Epidemiological Transition, the Burden of Non-Communicable Diseases and Tertiary Health Policy for Child Health in Ghana: Lessons from a Study on Children in a Ghanaian Teaching Hospital

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ABSTRACT

Evidence from research and other sources indicate that the pattern of disease and causes of ill-health and death in Ghana, as in other developing countries, has been changing. There has been a rise in noncommunicable diseases (NDCs). In Ghana, NDCs account for over 25% of all deaths, according to some recent statistics. Meanwhile, communicable diseases (infections and infestations) are still the main causes of ill-health in the country, accounting for majority of child death. The epidemiological transition is however not with respect to the adult population alone. Modern health technology and changing cultural explanations of childhood diseases have contributed to higher survival rate among infants and children with congenital malformations and other noncommunicable diseases. Despite these developments, the government of Ghana has not been able to address the challenges of the transition with policies on tertiary health care, the means by which persons with noncommunicable diseases are treated. For example, there has been no explicit national policy on tertiary health services with respect to children in the country though programmes to reduce child death in the context of the Millenium Development Goals (MDGs) have been pursued. The newly introduced National Health Insurance (NHI) policy is also silent on tertiary health care for children. Moreover, the response of government to children's need for tertiary health care has been limited to financial access, a reflection of the domination of financial access in matters of health delivery and care. This paper discusses some lessons from a study of children with noncommunicable diseases at the Children's Block of Korle Bu Teaching Hospital, Ghana's leading tertiary hospital. The study was based on qualitative data collected on the children through case studies, narratives, life stories, responses from in-depth interviews and participant observation in the wards and the hospital environment. A number of secondary sources of data and information were also used for the study. Its main findings indicate that tertiary health care, especially in the case of children, requires a comprehensive policy that covers several aspects of the illness conditions and health care: the hospital environment, the health workers' attitude, existing facilities and institutions and the illness experience of the children and their families, among others. It argues that neglect of tertiary health care for children is not compatible with the aims of the pursuit of the MDGs by Ghana. It recommends an integrated tertiary health care to maximize the chances of survival of children with noncommunicable diseases.

BACKGROUND

A number of studies and health statistics have indicated that there has been an increasing trend in chronic and noncommunicable (NCDs) diseases in Ghana, as in many other developing countries. In Ghana, clinical manifestations of some NDCs, including diabetes, hypertension, cardiovascular diseases and metabolic syndromes

associated with overweight and obesity have been increasing in the adult population over the past two decades or so (Amuna 2006, Amoah 2005). The epidemiological transition has been linked to the transitions in lifestyle resulting from economic change (development) and associated social dynamics in many countries in the developing world. Urbanization and new patterns of activity (move towards more sedentary work and dietary behaviours have been some of the factors associated with the transition (Akinyele 2006, Vuvor et al. 2006, Amoah 2005).

The epidemiological transition has not been limited to the adult population. Overweight and obesity have been the most cited conditions among children. Consequently, the burden of disease among children has been labelled as double since communicable diseases have also remained major causes of ill health among children. In the case of children, the introduction of conventional or modern scientific medical system in Africa since the early parts of the Twentieth Century, and especially from the 1950s (Addae 1996), and the subsequent explanation and treatment of diseases as natural or physical causes (as opposed to supernatural) have also contributed to the increasing survival of children with NCDs and congenital conditions.

Under the traditional medical system, the causation of disease is invariably linked to supernatural powers, and for that matter, magico-religious acts and concepts are used to cure diseases. Physical cures and treatment with herbs are also employed (Sackey 2002, Twumasi 1971: 9). But, generally, illnesses are not considered to be related to infections and infestations. Retardation of growth in childhood (both physical and mental), convulsion and kwashiorkor (a protein-energy deficiency syndrome) and convulsion are attributed to spiritual attacks of witches. (Awedoba 2002, Brempong 2001). Traditional Ghanaian societies, like some other African traditional societies, are also ambivalent in their attitude, care and treatment of children with abnormalities. Moreover, care for such children is given within the wider context of reproductive health practices and social norms. Survival of such children was linked with that of the parents, immediate family and society at large, with some being acceptable and others killed, even at birth (Awedoba's 2000, Nukunya 1969, Raum 1967). Faith healing among Christians is also becoming a major source of health care for some Ghanaians; and some who seek this source may not use conventional medicine at all (Sackey 2002). Spiritual explanation may be given for every health condition in faith healing just as under the traditional medical system.

Today, both traditional and scientific medical systems do exist and are very different with respect to explanation of cause of disease as well as the approach to their prevention and cure. The scientific medical system has provided opportunity for children to survive. But the main characteristic of contemporary health care has been the emphasis on financial access to health service to the neglect of other aspects such as the meaning of diseases and the illness experience. Research endeavours need to examine the contexts within which health care is received in contemporary society and identify other aspects of health delivery that may reduce the vulnerability of children with NCDs, for example. The consequent organization of the family and their occupational activities around the period of illness of the child, referred to as coping actions and strategies, also need investigation (Pierret 2003). The changing political economic contexts of health delivery and the effects of the exodus of health workers from the country, among others, are some changes that influence health delivery. Such investigation can inform public health policy and practice tremendously.

