GAPS BETWEEN SOCIAL SCIENCE RESEARCH AND SOCIAL POLICY IN GHANA: EVIDENCE ON CHILD HEALTH AND NUTRITION POLICIES.

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ABSTRACT

Paradigm shifts in economic development and emphasis on social policy have been one of the responses to failures of economic policies in many countries, including Ghana. But human development and social problems still plague many countries despite these efforts. Subsequently, there has been a move towards universal provision of social services since the beginning of the new millennium after the implementation of market-oriented policies of the 1980s and 1990s, particularly the Structural Adjustment Programmes (SPAs), that led to the removal of subsidies on social services, including health and education. Research has also been an important component of social policy adoption. Demographic and health surveys have been carried out in the developing world and have been intended to be the basis for evidence based policy formulation. Research evidence-based policies have also been regarded as critical means by which development goals can be achieved. But many social problems still plague many countries, including poor health and nutritional status of children. The present study, based on primary and secondary sources of data, examines policies that have been adopted in Ghana over the past three to four decades to promote child health and nutritional status and explains the gaps between the implementation of the policies and research findings. The findings indicate that national surveys that inform policy show average conditions of children and obscure some variations among them. It recommends that micro studies should, therefore, be combined with national surveys for more effective evidence-based policy. It also suggests that the policies that originate from international should be implemented with consideration for the local contexts of the problems that they address.

INTRODUCTION

Failures of economic policies that aimed at development in Africa and other parts of the developing world became evident as poverty levels have persisted or even increased over the last two decades or so in many countries. Paradigm shifts in economic development have been have been one of the responses to the worsening economic and living conditions. New approaches to develop planning and policy adoption have been some of the components of the paradigm shifts in economic development planning.

A common characteristic of the paradigm shifts in development planning and policy implementation, worldwide, has been the gradual shift towards emphasis on social policy. This

trend resulted mainly from the recognition of the unintended negative impacts of economic development on vulnerable persons in society, particularly women and children. Consequently many governments have been adopting social policies to remove some of the effects of economic development on their citizens and also promote better living conditions. The adoption of the Millennium Development Goals (MDGs) at the historic 2000 United Nations Summit is a culmination of efforts at the international level that recognizes the need to address human living conditions in development. The implementation strategies of the MDGs also and lays emphasis on social development. The cornerstone of the MDGs is human development through eradication of hunger, disease, inequities and other conditions that negatively impact human wellbeing.

Research has also been an important component of the efforts being made to solve social problems in this regard. Evidence-based policies have been regarded as critical means by which development goals can be achieved through appropriate evidence-based policy implementation. But human development and social problems still plague many countries despite these efforts.

There has, therefore, been a move towards universal, provision of social services since the beginning of the new millennium after the implementation of the market-driven policies of the 1980s and 1990s, particularly the Structural Adjustment Programmes (SAPs), which emphasized removal of subsidies on social services, including health and education. The SAPs basically promoted market-oriented production and delivery of goods and services, including basic needs such as health and education.

In Ghana, a number of social policies have been adopted and implemented since the 1990s and especially over the past eight years under the Ghana Poverty Reduction Strategy (GPRS) I & II following the recognition of the negative impacts of the SAPs on the population. Ghana has also adopted policies in line with the objectives of the MDGs and other human development goals that have originated from international levels. The Safe Motherhood Initiative, Expanded Programme on Immunization and free health service for children are among some of the national and public policies that have aimed at improving child health and nutrition among Ghanaian children.

Despite these efforts, the health and nutritional status of the Average Ghanaian child remains poor. In Ghana, anthropometric data from the 1988, 1993, 1998, 2003 and 2008 Ghana

