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Editorial

Sodzi Sodzi - Tettey

MESSAGE FROM THE PRESIDENT

The year (2013) under review saw the Ghana Medical Association tackle several issues including the following:

SINGLE SPINE PAY POLICY:

A. Market premium outstanding – the gma successfully was able to bring closure to the issues the market premium. Indeed payment of market premium based on 2012 basic salaries started in May 2013 together with arrears. Payment of arrears was effectively completed in September 2013.

B. Conversion Difference: is still outstanding and is currently before a High Court in Accra.

UNDERGRADUATE & POSTGRADUATE MEDICAL EDUCATION: The Ghana medical association raised concerns about dwindling government support for post graduate training and the impact it was likely to have on quality of health care in Ghana. A position paper was submitted to the minister of health on the way forward for postgraduate medical training in the country. Concerns were also raised on the gradual making of all medical schools in the country fee paying and the likely effect it will have on people who want to pursue medical education but have limited resources.

NHIS – CAPITATION: the 13th annual public lecture was dedicated to the issues of National Health Insurance Scheme (NHIS) and Capitation, the theme was; NHIS CAPITATION POLICY-EFFECT ON END USER AND PROSPECTS FOR NATIONAL SCALE UP. it became apparent that the issue of late payment of claims by the NHIS is still persistent.

FUTURE: We must plan our Pensions the 1st day we start work because it appears that state cannot take care of us. We must remember that one cannot get rich so easy as he or she works for somebody or government.

For the Association, we need to take pragmatic steps to start developing our plot of land at OKPONGLO.

I take this opportunity to wish all doctors a successful Conference.

Dr. Kwabena Opoku-Adusei
President

Starletter

I think I speak for many doctors in saying that the MDC often appears aloof and high-handed in its dealings with doctors (epitomized by Dr. Atikpui's infamous "sue them" rhetoric not too long ago). On a couple of occasions, the Council has missed opportunities to explain some of its actions which unfortunately gave the impression that the MDC was more interested in moneys it receives, than ensuring the country has quality doctors.

Two instances suffice:

1. when the MDC inexplicably refused to accept for CME/CPD points evidence a doctor presented of having participated in a continuous professional education event for which the MDC had not directly received payment. (e.g. residency programme activities; special training courses; internationally recognized training programmes; specialist society academic sessions etc).

2. at the time the Council was functionally suspended, and no CPD/CME events could be accredited, the MDC which had been stressing the necessity and rationale for continuous professional development demonstrated readiness to register CPD-less practitioners, as long as fees were paid ("forget CPD...are you paying?")

Currently, accreditation of CPD/ CME points for an event requires disclosing how much participants are being charged, among other things, all of which are used to determine the fees to be paid to the MDC, and the number of points awarded. This means that we indirectlypay the MDC for every MDC-accredited CPD event we attend. So this seemingly-arbirtrary increase from GH¢80 to GH¢200 is like a slap in the face.

As a democratic principle of accountability and fairness, doctors also have the right to know the basis of deciding on GH¢200.

Without a justifiable basis, then why not GH¢ 500? In fact, why not GH
¢1,000?

I suggest we officially request the MDC to brief doctors on this pressing need to increase retention fees by 150%. (on an optimistic note, could it be that they have decided to stop charging course organizers for CPD accreditation?). It's not that they need ourpermission, obviously, but as a principle of fairness and accountability. Here's an example: the UK's General Medical Council actually takes its time to explain what the retention and registration fees are used for. (... this year they even REDUCED the fees!) http://www.gmc-uk.org/doctors/fees.asp

Until the MDC officially justifies the need for this increase, I suggest a general boycott of these new retention fees.

Otherwise if this increment stems from a "We are doing it because we can" mindset, then NOTHING stops them from demanding another 150% rise
(i.e. GH¢500) next year, and again in 2014 (GH¢1,250)!
Maybe this GH¢200 is just to test the waters.

Maybe when the Council debated the issue, someone predicted: "Oh, don't worry, initially a few people will make noise. But by 31st December, thanks to Christmas goodwill and registration

panic, there'll be across-board compliance, and our barns will be overflowing" (I heard someone calculate GH¢ 1,000,000). Is that the case?

The JDA intends to raise this matter at the GMA's NEC meeting sometime this week, just in case GMA executives are unaware of this development (you will recall that a member 'stumbled' upon the new figures while attempting early registration).

It may be true, as Dr Atikpui is alledged to have declared, that MDC does not to seek our agreement before determining amount for retention fees. But then again, WE also have to agree to pay. Why do you think the government doesn't just decide to slap the citizenry with 50% VAT, just because it legally can?

DEAR COLLEAGUES,

I have followed with keen interest discussions on the goggle site after appearing before the Public Accounts Committee and noted that discussions have been grossly misplaced. I, therefore, found it necessary to provide colleagues with the facts.

