DEPARTMENT OF HUMAN DEVELOPMENT
NATIONAL CATHOLIC SECRETARIAT

MAKING GHANA'S PUBLIC HEALTH ACT WORK FOR ALL

PARTICIPATORY ASSESSMENT OF THE IMPLEMENTATION OF THE PUBLIC HEALTH ACT 2012 (ACT 851)

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We acknowledge the support and collaboration of the fifteen Metropolitan, Municipal and District Assemblies (MMDAs) who cooperated with us for this pilot monitoring. The full list of these MMDAs is already published as part of this report for reference. A number of local FM radio stations also collaborated with our DDOs to expand the reach of public education on the Public Health Act (Act 851). Representatives of diverse citizens' groups including women, youth, persons with disability, traditional authorities and faith-based organizations served on the Public Health Monitoring Teams (PHMTs). The lists are also contained in the annex of this report. The cooperation and collaboration of these actors from private, government and civil society is an excellent model of effective development cooperation which we all celebrate.

Finally, we are deeply grateful to the Ghana Catholic Bishops' Conference (GCBC) for setting the agenda for our work and exercising the overall governance responsibility for our organizational accountability. The Bishops' communiqué of November, 2012, among other things, called for the expansion of Economic, Social and Cultural rights in Ghana. This was the

basis for developing the project. It is our hope that this report will continue to further the realization of the agenda for the Right to Good Health in Ghana for the promotion of the Common Good, according to the aspirations of the Ghana Catholic Bishops' Conference.

ABSTRACT

Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.

From 2001, the development agenda of Ghana has been to transform the country into a middle income country with per capita income of USD1000 by 2015. The achievement of this dream requires educated, healthy, skilled and motivated population. This puts health at the centre of the development efforts of Ghana.

The National Health Policy of 2007 was developed to define the direction of government focus and programmes in the health sector. One key area of health that has been identified for greater attention within the National Health Policy Framework is the promotion of a healthy lifestyle in a healthy environment. This involves among other things enacting and enforcing legislation to reinforce health-promoting attitudes and behaviours and to protect the environment.

The Public Health Act of 2012, Act 851 was enacted in fulfilment of this strategy. After a year of passing the law, the Department of Human Development of the National Catholic Secretariat commissioned citizens monitoring of the implementation of the Act 851 at the district level to establish the status of public health services provision and the level of commitment of stakeholders to implementing the Act 851 especially at the district level. The monitoring focused on 15 districts in the Northern, Upper East and Upper West Regions and employed participatory Monitoring approaches.

The monitoring indicated that the Act 851 has not gone through the processes required for its full integration into the health system. Neither the relevant stakeholders have been educated on the law nor do they have access to it. Public health facilities are limited and many of these limited facilities are not in good shape at the district level. There are also inadequate Public health professionals in the districts. Stakeholders' collaboration and team work around public health is extremely weak and knowledge about the Act 851 and general consciousness of public health issues among stakeholders and citizens is very low at the district level. Thus, making the long standing saying that *"prevention is better than cure"* a mere talk.

LIST OF ACRONYMS

GPRS I	Ghana Poverty Reduction Strategy I
GPRS II	Growth and Poverty Reduction Strategy II
GDP	Gross Domestic Product
PHA	Public Health Act
PHMTs	Public Health Monitoring Teams
PwDs	Persons with Disability
PHC	Population and Housing Census
CSM	Cerebrospinal Meningitis
UNICEF	United Nations Children's Fund
DANIDA	Danish International Development Agency
WFP	World Food Programme
GFMC	Global Fund for Malaria Control
MoH	Ministry of Health
MLGRD	Ministry of Local Government and Rural Development
GHS	Ghana Health Service

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1.0 BACKGROUND OF PROJECT

The 1992 Constitution of Ghana under the Directive Principles of State Policy mandates the President of the Republic, to among other things, ensure the realization of basic human rights which includes the right to good health. The development agenda of the Government under the Growth and Poverty Reduction Strategy (GPRS II)[1] was to transform Ghana into a middle income country with per capita income of USD1000 by 2015. One of the strategies for achieving this growth was to improve on the Nations human capital. This strategic direction puts health at the centre of the development efforts of Ghana because improved productivity and increased Gross Domestic Product (GDP) can only be achieved by a healthy population.

The National Health Policy of 2007 was designed to give expression to the strategic direction of the country relative to health with the goal of ultimately ensuring a healthy and productive population that reproduces itself safely. The policy has highlighted the correlation between health and poverty reduction through the Ghana Poverty Reduction Strategy (GPRS I) and intimated that Ghana can create wealth through health. The goal of the sector is being pursued through three interrelated and mutually reinforcing objectives of:

- ensuring that people live long, healthy and productive lives and reproduce without an increased risk of injury or death;
- reducing the excessive risk and burden of morbidity, mortality and disability, especially in the poor and marginalized groups and
- reducing inequalities in access to health, populations and nutrition services and health outcomes[2].

Establishing an effective and well-coordinated public health system and the provision of quality public health services are central to the achievement of these objectives.

Box 1: Public Health

Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.

1.1 Disease Profile of Ghana

In Ghana, the high levels of morbidity and mortality are the product of interaction amongst demographic, lifestyle and environmental factors. The country's disease profile is characterized by high levels of communicable and pregnancy-related diseases, and by a rising number of non-communicable diseases[3]. The disease profile triggered a paradigm shift in health development in Ghana within the context of the National Health Policy of 2007.

1. Ministry of Health: National Health Policy "Creating Wealth Through Health" Accra, Ghana September 2007. P6
2. Ibid. p33

Box 2: Shifts in Paradigm for Health Development

- Health improves productivity and creates wealth
- Health promotion and nutrition ensure that people remain healthy and stay out of hospitals
- Healthy environment and healthy lifestyles play a key role in ensuring healthy individuals, families, communities and the nation
- Health delivery is more than health service delivery; it is every body's business, it is affected by individual lifestyles and it depends on multi-sectoral action

Health delivery is an industry that contributes to economic development.

Informed by the shifts in paradigm, promoting healthy lifestyles[3] in a healthy environment has become a critical pillar in achieving the health goals of the country. Healthy living involves disciplined and faithful sex, healthy eating, exercise, rest and recreation and a life free of addictive and substance abuse. A healthy environment is one that:

a. Ensures access to clean water and sanitation

b. Reduces the risk of contamination of food and water

c. Reduces the risk of injury and ill-health in public places

The promotion of a healthy lifestyle in a healthy environment is contingent on:

a. Empowering the population with the requisite information for making informed lifestyle choices

b. Providing infrastructure and services to the people in places where daily decisions are made and/or where harmful behaviours may be manifested

c. Enacting and enforcing legislation to reinforce health-promoting attitudes and behaviours and protect the environment

d. Strengthening institutions such as; the Food and Drug Authority, the police and local government and holding them accountable.

The Ministry of Health and Ghana Health Service in the Policy have identified specific areas that have the potential to address the issues of healthy lifestyle and environment. The box 3 outlines the areas the health sector is targeting to produce results in the promotion of healthy lifestyle in a healthy environment.

3. Ministry of Health; National Health Policy "Creating Wealth through Health" Accra, Ghana September 2007, P23
4. Lifestyle is the way people live within their socio-cultural and geographical setting. It embodies the set of people's daily behaviour patterns and the activities that shape their lives.

Box 3: Key Results Areas

- ✓ Information for making healthy lifestyle choices
- ✓ Food safety
- ✓ Environmental sanitation
- ✓ Healthy settings (communities, schools, homes and work places)
- ✓ Reaching people with infrastructure and services
- ✓ Enacting and enforcing legislation
- ✓ Institutional strengthening

This report assesses the extent to which these results areas have been pursued within the context of Ghana's Public Health Act of 2012 (Act 851). The assessment is informed by the results of a participatory monitoring process of citizens, mobilized and strengthened through training on the Act facilitated by the Department of Human Development of the National Catholic Secretariat of the Ghana Catholic Bishops' Conference (GCBC).

2. LEGISLATIVE FRAMEWORK FOR ADDRESSING PUBLIC HEALTH RISK AND IMPLEMENTATION

In line with the strategic direction of the sector and the results areas outlined in the National Health Policy Framework, the Government of Ghana sponsored a bill in parliament to give legal effect to the implementation of public health services and to enforce prohibitive and abusive conducts in society in 2012. The bill was subsequently passed into law, that is, the Public Health Act, (Act 851) in October 2012. The Act 851 is meant to partially contribute towards achieving the health sector vision and objectives by revising and consolidating the law relating to public health to prevent diseases, promote, safeguard, maintain and protect the health of humans and animals and to provide for related matters.

The Act 851 is divided into nine parts. The first five parts focus on communicable diseases, vaccination, quarantine, vector control, and environmental sanitation. The remaining four parts focus on tobacco control measures, food and drugs, clinical trials and miscellaneous provisions. Given that public health epidemic can manifest in many forms and can vary in terms of the speed of spread and havoc. These have been identified by the health sector actors as a critical sector for improving the quality of life of the population. In furtherance of this, a project was commissioned by the Department of the Human Development of the National Catholic Secretariat to assess the current status of public health service provision in the Country and to make recommendations for the effective implementation of the Act 851 from National to community levels.

3. METHODOLOGY

The project is part of a broader campaign for the recognition and inclusion of the Right to Health in Ghana's Constitution, as part of the Constitution Review Process. It was funded by STAR-Ghana a national pooled funding for Civil Society.

The method adopted in the monitoring was informed by the National Catholic Secretariat's experience in health service delivery across the country and its understanding of the nature of public health services. Our experience indicates that an effective public health system does not only educate people about the effects of lifestyle choices on their health or prepares people for the effects of catastrophes but actively involves the entire population. It is conceived as a multi-disciplinary field which includes professionals from different sectors and other stakeholders in society with the common purpose of protecting the health of a population.

