteur was informed that over 980 people were re-sited from Accra alone, many of whom have been able to return to work. These efforts to provide mental health care in the community setting accord with the principles for the protection of persons with

[21] Ghana National Health Insurance Authority, *Annual Report 2010* (2011).

[22] Committee on Economic, Social and Cultural Rights (CESCR), general comment No. 14 (2000), para. 17.

mental illness and the improvement of mental health care, which require that patients be treated in the least restrictive environment possible.[23] However, there is a lack of support within communities for individuals suffering from mental illness, both in terms of community-based treatment and integration into society and the labour force.

27. In addition to such deficits, there are concerns in respect of recruitment and retention of health professionals within the mental health sector. There is currently only one psychiatrist for every two million people in Ghana, and it is estimated that 98 per cent of people who require psychiatric treatment do not receive mental health care.[24] Significant stigma exists around psychiatric-related health-care work; professional roles in this area are viewed as undesirable and work is not adequately remunerated. These problems are compounded by the sizeable migration of key health-care personnel from Ghana. The country lacks resources to retain these health-care professionals. However, the Government has made efforts to remedy this situation.[25] The mental health-care sector is not immune to the heavy losses of personnel suffered due to the “brain drain”; it is estimated that the psychiatrist/population ratio would be between two to eight times higher in Ghana had it not been for emigration.[26] Considering these ratios, it is especially important that the Government create incentive structures and infrastructure that not only de-stigmatize and promote mental health work in Ghana, but also retain health-care professionals. Although the Special Rapporteur recognizes the obstacles the Government faces in improving mental health care, the current situation is unacceptable. While resource constraints may limit absolute coverage, existing deficits in coverage fall even below the minimum accessibility and availability requirements of the right to health.

28. There are also other challenges to providing quality mental health-care services. It is estimated that there are over 40 languages spoken throughout the country, and significantly more local dialects, presenting significant obstacles to access, especially for the rural poor and ethnic minorities. With respect to mental health, such barriers are particularly harmful because the patient’s ability to communicate symptoms is critical to the diagnosis of mental illness. The Special Rapporteur calls on the Government to ensure the availability of staff conversant in local languages and dialects or interpreters at all facilities.

29. Stigma surrounding mental illness often leads to the ill-treatment of persons who have mental illnesses, particularly in non-urban areas, and thus presents a significant barrier to families and communities seeking appropriate care for affected individuals, in addition to the physical and linguistic obstacles that those in more remote areas of the country already face. Although some outreach services are provided by NGOs in certain districts,[27] additional measures are urgently needed to ensure availability of adequate treatments in these regions. The Special Rapporteur encourages the Government to develop awareness building programmes with respect to mental illness and engage in other activities to reduce stigma and discrimination surrounding mental health. Moreover, the right to health requires that the Government of Ghana create the necessary infrastructure to ensure the availability of mental health services in areas outside of Accra and Kumasi, where services are currently severely lacking.

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[23] General Assembly resolution 46/119, annex, principles 7 and 9.

[24] WHO, Mental Health, *Ghana Country Summary: A very progressive mental health law* (Geneva, October 2007), p. 2.

[25] John Anarfi, Peter Quartey and John Agyei, “Key Determinants of Migration Among Health Professionals in Ghana,” January 2010 (Brighton, United Kingdom, Development Research Centre on Migration, Globalization and Poverty), p. 4.

[26] Rachel Jenkins and others,, “International Migration of Doctors, and Its Impact on Availability of Psychiatrists in Low and Middle Income Countries,” *PLoS ONE,* vol. 5, No. 2 (February, 2010).

[27] Basic Needs, *Share Learn Share*, Basic Needs Ghana Newsletter, No. 1 (December 2010), pp. 9-10.

30. The Special Rapporteur welcomes the introduction and use of newer medications with improved efficacy and side-effect profiles. However, the current supply of medications – both older and newer generation treatments – remains insufficient throughout the country. The Special Rapporteur was also informed that stock-outs occur regularly, and that medications are still unaffordable for many people.

31. More steps need to be taken by the Government in order to achieve realization of the right to health for persons suffering from mental illness. While efforts made to fulfil the obligation to respect the right to health, such as decreasing institutionalization, are encouraging, these efforts are currently very limited in comparison to the magnitude of the problem. At the moment, mental health care in Ghana is clearly inadequate, which is in large part due to the lack of resources, both financial and human, devoted to mental health. The State's obligation to fulfil the right to health requires that a comprehensive legislative and policy framework be put in place to address the problem.