1. The Audit report considered by the PAC was the 2009, 2010 report and neither 2012 nor 2013.

2. It presupposes that the fees referred to in the said documents were reviewed fees in 2007 which took effect from 2008.

3. Unfortunately, colleagues on the goggle site have devoted themselves on increases made in 2012 which took effect from 2013 –

Fees paid in November/ December, 2012 were fees paid towards retention for 2013. The question then is whether or not these fees had received parliamentary approval? The simple answer is YES.
I wish to refer colleagues to Fees and Charges Amendments Instrument, 2012 (LI 2191)
To make things easier for commentators, I have scanned and attached the cover page of the LI and corresponding pages which pertain to MDC fees page 33.

Those who wish to further satisfy their curiosity may visit the Assembly Press and procure copies. Other correspondence between the MDC and the Ministry of Finance and Economic Planning in relation to the approved fees may be accessed at the MDC Secretariat or the Non-Tax Revenue Unit of the Ministry of Finance and Economic Planning.

My humble advice to colleagues is to ensure that facts are obtained and critically analyzed before jumping to making derogatory comments.

Thank you.
Dr. Eli Kwasi Atikpui
Registrar

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Please include your name, address and phone number. Letters may be edited for clarity and length.

Lamentations of A...

Every human needs a measure of respect. Yes respect! But that is a far cry from what I experienced on a daily basis. I remember vividly how I used to enjoy the swimming lessons. My swimming instructor told me that the ideal condition was for me to learn those swimming skills for a full nine months. She started by teaching me the normal breast strokes and then the back strokes. I thought I had qualified to do the diving skills where I could roll and enter with my head. No, you are not yet ready for the engagement,..... engagement?...Nice word huh!

She also mentioned that until the full nine months I had no business releasing my anal sphincter into the swimming pool. "You will swim in it like that" was how she ended that stern warning. I really enjoyed that pool because I got everything from it. You name it! Food was not a problem. What was intriguing about the food was that I didn't need to swallow. By some miraculous way, it passed through that tube which also helped me to breathe under that pool. So far as that tube remained patent, voila! Life was sweet!

Food and air were not the only thing I miss about that swimming pool, the milieu temperature was optimum. Ahhba! Nothing beats those good old days. To crown it all, I also enjoyed RESPECT! My instructor carried me tenderly and gingerly wherever I wanted to go. Because she was in charge of the breathing tubes, I only needed so much as a kick and she will respond in a very kind and respectful manner. Those were the "better than ever" moments.

Then it suddenly happened!
I think it was my instructors fault. Why?, she started drinking too much water because she wanted to maintain my pool. I know that because I once took a peep downwards and realized how huge her feet have become. I whispered to her to limit her water intake but she wouldn't have it. I was so excited when she was told to put a stick in her urine to see if she was not drinking herself to death. When I look into the doctors eyes I could see beyond that smile, a thick wad of worry- something that gave way to leaps of joy when I saw her arm being wrapped up. I continued my earnest prayer as the kafu.... Kafu sound went on until the hissing sound rattled me awake. At long last, the fluid is being drained from my instructor's hand I imagined. Yaay!!! I screamed, soon the legs will also be wrapped and everything will be fine.

The next thing I heard was a mumble of some letters being high..... I think it was B...P and that my swimming lessons needed to be cut short. Oh but I have two months more to go but the "who cares" looks from that doctor told me to zip it up.... And so I did.

Frankly, I don't recall any of the events that took place after that. What I remember vividly was that same doctor holding my leg

with my head facing downwards rubbing my back. To my rudest shock, the whole room burst into laughter and "thanks be to God" resounded loudly when I started to cry. "This is plain nuts"! I thought.

Then came the woman in green with that funny scarf who took me and poked some tubes into my nostrils. " the suctioning went well" was her response when asked how I was doing. I was put on a flat pan and a shout of 1.1kg heard. I also heard about something K and before I realized, a very sharp pain tore through my thigh. What annoyed me most was the genuine smile she wore as she inflicted that pain on me. My shouts of "sadist, sadist, stop her" did not even turn heads.

Are all these people deaf? I soliloquized. How come they all seem so indifferent about my ordeal? In the mist of my confusion, four letters caught my attention...N...I....C....U.

I tried to smile at the nurse enroute to NICU but she quickly covered my face for reasons best known to her. The hostile nature of the environment was palpably clear.

It was at NICU that I really understood the definition of nightmare!

