THE NUMBERS OF THE LAST FIVE YEARS

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This analysis in this report combines information from the most recent nationwide official research into the nature and distribution of poverty with that from more recent but smaller studies on the subject by NGOs and other institutions.[1] The GLSS made a static (mainly household surveys) measurement of poverty. whilst the World Bank study, taking off from the GLSS findings undertook a qualitative and participatory assessment. A basic deduction from the available data and analysis is that poverty in Ghana is differentiated in terms of geography (i.e. rural–urban, rural north–rural south), gender and generation.

The last official quantitative measurement of poverty was undertaken in 1992, i.e. the Ghana Living Standards Survey (1992 GLSS). However there is broad agreement that in the last four years poverty has increased and the conditions of those living in poverty has worsened. In a September 1996 report[2] the Ghana Government's Technical Committee on Poverty (TCOP) stated that «there is a general perception among Ghanaian and watchers of the performance of the Ghanaian economy that there has been a downturn in the improvement in general welfare since 1993». In a similar vein a 1995 World Bank study[3] declares that «since 1992, there is evidence of a slow down in the rate of economic growth and of a deterioration in living standards.»

The 1992 GLSS survey of the economic dimensions of poverty defined two poverty lines based on mean household expenditures in 1988: an upper poverty line of two–thirds of and a lower line of half the mean expenditure. The 1992 GLSS found that 31% of Ghanaians lived below the upper poverty line and 15% below the lower. The upper measure is the common reference for poverty in Ghana.

The aggregate national figure hides some important variations. The percentage of poor in the urban areas and rural coastal areas are below the national average. 23% of the population of the national capital and growth pole, Accra, and 27.7% of the population in other urban areas as well as 28.6% of rural coastal inhabitants live in poverty. On the other hand 33% and 38.3% of the inhabitants of the rural forest and the ecologically fragile rural northern savannah areas live in poverty. Three quarters of the poor are to be found in the rural areas. Not surprisingly the biggest proportion of the poor, 48% of them are employed in agriculture with another 33% engaged in non–farm self employment, mainly provision of petty services and goods.

The GLSS data do not offer a clear basis for deducing the gender dimensions of poverty. So for example there are no data on the relative numbers of male and female poor. However the World Bank study clearly showed that men and women stress different elements of the experience of poverty. Also evidence from the GLSS and other sources point tothe fact that Ghanaian women suffer a greater share of the burdens of poverty than men. Furthermore there are indications that the increasing migration of young women into Accra, into a largely stagnant labour market, has aggravated the incidence of poverty among women in that city.

For example in the rural north, where poverty is greater, women spend 70 minutes a day collecting water compared to 25 minutes for men. Also in this area not only female headship of households was often associated with poverty. The poverty impact of childlessness, loss of spouse and age is greater for women.

Indications from Accra point to poor women bearing the brunt of inadequate provision of garbage disposal facilities and scarce water supply in the poor neighbourhoods of the city since water supply and environmental cleanliness are defined as the respon-

1 The main reports are the Republic of Ghana, Technical Committee on Poverty (1996) *Policy Focus for Poverty Reduction.* World Bank (1995) *Ghana Poverty Past Present and Future, The Ghana Living Standards Survey, 1992.* Smaller more recent reports used include a 1996 Voluntary Services Overseas (VSO) Ghana study on Technical Assistance and Poverty Reduction, the findings of a 1996 participatory assessment of women's reproductive health in Northern, Upper East and Upper West Regions by a national NGO, ISODEC and E.Aryeetey & E. Bortei–Doku Aryeetey (1996) *An Urban Perspective on Poverty in Ghana:* A case study of Accra.

2 Republic of Ghana, Technical Committee on Poverty (1996) *Policy Focus for Poverty Reduction.*

3 World Bank (1995) *Ghana Poverty Past Present and Future.*

sibility of women and children. Furthermore due to the huge urban job losses occasioned by the government economic policies, rooted in a World Bank backed Structural Adjustment Programme (SAP), the numbers of Accra poor households relying on the incomes of wives and female relatives in the informal sector is believed to have increased.

The differences are not simply in quantitative terms but there are also differences in what the poor perceive as the determinants of their condition, its social implications and therefore what is required to break out of living in poverty.

While poverty in the Northern Savannah is related to food insecurity in the rural south it is related to constraints to productivity. Rural poverty, particularly, in the North tends to affect whole communities while urban poverty tends to be more individually focused. In the rural areas poverty was seen in dynamic as well as community terms: in general community assets –such as access to resources, e.g. water for domestic and productive use, fertile farmlands and particularly, in the North, as a dynamic condition affecting entire communities.