Mental health bill

32. In June 2006, a bill on mental health was finalized after a lengthy consultation process, with the intention of overhauling the provision of mental health-care services in Ghana and providing much-needed resources to the sector. The Mental Health Bill 2006 was designed to decentralize psychiatric care throughout the country – which currently remains concentrated in the south, particularly in Accra – and introduce comprehensive care at the community level. It emphasizes the need for more resources and autonomy in the sector, alongside clearly enforceable rules with respect to service provision, particularly monitoring of human rights in mental health facilities, with which the Government will be required to comply. Inclusion of these accountability measures, alongside the special attention given to vulnerable groups in the draft law, is very encouraging and consistent with a right to health approach.[28]

33. This progressive draft law, when passed and implemented, could potentially serve as a model to other countries in the region that are looking to review their own mental health laws. However, although the bill is now over five years old, it has still not been adopted by Parliament. The Special Rapporteur was informed of the many reasons for this delay, the majority relating to political or logistical issues, and in particular, a reticence to unnecessarily establish a "parallel" mental health-care system that would operate besides the existing health-care system. The Special Rapporteur remains concerned about the lack of political will to reform the mental health-care system and urges the Government to take immediate action to rectify this situation in light of the major deficits.

34. The Special Rapporteur believes that all of the aforesaid evidences a failure on the part of the Government to take adequate steps to respect, protect and fulfil the right to health of persons living with mental health illnesses. The Government must urgently remedy this dire situation in accordance with the right to health.

V. Maternal health

Women: Millennium Development Goal 5

35. Ghana has made remarkable progress towards achieving Millennium Development Goal 4 of reducing child mortality. The Ghana Demographic and Health Survey recorded that the infant and under-five mortality rate declined from 64 per 1,000 live births in 1999-

[28] WHO, Mental Health, *Ghana Country Summary: A very progressive mental health law* (Geneva, October 2007), p. 1.

2003 to 50 per 1,000 live births in 2004-2008.[29] Furthermore, measles-related deaths have been completely eliminated as a result of a comprehensive immunization campaign.

36. However, more remains to be done to achieve Millennium Development Goal 5 to improve maternal health. The Ghana Maternal Mortality Survey of 2008 showed a decline in maternal deaths, from 503 per 100,000 live births in 2005 to 451 per 100,000 in 2008. However, even with this decline, unless maternal deaths are drastically reduced, it is unlikely that Ghana will meet the target of 185 per 100,000 by 2015.[30] In 2008, the Minister of Health declared the maternal mortality rate a "national emergency".

37. The Special Rapporteur commends the Government for providing free maternal health services for all pregnant women under the NHIS, thereby making antenatal services from skilled birth attendants more affordable. From 2000-2010, 90 per cent of pregnant women in Ghana visited an antenatal care provider once, and 78 per cent visited an antenatal care provider at least four times,[31] meeting the World Health Organization's standard for recommended visits during a pregnancy. While this progress is notable, the use of these services remains heavily limited by socio-economic factors such as women's education levels, wealth and geographic accessibility.[32] Approximately 70 per cent of all medical professionals are based in Accra and Kumasi, making rural accessibility critical.[33] Women in rural and remote areas, particularly those living in poverty, often cannot access these services due to indirect costs such as transport and accommodation. Increases in accessibility require support for both indirect costs and greater availability of rural health-care centres and providers.

38. While not strictly related to women's obstetric care, additional illnesses or diseases – comorbidities – may require treatment to ensure the health of pregnant women. However, treatment of comorbidities is not currently part of the maternal health benefits package. Women are therefore required to make additional payments in order to receive treatment for these illnesses. Such additional payments may bar pregnant women from treatment or discourage them from seeking otherwise subsidized maternal health services, which may result in significant negative health outcomes. For example, gestational diabetes, a common comorbidity during pregnancy,[34] may result in a number of negative health outcomes for the mother, such as problems with delivery associated with foetal overgrowth; increased need for Caesarian delivery; hypertensive disorders, including pre-eclampsia; and an increased risk of developing type-2 diabetes later.[35] Furthermore, the child may be at an increased risk of developing type-2 diabetes and obesity.[36] Failing to adequately treat comorbidities has the potential to complicate both intra-partum and post-partum care. In

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[29] Ghana Statistical Service and Ghana Health Service, *Ghana: Demographic and Health Survey 2008,* Preliminary Report (April 2009). Available from http://pdf.usaid.gov/pdf_docs/PNADO176.pdf.