As a result of the experiences and the understanding of the concept of effective public health system, two prong approaches were used. The first was monitoring by citizens and the second was public education. A participatory approach was adopted to the monitoring of the implementation of the Public Health Act of 2012 (Act 851). In line with the approach, a Participatory Monitoring Framework[4] was developed. The framework highlighted relevant areas of the Act for both public education and participatory monitoring. It established the Public Health Monitoring Teams (PHMTs)[5] by defining the size, composition and responsibilities of these PHMTs as well as the responsibilities of the Districts and Dioceses of the Catholic Church in the target areas. The PHMTs consisted of citizens groups (women, youth and PWDs), traditional authorities, and religious leaders, officers of the District/Municipal Assembly and led by civil society organizations physically present in the focused districts.

The framework required that data gathered through the participatory monitoring would be developed into a report for sharing with relevant Health sector stakeholders including District/Municipal Assemblies.

The geographical coverage of both the monitoring and the public education was purposively selected based on incidence of poverty and the health needs and challenges of the people. For instance, the tables below illustrate the Doctor/Patient and Nurse/Patient Ratios in Ghana. Table 1 below presents the doctor/patient ratio by regions. The table shows that, though there is slight improvement in the doctor/patient ratios for the Northern, Upper East and Upper West regions, their ratios are higher than the national average for all the years.

4. Refer to Annex A of this report
5. Refer to Annex B of this Report

Table 1: Doctor/Patient Ratio

Region	2009	2010	2011
Ashanti	8,288	7,184	7,704
Brong Ahafo	16,919	22,967	16,103
Central	22,877	18,218	20,442
Eastern	16,132	15,801	16,065
Greater Accra	5,103	4,099	3,751
Northern	50,751	18,257	21,751
Upper East	35,010	31,214	38,267
Upper West	47,932	27,050	38,267
Volta	26,538	32,605	23,660
Western	33,187	31,190	26,044
National	**11,929**	**10,423**	**10,034**

Source: Ghana Health Service, Annual Report 2011

Table 2 shows that the nurse/patient ratios in the Northern, Upper East and Upper West Regions are not as bad as pertains with doctors. In terms of nurse patient ratio, the Northern region had the highest number of patients per one nurse from 2009 to 2011. The Upper East and Upper West regions have ratios below the national average for all the years. However, the monitoring revealed that a large majority of these nurses are Community Nurses and not General Nurses because of the seriousness the regions in the north have attached to the CHPS compound concept.

Table 2: Nurse/Patient Ratio

Region	2009	2010	2011
Ashanti	1,629	1,971	1,568
Brong Ahafo	1,822	1,891	1,495
Central	1,518	1,538	1,309
Eastern	1,181	1,356	1,173
Greater Accra	1,069	1,017	1,255
Northern	1,934	2,067	1,547
Upper East	1,125	1,141	914
Upper West	1,136	1,163	950
Volta	1,174	1,422	1,242
Western	1,581	1,690	895
National	**1,497**	**1,489**	**1,240**

Source: Ghana Health Service, Annual Report 2011

On the basis of the indicators, the Northern Ecclesiastical Province of the Catholic Church which coalesces incidentally with the Northern, Upper East and Upper West administrative regions was the focus of both the monitoring and public education. In all 15 districts across the five Catholic Dioceses (i.e. Damongo, Navrongo-Bolgatanga, Tamale, Wa and Yendi,) of the Northern Province of the Catholic Church participated in the monitoring. Simple random sampling technique was used to select three Metropolitan/municipal/district assemblies in each

of the five dioceses. Thus, the data on which this report is prepared was gathered from 15 districts – three in each of the five Dioceses and analysed. The Municipal/Districts are presented in the table below. The draft of this report was validated with the stakeholders at the Northern Province and later at the National level with the Ghana Health Service (Public Health Division) and the Ministry of Health. Both institutions reviewed and provided inputs.

Table 3: Names of Districts/Municipals targeted for the monitoring

Municipal/District		
1. Bole	6. Kpandai	11. Sagnarigu
2. Bolgatanga	7. Kumbungu	12. Sawla-Tuna-Kalba
3. Bulsa North	8. Nadowli/Kaleo	13. Tatale Sangul
4. Garu-Tempane	9. Nanumba North	14. Wa East
5. Jirapa	10. Saboba	15. West Gonja

In terms of the public education, the monitoring team established partnerships with community radios and FM stations depending on their coverage. The radio and FM stations were used to reach out to the wider population while all Parishes in the five Dioceses (totalling 75) undertook parish-level education on the Act. At the parish level, a variety of channels were used to carry out the education including schools, churches, and mosques. Different local languages were used depending on the dominant language of the target communities.

The fifteen Municipal and District assemblies that were covered by this monitoring were located in the Northern, Upper East and Upper West regions. Nine of the districts are in the Northern Region, three each are in the Upper East and Upper West Regions. The results of the 2010 Population and Housing Census indicated that the total population of the three regions was 4,228,116. Out of this number, the Northern Region has a population of 2,479,461[7] while the Upper East and Upper West Regions have populations of 1,046,545[8] and 702,110[9] respectively. In this project, the public education did not only target the population of these regions but some of the adjoining districts of the Volta and Brong Ahafo regions.

4.1 Location of Districts

Nine of the fifteen districts that formed part of the monitoring are located in the Northern Region. These Districts are Bole, Kpandai, Kumbungu, Nanumba North, Saboba, Sagnarigu, Sawla-Tuna-Kalba, Tatale-Sanguli and West Gonja. Three of the fifteen districts are found in the Upper East Region, namely Bolgatanga Municipal, Builsa North and Garu-Tempane Districts. The remaining three Districts that participated in the monitoring from the Upper West Region include Jirapa, Nadowli/Kaleo and Wa East.

4.2 Population of the Districts

Three out of the nine districts in the Northern Region were created only in 2012 after the 2010 Population and Housing Census (PHC) and therefore it is quite a challenge to get specific population for those districts. These districts are Kumbungu (carved out of Tolon/Kumbungu), Sagnarigu (carved out of Tamale Metropolis) and Tatale-Sanguli (carved out of Zabzugu/Tatale). Though it was a challenge to get specific population figures for these districts, their inclusion presented an advantage to the monitoring process as the public health service situation in those districts may significantly reflect the situation of the districts from which they have been carved. The population figures for these three districts presented in this report are half of the mother districts with a basic assumption that those districts would constitute about half of the population of their mother districts.

In terms of population of the focus districts in the Northern Region, Bole has a population of 61,593; Sawla-Tuna-Kalba has 99,863; West Gonja has 84,727; Kpandai has 108,816; Nanumba North has 141,584; Tatale-Sanguli has about 61,927; Kumbungu has about 56,165 Saboba has 65,706 while Sagnarigu has about 185,675[10].

Unlike in the Northern Region where three districts are newly created, in the Upper East Region one out of the three districts (Builsa North) had another district (Builsa South) carved out of it. Therefore, the same assumption is made that the Builsa North district constitute about half of the

7. 2010 PHC Regional Analytical Report, Northern Region: Ghana Statistical Service. June 2013. P24
8. 2010 PHC Regional Analytical Report, Upper East Region: Ghana Statistical Service. June 2013. P25
9. 2010 PHC Regional Analytical Report, Upper West Region: Ghana Statistical Service. June 2013. P21
10. 2010 Population and Housing Census of Ghana

2010 population figure for Builsa District. By this assumption, the Builsa North district would have approximately a population of 46,450 while the Bolgatanga Municipality and the Garu-Tempane district have populations of 131,550 and 130,003 respectively[11].

The original Nadowli District has a population of 94,388 according to the 2010 PHC. If 50% of this figure was curved for the Nadowli/Kaleo district, then the population for Nadowli/Kaleo district would be 47,194. Jirapa and Wa West districts have populations of 88,402 and 81,348 respectively[12].

4.3 Health Sector of Districts

Understanding the nature of the health sector in the 15 districts is required to fully appreciate the need for effective public health in order to reduce morbidity in those districts. The Bole district has a total of twelve health facilities - one district hospital, five health centres, two clinics and three Community-Based Health Planning and Service (CHPS) compound[13]. For a population of 61,593, the implication is that on the average, each facility is serving 5,593 people. Meanwhile the district hospital serves as the highest referral centre for patients in the district and has a catchment area extending beyond the borders of the country into La Cote D'Ivoire. The number of deaths due to malaria for under 5 years is on the increase[14]. The water and sanitation situation of the district is poor especially in the southern part of the district.

In the Bolgatanga Municipality which serves as the capital of the Upper East Region, health services provided in the Municipality are both orthodox and traditional. There are 20 health facilities – one regional hospital, three health centres, ten clinics and six CHPS compounds. Only the Regional Hospital and one private clinic are the well-equipped facilities. The rest, located largely in the deprived parts of the municipality are poorly equipped. Patronage of these facilities has been low in the rural communities of the municipality as a result of poverty, illiteracy and ignorance.

Access to safe drinking water is limited and sanitation and hygienic practices are poor exposing many people to health hazards. There is high prevalence of malaria, diarrhoea, anaemia, acute respiratory infections and gynaecological disorders. Epidemics such as cholera, anthrax and Cerebrospinal Meningitis (CSM) are common occurrence.

There are 18 health facilities in the Builsa North district. One District Hospital, four health centres, two clinics and eleven CHPS compounds. In addition, there are two supplementary feeding centres which are responsible for boosting the nutritional needs of children in the communities. The district is not insulated from the nationwide inadequacy of medical personnel. There is only one medical doctor in the district; 15 practicing midwives; 24 Community health nurses; and 4 public health nurses.

11. Ibid
12. Ibid
13. www.ghnadistricts.com 24th November 2014
14. Ibid

The situation is not different in the Garu-Tempane district. There are only nine health facilities one health centre; and eight clinics. There are also some CHPS Compounds that serve the remote communities in the district. There is no medical doctor in the district. Most of the health professionals serving in the district are nurses. A total of 93 nurses are serving in the health facilities. The nearest hospital for referrals is 25 kilometres away from the district capital.