The present study examined the health delivery practices regarding a range of NDCs among children at the Korle Bu Teaching Hospital. It used mainly qualitative research methods and secondary sources of data to find out how factors other than financial access to health determined the contexts of the delivery of tertiary health service to children at the hospital, the illness experience, and the coping actions and strategies of the families of the children. The study is in five parts. The first part discusses the methods of inquiry. It is followed by the characteristics of the children and their parents and care givers. The third part in on the context of care at the hospital and the fourth discusses the political economy of health delivery in Ghana. The fifth part is on the illness experience, the coping actions and strategies of the families of the children and the support of the hospital staff in this regard.

Methods of Inquiry

A total of 38 children were selected from four wards in the Children's Block for the study. They were suffering from different kinds of diseases and health conditions, except one child, aged 12 years who said she was suffering from HIV/AIDS. One of the wards named Burkitts' Ward is occupied by children suffering from various kinds of cancers.

Data and other information were gathered through a number of qualitative methods- narratives, life stories, case studies, responses from interviews and participant observation in the wards and the hospital environment. A number of secondary sources of data and information were used for the study.

A lot of observations were made during various visits to the wards, other departments and other areas of the hospital. The initial visit was made to get acquainted with the Children's Block and the hospital. The questionnaires, one of the instruments for the study, too were administered to some of the parents and care givers of the children. The questionnaire was made of three parts- the socio- 1) demographic characteristics of the children and their parents and care givers and the diseases that the children were suffering from, 2) experience of the parents and care givers at Korle Bu and the impact of the hospitalization on them and their families, and 3) the parents and care givers' explanation or belief about the cause of the disease the children were suffering from and their coping with the illness experience.

Three nurses were interviewed at first with the use of an unstructured interview guide. It was completely difficult to interview any of them for more than fifteen minutes at this first visit as they were very busy. During subsequent visits, in-depth interviews were done on some areas with two senior nursing officers. Due to their very tight schedule, only one doctor could be interviewed at the hospital. A second one responded to questions outside her working hours.

The researcher also interacted with three of the children. They were 4, 5, and 12 years in age. The 12-year old was the HIV/AIDS patient. She showed excitement to have someone to talk to her. She spoke for a longer time than the other two who were cancer patients.

Case studies were also selected and some were followed for a period of twenty-two months. The whole study lasted for two years, from January 2004 to January 2006.

The findings of the study are presented in four sections. The first part discusses the cultural context of general and health care for seriously sick children in two traditional Ghanaian societies. It is followed by the political economic context of general health care for children in Ghana. The third section discusses the findings from the study of the 38 seriously sick children in the Children's Block. Pseudonyms were used in all cases to ensure confidentiality of the information provided by individual respondents. The conclusions of the study are presented in the final section.

General Characteristics of the Children and their Parents

The 38 children studied were of different ages and were suffering from a variety of diseases. Their parents were also of different socioeconomic backgrounds. Some were very poor and some were quite rich. Some travelled from far away and some were resident in Accra.

Age and Sex Distribution of the Children

The children were made up of 22 boys and 16 girls. Almost two-thirds (60.53%) of them were infants. Those aged 1- 4 years formed a quarter and the rest were aged five years and above. See Table 1.

Table 1 Age Distribution of the Children

Age	Number	Percent
< 1 month	10	26.32
1- 11 months	13	34.21
1- 4 years	10	26.32
5+ years	5	13.15
All Ages	**38**	**100.00**

Source: Field Work, January 2005

The age distribution shows that most of the children were probably being breastfed and, therefore, needed their mothers to be with them at the hospital.

Types of Diseases Reported

The commonest types of diseases that were reported or observed among the 38 children included congenital malformations, lung diseases, Downs Syndrome, Sickle Cell Disease (SCD), juvenile diabetes, cardiac problems, cancers (tumours and leukemia) and epilepsy. The congenital malformations found among the children were

described by the parents as follows: swollen skull, defective bladder, water in the spine, dysfunctional bladder, inability of baby to blink the eyes, no anus, difficulty in breathing, and defective stomach wall.

As a result of the nature of some of the diseases, some children were frequently admitted and some spend several months at the hospital.

Characteristics of the Parents and Care Givers

The persons who were taking care of the children at the hospital included thirty-six mothers, one grand-mother, one father and one male relative. They were aged between 18 and 65 years. The composition of the parents and care givers reflects what pertains in wider society. Care for children is primarily done by mothers who are supported by their kin. They may be helped by their husbands or the fathers of their children. The large proportion of infants among the children selected for the study also explains why most care givers at the hospital are mothers. At their tender ages, their mothers cannot delegate their maternal care to others.

The only father who was taking care of her daughter said he had to do so because his wife (the mother of the daughter and a son) divorced him and he had not yet married again. He said he has some sisters who could have been taking care of her daughter but they all thought that it was better for all of them if he could be at the health facility so that the sisters could rather do their work and also take care of his two-year old son. He himself was unemployed.

The other male, a paternal uncle of one of the children, was actually in the hospital to care for the mother of the sick child. The mother speaks only her mother tongue. It was going to be difficult for her to communicate with the hospital staff and also move about in the hospital and town so her husband's brother who could communicate in English and Akan came along with her and the baby to the hospital.