[30] UNDP and Ghana, National Development Planning Commission (NDPC), 2008 Ghana Millennium Development Goals Report (April 2010). Available from http://www.undp-gha.org/docs/GhanaGhanaMDGReport-2010.pdf.

[31] WHO, *World Health Statistics 2010* (Geneva, 2011), p. 94.

[32] Patience Asseweh Abor and others, "The socio-economic determinants of maternal health care utilization in Ghana," *International Journal of Social Economics*, vol. 38, No. 7 (2011), pp. 629, 642–643.

[33] "Maternal mortality and morbidity," Round-Up, *Reproductive Health Matters*, vol. 16, No. 32 (2008), pp 208.

[34] Gerardo Forsbach-Sánchez, Hector E. Tamez-Perez and Julia Vazquez-Lara, "Diabetes and Pregnancy," *Archives of Medical Research*, vol. 36, No. 3 (May 2005), p. 291.

[35] Robert Lindsay, "Gestational diabetes: causes and consequences," *British Journal of Diabetes & Vascular Disease*, vol. 9, No. 1 (January/February 2009), p. 29.

[36] Ibid..

some cases, comorbidities, such as hypertension, result directly in maternal mortality.[37] The exclusion of comorbidities from subsidized maternal care presents a substantial financial barrier to critical maternal health care. Access to treatment of comorbidities is vital to ensuring the realization of the right to health and the achievement of Millennium Development Goal 5.

39. Furthermore, the role of traditional birth attendants needs to be clarified and emphasis placed on support and referral of mothers to safe facilities. Although traditional birth attendants are essential for point-of-care service delivery, in many cases they are not best suited to emergency maternal care or situations in which complications arise. In such situations, appropriate and timely treatment is necessary to prevent both maternal and foetal mortality and morbidity. A network of correctly assigned responsibilities between traditional birth attendants, emergency health-care workers and other service providers must be developed in order to properly assess and assign responsibility for treating pregnant women in need of emergency care or treatment for complications. Proper diagnosis at the local level is necessary to enable appropriate and timely referrals to the correct services.

40. Unsafe abortions account for 12 per cent of maternal deaths;[38] however, both family planning and abortion procedures are excluded from the NHIS. Although middle-class and wealthy women access abortion services in regulated abortion clinics, poor and marginalized women cannot afford the rates charged in such clinics and often undertake procedures in unsafe and unregulated environments, which leave them vulnerable to avoidable incidences of maternal morbidity and mortality.[39] Extending the insurance scheme to include free or heavily subsidized family-planning and abortion services will assist in eliminating the inequality of access to quality services. The number of qualified abortion providers must be increased, particularly in rural areas, and there must be better regulation in order to ensure that the procedure is only carried out by qualified service providers.

41. In many cases, traditional practices violate the right to health, and more often than not, these practices are directed against groups that may already be more vulnerable to infringements of their rights, such as women and children. One example is *trokosi* – the practice of surrendering girls as young as 10 to village priests as an act of atonement for family sins.[40] Practices such as this continue to occur, predominately in the more remote regions such as the Volta, where women and girls are often already vulnerable to violations. The right to health requires that the Government make concerted efforts to prevent and remedy the effects of harmful traditional practices that may generate stigma and discrimination against women. Although the Special Rapporteur is pleased to note that this practice has been criminalized in Ghana, enforcement is lacking and the practice continues to occur in remote regions, particularly in the Volta. More must be done to promote the discontinuance of *trokosi*, including greater community awareness-building and improved enforcement efforts. In a promising development, local priests have begun taking steps to prevent the surrender of women and young girls in this manner.[41]

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[37] Catherine Brown and Vesna Garovic, "Mechanisms and Management of Hypertension in Pregnant Women," *Current Hypertension Reports*, vol. 13, No. 5 (2011), pp. 338-346.

[38] Ghana Statistical Service and Ghana Health Service, *Ghana Maternal Health Survey 2007*, (May 2008). Available from http://pdf.usaid.gov/pdf_docs/PNADO492.pdf.