My first encounter was with this nurse who, without giving a hoot about my privacy, tore the cloth wrapped around me and insisted on checking my weight. My shout of 1.1kg meant nothing to her as she placed me on another scale. "Oh my God, not again" was my prayer as she pulled out this scary green needle and pulled my left foot toward her. The jab was unquestionably more painful than anything imaginable. Hypoglycaemia was her scream as she stared down that little machine. In an instant a young doctor appeared and without a word to me, carried me to another room where there were a lot of my compatriots. I couldn't believe my eyes since I instantly became a movie star with all eyes focused on me. I still hear the loud " fresh meat" chants that greeted every cry from me in response to the numerous ravaging pierces from that long needle with yellow heads. The guy next to me opened one eye and encouraged me to brace myself up for the storm from those "evil witches".

I could feel the gush of some water running through my veins ... And truth be told I really felt good about that water.

They then transferred me into my prison after sticking some tubes into my nostrils. This is one of the most uncomfortable experiences I had to learn to live with for days. That gush of air through that narrow tube was the most uncomfortable feeling imaginable but anytime I pulled it out a loud piercing noise went forth and one of those jerks appeared to adjust it. Sometimes they suctioned me before adjusting it and boy! I hated those moments.

Feeding time was also another wahala period. Initially they passed a tube through my nostrils and pushed some milk into my stomach. What really annoyed me was the fact that they gave me0.5 Mls when I could gulp down 20mls. I used to doubt whether these people were really humans as the starvation continued until they were happy to give me more! Yes it was their happiness and never mine! Sometimes as a sign of protest I vomited most of their food out, a strategy I quickly learnt to discard because it always led to me being starved for hours on end.

Lack of respect epitomized my stay. Nobody respected my time lines. It was a common practice to wake me up anytime they liked. Irrespective of the time of day, somebody always woke you up under the guise of checking on you. For some reasons, these people refused to accept that I am entitled to sleep in whatever position I chose. They always opened my prison door to adjust my foot when I slept with it raised. Nobody warned me ahead of time when a procedure was to be done on me! Do these folks have any manners at all?

The few times I enjoyed myself in NICU was when I will defecate intentionally all over myself and watched with utter amusement as they struggled to clean my poops, yes my pupu! I also learnt to enjoy the number of times that I pulled my cannula out and they spent countless hours trying and wasting those cannulae. I had developed thick skin then and didn't care the number of times they poked me.

It was funny when they tried feeding me with that tiny spoon. I will intentionally keep the food in my mouth and then spit it all out again. Then they will quickly catch it with the spoon and put it back again. Oohhh that was fun. Perhaps what kept me going was the way I used to laugh at how they appeared gazing through my transparent prison walls. My first experience was not funny though. I opened my eyes and saw some big protruding eyes staring at me. That was not as bad as when they flashed those giant 32 at me. My heart raced as those giant hands reached into my prison and pulled me out. Then I realized that the transparent walls had distorted their faces and the shape of their heads. Later though, that afforded me an avenue to enjoy my prison which they called an incubator. My hobby then became giving names to those "aliens" and fashioning out the type of planets they came from. The most caring of them was the one I nicknamed Venus because I really thought she came from there. With the coarsest of voice, she will try to sing to me and sometimes I could feel that she was talking to me. The only hitch was that I didn't speak gibberish then. That notwithstanding, this alien really had time for me. Every three hours she will be there to do that disgusting act - squeezing that "thing"into a cup. In fact the day I got to know that they were passing that "thing" through the tube into me, I quickly pulled it out. Sadly they re- passed it and I have not regretted since then. As time went on I really looked forward to her coming. I knew that this was another angel sent by God to make me happy.

My perception about these people changed the day I saw them rejoicing when it was announced that my weight had gone up. I saw a tear drop from Venus which almost broke my heart. From thence, I viewed every action performed on me as an act of kindness and then it dawned on me that these aliens have all been working hard to ensure I survived. It also dawned on me that Venus is the same as my swimming instructor and all these aliens are a team of doctors and nurses trying hard to save me and my compatriots. What experience I have gathered afterall I just narrated my transition from fetal life to that of a premie.

LET THERE BE LIGHT, AND THERE WAS LIGHT

To make things happen leaders need power. Many of our leaders make promises and resolutions that do not see the light of day because they have no power. Power, simply defined is the ability to get someone else to do something you want done. The sources of power for managers and leaders are recognized as the sum of Position power and Personal power. The two should combine to give the leader the ability to say 'Let there be light', and workers will rush to make sure 'there is light'.

Managers should recognize and develop their own power to coordinate and support the work of subordinates. We should all remember that it is powerlessness, not power, that undermines organizational effectiveness.

POSITION POWER

One important source of power is a manager's official status or position, in the organization's hierarchy of authority. Even though in theory anyone holding managerial position has power, how well it is used determines how successful implementation of policies will be. It varies from person to person .Three bases of position power are reward power, coercive power and legitimate power.