Apart from these mothers and care givers, there were grandmothers and sisters who were also in and out of the hospital to help their daughters and sisters to care for the sick children. Some of these had traveled from other regions where the children were referred from.

Place of Usual Residence or Referral

The children were referred from six regions outside the Greater Accra Region. Almost two-thirds (64%, 24 out of 38) of the children were referred from health facilities that were located within the Accra Metropolitan Assembly (AMA) and four others were from other settlements in the Greater Accra Region. The usual regions of residence of the rest of the children from where they were referred include Eastern (3), Volta (1), Central (3), Western (2), Ashanti (1) and Brong Ahafo (1).

The mothers and/or care givers whose children were referred from outside Accra therefore needed a place to stay while taking care of their children at Korle Bu Teaching Hospital. Even those who were resident in Accra whose homes were far

from the hospital needed a place closer to the hospital to stay so as to avoid the daily routine of travelling to the hospital.

Employment

Most of the mothers who were working were self-employed in the informal sector. Only two of them were working in the public sector as teachers. Being away from their jobs, therefore, meant loss of earnings for some of the self-employed. Those in this category included seamstresses, hair-dressers, bakers, food vendors, perishable food sellers and those whose activities cannot be easily delegated to someone in their absence. Those who trade in non-perishable goods such as ice water, manufactured products, spare parts, clothing and the like indicated that they had their assistants, apprentices, relatives or others to carry on their economic activity in their absence. But the long periods of hospitalization, or even short ones, had financial implications for these families.

Korle Bu Teaching Hospital

The British Colonial Government opened the Korle Bu Teaching Hospital in 1923. Governor Sir Frederick Gordon Guggisberg, the then governor of the Gold Coast Colony (renamed Ghana after independence) intended that the hospital served as a leading general hospital in the colony. It was initially designed to receive 200 outpatients daily and located at a site that was not susceptible to flooding and within easy reach of the population.

Korle Bu serves as a teaching hospital for University of Ghana's College of Health Sciences. It also trains health professionals in Public Health Nursing and Midwifery and engages in outreach services. By 1962 the Korle Bu Teaching Hospital was restructured, modernized and transformed into a general and teaching hospital (Korle Bu 2003: 3-6).

Though the hospital has seen a lot of extension and restructuring to meet growing demands it has been overcrowded with patients. The introduction of the health user-fee might have initially led to a fall in attendance but the overcrowding has continued. Korle Bu was opened at a time when the total national population was under three million. Today the population of the Accra Metropolitan area alone is about that. It does not seem to be capable of meeting the increasing demand for its services. The infrastructure of the hospital is dilapidated and a number of blocks and wards need rehabilitation. There has been growing public investment in the rehabilitation work yet one can observe that generally the hospital has been run down. It also lacks adequate modern information technology for keeping records. Philanthropist support that used to comprise donation of perishables is now made up of donation for building, equipment and cash. Patients also sometimes abscond from the hospital without paying their bills (Korle Bu 2003: 44, 55, 61). The following statements from the Chairman of the Management Board of the hospital at the 80th anniversary describe these and some other conditions at the hospital that are obvious to any one:

> Korle Bu today is physically congested and in part dilapidated… The land that was acquired for the hospital in the expansive 1920s has over the years been seriously encroached upon. … The staff is overworked and under-motivated in an institution that tries heroically against all odds to maintain an admirable level of technical excellence. For a tertiary health care institution there are too few health workers trying to serve too many patients, many of whom do not even require tertiary care. The most obvious deficiency is in the nursing cadre. The migration of health personnel is a serious national problem (Korle Bu 2003: 42- 43).

In spite of these constrains, Korle Bu Teaching Hospital is still Ghana's leading national referral hospital. It's 80th Anniversary (1923- 2003) report indicates that it had grown from a 200-bed capacity hospital to 1,600 in 2003. Its staff strength was 3000 and it had daily out-patient attendance of 1,500 and daily average admissions of 150. It still provides high standard of medical care comparable internationally in some of its seventeen clinical departments and centres, including the Department of Child Health. It receives referrals from other African countries, particularly the West African sub-region It is one of the biggest hospitals in Sub-Saharan Africa. It has seventeen clinical departments and centres. In 1990, the Korle Bu Teaching Hospital and the Komfo Anokye Teaching Hospital (the second leading hospital) were vested with semi autonomy. Since then, they have been run by management boards (Korle Bu 2003: 42).

The Social Welfare Department mediates between the hospital administration and patients or their families to pay their bills by installment or have them written off when they are declared paupers. A number of foundations such as The Ghana Heart Foundation raise funds for the treatment of patients while the media aid in appealing for financial assistance from the public.

The Children's Block

The Children's Block was opened in 1965 as a tertiary referral centre for children. The Department of Child Health provides promotive, preventive and curative health care for children. It also trains doctors and nurses to provide health care for the children and carries out research into childhood illnesses. The department conducts daily and long-term care and also organizes specialized clinics. It also has a Non-Government Organization (NGO), the Korle Bu Child Health Foundation which raises funds for a number of needs of the department including refurbishment and equipping the wards and the needs of the children. It was set up by the staff of the department.