[39] Frank Baiden, "Making Safe Abortion Services Accessible in Ghana," *Journal of Women's Health*, vol. 18, No. 12 (December 2009), pp. 1923-1924.

[40] CEDAW/C/GHA/3-5, para. 45.

[41] Amy Small Bilyeu, "Trokosi - The Practice of Sexual Slavery in Ghana: Religious and Cultural Freedom vs. Human Rights," *Indiana International and Comparative Law Review*, vol. 9, No. 2. (1999), p. 474.

42. Similarly, female genital mutilation has also been criminalized but continues to occur,[42] despite attempts to enforce the law through prosecutions.[43] As for *trokosi*, effectiveness of the law is largely dependent on significant cultural change, which likely cannot be made through criminalization alone. Community-led efforts should be encouraged, as they present the most effective and sustainable solutions to eradicating harmful traditional practices.

VI. Malaria

43. Malaria remains hyperendemic throughout Ghana, with nearly 3.7 million cases reported nationwide in 2009.[44] The disease also exacts a substantial economic toll, estimated at one to two per cent of Ghana's GDP. And while malaria is widespread, the most vulnerable groups of society still bear the overwhelming burden of the disease. Disparities remain within the health system at large, and accessibility and availability of necessary goods and services for vulnerable populations, such as children, are even lower in rural areas and for the poor.[45]

44. Malaria is responsible for 9.4 per cent of maternal deaths,[46] and infants born to mothers with malaria are more likely to be of low birth weight, the single greatest risk factor for death in newborns. The incidence of low birth weight has been rising and contributes in part to the 20,000 children dying annually in Ghana due to malaria.[47] Malaria can also lead to long-term disability in survivors. Repeated bouts of malaria have also been known to impair as much as 60 per cent of a child's schooling, impacting on opportunities and productivity in life.[48]

45. In light of the severity of this issue in Ghana, the Special Rapporteur commends the Government on the admirable work done through the successful implementation of the Roll Back Malaria strategy, which includes the distribution of insecticide-treated nets and indoor residual spraying.[49] It is also encouraging that high treatment rates have been achieved throughout the country, with steady gains recorded in artemisinin combination therapy (ACT) coverage. The provision of free treatment through the NHIS to vulnerable groups, such as pregnant women and children, is also a welcome initiative. However, despite the scaling-up of GFATM interventions throughout the country and improvements in many districts, the target treatment rate of 60 per cent for vulnerable groups by 2010 was not achieved.[50] Moreover, the Special Rapporteur was informed that many cases of uncomplicated malaria were reported and reimbursed as complicated cases, which represents a major financial drain on the insurance scheme.

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[42] Matilda Ako and Patricia Akweongo, "The limited effectiveness of legislation against female genital mutilation and the role of community beliefs in Upper East Region, Ghana," *Reproductive Health Matters*, vol. 17, No. 34, (November 2009), pp. 47-54.

[43] A.R. Oduro and others, "Trends in the Prevalence of Female Genital Mutilation and its Effect on Delivery Outcomes in the Kassena-Nankana District of Northern Ghana," *Ghana Medical Journal* vol. 40, No. 3, (September 2006) pp. 87–92.

[44] WHO, Malaria Profile Ghana (2011), p. 1.

[45] WHO, Maternal Health, Ghana Country Profile (2010), p. 10

[46] UNICEF, Ghana Fact Sheet- Malaria (July 2007). Available from http://www.unicef.org/wcaro/WCARO_Ghana_Factsheet_malaria.pdf.

[47] WHO, Malaria Profile, Ghana (2011), p. 4.

[48] UNICEF, Ghana Fact Sheet-Malaria (July 2007).

[49] Ibid.

[50] Ghana, Ministry of Health, *Strategic Plan for Malaria Control in Ghana (2008-2015)*, p. 21.

46. Alongside these efforts to ensure accessibility and availability of good-quality treatment and preventive services for malaria, full realization of the right to health requires focused and targeted interventions related to the underlying determinants of health. Sanitation, hygiene, water and other factors that contribute to disease activity must be addressed. Sustainable and long-term gains in malaria prevention requires improvement in the availability and accessibility of preventative and treatment-related goods and services, such as insecticide-treated bed nets and malaria medications, along with government efforts to reduce standing water and drain marshy areas that serve as breeding grounds for malarial vectors.