In collaboration with United Nations Children's Fund (UNICEF), Danish International Development Agency (DANIDA) Health Support Services Programme, World Food Programme (WFP), Global Fund for Malaria Control (GFMC) and Red Cross the health sector in the Jirapa district is comparatively effective. There is a 193-bed District Hospital, three health Training Schools, thirteen Health Centres and two CHPS compounds.

The condition and distribution of Health Facilities in the Kpandai district is poor limiting access to quality health care. There are ten health facilities in the district – one poly-clinic, three health centres, and six clinics. In terms of personnel, there are virtually no qualified personnel to man some of these facilities. Of all the ten health facilities in the District, there is no medical doctor and currently there are only four medical assistants in four of the facilities.

The health sector in the rest of the districts i.e. Nanumba North, Saboba, Sagnarigu, Sawla-Tuna-Kalba, Tamale-Sanguli, Wa East and West Gonja have characteristics similar to those described above. All the districts have weak health delivery systems with few health professionals. Although health indicators nationwide point to improved health conditions of the people of Ghana, there exist constraints in terms of access and affordability in these districts. Generally, in all of these districts little attention is given to public health issues. The district assemblies have over the last two years provided public health facilities for the people without recourse to the Act 85 1.

5. RESULTS OF BASELINE STUDY ON PUBLIC HEALTH IN THE DISTRICTS

The monitoring was commissioned just about eight months after the passing of the Public Health Act 2012 (Act 851). Thus, in developing the Participatory Monitoring Framework, a decision was taken to establish the grounds upon which to engage stakeholders especially at the district level on how well or how bad we are doing on public health service provision and to assess the awareness and preparedness to implement the Act. The strategies and approaches adopted to address public health concerns in the districts were also assessed. The baseline study focused on:

5.1 Access to Public Health Facilities in the districts

Generally, the baseline study revealed that some critical public health facilities are unavailable in many of the districts monitored while those that are available are woefully inadequate. Table 4 presents health facilities in the Jirapa district including public health facilities. The only area the district has provided significant number of facilities is in the area of water. The water facilities include 391 useable boreholes, 78 wells, 4 dams, 1 small town water system and 6 mechanized boreholes. Only 38 facilities have been provided for sanitation. These facilities include 22 usable public toilets, 8 refuse containers, 8 refuse dumping sites. Important public health facilities like Butchery or slaughter houses, veterinary clinics are not available.

Table 4: Number of Public Health Facilities in Jirapa District

	Facilities	Quantity
1	Health facilities	20
2	Sanitation Facilities	38
3	Water Facilities	480
4	Butchery/Slaughter Houses	0
5	Treatment Centres for Tobacco Addicts	0
6	Mortuary Facilities	1
7	Veterinary Clinics	0

Source: Department of Human Development, National Catholic Secretariat PHMT Baseline Study, 2014

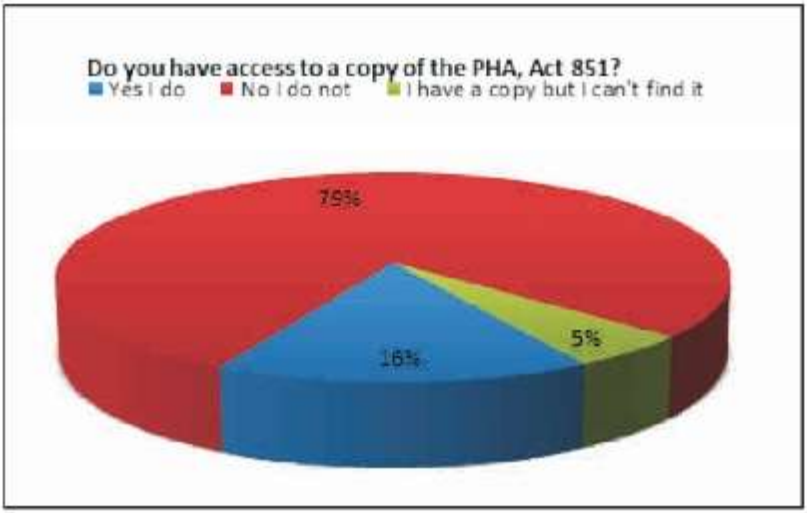
5.2 Awareness of District Level Stakeholders of the Existence of Act 851

In terms of awareness of the existence of the Act 851 among stakeholders of the health sector at the district level, a high majority of the stakeholders are aware. As many as 95% of stakeholders in the Kpandai district were aware of the existence of the Public Health Act, Act 851. However, only 5% of stakeholders interviewed indicated that they had access to a copy of the Act. A whopping 79% of these stakeholders did not have access to the Act. Figure 1 below shows the

percentage of stakeholders who had access to the Act. About 16% of the stakeholders contacted in the district claimed they had copies of the Act but could not find them.

After almost a year of the passage into law of the Public Health Bill, no district had had their public health sector stakeholders trained on the law as of the time of this study. These stakeholders imagined that their role in promoting public health will not be altered by the Act though they have not been trained on it. They regard their traditional role in public health promotion as in public education; inspection, monitoring and supervision of hospitality industries and stores; prosecution of offenders and provision of public health infrastructure. It is interesting to learn that the core public health personnel in the Districts indicated that they invoke provisions of the Criminal Code of 1960 to ensure that people abide by standards set to promote healthy public lifestyle and environment.

Figure 1: Access to the Act 851 in the Kpandai Districts



5.3 Availability of public health professionals in the district

The study revealed that access to health professionals of all kind in the remote and poor districts of the country is a major challenge. The study was designed to capture all public officials that are directly or indirectly involved in the promotion of public health at the district level. The study indicated that public officers that are directly engaged in public health issues on a daily basis in the districts are very few. Table 5 is a presentation of health personnel in the Jirapa district. The table shows that only 84 health personnel provide all the different types of health services needed by the over 88,402 people in the Districts. How would the safety of this population against the consumption of unwholesome meat and meat products be guaranteed in a district that has only two (2) veterinary officers?

Table 5: Number of Public Health Officials in Jirapa, Wa East and Nadowli Districts

Categories	Health Professionals	Jirapa	Wa East	Nadowli
1	Medical Officers	2	0	2
2	Veterinary Officers	2	3	4
3	Sanitary Inspectors	15	9	
4	Police Officers	33	17	23
5	Public Health Officers	15	48	79
6	Disease Control Officers	1	2	3
7	Environmental Officers	1	1	19
8	Community Health Nurses	45	34	26
9	Nutrition Officers	3	2	

Source: Department of Human Development, National Catholic Secretariat PHMT Baseline Study, 2014

The situation of the Wa East and Nadowli districts are not significantly different from what pertains in the Jirapa district. With the exception of the number of public health officers that is remarkably higher in the two districts compared to Jirapa, the number of all other personnel has remained fairly the same.

5.4 Level of stakeholders' collaboration in promoting public health in the districts

When there is public health threat in society, every member is at equal risk irrespective of how far the threat is from the person. The recent Ebola Virus Disease scare and even the cholera outbreak in Ghana in 2013 typically illustrate the collective risk public health issues pose to humanity. Health threats that have collective effect require collaborative effort and response in society in order to effectively prevent the occurrence of these threats or respond swiftly to contain them when they do occur. This would only happen if all stakeholders in the health sector are effectively organised and prepared to engage in promoting and responding to public health concerns at all levels of government.

Unfortunately, it was found from the study that none of the districts covered has put in place a public health team that involves all stakeholders to educate and enforce public health standards stipulated in the Act 851. Most districts referred to the District Health Management Teams (DHMTs) as being responsible for public health and indicated that it would be unnecessary to establish a team just for public health. Other districts claimed to have established Emergency Health Committees albeit inactive and ineffective. The questions to ask are whether public health does not require more than conventional approach to health care delivery and management? And whether other stakeholders of the communities such as traditional rulers, religious leaders, youth and women's groups are not central to the promotion of public health and whether they have representation on the DHMTs?

5.5 Major Public Health Threats

The study explored what the people considered potential public health threats in the 15 districts. Figure 2 below illustrates what the people regard as serious public health threats in the districts. All the 15 districts covered in the study considered Cerebrospinal Meningitis (CSM) as a serious public health threat. This is obvious because all districts in the savannah ecological zone are threatened almost on annual basis by the scourge of CSM. The Figure shows that 13 out of the 15 districts consider cholera as a major public health concern while seven each of the districts thought Tuberculosis and Bilharzia could severely threaten the lives of their people. Interestingly, five of the districts indicated that Hepatitis is becoming a public health concern among the population (Refer to Figure 2). This situation is worrying because, health service providers have given very little attention to Hepatitis especially in the rural districts meanwhile the health havoc Hepatitis can cause is much more than many other public health cases that have attracted a lot of public attention.

Figure 2: Public Health Threats and Concerns in the Districts

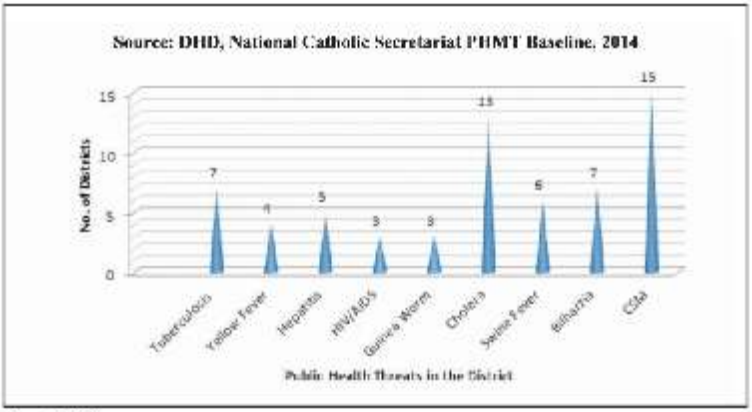


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Table 6: HIV Prevalence Per Region

Region	HIV Prevalence
Eastern	3.70%
Ashanti	3.20%
Greater Accra	2.70%
Western	2.40%
Brong Ahafo	2.10%
Upper East	1.70%
Volta	1.20%
Central	1.10%
Northern	0.80%
Upper West	0.80%
National	1.30%

Source: Summary of the 2013 HIV Sentinel Survey

Luckily, the HIV prevalence rate in the country is generally declining and therefore only three out of the 15 districts identified HIV as a serious public health threat. Table 6 above presents HIV prevalence per region in Ghana. The national HIV prevalence rate of 1.30% for Ghana is about the lowers in the West African Sub-region.