There are six wards in the block and a number of side wards. Some of these were being rehabilitated during the period the field work was conducted for the present study. The side wards, four of which were in use in 2005, have beds for parents or caregivers who may need to stay with their wards in the night. In 2005, the daily charge for amenity ward was C65,000.00 (Sixty-five thousand cedis) per day. Foreigners are charged double that rate.

Those who stay in the wards pay C5,000.00 (Five thousand cedis) daily for accommodation. There is a feeding charge of C6,000.00 (Six thousand cedis) per day for any child who is fed in the ward.

Some of the mothers, especially those whose children are referred from outside Accra, stay in nearby hostels where they pay between C5,000.00 (Five thousand cedis) and C100,000.00 (One Hundred thousand Cedis) per night depending on the type of facility. They also pay for water and other utilities too. Having a child on admission at Korle Bu, especially in the case of long-term illnesses, is expensive. Poor families whose children are referred from outside Accra may not be able to afford such expenses. For even those resident in Accra, the daily trip to and from the hospital may not be affordable. It is a common sight to see some parents and care givers resting or sleeping on corridors and obscure places in the hospital.

Upon arrival, parents are expected to pay some deposit, starting from C100,000.00 (One hundred thousand cedis). The hospital provides drugs for the children for the first 24 to 48 hours. After that the parents are expected to buy all prescriptions and pay for those provided earlier. There is also a "Needy Fund" from which some needy children may be provided assistance once or more, depending on the circumstances (Grace, Field work, November 2005).

Parents who are not able to pay their bills are referred to the Social Welfare Unit of the Administrative Department. The unit acts as intermediary between the Child Health Department and the parents. They may bring guarantors and be released so that they can pay by installment. An interview with an officer from the Social Welfare Department revealed that some of such parents gave wrong addresses and some abscond from the hospital even before they could be referred to the unit.

The health facility managers and the parents and care givers have financial needs. Other needs, including more amenity wards or hostels within the hospital for mothers with newborns, are also urgent. In the mean time, payment for health services seems to take root and there may not be any free health care in the near future as the political economy of health delivery shows.

The Political Economy of Health Care

Public health facilities in Ghana begun to charge fees for health services over the past 36 years. Earlier, health services were free throughout the country and in all categories of health institutions, including the Korle Bu Teaching Hospital and other tertiary health institutions in the country.

The fees that were introduced in 1971 were low and just meant to discourage abuse of health services. In 1992, however, non-subsidized health user-fees were instituted in all public health facilities and the policy sought to remove subsidies on all health services that were hitherto provided freely (Badasu 2004, Agyepong 1997).

The new health-user fees and others that were introduced around the same period were actually part of a macroeconomic policy commonly referred to as the Structural Adjustment Programmes (SPAs). The SPAs was a response to the downturn in the

economies and associated budgetary constraints that faced the African countries from the mid-1970s. Generally, the African countries then had to deal with imbalances in the economy, particularly increasing gaps between demand for and supply of basic social services especially health and education. These sectors were already receiving the highest proportions of national budgets. The introduction of user fees policy in Ghana and elsewhere in other parts of the developing world was based on the premise that people pay fees at private health facilities and will pay for better services (Gertler and Hammer 1997). The user fees were therefore expected to improve quality of health services, especially access to drugs. Contrary to expectations, apart from some improvement in availability of drugs in public health facilities, quality of health services deteriorated in many countries (Russell 1997, Nyonator et al. 2001).

In Ghana, a number of administrative and bureaucratic factors also contributed to the failure of the health user-fee policy to improve access to health services and at least sustain the quality of health service in the country. There were a number of fees that even those exempted had to pay in all the public health facilities. Though these may be considered as unauthorized, the financial constrains of the health sector due to relatively reduced and delayed government budgetary allocations seem to justify them.

Meanwhile, increasing levels of poverty, due mainly to the economic crises, have adversely affected the financial access to health services for many. Lay-offs resulting from privatization of public corporations (which was part of the SAPs) also created a new set of poor people. With such increasing levels of poverty, it became difficult for the health administrators to absorb the financial cost of those who are unable to pay their bills.

The health user-fee policy exempted the poor, children, the elderly and maternal cases from hospital charges in line with the government policy to further promote the health of children and these other vulnerable sub-groups of the population. The exemption policy however covered only primary health care or health services offered in health posts, health centres, district and regional hospitals.

Consequently, all patients are charged for services in tertiary health institutions. In Ghana, there has been no definite policy on financial access to tertiary health even for children though such services have become important components of child health in the country.

The media often carry stories of children who are detained at hospitals after their treatment and recovery following the inability of their parents to pay their hospital bills. Such stories create the impression in the society that the health administration is not sensitive to the plight of the people. But it just shows that the exemption of children in practice is completely different from what the policy says. Secondly, it creates the impression that financial access to health is the only problem facing the Ghanaian population. In succeeding sections we show how other aspects of health delivery to children at the Korle Bu Teaching Hospital are crucial and need government intervention.

Economic and Financial Loss

Apart from the mothers who had newborns and infants aged below three months and those who were unemployed prior to the hospitalization of their children, all the others indicated that they wished being at the health facility meant loss of income them and their families. Almost all the mothers were working in the informal sector, earning income that is not regular. None of them had employment insurance that could entitle her to unemployment benefit. Two of the mothers were employed in the public sector. They were on casual leave and were receiving their salaries. This also meant some financial loss to their employers.