47. Access to adequate sanitation remains poor. Only 13 per cent of the total population and fewer than 10 per cent of the rural population have access to improved sanitation facilities,[51] which falls far below the targets set in the Millennium Development Goals. The Special Rapporteur is concerned that this lack of progress significantly undermines the effectiveness of any other malaria-related initiatives by failing to contain mosquito breeding. To affect long-term change and effectively prevent mosquito breeding, the Government should commit to mobilizing resources to achieve nationwide structural change in this area.

VII. Environmental health and mining

48. Article 12 of the International Covenant on Economic, Social and Cultural Rights explicitly calls on States to take steps to ensure "the improvement of all aspects of environmental and industrial hygiene" in achieving full realization of the right to health. Occupational and environmental conditions have been recognized as an underlying determinant of the right to health. Enabling occupational and environmental conditions, which must be achieved through formulation of national policies concerning elimination of pollution, are a core aspect of the obligation of States.[52] Furthermore, the State has an obligation to protect rights holders from violations of the right to health by third parties, in this case third parties within the extractive industry.

49. In light of these requirements, the Special Rapporteur wishes to express his concern regarding the continued impact of the mining industry on environmental health in Ghana. While mining and resource extraction are very important to the Ghanaian economy, the wealth they generate must not come at the expense of securing the health of the affected populations. As recently as 2008, mineral levels in water were found to be above WHO limits, and led to instances of water and food contamination. This poses a serious threat to the health of persons living in Ghana, which is of great concern to the Special Rapporteur. Monitoring of the industry by the Commission on Human Rights and Administrative Justice is welcome, but more specific measures must be taken to ensure that affected populations are not again put at risk.

50. Additionally, the Government is obliged to respect the rights of those protesting the health effects of mining, and who have sometimes been met with violence.[53] Any failure to respect those rights is unacceptable, irrespective of whether violations are committed by

[51] WHO, Environmental health - Water, sanitation and hygiene, Exposure. Available from, http://apps.who.int/ghodata/.

[52] CESCR, general comment No. 14 (2000), paras. 11 and 36.

[53] Citizens are entitled to freedom of thought and expression, and have the right of peaceful assembly and free association with others: International Covenant on Civil and Political Rights arts. 18-19, 21-22; University of Texas Law School, Human Rights Clinic, *The Cost of Gold: Communities Affected by Mining in the Tarkwa Region of Ghana* (June 2010), p. 41

agents of the State or private entities, as the State must protect right holders against third party infringements of their rights.

51. Recent efforts to stem illegal mining are an encouraging step towards reducing environmental contamination. The education and training of small-scale miners in mercury abatement is also promising and should receive further government support.[54] Nonetheless, more must be done in this area. The Government should continue to formulate and implement policies in accordance with the right to health framework, including following appropriate consultation procedures to ensure participation of affected populations in analysis and policymaking and ensuring accountability with respect to State and third-party violations, in order to address environmental and health issues in the mining sector.

52. These issues are even more pressing in light of newly-discovered oil deposits in Ghana. It is encouraging that the Government has proposed that some of the profits be used to fund health and education within the country, or to create a fund similar to the Norwegian model to save and invest resources so they can be used when oil reserves are depleted.[55] The Special Rapporteur supports such suggestions, but reiterates that measures need to be put in place to ensure that these profits are used sustainably, and that extraction does not occur at the expense of the health of those directly affected by such operations.

VIII. Occupational health and safety

53. Implementation of a national policy to minimize the risk of occupational accidents and diseases, in addition to provision of occupational health and safety services, is required by State parties in order to fulfil their obligations under the right to health. Elements of such a policy include identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; provision of health information to workers; provision, if needed, of adequate protective clothing and equipment to workers; enforcement of laws and regulations through adequate inspection; requirement of notification of occupational accidents and diseases; conduct of inquiries into serious accidents and diseases, and production of annual statistics; protection of workers and their representatives from disciplinary measures for actions properly taken in conformity with such a policy; and provision of occupational health services with essentially preventive functions.[56]

54. The Special Rapporteur commends the Government for developing legal protections of the health and safety rights of workers. Section 24 of the Constitution provides for the right to work under satisfactory safety and health conditions,[57] and Labour Act No. 651 of 2003, which covers nearly all Ghanaian employees in the formal sector, meets the standards set by the various International Labour Organization conventions ratified by Ghana.[58] The Government has put into effect numerous laws pertaining to areas of occupational health including the Factories, Offices, and Shops Act 1970; Mining Regulations 1970;

[54] Ghana, Ministry of Finance and Economic Planning, "Budget statement and economic policy for 2010" (November 2009), p. 77.