6. Key Outcomes of the Monitoring and Public Education

The results of the baseline study served as the foundation upon which the Public Health Monitoring Teams (PHMTs) in the Districts defined the public health issues for public education and stakeholder dialogues. Series of public education activities were carried at the Diocesan, District and Parish levels across the five Dioceses the project covered. Different strategies were employed to reach the target groups for the public education including the use of radio, Churches, Mosques, Schools and many others. In addition to the public education, dialogue meetings were organised with the key stakeholders and duty bearers in all the 15 Districts. This provided the stakeholders a unique platform to discuss public health issues as many of the stakeholders who participated in these dialogue sessions would conventionally not be part of discussions on public health at the level of district authority. The combined effect of the public education and stakeholders dialogue meetings produced visible changes in efforts at promoting public health in many of the districts while at the same time engendering several commitments on the part of District Assemblies to providing Public Health facilities for communities. Some of the outcomes of the process that are worth stating in this report include:

6. 1. Creating public awareness on public health and particularly on the Act 851 – the education focused on discussing issues associated with communicable diseases, tobacco control, food handling and drug usage, environmental sanitation and on the provisions of the Patient Charter.

1. Cumulatively, the public education reached about seven (7) million people across the Northern, Upper East and Upper West Regions and adjoining districts of the Volta and Brong Ahafo Regions.

2. As stated earlier, many key stakeholders in the Districts including District Central Administration Officers, District Health Management Team members, staff of hospitals and other health facilities indicated that they were aware that a Public Health Act had been passed but it was through this monitoring that these stakeholders got to see the Act and the provisions therein.

3. Through this engagement, many health facilities in the Bolgatanga Municipality as well as Garu-Tempane, and Builsa North districts have pasted the Patient Charter at vantage points for easy access to the public.

6.2 Securing tangible actions by duty bearers in the focused districts – the monitoring process enabled several actions by authorities at the district level. Some of these actions are basic and core to the mandate of the District Assemblies but most of them were overlooked. Below are some of the actions different assemblies and other stakeholders have taken in the different districts:

1. The Garu Tempane district in deciding on the best way to run clean and well patronized public toilet facilities in the district has led to the privatization of many of the public toilets in the district. Those toilets that have been privatised are now very clean and patronage has also improved. In addition, the Garu Tempane district assembly has constructed urinal pits at some markets in the district which hitherto was not part of the Assembly's priorities.

2. In the Builsa North District, the monitoring team drew the attention of the Office of the District Chief Executive (DCE) to the fact that the Assembly did not have copies of the Act 851. Consequently, the DCE has bought a copy of the Act and from line Officers of the Assembly. Assembly Members and members of the DHMT have accessed the Act online. The District has also privatised some of the Public toilets to ensure that they are effectively and efficiently managed. Also, before the start of the monitoring, the main slaughter house located in Sandema township had had most of the slaughter slaps broken but through the dialogue meetings with duty bearers the slaps have been reconstructed and are now in use. The District Assembly has formed a Public Health Monitoring Team under the chairmanship of the DCE to enforce provisions of the Act 851.

3. Prior to the work of the Public Health Monitoring Team in the Jirapa District of the Upper West Region, dead bodies were buried in the compounds of various houses. There was no cemetery for burying dead bodies. Through the public education, people were informed of the dangers associated with burying dead bodies within the surroundings especially as the source of water for domestic use for many households is hand dug wells. As a result, people are now ready to bury dead family members in a cemetery and the District Assembly has acquired a plot of land at Silir to serve as a cemetery. In addition, the assembly has acquired one more refuse container to support proper disposal of garbage in the district capital.

4. Similar to what pertained in the Jirapa district, many communities in the Sawla-Tuna-Kalba District used to bury dead bodies at home. The education has shifted attitudes especially in the Mandari and Laribanga communities where cemeteries have been established and people are now ready to bury at the cemeteries.

5. In the Nadowli/Kaleo district, a slaughter house is being constructed at the district capital and it is currently at roofing level.

6. The monitoring and dialogue meetings with duty bearers influenced the DHMT in Bole and Damongo Districts to embark on sensitization and medical screening of food venders, restaurant operators and cooks under the Ghana School Feeding Programme (GSFP). Though negative in some sense, some people serving as Security at the Bole district hospital were dismissed for smoking cigarette at the hospital which is a public place.

7. In the Kpandai and Saghanigu districts, there has been improvement in the condition under which some meat sellers and food vendors carried out their businesses. In Kpandai, a meat seller who hitherto sold meat in the open was engaged by the PHMT on the need to improve the hygiene and safety of the meat. This led to a complete transformation of the place in

which the meat is sold. The place is now well constructed and netted and two deep freezers have been acquired for storage of meat. In the Sagnarigu district the food vendor has now built a container with glass screen to protect the food from flies and other contaminants. In both cases patronage has increased significantly.

6.3 Securing commitments of stakeholders towards implementing effective public health systems in the districts – the dialogue meetings with duty bearers also led to certain commitments by the District Assemblies and other stakeholders. Some of the commitments include:

1. It came out strongly and rightly that the District Assemblies are fast moving away from the provision of public toilet facilities except in schools and health facilities especially in the towns. Instead many of the Assemblies are adopting Community Total Led Sanitation Policy to encourage households to build private toilets in their homes. In line with this policy, most assemblies have enacted bye-laws that are supposed to ensure that every house owner provides toilet facilities. Unfortunately, many of these bye-laws are either not gazetted or not enforced by the Assemblies. Through the dialogue meetings with the stakeholders, the Builsa North and Garu-Tempane District Assemblies pledged to enforce the bye-laws and to put in place a committee to be responsible for its enforcement. Other districts that are new (i.e. Nadowli/Kaleo and Tatale-Sanguli) made commitments to enact and enforce similar bye-laws.

2. There was no readily available data on the public health facilities in most of the districts and therefore different stakeholders gave different figures as regards the number of public health facilities in the districts. As a result, the Bolga Municipal and Garu-Tempane District Assemblies made a commitment to document these facilities and professionals so it would be handy for use.

3. Many of the District Assemblies also made commitments to train relevant stakeholders on the Public Health Act. Some of these districts include Builsa North, Garu-Tempane and Bolgatanga Municipal.

4. The Tatale-Sanguli District Assembly pledged to collaborate with the Department of Public Health, Community Water and Sanitation Agencies (CWSA) and relevant Non-Governmental Organisations (NGOs) to design and implement intermediate technology base toilet models appropriate to local community needs and capabilities.

The commitments above by the Municipal and District Assemblies would not necessarily happen if there is no effective and sustained follow up discussions between civil society groups and duty bearers at the district level.

7.0 Challenges in the Monitoring and Public Education Process

The Public Health Monitoring Teams encountered a number of challenges in the monitoring process. Some of the main challenges they faced are outlined below:

1. Extreme difficulty in accessing relevant data from the various District level stakeholders in the health sector including the Municipal and District Assemblies. In some districts, figures provided by different offices such as the office of the DCE and the DHMT were different and it was difficult to reconcile the figures.

2. In many districts the language mix required the use of multiple languages which was challenging for some of the monitoring teams especially in the public education drive.

3. More outcomes would have been achieved if the District Assemblies had funds. Unfortunately, throughout the monitoring period only one central Government transfer (the Common Fund) was made. This according to the Assemblies was even the last tranche transfer for 2013. The lack of transfer of funds hampered the District Assemblies' responsiveness to some of the urgent demands made by the monitoring team.

4. It was also challenging to get some of the Municipal and District Assemblies to collaborate with the PHMT's especially at the initial stages of the project.

8.0 LESSONS LEARNT

One of the lessons this project recorded had to do with how deep seated cultural practices are entrenched by lack of information and knowledge about their effects. In many of the communities it was difficult initially to ask the people to consider changing the "age old" tradition of burying the dead at home but with education and awareness at least four communities have embraced the idea of burying in a cemetery.

The other lesson learnt through this process relates to the proactivity of decentralized departments and agencies at the district level. It was shocking for the PHMTs to know that some key stakeholders including officers of the district administration and health personnel did not know that the Act 851 which is supposed to guide their day to day work on public health existed. The lesson is that not all laws that government sponsors are consciously implemented.

9.0 CONCLUSION AND RECOMMENDATIONS

9.1 Conclusion

The participatory monitoring of the implementation of the Public Health Act (Act 851) has contributed to creating huge public awareness about the Act and strengthening the hands of district authorities to give particular attention to public health issues. The monitoring shows that even though the various districts provide some public health facilities for the people such effort is without recourse to the Act 851. The Ministry of Health and Ghana Health Service have not been vigorous in the implementation of the Act and in Ghana where health facilities are limited, health personnel are in short supply and unevenly distributed, certain public health threats are almost annualized, majority of the people cannot afford quality healthcare, and maternal and under 5 years mortality rates are unacceptably high, greater attention to public health promotion by all health sector stakeholders is not only necessary but unavoidable. Everybody – Government, Development Partners, Intergovernmental Organizations (IGOs), Financial Institutions, the private sector, Civil Society Organizations, and communities have to wake up and perform their respective roles in the promotion of public health. "The time is now"!