Some mothers were teenagers who were not working; some were apprentices and one was in Senior Secondary School after the delivery of her daughter. They were in greater need of financial assistance.

The presence of the parents at the health facility was necessary in most cases since they were lactating and needed to breastfeed their infants regularly. This required a number of visits during the course of the day. Even if, mothers residing in Accra for instance, may attempt to engage in their economic activities while caring for their children at the health facility at the same time, the cost of transport and inconvenience may cancel out any financial gains that might accrue.

The amount of money lost to the mothers and caregivers depended on the type of employment they were engaged in. While some mothers could delegate their economic activities, others could not. Those trading in non-perishable goods had their trading activities carried out by others. In some of these cases, repeated visits to the health facility and hospitalisation did not affect the economic activity of the mothers, as was the case of Dora.

Dora

Dora frequently spends a number of days caring for the children at the Korle Bu Teaching Hospital. She trades in automobile spare-parts. She has a sales attendant and her work is that of supervision. She therefore loses no income when she is away from the shop caring for one child or the other frequently at the hospital. Her financial standing makes it possible for her to s end the children to the Korle Bu Teaching Hospital where she even pays higher fees for treatment than elsewhere. She said Korle Bu Teaching Hospital has more qualified doctors than any other health facility so she prefers to go there.

The type of employment and income level therefore determined the affordability of the services at Korle Bu Teaching Hospital for Dora. There were others who chose to go or send their children for treatment at the hospital though they could be treated elsewhere. The overcrowding there could be expected to continue as users of the facility, such as Dora, can afford to pay the fees for service.

Unlike Dora, some mothers do not only have financial loss during their stay at the health facility but even some period after the treatment is over. As the hospital has experienced non-payment of bills by patients or parent for their wards who were

treated and discharged regularly, it has decided to detain treated patients in the ward until their bills are paid. In such cases the mother or care giver has to continue to stay with the child. The loss of income then continues when the mother or care giver cannot delegate her economic activity. Maami is one such parent.

Maami

Maami's son was treated and discharged three days before the study was started in the ward in which he was detained. Unable to pay the cost for treatment, Maami had to stay at the health facility with the son. Her son was breastfeeding and needed her to be around. Her husband was trying to get a guarantor to pledge to the hospital that they would pay the bill by instalment. He was not successful and was still trying. Meanwhile, Maami has three other sons at home who were staying with her neighbour. Her neighbour takes care of the three children anytime she had to be with the fourth child at the Korle Bu Teaching Hospital during the several hospitalizations. Maami had tears in her eyes as she narrated the rest of her story, "I just buried my father who was sick for a long time. He had stroke. My siblings were negligent. I ran into debt caring for my father. It was at his funeral the funeral that my son fell sick again. Everyday that we continue to stay in this hospital means that I cannot earn any income. It is a favour that my neighbour is doing for me. You see, my work is breaking store. Everyday that I am in this hospital means a loss of income to me.

Maami's case is another dimension of the crises in the health sector. As government subvention continues to dwindle and becomes unreliable, health facility managers are unable to treat patients free of charge; and there are always a large number of them. Cost recovery has been difficult. Philanthropists sometimes bail out the patients. This source is not a reliable though. It takes long sometimes before a response comes so patients are at the mercies of the philanthropists.

The case of some 36 newborns at the Neo-natal Intensive Care Unit (NICU) of the Korle Bu Teaching Hospital which occurred during the period of the present study illustrates the situation. The newborns were detained at the hospital for non-payment of their bills. The total cost of treatment for all the children was C150 million (One hundred million cedis. A philanthropist, Dr. Kofi Amoah paid the full amount and the children were released.

The story on the children had some information from the Ministry of Women and Children's Affairs which indicated that the ministry, in conjunction with other stakeholders, such as the Ministry of Health, will launch a fund-raising project on June 1, 2005 which the ministry will use for such cases since it will recur in future and government alone cannot take up such responsibility (*Daily Graphic May 17, 2005*).

Further information in the story was an interview by Rebecca Quiacoe, the journalist, with an official Department of Paediatrics of the Hospital who indicated that treatment at the unit is very expensive and cannot be afforded by most parents in

Ghana. Yet, the turnover of the unit is high; about six to ten sick or premature babies are admitted daily from across the country. Mortality rate has reduced drastically, by 50%, since the upgrading of the unit in October 2004 and has taken care of 1,000 babies since then, according to the official. Some of these babies would have died had the unit not been established. But it has been difficult for the unit to recover its cost as non-payment of bills has always been a problem at the unit even before it was upgraded. Most of the mothers were the poor who did not seek antenatal care and have complications of pregnancy and delivery. The unit always had about eight to ten babies detained.

The official also added that, abandonment of babies by their mothers at the unit, which has been another long-term problem at the unit, has not changed. These mothers are teenagers who did not want their babies. In some cases some of the babies were severely deformed. (Quiacoe, 2005: 17).