[55] Clemens Breisinger and others, "Managing future oil reserves in Ghana – An assessment of alternative allocation options," *Kiel Working Papers* No. 1518 (May 2009), p. 1.

[56] CESCR, general comment No. 14 (2000), endnote 25; see also, ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161)

[57] Constitution of Ghana (1992), Chapter V, Article 24(1).

[58] ILO, National Labour Law Profile: Ghana (17 June 2011). Available from http://www.ilo.org/ifpdial/information-resources/national-labour-law-profiles/WCMS_158898/lang--en/index.htm.

Workmen's Compensation Act 1987; Environmental Protection Agency Act 1994. Various other laws contain relevant provisions concerning the elimination of child labour[59] and human trafficking.[60] Additionally, the Act establishing the Commission on Human Rights and Administrative Justice allows for the investigation of and administration of remedies for violations of rights, including protection from slavery and forced labour.[61]

55. Nonetheless, much more remains to be done. In particular, the occupational health and safety regime in Ghana remains highly fragmented in the absence of a national policy on the subject. This means that different laws and their implementing ministries independently cover various areas or sectors of the economy, which has resulted in sizeable lacunae in occupational health coverage, particularly with respect to preventative measures and access to remedies. While it is reported that a draft policy was jointly developed by the ministries of Labour, Health, and Mines and Energy early in the last decade, it has not yet been adopted.[62] Trade unions have called on the government to ratify ILO Convention No. 155 concerning occupational safety and health in order to strengthen the national framework protecting workers.[63]

56. It is also of great concern that there is currently no explicit legislation or stated policy focusing on how to realize the right to health within the informal economy. Further, current statutes do not extend their coverage into this area. Nearly 90 per cent of the work force is employed in the informal sector,[64] ensuring that realization of the right to health of these workers through effective implementation of occupational health policies remains a challenge. It is particularly necessary to address this area in light of the fact that the majority of the population is employed in industries which present significant health risks, including agriculture, manufacturing, construction and food processing.[65] Although it may not be possible or even in the interests of these workers to formalize all aspects of the informal economy through legislation, it may nevertheless assist in developing a normative paradigm for occupational health and promote realization of the right to health.

57. Although the Government has taken some steps toward realizing the right to health of workers, such as the introduction of the legislation mentioned above, much more will need to be done to overcome obstacles in this area. Steps taken by the Government should include ratifying ILO Convention No. 155 and developing a comprehensive system of occupational health and safety protection at the central level to address the issues arising from fragmentation in responsibility for oversight of occupational health and safety. The Government should address the informal economy in its occupational health and safety policy. Institutional capacity to monitor and prevent occupational injuries must particularly be addressed, as injuries generally reduce the expected lifespan of an individual in Ghana

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[59] Ghana, Children's Act No. 560 of 1998.

[60] Ghana, Human Trafficking Act No. 694 of 2005.

[61] Ghana, Commission on Human Rights and Administrative Justice Act No. 456 of 1993.

[62] Edith Clarke, "Do occupational health services really exist in Ghana? A special focus on the agricultural and informal sectors," in S. Lehtinen (ed.) *Challenges to occupational health services in the regions: The national and international responses,* Proceedings of a WHO/ICOH/ILO Workshop, 25 January 2005, Helsinki, Finnish Institute of Occupational Health, electronic publication available from http://www.ttl.fi/en/publications/Electronic_publications/Challenges_to_occupational_health_ services /Documents/Ghana.pdf.

[63] Ghana News Agency, "Government must ratify ILO Convention on Occupational Safety and Health," 27 April 2011. Available from http://www.ghananewsagency.org/details/Social/Government-must-ratify-ILO-Convention-on-Occupational-Safety-and-Health/?ci=4&ai=28167.

[64] Martha Chen and others, *Progress of the world's women 2005: women, work, & poverty* (New York, UNIFEM, 2005), p. 44.