Demographic and Health Surveys (GDHS) and other sources indicate that the nutritional and health status of the average Ghanaian child is still poor though some gains have been made over the past few decades. The 2003 GDHS, for example, showed that 22% of all children under five years of age were underweight and the percentage dropped to 14% at the 2008 survey. Almost a third (30%) were stunted and 7% wasted in 2003. While the proportions that were underweight and wasted in 2003 showed slight decline from the 1998 levels, the percentage stunted however increased from 26% in 1998 to 30% in 2003 before declining to 28% at the 2008 GDHS. The proportion that was wasted has however increased to 9% at the 2008 GDHS. The infant mortality rate also rose from 57 deaths per 1,000 live births in 1998 to 64 in 2003, while the under-five mortality rate increased from 108 to 111 (Ghana Statistical Service (GSS) et al. 2004:13-14, 1999:118-122, 2009: 139, 183). The results of the Multiple Indicators Cluster Survey, 2006 indicate that the Infant Mortality Rate (IMR) is still gradually increasing and was 71 deaths per 1,000 live births; and the under-five mortality rate has remained at 111 deaths per thousand live births. The proportion of children who are exclusively breastfed has remained at about the same level; 53.4% at the 2003 GDHS and 54.4% at the Multiple Indicators Cluster Survey, 2006. The results of the 2008 GDHS have however shown that the levels of infant and child mortality rates declined further and are now 50 and 80 respectively at the survey.

The present study examines the policies and programmes that have addressed child nutrition and health over the past one-and-half decades and the research evidence that have informed them. It is in four parts. The first part discusses the main sources of data and information used in the study. The second part discusses the policies and their implementation. It is followed by the discussion of the gaps between the policies and the research. The fourth section is a summary, conclusion and recommendations.

DATA SOURCES

The study used three main sources of both primary and secondary data and other information. The primary source of data is a study on child care and the associated nutritional and health status among children of Ewe migrants in the city of Accra that was carried out between 2003 and 2006. It was part of the author's Ph.D research work.

The main secondary sources include the Ghana Demographic and Health Surveys (GDHSs) of 1988, 1993, 1998, 2003 and 2008 and the Multiple Indicator Cluster Survey (MICS) carried out by Ghana Statistical Service. Others are studies on gendered family strategies and responsibilities of grandparents in Sub-Saharan Africa by Oppong (2004) and Awumbila's (2003) study on social dynamics and feeding practices in northern Ghana, among others.

SOCIAL POLICIES ADDRESSING CHILD NUTRITION AND HEALTH

A number of social policies have been adopted to address the nutritional and health problems of children over the past four decades and especially since the 1990s. The earliest initiative, the Maternal and Child Health (MHC) policy and the Ghana National Family Planning Programme (GNFPP) were components of Ghana's Population Policy that was adopted in 1969 and revised in 1994. The GNFPP was launched in 1970, a year after the adoption of the population policy. The MHC policy has a number of programmes such as the Expanded Immunization Programme that was launched in the mid-1980s. Major policies adopted to address child nutrition and health since the 1990s include the Safe motherhood initiative and Exclusive Breastfeeding Policy. The MCH has since the mid-1990s been implemented under a new name, Reproductive and Child Health (RCH) policy, following the recommendations of the 1994 International Conference on Population and Development (ICPD) which was held in Cairo. The official document of the ICPD, Programme of Action, recommended that the scope of the hitherto family planning programmes be expanded to incorporate human rights and development issues, making fertility issues integral parts of development agenda.

More recent policies adopted to promote child health and nutrition include the Safe Motherhood Initiative and the Exclusive Breastfeeding policy. Both policies aim at improving further the health and nutritional status of mothers and children as the achievements of the previous two decades were followed by a stagnation in the child health and nutritional status (Ghana Health Service 2008).

The Safe Motherhood Initiative has its origin in the international efforts that address women issues in population and health matters. It was adopted at the ICPD and hammered at the International Conference on Women held in Beijing in 1995. By its implementation strategies, the health of children is expected to be improved as mothers are provided with adequate maternal

services and assisted throughout the nine months of pregnancy with health and other services so as to have healthy pregnancy outcome. In this regard children's health, which is directly linked with their mothers', is also promoted. In 2005, as a component of initiatives that aimed at reducing high maternal mortality rate in the country, Ghana introduced a free delivery service in all health facilities.

The Exclusive Breastfeeding policy aims at improving infant nutritional status through six months of exclusive breastfeeding for the first six months of infants. Exclusive breastfeeding provides infants with their required nutritional needs and afford them protection against infections and other diseases as their immunity against diseases is enhanced through exclusive breastfeeding. A component of the Exclusive Breastfeeding policy is a concession given to lactating mothers who work in the public sector to work half-day upon resumption of work from a three-month maternity leave until their infants are 12 months old. The objective of the concession is to allow mothers to continue exclusive breastfeeding up to six months.