9.2 Recommendations

In view of the gaps the PHMTs identified at the district level in respect of implementing the Public Health Act, (Act 851), the following recommendations have been put forward for consideration by the Ministry of Health and Ghana Health Service as well as the Ministry of Local Government and Rural Development and the Metropolitan, Municipal and District Assemblies. The recommendations can be addressed either at the level of policy or at the operational level in the Districts.

- At the policy level it is recommended that the Public Health Act (Act 851) is operationalised to engender mutual understanding of the provisions among stakeholders and to clearly indicate the roles each of the stakeholders would specifically be responsible for. The Act itself seems to confer all the powers and responsibilities on the Minister for Health. It would therefore be good if the Ministry of Health develop regulations to the Act to give clarity to its content
- Also, at the policy level, the Ministry of Health, Ghana Health Service in collaboration with the Ministry of Local Government and Rural Development should develop and roll out an exclusive and comprehensive medium to long term programme of work on public health in Ghana. Public health strategies and activities should not continue to be subsumed under the general health sector programme of work.
- At the local level, MMDAs should prioritise public health issues and establish broad based stakeholders' committees to enforce public health standards and to respond appropriately to outbreak of public health threat. Key stakeholders should also be trained on the requirements of the Act 851 and how to apply it in addressing public health concerns.

- The culture of joined-up planning and inter-ministerial dialogue seem to be weak in Ghana. In the area of Public health, such approaches are critical to achieving impact. Beyond developing regulations to Act 851, practical effort is also needed for coordination.
- Also, the Functional and Organisational Assessment Tool (FOAT) process should incorporate elements of public health to assess MMDAs responsiveness to issues of public health.
- Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs) should increase community sensitization on public health and advocacy for duty bearers at the district level to keep their focus on promoting public health and delivering effective public health services.

Annex A.

NATIONAL CATHOLIC SECRETARIAT
DEPARTMENT OF HUMAN DEVELOPMENT

PARTICIPATORY MONITORING FRAMEWORK ON PUBLIC HEALTH IN GHANA

THE PUBLIC HEALTH ACT (ACT 851) IN FOCUS

APRIL, 2013

Supported by STAR-Ghana with funding from DFID, DANIDA, EC and USAID"

STAR-Ghana
Strengthening Transparency, Accountability and Responsiveness in Ghana

ACKNOWLEDGEMENT

The Department of Human Development of the National Catholic Secretariat has developed this document to serve as a framework for monitoring and advocating for an effective implementation of public health programmes in Ghana with special focus on the Public Health Act (Act 851). The monitoring framework will cover critical areas for public education, media for the public education, monitoring checklist, areas of focus of the monitoring and nature of monitoring teams. The tool was developed by Mr. Mohammed Mahamud, Policy Advisor of IBIS West Africa and Mr. Samuel Zan Akologo - Executive Secretary for the Department of Human Development. Feedback and enquiries should be addressed to: szan@ighmail.com/ dhdncs@gmail.com / dhd.ncs@cbcgha.org.

We are grateful to Mr. Chals Wontowe Country Director of IBIS West Africa for facilitating the technical support from IBIS. We thank STAR-Ghana for supporting the Departments' Health Advocacy Project **AGENDA FOR RIGHT TO GOOD HEALTH FOR THE 1992 CONSTITUTION REVIEW - ARIGHT 1992 CONSTITUTION REVIEW!**

1. INTRODUCTION

The Department of Human Development of the National Catholic Secretariat is a faith-based organization that is involved in providing social services including education and health and participates in the discourse of critical development issues of Ghana. The Department is developing this participatory Monitoring Framework for mobilizing critical mass of citizens to engage in the implementation process of public health programmes and projects within the context of the Ghana Public Health Act of 2012, (Act 851). The framework will focus on the organization of citizens at the district level into monitoring teams, sensitizing citizens through public education, monitoring and gathering relevant data, analyzing the data and engaging key stakeholders with the findings of the analysis. The department considers public health as a basic right and holds the conviction that effective disease prevention results in healthy communities and a healthy community is a productive and wealthy community. Hence this effort will form part of the broader campaign on the RIGHT TO HEALTH in Ghana to realize an expanded Bill of Rights in our national Constitution; especially in the category of Economic, Social and Cultural Rights (ESCR).

2. Why Public Health?

The vision of the health sector in Ghana is to create wealth through health and to contribute to the national vision of attaining middle-income status by 2015 with the goal of ultimately ensuring a healthy and productive population that reproduces itself safely. The goal of the sector is being pursued through three interrelated and mutually reinforcing objectives of ensuring that people live long, healthy and productive lives and reproduce without an increased risk of injury or death; reducing the excessive risk and burden of morbidity, mortality and disability, especially in the poor and marginalized groups and reducing inequalities in access to health, populations and nutrition services and health outcomes. Central to the achievement of these objectives is the establishment of an effective public health system and provision of public health services.

Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals. **Public Health is so critical in any nation because it saves money and improves quality of life.** A healthy public gets sick less frequently and spends less money on health care; this means better economic productivity and an improved quality of life for everyone. An effective public health system does not only educate people about the effects of lifestyle choices on their health but also reduce the impact of disasters by preparing people for the effects of catastrophes.

Public health is a multi-disciplinary field which includes professionals from many fields with the common purpose of protecting the health of a population. **These professionals in:**

a) **Emergency Responders**

b) **Restaurant Inspectors**

c) **Health Educators**

d) **Public Policymakers**

e) **Scientists and Researchers**

f) **Public Health Physicians**

g) **Public Health Nurses**

h) **Occupational Health and Safety Professionals**

i) **Social Workers**

j) **Sanitarians**

k) **Epidemiologists**

l) **Nutritionists and**

m) **Community Planners**

Hence, the Public Health Act of 2012, Act 851 which received presidential assent on the 9th of October 2012 is meant to partially contribute towards achieving these health sector vision and objectives by revising and consolidating the law relating to public health to prevent disease, promote, safeguard, maintain and protect the health of humans and animals and to provide for related matters. The act is divided into nine parts. The first five parts focus on communicable diseases, vaccination, quarantine, vector control, and environmental sanitation respectively. The remaining four parts focus on tobacco control measures, food and drugs, clinical trials and miscellaneous provisions.

Except in few sections where district assemblies are assigned specific responsibilities, all powers under the act are reserved for the Minister of Health and any other body can act under any section if authorized by the Minister. Given that public health epidemic can manifest in many forms and can vary in terms of the speed of spread and havoc, one would expect the district and regional authorities to have the power to act swiftly in an emergency before national level intervention. This makes understanding of the infrastructure, the resources and strategies that have been put in place to ensure timely response to public health issues under the act at district and regional levels very crucial.

3. Focus Areas for Public Education

The Act has many parts and sections but not all are relevant for educational purposes especially at the district level. Among these sections, public education is necessary in those that deal with *communicable diseases*, *vaccination*, *vector control*, *tobacco control*, *food and drugs*, *environmental sanitation* and *the Patients Charter* under the miscellaneous provisions.

On communicable diseases, we discuss issues of destruction of buildings and animals; removal and detention of infected persons or disposal of corpse; isolation of contact; compensation and its procedures, and conditions relating to presumption of knowledge of disease.

Issues of compulsory vaccination and conditions under which exemptions are granted as well as the role of the district assemblies in vaccination could be the focus under vaccination. Under vector control, it will be important for education to be carried out on the roles of district assemblies and individual citizens in vector control and the penalties associated with refusal to comply or obstruction and breach.

On tobacco control, public education effort should target the prohibitions of smoking in public places and the meaning of public places under the Act and how tobacco addiction is treated. Food and drugs issues that need focus are conditions under which food for sale and for public consumption should not be prepared, regulations of slaughter houses, transportation of meat for sale and penalty for offenders.

The patients charter with special reference to the rights and responsibilities of patients and diseases for which advertisement for treatment, prevention and cure are prohibited under the miscellaneous provisions could be given particular emphasis in the education process.

4. Focus Areas for Participatory Monitoring

Considering that the Act was assented to only in October 2012, not much has been done towards its application or enforcement. Therefore, our entry point is for us to focus on establishing a baseline on public health issues in the districts, and the strategies and approaches adopted towards addressing public health concerns in the districts. In line with the objectives of this project, the baseline study would focus on:

1. Establishing the level of access to Public Health Facilities in the districts
2. Assessing the level of Stakeholders awareness of the Public Health Act (Act 851) at the District Level
3. Quantifying public health professionals and assessing access to these public health professionals in the districts
4. Assessing the level of stakeholders collaboration on public health concerns in the districts
5. Assessing extent to which district assemblies prioritise public health Issues in their development agenda (plans and resource allocation).

These focus areas for the baseline study are subject to change depending on the appropriateness and relevance.

6. Geographical Coverage

This Participatory Monitoring Framework will be applied in 15 districts across five Catholic Dioceses (Damongo, Navrongo-Bolgatanga, Tamale, Wa and Yendi,) in the Northern, Upper East and Upper West Regions. Thus, data will be gathered in the 15 districts – three in each of the five dioceses and analysed. In terms of the public education, community radio or FM radio stations shall be used. Depending on the coverage of the radio stations, a very large people will be

reached beyond the project focused districts. All Parishes in the five Dioceses totaling 75 as at April, 2013, will also undertake Parish-level education on the Public Health Act.

7. The Monitoring Team

There will be a total of 15 monitoring teams across the 15 districts in the Northern, Upper East and Upper West Regions. Each monitoring team will have a total of 13 members and shall be referred to as Public Health Monitoring Team (PHMT). The monitoring teams will consist of citizens groups (women, youth and PWDs), traditional authorities, religious leaders and led by civil society organizations physically present in the focused districts.