[65] Ernest Aryeetey and William Baah-Boaten, "Growth, Investment and Employment in Ghana," Working Paper No. 80, (Geneva, International Labour Office, March 2007), pp. 3-4.

by an average of nine per cent.[66] The capacity of the Government to monitor and prevent such injuries is grounded in an understanding of occupational health and safety as a distinct and coherent area of concern and ensuring that there exists a national policy or comprehensive legislation to cover the area.

IX. Conclusions and recommendations

58. **The Special Rapporteur was impressed with the advances that have been made in Ghana's overall health system and the Government's willingness to explore means of further improvement, particularly given the possible future resource constraints. While Ghana has made notable gains with respect to health, more remains to be done, particularly in key areas such as mental health, family planning and empowerment of women.**

59. **The Special Rapporteur is concerned with the lack of disaggregated data available with respect to key affected populations. The Government must continue to gather and make use of disaggregated data in policymaking in order to appropriately identify, monitor and evaluate interventions. Achieving and sustaining long-term gains in core areas and fully realizing the right to health will require the participation of affected communities. This is particularly true with respect to addressing the continuing discrepancy in outcomes between rural and urban centres and reducing the stigmatization of PLHIV. The Special Rapporteur urges the Government to consider the following recommendations pertaining to the overall healthcare system:**

(a) Gather comprehensive and disaggregated data to assess access to health-care services under the NHIS, and examine how the gaps in coverage can be addressed;

(b) Remove registration fees for NHIS cards for groups for whom such fees impede access;

(c) Enable community participation in health-care service delivery through active engagement of civil society organizations in health-related policymaking at all levels of the Government;

60. **In respect of HIV/AIDS, the Special Rapporteur urges the Government to:**

(a) Provide anti-retroviral treatment free of charge;

(b) Decriminalize sex work and men having sex with men;

(c) Ensure that access to anti-retroviral treatment is maintained and expanded by developing a plan to make up for funding shortfalls that may result from reductions in international assistance.

61. **In respect of mental health, the Special Rapporteur urges the Government to:**

(a) Adopt and implement the draft Mental Health Bill of 2006 in order to reform the mental health-care system;

(b) Develop strategies and incentives to ensure that mental health facilities, both rural and urban, are staffed by qualified mental health professionals;

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[66] WHO, Ghana, Country Statistics, Distribution of years of life lost by broader causes (%), Injuries. Available from http://apps.who.int/ghodata/?theme=country.

(c) Develop and engage in community-based programmes designed to reduce stigma surrounding mental illness;

(d) De-institutionalize, where possible, the provision of mental health-care services;

(e) Rapidly train additional mental health-care professionals, and create strong incentives to induce those professionals to provide mental health-care services in rural areas;

(f) Ensure the availability and adequate supply of the safest and most effective mental health medicines;

(g) Ensure the availability and accessibility to mental health services to areas outside of Accra and Kumasi;

62. **In respect of maternal mortality, the Special Rapporteur urges the Government to:**

(a) Increase efforts to contain the national fertility rate, particularly through implementation of comprehensive family-planning services which include women in their design;

(b) Seek to increase the number of antenatal visits attended by women during pregnancy, and consider establishing mechanisms to ensure patients are given appropriate follow-up;

(c) Provide vouchers or another system of subsidy to poor women located in rural settings to accommodate costs related to transportation and accommodation when seeking maternal health services;

(d) Invest increased resources in provision of health care during the postnatal period, and develop mechanisms allowing for community involvement in establishing programmes that engage and empower women;

(e) Expand existing and seek new methods of enforcing laws prohibiting harmful "traditional practices," especially those that discriminate against women, including *trokosi* and female genital mutilation;

63. **In respect of malaria and occupational health, the Special Rapporteur urges the Government to:**

(a) Accelerate programmes that address long-term solutions to malaria transmission, including those related to the underlying determinants of health;

(b) Ratify the ILO Convention No. 155 and other conventions pertaining to occupational health and safety;

(c) Reorganize and defragment central governance related to occupational health;

(d) Ensure accountability and the availability of remedies with respect to occupational health;

(e) Address the right to health of people who work in the informal sector through a variety of policies and programmes and using the right to health framework;

(f) Collect and publicly release comprehensive data relating to environmental health and safety and occupational health and safety;

(g) Further examine the possible environmental and occupational health impacts of the Government's short-term and long-term plans for petroleum extraction and refinement.