THE IMPLEMENTATION OF CHILD HEALTH AND NUTRITION POLICIES AND THE RESEARCH POLICY GAPS

Since the adoption of the MCH and the family planning programme, child health and nutrition education has generally been a component of antenatal and post-natal services in health facilities. Community health services have been delivered in some selected geographical areas where deprivation and lack or limited access to health facilities and services contribute to poor general health conditions.

Antenatal and post-partum attendance offered in public health facilities by the Ghana Health Service (GHS). According to the 2006 MICS, the attendance rate of antenatal clinic was 96% and 90% in urban and rural areas respectively but only 41% of deliveries were assisted by nurses/midwives and doctors assisted with 9%. The rest were by trained (21%) and untrained (10%) Traditional Birth Attendants (TBAs) and others. The percentage of children exclusively breastfed was 55%.

There are some percentages of women who have limited financial access to health services but with the introduction of the free delivery service, a lower percentage of pregnant women may not be reached with health information at public health facilities.

There are still some women who are care givers to children who have not been targeted for child health and nutrition education. They include grand-mothers and other extended family members who foster infants and children. The various GDHSs, MICS and the studies by Oppong (2005, 2004), Awumbila (2003) and Badasu (2009, 2004) indicate that some significant percentage of infants and children are raised by persons other than their biological parents. Table 1 shows the percentage of children who were not living with their biological parents as reported at the 2003 GDHS and the 2006 MICS.

Table 1 Percentage of Children Not Living With Biological Parents

Age in (years)	2003 GDHS	2006 MICS
< 2	0.7	5.2*
2- 4	8.1	5.2*
5- 9	14.7	15.3
10- 14	19.5	19.5
15- 17	19.7	19.3

*** Average for ages 0- 4.**

Source: Ghana Statistical Service 2004: 237, 2008: 178

Fostering has been a traditional practice in most West African countries, including Ghana, as a means to maintain kinship ties and for crisis situations such as death of parent(s) or divorce (Goody 1975, 1982). This practice is still prevalent (Ardayfio-Schandorf 1996).

Badasu's (2004, 2009) studies also indicate that a little over six percent of all the children aged under-five years studied were not co-resident with their parents. See Table 2.

Table 2 Living Arrangements of the Ewe Migrant Children

Living Arrangements	Number	Percent
Mother and father	104	64.6
Mother only	40	24.8
Mother's mother	7	4.3
Mother's sister	2	1.2
Other	8	4.9
Total	**161**	**100.0**

Source: Badasu 2009: 148

A common feature of the living arrangements of the Ewe children also was that both the child and mother were part of a household whose head was not the mother of the child. Table 3 illustrates this.

Table 3 Household Headship by Residential Area, Percent

Household Head	Low	Middle	High
Father	55.1	75.7	82.1
Mother	24.5	13.5	3.0
Mother's Mother	20.4	8.1	1.5
Other Relative	-	2.7	13.4
All	**100.0**	**100.0**	**100.0**

Source: Field Work 2004-2005

As can be seen from Table 3 between 15% and a little over 20% of the Ewe children were part of households of which none of the parents was a household head. Mother's mother constitutes the largest percentage of the heads of such households. In such households, the health behaviours and other child care behaviours of the non-biological parents of the children can positively or adversely affect the health and nutritional status of children.

According to Awumbila (2003), grandmothers exert some influence on young mothers in their households regarding breastfeeding practices. They encourage them to practice traditional behaviours that are different from conventional practices that are taught at antenatal and post natal clinics.

The probability of young mothers accepting the instructions of the elderly women is high under conditions under which some of them reside with them. Early childbearing and also outside marriage characterize the reproductive behaviour of most teenage and young mothers.