Reward Power is based on the ability to control rewards and resources. It is the capacity to offer something of value to a worker to do what you want them to do. Examples include pay raises, bonuses,promotions,special assignments, and verbal or written compliments. In these days of scarce resources, many managers are unable to say 'If you do what I ask, I'll give you a reward. Most people are appointed to positions without access to direct control of some organizational resources. An example is sometimes heads of departments are appointed and their hands are tied. The bureaucracies that are required to even buy drinks for workers at a meeting make the person incapable of exercising some form of Reward power. To have the power to ensure that workers do overtime so that important deadlines are met, managers need to use reward power if they have it. In the health system, overtimes are required because of shortage of staff or increased number of patients. Managers and leaders should look at how to influence by exercising their reward power. Unfortunately, some greedy managers may not

use the available resources to exercise reward power, instead the will consume the available resources alone.

Coercive power is based on the ability to control punishments. In these days of 'protocol' students and workers how managers in health can comfortably use coercive power? Some managers even fear some workers because they are untouchables and are above the organizational laws. Managers should be able to say 'If you don't do what I want, I'll punish you.' If you ever seen a manager who has been compromised by sexual relationships and bribery at the workplace, you will be sure he cannot dare to say such a managerial sentence to some of the workers. In workplaces where managers do not use coercive power, workers are unproductive and exhibit bad attitudes. The health system managers should begin to look at their documents on the required code of conduct. Many of the codes do not work because the senior officers themselves break them with impunity and are in no position to enforce the code.

Legitimate power is based on the control of formal authority, the right to direct the activities of other people in subordinate positions by virtue of one's status or organizational position. This power needs to be looked at more carefully by the health system. Some appointments make it difficult for the manager to say 'I am the boss and therefore you are supposed to do as I ask'. Their qualifications, knowledge and experience are lower than their subordinates! Their legitimacy is question daily by subordinates. Appointments in District Health Directorates in relation to hospitals as well as appointment of heads of departments should be examined in the way we manage legitimate power.

PERSONAL POWER

This power derives from attributes rather than position. It is the unique personal qualities that a manager brings to the workplace. Without personal power implementation becomes difficult and subordinates find it difficult to obey their manager. This is a very important source of power because a truly successful manager cannot do without it.Two bases of personal power are expert power and referent power.

Expert power is the ability to control through special expertise and knowledge. It is the capability to get other people to do what you want them to do because of your recognized experience, understanding and skills. Square pegs in round holes do not win the day. Subordinates and colleagues must recognize the power to allow it's usage by the manager. I am talking of task relevant knowledge and skills. The person should be willing to admit when personal expertise is insufficient and to recognize and respect the expertise of others. Expertise derives from the possession of technical know-how or information pertinent to the issue at hand that others do not have. This is developed by acquiring relevant skills and competencies as well as gaining a central position in relevant information networks. Imagine a manager trying to change a bad practice in midwifery and showing absurd ignorance on the subject. Most of the midwives will continue in their wrong ways. This is because sometimes managers have to explain the concepts behind new policies to influence compliance. Ignorance of the manager may be used to infer that the policy is wrong or inappropriate.Appointing managers who are ignorant of the relevant information required for executing the core task of the health systems and institutions will definitely make implementation ineffective. The credibility of the manager is at stake any time situations that call for relevant knowledge occur.

Referent power is the ability to control through admiration and idenfication. Workers should comply because they admire and identifypositively with the values of the manager. It is always easier to work with people and get them to work

well with you when they like you.At the lower end of the continuum of admiration is an approachable leader and at the upper end is a charismatic leader. Managers must develop good interpersonal relations that generate the admiration and respect of others. Values like integrity, honesty, sincerity, courage and humility are some of the attributes that generate referent power. Abrasive, intimidating and bullying managerial styles depletes the manager of referent power. Also, Cold, aloof and arrogant managers tend to have very little referent power.

INFLUENCE

Influence is the behavioral response to the use of power. Compliance by workers is a temporary response that involves acting in a desired way as long as the power source is visible. This is associated with the use of reward, coercive and legitimate power. A manager using only position power will notice that workers only work when he or she is around.

Identification is a longer lasting response that involves workers acting in the desired way as long as the power source is viewed positively. This is associated with the use of referent power the person should be willing to admit when personal expertise is insufficient and to recognize and respect the expertise of others. Internalization is the ultimate worker response desired by every manager. It is the long lasting that involves workers acting in a desired fashion because of a personal belief in its value or appropriateness. This is associated with the use of expert power being added all the other sources.