Composition of Team:

i.	DDO's Office / Project Team	- TWO REPS (man & woman)
ii.	Parish Education Coordinator	
iii.	Women's Association or NGO reps.	- TWO WOMEN
iv.	Youth Association or NGO reps.	- TWO (ONE MAN, ONE WOMAN)
v.	District Assembly reps	- TWO (ONE MAN, ONE WOMAN)
vi.	Local (District-based) NGO rep.	- ONE PERSON
vii.	Disability rep	- ONE PERSON WITH DISABILITY
viii.	Traditional Authority	ONE PERSON

ix. Co-opted Person for Gender and Social inclusion consideration.

The Catholic Diocesan Secretariat of each targeted Diocese will facilitate and coordinate the education and monitoring processes within their jurisdiction. There shall be training of trainers workshop for representatives of the dioceses who will in turn cascade the training to the monitoring teams. These teams together with the Diocesan Secretariats will be strengthened to embark on both the public education and monitoring.

8. Follow-up

The Joint Monitoring Team shall gather relevant data in their respective districts. This data shall be analyzed and the findings disseminated to key stakeholders, development partners and citizens. The dissemination may take the form of launching or distribution of hard copies of reports. The report can also be uploaded unto the Ghana Catholic Bishops' Conference (www.cbcgha.org) or a combination of these methods. After the reports have been disseminated, series of dialogue meetings will be held with District Assemblies, District Health Management Teams and other public health sector key stakeholders across all the operational districts or in districts with special public health issues and concerns.

Where necessary, interface meetings with national level stakeholders shall be organized either through the media or through face to face discussions.

9. Baseline Monitoring Checklist

The questionnaire below is the checklist that will be used to gather baseline data for analysis in order to establish the current level of public health service provision in the districts.

9.1. Preamble

In October 2012, the President of the Republic of Ghana assented to the Public Health Act (Act 851) to provide a legal framework for the provision of public health services. ***The National Catholic Secretariat*** *is conducting this baseline survey to establish the current situation of public health facilities and services in this district. This baseline data will then be used by civil society to advocate for the full implementation of Act 851. We highly appreciate your cooperation and support in this exercise. Any information provided will be used for official purposes only.*

QN	Question	Responses	Comment
Indicator 1: Access to Public Health Facilities at the district level			
1.	How many usable public health facilities are available in this district?	1. 5 2. 6 3. 7 4. 8 5. 9 Other (specify)…….	
2.	Group the public health facilities into the following:	1. Healthcare facilities (.....) *(hospitals, health centres, clinics, CHPS Compounds etc)* 2. Sanitation facilities (……) *(Usable public toilets, drainage systems, refuse containers, dumping sites etc.)* 3. Water facilities (……) *(Usable boreholes, wells, dams, small town water systems, mechanized boreholes etc,)* 4. Butchery/Slaughter houses (……)	

		5. Treatment centres for tobacco addicts (……..) 6. Mortuary facilities (……..) 7. Veterinary clinics (……) 8. Non-communicable diseases screening facilities (……) 9. Others (specify)……	
3.	How many communities (according to District Assembly Classification) are in this district?	…… ……	
4.	Out of these public health facilities, how many are in the district capital?	…… ……	
5.	What is the total population of the district?	…… ……	
6.	What is the population of the district capital?	…… ……	
Indicator 2: Level of Stakeholders Awareness of the Public Health Act (Act 851) at the District Level			
1.	Is there an Act of parliament (law) on public health in Ghana?	1. Yes 2. No Don't know	
2.	If your response to question one under **Indicator 2** is yes, do you have a copy of the law?	1. Yes, I do (Check to see) 2. No, I do not 3. I have a copy but I can't find it 4. Someone took my copy Other (specify)……	
3.	Have you had training on the law?	1. Yes 2. No I can't remember	

4.	What role(s) are you expected to play or are you playing under the Public Health Law? *(tick all that apply)*	1.Public education 2.Provision of facilities 3.Providing surveillance 4.Providing quarantine services 5.Food and drugs inspection 6.Vaccination 7.Other (specify)…… …… ..
5.	What effort have you made so far in relation to the roles assigned to you under the law	

Indicator 3: Access to Public Health Professionals in the Districts

1.	Which public health professionals do you have in this district? *Check all that apply*	1. Medical officers 2. Veterinary officers 3. Sanitary inspectors 4. Police officers 5. Public health officers 6. Disease Control Officers 7. Immigration Officers 8. Environmental Officers 9. Other……
2.		1. No. of Medical Officers ( ) 2. No. of Vet. Officers ( ) 3. No. of Sanitary Inspectors ( ) 4. No. of Police Officers ( ) 5. No. of Pub.Health Officers ( ) 6. No. of Disease Control Officers ( )

3.	In which part(s) of the district are these professionals located?	1. In the district capital only 2. In the district capital and the sub district centres only 3. In the district capital, sub-district capitals and other major towns and villages 4. Other (specify)……
4.	How many times in a year do these professionals embark on outreach programmes in the district?	1. Once 2. Twice 3. Thrice 4. Four times 5. Five times 6. Six times 7. Other (specify)……
5.	Are these public health professionals adequately resourced to perform their roles effectively?	1. Yes 2. No 3. Not adequate but they have some resources to perform 4. Yes, but they are not utilizing the resources for the intended purpose Other (specify)……
6.	What resources or logistics do these public health professionals have that enable them perform their roles effectively?	1. Funds 2. Cars 3. Motorcycles 4. Well equipped offices 5. Surveillance ganges 6. Well equipped veterinary clinic 7. Others (specify)……
Indicator 4: Level of Stakeholders Collaboration on Public Health Concerns in the Districts		
1.	Is there a Public Health Team in this district?	1. Yes 2. No Don't know

2.	If your response to Q1 under Indicator 4 is Yes, who are the members of the team? Check all that apply	1. Members of the Social Services Sub-Committee of the Assembly 2. Public health Nurse 3. Veterinary officer 4. Medical officer 5. Police officer 6. Social welfare officer 7. Presiding member 8. Environmental officer 9. Other (specify)…… ……	
3.	How many times does the team meet in a year to review the public health situation of the district? *(Check for the last two minutes or ask for date of meeting)*	1. Once 2. Twice 3. Thrice 4. Four times 5. Five times 6. Six times 7. Seven times 8. Other (Specify)……	
4.	Do the public health professionals embark on joint public health outreach in the district?	1. Yes, always 2. Yes, sometimes 3. No	
5.	How will you describe the level of collaboration among the public health professionals in this district?	1. Very strong 2. Strong 3. Weak 4. Very weak 5. Other (specify)…… ……	

Indicator 5: Level of Priority of Public Health Issues in the District Assemblies Development Agenda

1.	What percentage of the development projects of the district assembly in a year are geared towards enhancing public health?	1. 5% - 10% 2. 15% - 20% 3. 25% - 30% 4. 35% 40% 5. 45% - 50% 6. Other (specify)……	
2.	On the average, how many times in a year do you discuss and take decisions on public health issues at District Assembly sessions? *(Check from minutes of DA)*	1. Once 2. Twice 3. Thrice 4. Four times 5. Five times 6. Other (specify)……	

3.	What percentage of the district assembly annual budget is allocated to the public health sector? *(check the last two annual budgets)*	1. 5% 2. 10% 3. 15% 4. 20% 5. 25% 6. 30% 7. 35% 7. 40% 8. 45% 9. 50% 10. Other .....
4.	How much of the allocated funds to the public health sector is actually disbursed? *(check in expenditure or audit reports)*	1. All allocation is disbursed 2. At least 50% of allocated funds are always disbursed 3. At least 60% of allocated funds are actually disbursed 4. At least 70% of allocated funds are actually disbursed 5. Other (specify) ....
5.	Does the assembly have programme of work on public health in the district? *(check a copy of programme document)*	1.Yes 2.No 3.Don't know
6.	What arrangement has been made to respond expeditiously to emergency public health threat in the district?	

Indicator 6: Major Public Health Concern(s) in the Districts

1.	What is/are the major public health threats in this district?	1. Tuberculosis 2. Yellow Fever 3. HIV and Hepatitis 4. Guinea Worm 5. Cholera 6. Swine Fever 7. Bilharzias 8. Cerebrus Spinal Meningitis (CSM) 9. Other (specify)..... .....

2.	What is the major cause of the public concern in the district	1. Polluted Drinking Water Sources 2. Insanitary Environment 3. Stigmatization 4. Lack of knowledge of the causes of the threat 5. Poor ventilation of homes 6. Other (Specify)…… ……	
3.	In your view how can the public health threat of the people be addressed?		
4.	What measures have been taken to address the public health concerns at the district level?		

10. CONCLUSION

On the basis of the project objectives, the participatory monitoring framework has been designed in a way that it builds adequate and capable infrastructure at the district level to enhance public awareness through public education and to effectively engage in participatory monitoring of public health issues. Particular attention will be paid to organizing citizens, building their capacity and providing leadership for effective education and monitoring on public health in 15 districts and Parishes. The initial monitoring will aim at establishing a baseline on the current status of public health provision in the districts. It will also provide evidence for advocacy on the public health Act in relation to public awareness, government commitment to implementing the act and provision of public health facilities.

Appendixes

1. Pilot Districts for Monitoring
2. Catholic Parishes undertaking Public Education of PHA.
3. FM Radio stations partnering Dioceses for Public Education in PHA.