The World Bank study found that the urban poor were strongly concerned about inadequate employment opportunities and small enterprise credit. Persons living in poverty in both urban and rural areas showed a strong concern for better access to both educational and health facilities, water and sanitation.

SAP

Since 1983 an IMF/World Bank Structural Adjustment Programme (SAP) has defined the government's strategy for economic growth and poverty reduction. Since the mid 1980s there has been a four pronged poverty reduction strategy. This includes increasing and sustaining economic growth and stability, improving basic social services, reducing population growth and to a lesser degree providing services narrowly targeted at the most needy.

Most of the adjustment and sector loans (75%) contracted from the World Bank, (more than $2 billion by 1995), and other financing from the European Union and bilateral donors has been in support of the growth objective. Out of 14 sector adjustment credits from the World Bank since 1992, two were narrowly targeted at poverty reduction, five were for broad services while the rest was for growth.

The 1996 TCOP report includes 383 projects receiving support, for the period 1985–99. It found that 58% of them are poverty focused, i.e. «benefit the poor without targeting them», while 22.4% of the projects were directly targeted at the poor, a situation it described as «most unsatisfactory». The report noted that the terms of reference of the National Action Programme for Poverty Reduction (NAPPR), the Government's post WSSD framework document, did not include food security, nutrition and population policy. TCOP also argued that the NAPPR – «should have provided for broader consideration of service delivery issues». The NAPPR is the framework document for future donor assistance and poverty reduction activities.

The official admissions of increasing numbers of poor and deterioration in living standards contrast with the previous official optimism which considered that a decade of SAP (during which economic growth averaged 5% a year) had led to a reduction in poverty. Growth has faltered since 1992. The 1992 poverty figures are an improvement on those from 1989, particularly reflecting a drop in the percentage of rural people living in poverty.

Even as the figures point to an overall reduction in percentage of those living in poverty between 1983–1992 they also highlight the grave poverty causing impact of SAP in the urban areas. The 1992 figure of 23% of Accra's population living in poverty is a dramatic jump on the 1988 figure of 8.5%. Beneath the figure is the human cost of the SAP driven budgetary reforms which have seen nearly 70,000 persons laid off in the public service, as well as large scale redundancies, in privatised public corporations and in manufacturing enterprises which have been bankrupted by cheap imports due to trade liberalisation. Another factor behind the growth in the percentage of the poor in Accra is the already mentioned migration from the countryside into a stagnant labour market.

POVERTY AND HEALTH

As already indicated, an improvement in basic social services including health is one of the defined objectives of the GoG's poverty reduction strategy. This is reflected in a number of policy documents. These documents include the NAPPR, The Medium Term Health Strategy, 1995 (MTHS), The Child Cannot Wait: a National Programme of Action (1993–97), Programme for Sexual and Reproductive Health, and Ghana Vision 2020. All of these defining overlapping goals for improving the health status of the population as part of a wider poverty reduction drive.

Present average life expectancy is 56 years. This average is heavily influenced by the high infant (under 1 year) and child (under 5 years) mortality rates of 66 per thousand and 119 per thousand respectively. Life expectancy for those who survive the first five years is 63 years. 45% of one year old children are not immunised and national immunisation coverage for the main child killer diseases is 70%. 26% of children under age three are stunted and 11% are wasted.

The indicators for health and health care delivery in Ghana bear a strong correlation to the spread of poverty. For example:

- It is well established that most causes of morbidity and death in Ghana arise from poor environment and sanitation, defining features of the situation of the poor. The major ailments malaria, acute respiratory infections and diarrhoea diseases, are linked to poor environment and sanitation.
- Major causes of childhood morbidity and mortality such as lack of protection from preventable diseases, short interval between births malnutrition, are largely linked to poverty.
- Rural Ghana, in particular Northern Ghana, record the lowest in terms of health indicators:
  - Only 12% of rural households have access to potable water compared to 75% in urban areas.