The case of the 36 newborns is one out of the numerous ones that go out to the press from other health facilities. The problem of abandonment also shows another dimension of the problem of reproductive health behaviour which has been a common phenomenon in Ghanaian society: unwanted pregnancies and children. The results of the various Ghana Demographic and Health Surveys (GDHS) show that the actual fertility levels in the country have been higher than the wanted fertility levels. Again, the high rate of unmet needs for contraception also indicates that some pregnancies and consequent births are unwanted.

One of the 38 children born to a teenage mother was also born without an anus. She was in the ward for the third of a series of surgeries. It is a common observation in Ghana that teenagers who have unwanted pregnancies attempt to have abortion, and when they are not successful, the foetus may be damaged and born with some birth defect.

These situations suggest that the problem of reducing the burden of disease among children must target reproductive health behaviour of the reproductive age groups. As technology has improved, some of the unwanted and deformed babies will survive and become another burden on the already overstretched resources for health care.

Lodging and Living at Korle Bu Teaching Hospital

Against this background of loss of income are financial needs regarding lodging and other aspects of living at Korle Bu Teaching Hospital. Most of the health conditions of the children required long periods of hospitalization, repeated visits or follow-ups. Some of the cases, especially cancers, needed follow-up visits over at least one year.

The parents and caregivers whose children were referred from six different regions and those who came from other parts of the Greater Accra Region needed a place to lodge while taking care of their children at the Korle Bu Teaching Hospital. There were a number of choices for them regarding lodging – staying with a relative, a friend, a benevolent non-relative or renting a room in a hostel. Since housing facilities in the city has been inadequate many households live in houses with inadequate number of sleeping rooms. It may not possible for them to have a guest to stay with

them for a long period of time. Moreover, some of the mothers with newborns came with their own mothers; they came to support them and to give them some post-partum care. For these reasons, most of the mothers had to rent a room in a hostel

The low cost hostels charge between ¢5,000 and ¢10,000 daily for four or six persons in a room. It excludes charges for water, which is between ¢300 and ¢400 per bucket. Each mothers and care givers needed not less than three buckets a day for bathing and another two for washing. Other expenses include payment for use of toilet facilities on the premises of the hospital when they come to the wards. Each visit to the washroom attracts a fee of ¢100 and ¢200, respectively for urinating and bowel movement. Beside these expenditures, the mothers and care givers purchase of food from food vendors or restaurants at the hospital or nearby.

These expenditures were affordable to some of the mother and care givers. Indeed, some were living in the amenity wards in the wards where they pay much more than those who live in hostels. But for mothers who came from rural settings, where there is subsistent production of food, public water supply or river or spring sources are also free or cheap and people live in family homes, the completely new way of living was unexpected. They described the daily expenditure as incredible and their experience at Korle But Teaching Hospital as a trauma, in fact, another trauma. Some mothers said they had the first trauma when their children were diagnosed with the diseases that they did not understand or least expected. According to them, just being referred to Korle Bu alone was enough a worry since, as they know already, it is place for treatment of "serious" health conditions that may even claim the life of their children. One mother described her experience at the hospital in the following words:

> "Madam, why can't these nurses at least allow us to fetch water from the sinks or wash in the sink rooms in the hospital? Where am I going to get money from and pay for the hostel fee and buy water everyday? Ah! As for Korle Bu ... it is so difficult!

The nurses are constrained, even if they wished to allow the mothers and care givers to fetch water from the sink rooms and wash there. Their numbers have dwindled over the years as a result of the exodus of nurses from Ghana who seek greener pastures. Also, the water flowing anywhere in the hospital is not free. Since government removed subsidy on utilities, including water, pipe-borne water is not free. This may not be known to some of the mothers who depend on other sources of water that may be free in their rural settings.

The mothers and caregivers whose permanent place of residence is Accra also had problems with commuting to and from the hospital daily. Korle Bu Teaching Hospital was originally located at a site that was considered accessible to the residents of the city. Sprawling of the city and inadequate transport networks linking various parts of the city have made travel to the hospital and other parts of the city unnecessarily difficult and long. Moreover, vehicular traffic congestion makes journeys longer than they should be. Commuting to the hospital daily was reported as a major problem, especially for mothers who needed some amount of rest to recuperate from childbirth and also lactate.

Some mothers chose to spend the whole day at the premises of the hospital rather than go back home and return later in the course of the day. This option is not without problems. First of all, resting at the Out Patient Department (OPD) is not pleasant for them. Some decided to sleep on mats under shady trees. Secondly, buying food from vendors and restaurants was more expensive for them than preparing their meals at home. Staying at the hospital premises on the one hand or making a number of trips to and from the house on the other were both problematic for Accra residents. Some of them also could not afford hostel accommodation.

Some mothers had husbands who own private vehicles and were able to bring them to Korle Bu Teaching Hospital every morning and bring them back home after work. The problem with that also is the need to rush out very early enough to avoid vehicular traffic. Some families who had private vehicle also have younger children at home who must be taken to and from school. The rearranging of daily schedules and the whole illness experience then, some said, posed a lot of crisis for the whole family. The coping strategies that they adopt have to factor in other demands on the family car.