Oppong's (2004) study indicates that grand-parenting among African grandmothers is largely a result of premarital births which are becoming the responsibility of the mothers of the young mothers as their sexual partners fail to accept responsibility for the outcomes of their sexual relations. In several previous and more current works, Oppong discussed the role of grandmothers and other kin as an important component of social capital for social reproduction. The more recent burden of care on grandmothers is more of response to crisis rather than the institutionalised. The Badasu's (2007) study also indicates that young mothers face the responsibility of caring for their children alone as some sexual partners fail to accept responsibility even for the pregnancy. In her study, the paternity of 5% of the 208 children studied was not determined and for that reason the parents of their mothers have taken responsibility for the children. Some of the mothers were being cared for by the mistresses with whom they were living and learning some vocation before they got pregnant.

Some of the grandmothers who are supporting their children to care for their infants are working mothers. There is, however, no recognition of this in the labour law of Ghana that may result in adoption of a policy that can grant them something equivalent to sympathy leave or the half-day working hours that has been granted to nursing mothers.

Another dimension of the role of grandmothers in child care was examined by Badasu (2007) among Ewe grandmothers that were giving postnatal care for mothers and their children in Accra. The grandmother's notion of neonatal care differed from the conventional perspectives delivered at the public postnatal clinics. Some insist on avoidance of some foods during pregnancy. Others emphasize practices such as bathing children in certain ways to make them look beautiful and socially acceptable. Some also prescribe very hot water for bathing them and the use of soap for their face. Feeding children with hot spicy food was also being practised by some grandmothers. They explained that a child must get used to such food and join the family meal early.

It can be concluded that the education on child health and nutritional status excludes some child care givers because they are not attendants of the antenatal and post-natal clinics. Meanwhile,

their care behaviours contribute to the development of the children in their care or whose mothers they influence. Offering the education at community level will be more effective since child care behaviours contribute to chid nutritional and health status an indicated by recent review of child development (Berggren 2002), just as does cultural practices (Baataar 2004, Brabin 2001).

With respect to breastfeeding, the study on the Ewe children by Badasu (2009, 2004) found that short maternity leave and maternal and occupational role conflicts prevent almost all the mothers of the children who were professional and career women from practising exclusive breastfeeding up to six months, though they know the benefits. Some could not even take advantage of the half-day work schedule till their infants were one year old because of vehicular traffic that makes them spend more time to and from work.

CONCLUSION

Various policies and programmes have been adopted to address child nutritional and health status in Ghana. The earliest policies and programmes were and remain components of Ghana's national population policy and health delivery. International recommendations have been depended upon in the formulation and implementation of most of them. Indeed, international consensus has contributed to the realization of political will, that is required to address issues concerning children.

Failure and the modest achievement of the policies have necessitated the adoption of social policies to address children's health and nutritional conditions. Clearly, the gaps in policy and research, as this study identified, can be a major setback in addressing children's health and nutritional status in Ghana. Research has produced evidence for policy adoption but the research endeavors have focused on macro analysis and, therefore, failed to provide evidence on the variations of the conditions of health and nutrition of some segments of the children's population as well as their parents and/or care givers. Qualitative approaches and micro studies are indispensable for realization of evidence-based policies. Moreover the local contexts within which policies are being implemented must be recognized. Good policies fail because of recognition of the cultural and social contexts that conflict with them. The recognition of the role of grandmothers is long overdue.

Some of the local conditions that have more or less been ignored are not entirely negative so far as their impacts on child nutrition and health is concerned. A good example is fostering that forestalls the deficits in parental care for biological children. The failure to acknowledge the practice, however, has meant that some conventional information on child health and nutritional is not delivered to the care givers of the children, both primary and secondary child care givers. The role of grandmothers also goes beyond passive care for children. Decision-making on breastfeeding and other areas of care is influenced by the older female members of households but they are not exposed to the recommendations on these practices by conventional health practitioners.

For many young adolescent or young mothers, support for child care, both material and time are from their own mothers. The dependence on them requires some level of submission to their preferences. Community-based education on child health and nutrition that targets grandmothers and foster parents can be adopted in addition to clinic-based approach.

For career and professional women, flexible work schedules may be a better option for them that the concessions that are given to all mothers regarding breastfeeding.

Closing the gaps between evidence-based knowledge and policy adoption requires that all players in the provision of children's nutritional and health needs are targeted for better achievement of policy implementation.

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