- **In 1989 the coverage of the government's primary health care programme was 45% in the rural areas compared to 92% in the urban centres.**
- **According to the 1992 GLSS only 3% of rural households live in communities with a resident doctor. The Ministry of Health's physical accessibility standard is to provide one health facility within a walking/travel distance not exceeding 8 km (5 miles).** For 36% rural people the nearest doctor is 1– 9 miles away, for 31% the distance is 10–19 miles and for nearly 18% of them the distance is over 30 miles. A similar situation exists for pharmacists.
- **It is estimated that 8.36 million people living in 47,000 rural settlements have no ready access or none at all, in terms of physical availability, to basic government provided health facilities.**
- **Only 11% of the population of the three Northern Regions have access to health facilities. In 1987 the doctor– population ratio in the Northern Region was 1:63,095 compared with 1:5764 in Accra.**
- **The three northern regions record the highest child, infant and maternal mortality rates in the country as well as the most nutrition deficient statistics.**
- The National Report for the Beijing Conference, Status of Women in Ghana (1994) disclosed that 45% of all women and 65% of pregnant women in northern Ghana are malnourished compared to 30% and 45% respectively in the south.

Despite the geographical differences in health indicators, urban and rural poor are united in their priority identification of inadequate physical availability of social services, including health as an element of their social deprivation. According to the 1995 World Bank study, health care was one of the four priorities identified by the rural poor. A separate study in Accra found the poor rating inadequacy or absence of sanitation facilities as priority concerns.

GOVERNMENT POLICY AND ACCESS TO SERVICES

The government's broad policy for improved health within poverty reduction has three key elements: building a firm foundation for an improvement in the quality of health care, increasing access to quality health care and establishing an enabling environment for health. More specific elements include reduction in the rate of infant, child and maternal mortality rates, effective control of risk factors that expose individuals to communicable diseases, increased access to health services especially in the rural areas, establishment of a health system effectively oriented towards delivery of public health services.

Despite these commitments health expenditure is low, even compared with other low income countries, stagnating under 2% of GDP ($6 per capita) from the late 1980s –incidentally– the peak of years of SAP driven economic growth. The World Bank has described this level of expenditure as not allowing for the adequate provision of a minimum package of health services. However there has been an increase in the numbers of community health facilities in the past five years and there is an ongoing strong drive to raise the percentage of immunised infants and children.

The inadequate funding of the public health sector is reflected in a range of problems apart from insufficiency of infrastructure: low pay and poor morale of the inadequate staff, and the patchy delivery of the Primary Health Care Outreach programme in rural areas.

Within this inadequate expenditure the rural areas and the poor get a less than average share. According to the 1992 GLSS in 1989 urban Ghana with one third of the country's population took up 42% of the total government health budget and over 50% of total outpatient spending. In 1992 this urban share had increased to 49% and 55% respectively. The 1992 GLSS also showed that whereas the top 20% of the population, according to income, received 33% of government expenditure on health, the poorest 20% enjoyed only 12% of this expenditure.

The inequity in the share of public health expenditure going to the poor is partly a function of the already described spread of health facilities and personnel. In recent years the situation has been aggravated by the government's commercialisation of services. Charges, largely nominal, for the use of public health facilities were first introduced in 1971, under an IMF backed stabilisation programme, but since 1985 the government has aggressively pursued a cost recovery programme.

Currently the commercialisation programme covers a higher than full cost charge for drugs, and the use of other curative services with exemptions for a handful of diseases. The costs borne by patients have been compounded by additional illegal charges by poorly paid hospital staff. There is an official policy, under the Department of Social Welfare, of exemption for the poor and support for «paupers». This policy has been all but impossible to enforce. It is inadequately funded, and the procedures for exemption are bureaucratic. In 1994 only 723 persons benefited by way of funding for drug purchases with another 3838 receiving free treatment.

The most dramatic impact on the utilisation of health facilities has been caused by the introduction of a «cash and carry» system, which requires that payment be made before a person is attended. Numerous official and NGO studies have reported substantial drop in hospital/clinic attendance in many people as a result of the cash and carry system. In some places the drop has been as much as 50%. In the rural areas the policy has added to the economic cost of health represented by transport costs.

The national media have carried stories of accident victims being left to die in hospitals because the persons who took them there did not have money; the cash and carry system has become the focus of widespread criticism of the SAP derived health policy reforms. The poor are unlikely to find the resources for health emergencies requiring large expenditure.

There are indications of the specific impact of these policies on poor women. According to the 1992 GLSS the most likely rea-

son, 36% of cases, for a woman's non– attendance at pre– natal clinics was that they could not afford the cost. Cost is also militating against the drive to encourage women in the rural areas to deliver in health facilities.

Political liberalisation since 1992 has made a much more open discussion of the impact of the government's economic policies on the poor and on health delivery. In the run up to national elections in December 1996 the growing incidence of poverty and the impact of the commercialisation of health on the poor were key issues in the campaign. The government, which was re–elected for another four year term, has acknowledged there are problems but has given no clear indication of what policy changes it intends to carry out in response to the situation.

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