The hospital management had attempted to provide a hostel for the mothers some years ago. It was to be named "The Mothers' Hostel" and to be located on the hospital premises. This could probably be a better arrangement for the mothers who now depend on facilities and services rendered by private and profit-maximizing providers. The financial constraints of the hospital did not permit this to materialize.

The experience of the families of the sick children shows that beyond the need of financial access to the health service, there were numerous aspects of accessing the health service that must be addressed. Unpleasant experiences may result in a decision to seek alternative health service. Already, herbal and faith healing centres exist and new ones spring up regularly and some of them have claims that have not been *proven* to be authentic.

Some mothers and care givers attributed the cause of the disease of their children to spiritual causes. They may seek the alternative sources only for treatment of the sick children if they have the chance. Two cases are cited here.

Case 1

Ama said her baby was "made sick" by the people in the compound house where she resides. Her pastor told her during the pregnancy that the people were jealous of her pregnancy so she should be careful. He brewed some medicine for her to drink as protection against their evil works. She took the medicine throughout the pregnancy. She however gave birth to a baby that had congenital problems. One of them is the inability of the baby to blink the eyes. Ama believes that the people in their house are responsible for her baby's condition. She therefore prays for the baby and asks the pastor to continue to pray for her.

Case 2

> "Everybody admired Papa when he was born. He was so nice. It may be that someone was so jealous of him and did something to him". These were the words of Ali, Papa's father's brother who brought him and his mother to Korle Bu. Papa's mother speaks only her mother tongue. Since she wouldn't be able to communicate with the doctors, nurses or any other person her husband's brother had to come along with her. Ali was very weak and had lost so much weight and become so bony. According to his uncle, he vomits everything that he eats. By observing Papa very well, I saw that her hands were unusually large and the skin had wrinkled too. He looked like he had AIDS. If he did, then it calls for concern for the rest of the family. Papa had been sick since he was about three months old, and he was eleven months old when I first came to the Children's Block. His mother could not efficiently care for him and the rest of the family- the father and four siblings, all under ten years of age. Papa's father decided to marry another wife. She was taking care of the family back home as Papa was brought to Korle Bu.

Some of the nurses also said that the children's diseases are of supernatural causes. One of them said, "You need to pray very well before you enter the ward everyday to care for these children. Some of them are not normal. They just come to test you. You need patience to care for them, she added.

The Social Cost of the Illness Experience

The living experience of mothers and caregivers was not calculated by the mothers and care givers in financial terms only. Traditionally, mothers and newborns are not confined after the delivery of the baby. The period of confinement ranges from eight days to several weeks among different ethnic groups. During this period, the mother is bathed by her mother, a traditional birth attendant or one who is skilled in doing so. Some special herbs are used for bathing the mother and she is also fed on some special meals and spices that are believed to cure the injuries that she had during labour and delivery. Some of these practices are not possible at the hospital.

Again, traditionally, newborns are not expected to be exposed to the public until the period of confinement is over and the child is out-doored, for fear of harm by an evil person. Among the Ewe, for example, the towel that is used to bathe the baby is not dried outside until after a period of time has passed.

In traditional Ghanaian societies, newborns sleep with their mothers. It is believed that their spirits are weak and for that reason their mothers' "stronger spirit cover" them from any attack on them, especially when they are asleep in the night. Some mothers complained that they spend their nights thinking about the kind of care their infants were receiving from the nurses, knowing that they do not seem to be enough for the job.

The hospital, like all other health facilities in the country, has been faced with shortage of staff as a result of the exodus of Ghanaian nurses to other countries, seeking greener pastures. Yet the number of referrals to the hospital continues to

increase. Individuals, knowingly or unknowingly of the fact that Korle Bu Teaching Hospital is a referral hospital providing tertiary health services, also flock the hospital in their numbers with cases that could be treated in other facilities, even by general practitioners. Ethical reasons prevent the hospital staff from turning away such category of patients. Consequently, there has been pressure on the staff to work harder and longer hours. In line with government directives to the health sector to officialize overtime. The normal schedule for work was 14 hours. Some staff, especially the specialists, even go up to 24 hours or more on some days. Despite this arrangement, there is an obvious staff shortage, particularly in the wards.

The mothers and caregivers' responses to questions on adequacy of staff attending to their children, especially infants, indicated that they did not think that the nurses were able to take care of their children when they were away during off-visit times. There were not enough of them for the job, some mothers said. For this reason, some of the mothers with newborns expressed their desire to stay in the wards for longer periods especially in the night. But this is not allowed by the hospital administration. One mother expressed her fears thus:

> Look at the number of babies and consider the number of nurses. How can they alone care for all these babies in the night? When the babies cry, they claim that there is nothing wrong with them. I don't think so. These nurses alone cannot care for these many babies. We can be around in the night and feed them, carry them and change their diapers too, even if we don't sleep in the wards with them. How can these few nurses do all that for these many babies when we go away? (Esther Jan.19, 2004)

Some of the traditional practices have been eroded by modernization but those of the mothers who came from rural background know and desired them. They said they felt that they were not having a pleasant post-partum period. Generally, referrals from rural areas may face the living condition more strange though they might be expected to know the difference between rural and urban ways of living.