EMPOWERMENT

Empowerment is the process through which mangers allow and help others to gain power and achieve influence within the organization. One can only empower if he or she has the power. Good managers empower the people with whom the work. They realize that when workers feel powerful, they are more willing to make decisions and take the actions needed to get their jobs done. They know that power in organizations is not a zero-sum quantity, that is, for someone to gain power it isn't necessary for someone else to give it up.The more power you give away, the more you have. I know that this can be a difficult concept to grasp for traditional authoritarian managers who see empowerment as a threat to their authority and feeling of being in control. Indeed, to master the complexity and challenges of today's health system, our success may well depend on how much power can be mobilized throughout all levels of employees. We must also remember that no amount of empowerment and supportive management can overcome dish onesty,untrustworthiness,selfis hness and inadequate skills.

In conclusion, managers in our health system should try to gain power .The 'Pull Him Down' Syndrome should give way to empowerment. Managers should create environments of cooperation, information sharing and shared ownership of goals. They should have the courage to encourage others to take initiative, make decisions and use their knowledge. When problems arise, they should find out what others think and let them help design the solutions. Above all, they should have the power to sometimes stay out of the way, and let others put their ideas and solutions into practice.

Jokes! Jokes!!

PREGNANCY Q&A

Q: Should I have a baby after 35?
A: No, 35 children is enough.
Q: I'm two months pregnant now. When will my baby move?
A: With any luck, right after he finishes university.
Q: What is the most common pregnancy craving?
A: For men to be the ones who get pregnant.
Q: What is the most reliable method to determine a baby's sex?
A: Childbirth.
Q: Is there anything I should avoid while recovering from childbirth?
A: Yes, pregnancy.

MISS-DIAGNOSIS

A man comes into the labour ward yelling, "My wife's going to have her baby in the taxi!" The doctor, desperate to help the lady, grabs his stuff, rushes out to the first taxi, lifts the lady's dress, and just finishes jerking off her underwear when he looks at the lady's shocked face. The doctor then realizes his blunder.
There were several taxis lined up and obviously he was in the wrong one!

AMBULANCE

A resident was on his daily rounds and was examining a new patient who was an elderly man. The resident started his examination by asking the patient, very politely, "What brought you to the hospital?"The old man replied, "An ambulance."

DROPS FOR THE RIGHT EAR

A woman once went to the ENT clinic with her crying baby. The doctor determined right away that the baby had right otitis media. He wrote a prescription for oral antibiotics and ear drops.
He wrote on the prescription "Put two drops in R ear every four hours"

The woman returned to the doctor after several days and complained that the baby still had an earache, and his little behind was getting really greasy with all those drops of oil.

The woman continued, "the dispensing technician said I should put 2 drops into the rear opening every 4 hours. Here is the prescription"
The doctor was confused.
He looked at the prescription and realised he should have written the word right in full.

TOOTHACHE

Patient: My tooth aches. I want you to check it for me
The Dentist comes forward with his instruments and the patient starts screaming.
Doctor:I have not even touched your tooth
Patient: But you are stamping on my foot

SEMEN ANALYSIS

There was this guy that went to the doctor to get his sperm counted. The lady behind the desk handed him a jar and said, "Bring it back tomorrow, full." He says, "Okay, I'll be back tomorrow then." Well he goes home and comes back the next day, and he hands the woman the jar. She says, "Nothing's in it." The man responds, "Well, I went home and I tried with my right hand and I tried with my left hand and nothing happened. I called my wife into the room, and she tried with her right hand and she tried with her left hand. Nothing still happened. Well, we called our neighbour and she came over, and she tried with her right hand and she tried with her left hand, and still nothing happened.
And the woman behind the counter looked stunned and asked, "You asked your neighbour over to help you!?" And he says, "Yeah, we couldn't get the jar open."

THE DRAFT COMPREHENSIVE ABORTION CARE PROTOCOLS – LEGAL AND ETHICAL CONSIDERATIONS

The Draft Comprehensive Abortion Care (CAC) Protocols were put together by a team of experts from various sectors under the Ghana Health Service. The current reviewed Draft Protocols were published in 2006.

The document is a comprehensive one and deals with every aspect of care before and after the abortion. It discusses prevention of pregnancy and even encourages health workers to discuss the option of the mother having the baby and giving it up for adoption. It encourages in depth counselling of mothers before and,(should the mother still decide to opt for an abortion), after the procedure It was put together in response to the significant contribution that unsafe abortions make to Ghana's unacceptably high Maternal Mortality rate of 350/100,000 live births of which about 16% are believed to be due to unsafe abortion. It was recognised that despite the many religious and moral objections to the practice of providing abortions in Health Facilities, the reality was that many women were dying because these services were not available to them. Recently another extremely worrying consequence of unsafe abortions is coming to light and this is the damage to the foetus resulting from the unsuccessful use of abortifacient drugs such as Misoprostol for the termination of pregnancy. This has been demonstrated in parts of South America to be an important cause of Birth Defects. Increasingly, we in Ghana are also recognising this problem.

The subject of abortion is always fraught with highly emotive religious and moral arguments but for the purposes of this discussion, I would like to sidestep these (which is not meant in anyway to detract from their importance) and look at some of the sticky ethical and legal issues that may arise out of the document.