Parishes for Education on Public Health Act

Yendi

- Cathedral Parish, Yendi
- St Charles Lwanga Parish, Saboba
- Holy Cross Parish, Sambuli
- St Josephs Parish, Bimbilla
- Ss Peter & Paul Parish, Tatale
- Holy Spirit Parish, Chamba
- Christ the King Parish, Gushegu
- St Bridget Parish, Chereponi
- Wulensi Rectorate, Wulensi and Lungni
- Chati Rectorate, Chati
- Sang Rectorate, Sang, Sambu & Bincle
- Wapuli Rectorate, Wapuli

Wa

- St Andrews Cathedral, Wa
- St Cecilias Parish, Wa
- St Benedicts Parish, Wa
- St Ignatius Parish, Lassia-Tuolo
- St Augustines Parish, Kaleo-Chaggu
- Immaculate Conception Parish, Kaleo
- St Josephs Parish, Jirapa
- St Peters Parish, Lawra
- St Catherine of Sienna Rectory, Sabile
- Sacred Heart Parish, Dompwee-Duo
- Queen of Peace Parish, Kaleo
- Immaculate Heart of Mary Parish, Daffiama
- All Saints Parish, Issa
- St Raphaels Parish, Han
- Our Lady of Lourdes Parish, Tumu
- St Thomas Parish, Gwollu
- St Charles Lwanga Parish, Wa
- St Johns Parish, Funsi
- St Theresa of the Child Jesus Minor Basilica, Nandom
- St Mary Magdalene Rectory, Nandom
- Nativity of Our Lady Parish, Ko
- St Georges Parish, Hamile
- St Pauls Parish, Piina
- Holy Family Parish, Hamile
- Nas Kristo Parish Rectory, Nandom

Navrongo-Bolgatanga

- Our Lady of Hope Parish, Bawku
- Holy Angels, Garu
- St Anthony, Zebilla
- Charles Lwanga, Zebilla
- St Pauls Parish, Walewale
- St Thomas Parish, Tongo
- Our Lady of Africa, Bolga
- Sacred Heart Cathedral, Bolga
- St Annes Parish, Bongo
- St Martin De Porres Rectorate, Zuarungu
- St Peter and Paul, Pumbisi
- St Francis Xavier, Wiaga
- Christ the King, Chiana
- Our Lady of Seven Sorrows Minor Basilica, Navrongo
- Martyrs of Uganda, Sirigu
- Christ the King, Sandema
- St Theresa, Paga

Tamale

- OLA Parish, Tamale
- Sacred Heart Parish, Fuo-Kalpohin
- St Theresa Parish, Tamale
- Holy Cross Parish, Chogu
- Ss Peter and Paul, Education Ridge
- Our Lady of Fatima, Kanshe
- St Peters Parish, Bawa Nanton
- St Monicas Parish, Nyankpala
- Vincent Parish, Savelugu
- Our Lady of Fatima, Salaga
- St Kizito Parish, Kpandai
- Blessed Sacrament, Chapel TTH
- Christ the King Parish, Jimbo-Kpandai
- St Arnold Janssen Parish, Kumbungu

Damongo

- St Annes Cathedral Parish, Damongo
- St Theresas Rectorate, Canteen
- St Peter Canisius Rectorate, Busunu
- St Pauls Parish, Larabanga
- St Francis Xavier Parish, Yapei
- Queen of Peace Parish, Bole
- St Anthony of Padua Parish, Buipe
- Christ the King Parish, Tinga
- Martyrs of Uganda Parish, Bole
- Holy Trinity Parish, Sawla
- Good Shepherd Parish, Tuna
- St Marys Rectorate, Kalba

	Yendi	Wa	Nasrunga-Bolgatanga	Tamale	Damongo
Pilot Districts for Monitoring	- Nanumba North District (Bimbilla) - Tolon District Sababa District	- Wa East District Funsi - Nadawli Diaric. Nadawli - Jirapa Diaric; Jirapa	- Gusa Tempane District - Bolgatanga Municipal Builsa District	- Sagnarigu Distric. - Kumbungu District - Kpandai District	- West Gonja District - Sawla-Tuna-Kalba District Bole District
Partner FM Radio Stations for Education on Public Health Act	-Maranatha Radio 96.1 Bimbilla - Radio Gush 88.3 Sababa	- Radio Upper West 90.1 Wa - Radio Progress 88.1 Wa	- URA Radio 98.9 Bolga - Quality Fm 105.3 Gusa	- Radio Savannah 91.2 Tamale - Pillar Fm 89.3 Tamale	- Radio Peace & Development 95.1 Damongo - Radio Upper West 90.1 Wa

Annex B:

NAMES OF PARTICIPATORY HEALTH MONITORING TEAM MEMBERS

KPANDAI DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
ANUADONG STELLA	YOUTH	0208945988
HADIA ABDULLAI	SOCIAL/ GENDER	0205721710
KPGBU BEDIAKU		0249914366
ABDULLAI ABDUL FATAWU	DISTRICT ASSEMBLY	0277751715
NAAYO CHRISTOPHER	DISABILITY	0240526596
ASUNKI SERWAA CELESTINE	WOMEN REPRESENTANT	0248256136
DAREKWASI MOSES	YOUTH	0249334131/ 0200110724
ANYASONG KOFI ANNE	TRADITIONAL AUTHORITY	0246917639
MATTHEW DIMANG	DISTRICT ASSEMBLY	0243888375
MBEMANDONG JOSHUA	YOUTH	0204549977
BRUCE BAGNAM DAM	NCTE	0243262480
NSIADONG ESTHER J.	WOMEN REPRESENTANT	0247807635
GEORGE NINDOW	YOUTH/ PARISH	0209091521

SAGNARIGU DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
LAMPTEY GYAN B.	DISTRICT ASSEMBLY	0506261604
ZAKARIA ABDUL – KASSIM	GHANA HEALTH SERVICE	0203498698
ABDUL WAHAB AWULATU	GUB KATIMA WOMEN GP	0205795897
HAULATU ABUBAKARI	SUGRINUMA WOMEN GP	0243389519
ALHASAN BABA	DEHSUN YOUTH	0240441723
SHAIBU ISSAH	DIDOMSUHUEDO YOUTH	0246033144
ABDUL – GANIU	WUDZA	0246829532
ABUKARI MARIAM	PEOPLE WITH DISABILITY	0541620432
CHIEF MALGU NAA	SAGNARIGU TRADITIONAL COUNCIL	0208025863
HAWA HARUNA	DEPT OF SOCIAL WELFARE	0208237922

KUMBUNGU District Assembly

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
ALHASSAN MOHAMMED	DISTRICT ASSEMBLY	0200233333
HARDI AYISHETU ABUKARI	DISTRICT ASSEMBLY	0208503499
ANISHAWU ANAS BATAARA PRISCA	KUMBUNGU YOUTH ASSOCIATION	0249616723 054243342
ADAM BUKARI	YOUTH ASSOCIATION	0541138447
GRACE YIN	WOMEN ASSOCIATION	0244041958
MWENSO PALLINA ZAKARIA ALHASSAN SULEMANA ADAM	WOMEN ASSOCIATION PERSON WITH DISABILITY TRADITIONAL AUTHORITY	0206736812 0245699033 024433961
ANAMBIAK ELIZABETH	SOCIAL AND GENDER WORKER	0203265004

BOLGATANGA MUNICIPAL ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
STELLA ABAGRE	WOMEN'S ASSOCIATION	
LINDA ATIBILA	YOUTH GROUP	
BEATRICE ISSAKA	NGO(CENSUDI)	0246403118
JOHNSON AWINI	TRADITIONAL LEADER (CHIEF)	
CLETUS ANNAAYA	DISABILITY ASSOCIATION	0208340303
VERONICA BARIK HON. AUGUSTINE ABAMBIRE HON.AGNES ATAYILA	SOCIAL AND GENDER ISSUES ASSEMBLY MEMBER ASSEMBLY MEMBER	0242634967 0200641366
AMOAH DAMIEN ATONGO HERTY	PARISH EDUCATION MEMBER PARISH EDUCATION MEMBER	0205643249 0243976071

BUILSA NORTH DISRTICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
ROBERT ASEKABTA	PARISH EDUCATION MEMBER	0244105355
ALAGPULINSA EMMANUEL	YOUTH ASSOCIATION (CHUCHULIGA)	
AZAAYAM JOSEPH	YOUTH ASSOCIATION (KOLODEMA)	
NAB-APIGJIAK AFULANG	TRADITIONAL LEADER (CHIEF)	0208418199
HON.GILBERT ASEKABTA YAMSA GILBERT	DISABILITY ASSOCIATION PARISH EDUCATION MEMBER	0545462311
MRS ESTHER BABA	RED CROSS SOCIETY	
MRS.CATHERINE APENTIRATIDOK	CHRISTIAN MOTHERS ASSOCIATION	0248223773
AKURUGO BENJAMIN TIAWAN SIMON ABDULAI	DISTRICT ASSEMBLY DISTRICT ASSEMBLY	0200739581 0206413667

GARU-TEMPANE DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
WAHABU AYISHETU	NGO	
ALEX ASASIM	YOUTH GROUP (KUSASI)	0246213776
LILIAN AZURE	WOMEN GROUP	0200501194
HALIDU MUKAILA YUSSIF	YOUTH GROUP (BISSA)	0206634099
BEN GBANWAA	NGO/CBO	0204524518
JUSTICE ABUGRE ALHASSAN	DISABILITY ASSOCIATION	0204524518
A.B.CHIMSA	TRADITIONAL LEADER (CHIEF)	0242614581
HON. ROSE LARIBA ABAKUDUGU	ASSEMBLY MEMBER	0546919133
HON. AKWESI IDDRISU	ASSEMBLY MEMBER	0208391257
JULIANA AWIAH	DISTRICT ASSEMBLY	0209065969

NANUMBA NORTH –BIMBILLA DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
SUGRI SULEMANA	GHANA HEALTH SERVICE	
NASIGRI ABUBAKARI	DISTRICT ENVIROMENTAL OFFICER	
DAWUDA ABDUL FATAWU	ASSIST DIRECTOR –DISTRICT ASSEMBLY	0208562792
ATIA S. EMMANUEL	BIMBILLA HOSPITAL(PARISH EDUCATOR)	0245487502
SUMANI NANTOGMA	TRADITIONAL COUNCIL	
TANA PETER	COMMUNITY DEVELOPMENT OFFICE	
DAVID SUGLO	BIMBILLA HOSPITAL	0208926745
KIPO	ASSIST FINANCE OFFICER	
ALIL ABUBAKARI	ASSEMBLY MAN	
REGINA NAMPUR	BIMBILLA HOSPITAL(PARISH EDUCATOR)	0541620488
AHMED ABDULAI OSMAN	ASSIST PLANNING OFFICER	0200563964
ABDUL RAHAMAN ALIDU	MASS EDUCATION OFFICER	