Initiatives by Physicians

The inconveniences of caring for patients at the Korle Bu Teaching Hospital have been recognized by the hospital administration and staff. They have taken some steps to ameliorate their negative experiences. The efforts that have been made are by both individual staff and the hospital administration. As already discussed, there were attempts to provide a hostel for mothers. Longer working hours has also helped to have a higher number of the health workers at the hospital at any time.

The assistance given to patients and mothers in need by individual physicians was observed on a number of occasions. Self-initiative by the physicians was involved in some cases where the paediatricians themselves acted on behalf of the persons in need. Two typical cases are cited here.

Case 1

Mercy, a teenage mother had her newborn admitted to the intensive care unit for treatment of a congenital condition. She was unable to have the father of her baby informed about the delivery because no one, she said, could get him and ask him to visit Mercy and the baby at the hospital. The last attempt was being made by Mercy's grandmother who was going to look for him and have him come to visit Mercy and also take financial responsibility for the mother and child. But three days had passed since Mercy's grandmother went to look for the man. On that third day Mercy burst out weeping loudly in the ward. She was very hungry that morning but had no money to buy any food. The doctor who admitted her baby was doing her ward rounds. She went round the ward and begged every person present in the ward to donate to Mercy. She came out of the unit with a flat file to beg for money for Mercy. She just said, "just something small so that she (Mercy) can have some food to eat", As she went by, and sometimes without saying a word, the people dropped in their money. When the collection was over she went inside to Mercy's unit and soon the cry ceased and she doctor continued with her work.

The whole exercise lasted for a few minute. Most of the people in the ward seem to know what was going on and responded promptly. During an interview with the head of the Social Welfare Department and one of the nursing officers, Mercy's case came up. According to them, the practice was not new. The hospital staff, she said, has to find clothing for some newborns. They make appeal to parents and visitors to the ward for support for patients. Those who can afford donate money and other items to the needy babies and mothers.

Irresponsible fathers were mentioned in two other cases in the ward. In one case, the grandmothers of the child said that she did not even know where the father of the grandson was. She herself had to come and stay with the five-year-old grandson who was dying of stomach cancer because her daughter was too young to do that.

The physicians have also been involved in raising funds for treatment through the media; the publicly owned newspapers especially. With a letter from them an appeal goes out to the public seeking the help of a philanthropist to help a dying patient. One of the cases was successful and the narrative from the four-year-old patient's father showed that without the self-initiative of the doctor, the girl would not have survived.

Fafali

Fafali's doctor wrote a letter in which appeal was made to the public to donate ¢12,500,000 (Twelve million and five hundred thousand cedis) to start the treatment of leukaemia for Fafali. The hospital started the treatment. It took a few weeks before the monies started coming in. Fafali had reactions to the medication after she was discharged. She came back for treatment and, after a period of one year and a number of follow-ups, she recovered fully and went to school.

As Fafali's father narrated his life story, it was obvious that his daughter could not have survived without the initiative of her doctor. He was divorced, lost his job and had no source of income just before the daughter was diagnosed of leukemia. His sisters were taking care of his two-year-old son while he stayed with Fafali at the hospital.

The initiatives of the doctors were important in both cases. In the first case, the wellbeing of the mother was what was at stake. In the second, the whole family was qualified to be declared paupers. The job description for the physician might not have included care for the mother who was not admission. Yet, the doctors acted on their own initiative to appeal to others to support the mother of the sick child. Very often, there are publications in the media appealing to the public for financial support for sick children and adults.

In some traditional societies, the attitude to unusual births or deformities always took account of the effect of the health condition on the lives of the parents, immediate family or even society at large, whether to let the child survive or be killed (Awedoba 2000, Nukunya's 1969, Raum 1967). Modern health delivery may have a policy for both mother and child- maternal child health (MCH)- but the implementation thereof may be found wanting.

Conclusion

Evidence from the present study conducted at the Korle Bu Teaching Hospital shows that the epidemiological transition among children in Ghana has been linked to the introduction of conventional or modern scientific medical system. Being the leading tertiary hospital in the country it has experienced pressure on its resources- human and material- as government subvention has been inadequate for the running of the hospital. The government has not adopted any policy on tertiary health care for children in Ghana. Consequently, the hospital has provided health care to the children under financial constraints. Financial access to health service needed by the children has been a major concern for the hospital and the public. The findings of the study show that the need for financial support was great among almost all the children. Since the hospital also has not realized cost recovery under the dwindling government subvention, it takes a number of measures to have bills paid by parents of the children and also appeals to the public for support

The findings of the study, however, show that besides financial needs of the average child at the Children's Ward, there were a number of other concerns that need redress so that improve the illness experience and coping strategies. The most urgent is the provision of amenities for the mothers of the children, particularly those with newborns. There is also the need to address problems of fathers who refuse to take responsibility for their children. Teenage childbearing also contributed to the abandonment of some of the children, especially those with deformities. Efforts to promote better survival chances for the children, some of whom are from unwanted pregnancies, must therefore include responsible reproductive health behaviour. The government can consolidate the support by philanthropists who have so far donated to support the children. Tax rebates may be given to businesses to encourage them to

donate more liberally. What is the most urgent need is adoption of a policy on tertiary health care for children, a comprehensive one that addresses all the aspects of health delivery for children with NCDs.

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