PROTECTION OF YOUNG GIRLS UNDER THE CAC PROTOCOLS

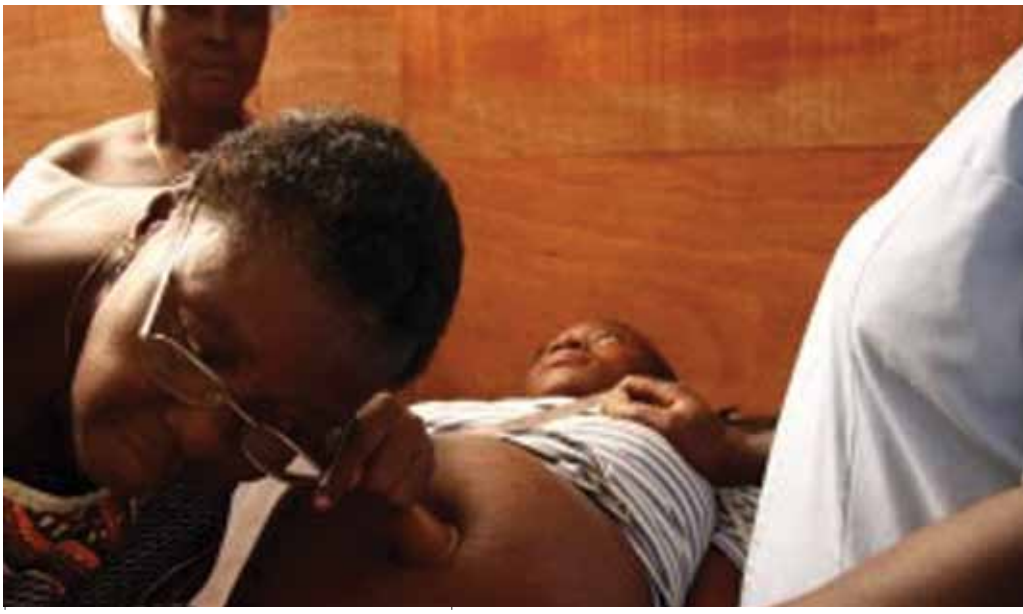
One of the troubling areas in the CAC Package is the fact that a young woman under the age of 18 can walk into health facility and ask for an abortion without the knowledge or consent of her parents. This is clearly to protect young women who need abortions but are not prepared to let their parents know and it is apparently designed, like many other aspects of the package, to put as few impediments as possible in the way of women seeking abortion services.

The difficulty may, however, arise where a very young girl of 12 or 13 years has been sexually abused by an older man (for example an uncle) who then bullies her into seeking an abortion andis allowed by the health care provider under the CAC guidelines to act as the adult "in loco parentis"(i.e. in the place of the parents)to give consent. Typically, such men will threaten the young girl with death if she tells anyone and thus her unwillingness to tell her parents may arise from fear of such a threat, rather than her genuine desire not to let her parents know. Under such circumstances, a health worker who goes ahead to terminate such a pregnancy may unknowingly

collude with the perpetrator of the crime and encourage such a perpetrator to repeat the act over and over again at different health facilities.

Who then can consent to an abortion in a minor? The CAC says on page 4 of the draft document under the heading "Minor Consent" that "A parent or next of kin or another adult acting in loco parentiscan give consent on behalf of a minor"
The concept of in loco parentisimplies someone who isnot a parent or a legal guardian but who temporarily assumes a parent like role of providing for and protecting a child. For example teachers act in loco parentis to children during school hours when the children are under their care. In an emergency, therefore, a teacher can consent to medical treatment if the parents are not immediately available.

Thus one way a health worker can help prevent a person who is abusing a young girl from being the one to consent to the abortion is by insisting that that person is truly standing in loco parentis to the child.An older man who is sexually abusing a young girl cannot be said to be standing in the place of a parent. It also means that when dealing with very young girls, health workers must make extra effort to get parental consent and perhaps try to understand better the reasons why the child is unwilling to contact a parent. Where a health worker has reason to believe that a wrong is being perpetrated against a young girl, the health worker has a duty to protect the child. This is because The Children's Act in Section 2 says that:



1. The best interest of the child shall be paramount in any matter concerning a child.
2. The best interest of the child shall be the primary consideration by any court, person, institution or other body in any matter concerned with a child.

STATUTORY RAPE AND THE DUTY TO REPORT A CRIME

The Children's Act states in Section 17 that
Any person with information on—

a. child abuse; or
b. a child in need of care and protection

shallreport the matter to the Department.