SABOBA District Assembly

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
PETER TAABAN	SCHOOL FOR LIFE (PARISH EDUCATOR)	0246292488
TINDAAN DUOGLAS	COMMUNITY WORKS DEPARTMENT,SABOBA	0204924897
AMADU S. AGANDA SEIDU SHIRAZU	PLANNING OFFICER DEPUTY CO-ORDINATING DIRECTOR	
ALEX KOJO WUMBORTI	NCCE	0242176940
BAKANTICHE ROSE	GES (PARISH EDUCATOR)	0242081596
OSMAN HALIDU	CHAIRMAN SOCIAL SERVICE COMMITTEE	0207957812
NEINDO EDMUND	MEDICAL ASSIST, SAMBULI CLINIC	0201763397
KEN WUJANGI JACOB BAKANTICHE	IDC DIRECTOR DISTRICT ENVEROMENTAL OFFICER	0244628829
CHARLES NYOJA	JUSTICE AND SECURITY CHAIRMAN	0242177616
ABDULAI ABDUL MAJEED	DISTRICT BUDGETING OFFICER	0240935407

TATALE SANGULI

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
ALHASSAN ASIMAWU	DISTRICT PLANNING OFFICER	0243518915
JOHN NSIAH NAMBO	CHAIRMAN DISTRICT WORKS SUB COMMITTEE	0209425168
ATUBIGA RICHARD	DISTRICT VETINARY OFFICER	0246318341
KWAME BEN ALI	TOWN COUNCIL.	
MARY TAGBA	PRESIDING MEMBER,TATALE SANGULI DIST	0242573170
DENNIS MENSAH		0243389383
GEORGE ABRAHAM	DISTRICT DIRECTOR OF HEALTH	0208161222
BOAKYE NICHOLAS	TATALE POLYCLINIC(PARISH EDUCATOR)	0247534102
MATILDA BETINIM	CHRISTIAN MOTHERS ASSOCIATION	0242560062
TINDA JANET	PARISH EDUCATOR	0249767946
ROBERT B. AWUNI	DISTRICT WORKS DEPARTMEENT	…

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
DOUGHLAS KAN - DUORI	DDO REP., ACCOUNTS OFFICER, BOLE	024-5944429
FR. MARTIN KUUSANGNAYIR	DDO REP., DIOCESAN DEV'T COORD.	020 0261378/024 2512089
MICHAEL GYABURO	PARISH EDUCATION COORDINATOR, BOLE	027-5614129
GRACE TIERWUL	WOMEN ASSOCIATION, BOLE	024-3763919
SR. FELICITES ANGSOAYIR	WOMEN ASSOCIATION, BOLE CLINIC	020-7838205
YAKUBU ABDUL - RAHAMAN	CDO, DISTRICT ASSEMBLY, BOLE	024-8276962
IBRAHIM ALHASSAN TONDE	ENV. HEALTH OFFICER, DISTRICT ASSEMBLY, BOLE	024-6341083/026-9090290
JEREMIAH A. SEIDU	JAKSALLY, DISTRICT BASED NGO, BOLE	027-7333480
JIMAH JAKALA	DISABILITY	024-6220311
EDWARD NOBAYELE	YOUTH ASSOCIATION, BOLE	054 7746064
DAMBA A. RASHID	COPTED MEMBER, BOLE	020-5598304
CHRISTINA	PUBLIC HEALTH NURSE	024-9247106
	TRADITIONAL AUTHORITY REPRESENTATIVE	

WEST GONJA DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP /SOCIETY	CONTACT DETAILS
FR. FELIX KUULAARE	DDO REP., UNITY CENTRE GUEST HOUSE, D'GO	024-6663561
EVELYN NABIA	DDO REP, DAMONGO	024-4441344
FR. CORNELIUS TERMAGHRE	PARISH EDUCATION COORDINATOR, D'GO	020-8915069
GLADYS MORO PETEY	WOMEN ASSOCIATION, DAMONGO	050-7172705
MARY KELLY	WOMEN ASSOCIATION, BUSUNU	
LAZARUS HARUNA	YOUTH ASSOCIATION, DAMONGO	024-7798272
ABDUL - HAMIDTOYIBU	DISTRICT PLANNING OFFICER,	050-8461330
ELIJAH FANT	ADIIB, DISTRICT ASSEMBLY, DAMONGO	020 8397796
JEREMIAH A. SEIDU	JAKSALLY, DISTRICT BASED NGO, DAMONGO	027-7333480
ISSAUAKU ISAAC	DISABILITY	
CHIEF MORNOH	TRADITIONAL AUTHORITY	050-7177413
AJETA HARUNA	COPTED MEMBER	022 43389534
ELIZABETH TINDAANA	PUBLIC HEALTH NURSE	020-7363250

SAWLA-TUNA-KALBA DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/ SOCIETY	CONTACT DETAILS
SR. CHRISTINA POGBEYIR	DDO, DIOCESAN HEALTH OFFICE, D'GO	024-3507423
FRANCIS SUTAAH	DDO, WEST GONJA HOSPITAL, D'GO	020-8679879
LUCILLA DAYUOR	WOMEN ASSOCIATION, TUNA	026-2010277
ESTHER MWIER/THERESA WIA	WOMEN ASSOCIATION, SAWLA/TUNA	026-2009859/026 - 2043886
MWANGU JAMANI JERRY	YOUTH, TUNA	020-7153406/024 - 8476472
ABUBAKARI SADAATU	DISTRICT ASSEMBLY, STK	024 5393605/020 7681137
DAUDAA SADDIQ	DISTRICT ASSEMBLY, STK	054-2829446
JEREMIAH A. SEIDU	JAKSALLY, DISTRICT BASED NGO	027-7333480
SIR ROMANUS T. BORGKUR	DISABILITY, TUNA	020-7352429
TUNA WURA	TRADITIONAL AUTHORITY	026-1716393/024-2555454
REMY F. NYEWIE	COPTED MEMBER, TUNA CLINIC	020-8927670
PARISH EDU. COORDINATOR	FR. ANDREW KUUBA	020-3016401

JIRAPA DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
FULGENCIOUS MWIN-NINGE	DIOCESAN DEVELOPMENT OFFICE	0200335099
CECILIA YUONI	DIOCESAN DEVELOPMENT OFFICE	0208991891
BERNADETTE BACHEYIE	PARISH EDUCATION COORDINATOR	0246160514
EUSEBIA KUUZUING DONGZUING	WOMEN'S ASSOCIATION	0207602874
HYACINTH SALIFU	WOMEN'S ASSOCIATION	0249479088
RICHARD DAKPIR	YOUTH ASSOCIATION	0207093558
RUKYA WUMNAYA	YOUTH ASSOCIATION	0209001251
MORNAH BABA PAUL	DISTRICT ASSEMBLY	0208991891
OSMAN AL-HILAL	DISTRICT ASSEMBLY	0203210800
MOOT ROCHSON	LOCAL DISTRICT BASED NGO	0244765412
BAMUAH TAHIRU	DISABILITY	0208394862
REMY NOORA	TRADITIONAL AUTHORITY	0246323168
THEODORA MWAAMAAL	GENDER AND SOCIAL INCLUSION	0244135879

NADOWLI/KALEO DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
EBENEZER NAAH	DIOCESAN DEVELOPMENT OFFICE	0208073109
DAKUBO JOSEPH	DIOCESAN DEVELOPMENT OFFICE	0248464035
HELENBAGIRO	PARISH EDUCATION COORDINATOR	0208722485
GLADYS CHEYUO	WOMEN'S ASSOCIATION	0243077368
THERESA DABUO	WOMEN'S ASSOCIATION	NIL
KUUBABANG BABARA KIZITO	YOUTH ASSOCIATION	0208392702
DAKUBO ALICE	YOUTH ASSOCIATION	0200640314
MOHAMMED IBRAHIM	DISTRICT ASSEMBLY	0209075722
JOYCELYN F. MUSAH	DISTRICT ASSEMBLY	0207677962
DAVID BAGONLURI	LOCAL DISTRICT BASED NGO	0204367213
DERBIE DOMINICA	DISABILITY	0206686329
DAKUBO JOSEPH	TRADITIONAL AUTHORITY	0248464035
YANGNUU CECILIA	GENDER AND SOCIAL INCLUSION	0209195345

WA EAST DISTRICT ASSEMBLY

FULL NAME	ORGANISATION/GROUP/SOCIETY	CONTACT DETAILS
JUSTIN HOGH BAYONG	DIOCESAN DEVELOPMENT OFFICE	02453373681
MATTHEW DASSAH	DIOCESAN DEVELOPMENT OFFICE	0245643218
EMMANUEL MBANIA	PARISH EDUCATION COORDINATOR	0241374630
KUNDIE ELIZABETH	WOMEN'S ASSOCIATION	024852781
HELEN NWADE	WOMEN'S ASSOCIATION	0543362099
ALHASAN SURAKA	YOUTH ASSOCIATION	0245249233
JAMILA BAWA	YOUTH ASSOCIATION	0246078963
MARTIN TEE	DISTRICT ASSEMBLY	0243804342
ABIBA BENIN	DISTRICT ASSEMBLY	0247113306
JAMES B. DUMA	LOCAL DISTRICT BASED NGO	0243172780
JOHNSON DOGHSORI	DISABILITY	NIL
NWADE KENNETH	TRADITIONAL AUTHORITY	020460774078
RAFIKATA MOHAMMED	GENDER AND SOCIAL INCLUSION	0248655956

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