Sex with a girl less than 16 years old, even with her full consent, is considered by law to be rape. Thus if a child of 15 years turns up pregnant and requesting an abortion, that child has clearly been sexually abused and may be in need of care and protection. The Children's Act places a mandatory (the word used is "shall" report) obligation on whoever becomes aware of this (in this case the health worker who is being asked to provide an abortion) to report to the Department of Social Welfare. The CAC document does not mention this, perhaps because the aim of this document is to eliminateimpediments being put in the way of women seeking abortion. It does, however point out that one of the conditions under which an abortion can be performed legally is when the woman has been raped and since any girl who is pregnant under 16 has by legal definition been raped, then there is no question about the legality of an abortion. A health worker who finds herself in such a position must consider whether a report needs to be made to the Social Welfare Department if that is in the best interest of the child. Whether this should be done before or after providing the abortion is unclear.

CONSCIENTIOUS OBJECTION

Another potentially sticky area is the area of conscientious objection. The draft document says that Management of Government facilities must provide CAC services, except those facilities excluded under specific agreements with government. This presumably refers to certain religious based health institutions such as Catholic hospitals and other religious health facilities. The document also states, however that "No provider has the right to conscientious objection in an emergency situation" One wonders whether this last statement includes health care providers in facilities which have signed these agreements with government not to provide CAC services. In other words if a patient needing an emergency abortion turns up at such an excluded facility, can the facility turn her away based on this agreement or are they obliged to treat her? What sorts of clinical situations would be considered emergencies? Obviously the patient who turns up bleeding profusely from an incomplete abortion would be considered an emergency. What about the woman who starts her abortion off at home with Cytotec and then begins to bleed and comes to complete the abortion in the hospital?

It would seem a little unfair that a health worker who works in an exempt hospital can turn his back on a patient requesting CAC even if he himself has no religious objection to the procedure whilst a healthworker who has strong objections to performing abortions may be forced to do so simply because the facility where s/ he works has not signed such an agreement and the patient has turned up in an emergency or is a minor.

CONSCIENTIOUS OBJECTORS AND MINORS

The CAC draft document states on page 5 that no individual may claim conscientious objection, if the client is below 18 years. It bases this on Article 28 Clause 4 of the 1992 Constitution which states that

"No child shall be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs."

This provision is sometimes used when parents are refusing treatment for their children. This time, the boot is on the other foot and the provision is being used to prevent a health worker from refusing to treat a child based on the health worker's religious belief. The question is, does refusing to perform an abortion on a healthy young woman constitute "refusal of treatment"? If it does, what disease is the health worker refusing to treat? Is pregnancy being considered a disease, the treatment of which is an abortion?

Secondly does this provision about conscientious objection and minors apply to the exempt health facilities? If it does not, does this not mean that a government agreement is in contravention of a constitutional provision?

The CAC document says that "a service provider "validly" claiming conscientious objection has a duty to provide information to the client about her rights to the service and refer her to an accessible provider".

One thing that may be a challenge is to decide is the question of what constitutes "valid" conscientious objection and how this is determined. Is it by offering a baptismal certificate? Or by making a declaration on oath? The very personal nature of conscientious objection makes it very difficult to determine if it is "valid" or not and should it ever become an issue it might be difficult to call into question the validity or otherwise of the service provider's conscientious objection to performing an abortion. A health provider may not formally belong to a religious group that is known to object to abortions but may hold strong personal views against doing the procedure. Is this health worker's objection any less "valid" than that of a Catholic nun who happens to be a doctor?

WHO CAN LEGALLY PERFORM AN ABORTION UNDER THE CAC DOCUMENT?

The CAC protocol of 2006 allows Medical abortions under 9 weeks gestation to be performed by Community Health Officers trained in Midwifery, Midwives, Medical Assistants trained in midwifery and Medical Practitioners. This is clearly a practical measure as it ensures

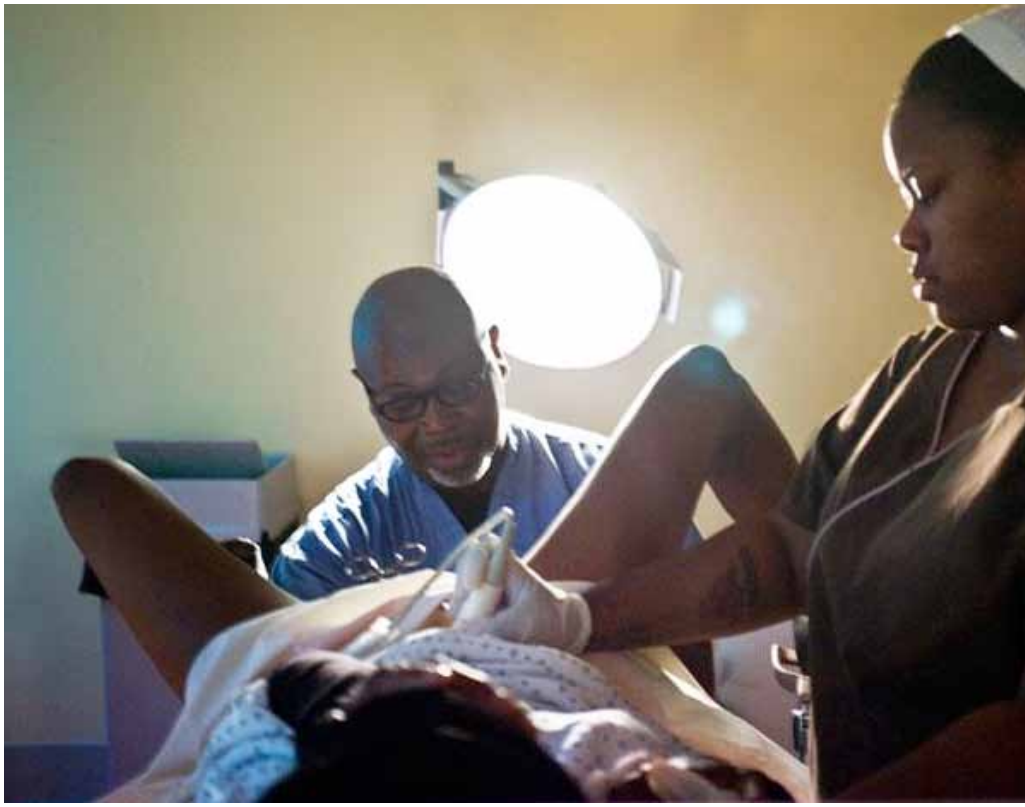
that abortion is as accessible as possible, not only in facilities that have doctors or obstetricians. Presumably all these categories are actually trained to do the procedure.

However this sits in an uneasy relationship to S. 58 of the Criminal Act which makes (perhaps unreasonably so!) abortion the preserve of Registered Medical Practitioners. The performance of abortion by other categories of health workers seems to be justified by the invocation S.67 (2) which says

"Any act which is done, in good faith and without negligence, for the purposes of medical or surgical treatment of a pregnant woman is justifiable, although it causes or is intended to cause abortion or miscarriage, or premature delivery, or the death of the child"

In other words, a person who is not a Registered Medical Practitioner who performs an abortion is "justified" if s/he does the abortion "in good faith and without negligence".

The difficulty here is that this provision can apply equally to any other person, not necessarily even a health worker, provided the abortion is done "in good faith and without negligence". This is clearly not satisfactory and may lead to some abuse of the process, with unqualified health workers, and even persons with no formal health training at all performing abortions including surgical abortions. Although the CAC protocol makes a distinction between medical and surgical abortions, neither S.58 nor S.67 of the Criminal Act makes that distinction.



Indeed Section 58 of the criminal Act reads as follows

" any person who…administers to a woman any poison, drug or other noxious thing or uses any instrument or any other means whatsoever with the intent to cause abortion … shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.."

Thus in the eyes of the law, medical abortions (abortions with a drug) are just as criminal as surgical abortions

CONCLUSION

Ghana's high Maternal Mortality Rate is a serious national health issue and needs to be tackled with every available tool. The CAC protocol is one such crucial tool. However it is important not only to provide safe abortions for women seeking them but also to inform them about the other alternatives such as adoption etc.

It is important therefore that as CAC services becomes more widely available in health facilities across the country, some of these ethical issues are addressed and guidelines clarified. It is also hoped that the old abortion laws will be substantially amended to reflect the current reality of the need for more easy access to Comprehensive Abortion Care, including prevention of abortions, for women who needthis care, in order to prevent deaths from unsafe abortionand reduce our unacceptably high maternal death rate.

BREASTFEEDING - GOING DOWN THE DRAIN IN GHANA – WHO IS PULLING THE PLUG?

In 2008, the Ghana Demographic and Health Survey (DHS)report put the percentage of babies who had any amount of exclusive breastfeeding at 63% and even though not many mothers were practicing exclusive breastfeeding up till 6 months it was at least encouraging to know that mothers were doing some exclusive breastfeeding even if the periods were short. Although the DHS report for 2013 (assuming there will be a survey) will probably not be available till next year, there are indications that the exclusive breastfeeding rates in Ghana are falling.

This is worrying because the evidence for the positive effect of exclusive breastfeeding on the health of the individual continues to mount up. Exclusive Breastfeeding has been shown to impact positively not just on the health of the newborn baby and young child but even to play some role in influencing whether the child will grow up to have certain chronic diseases like diabetes and hypertension and problems with cholesterol as an adult. Since these are diseases which are increasingly becoming important as major causes of death and disability in Ghana, it is sad that fewer and fewer mothers are practicing exclusive breastfeeding.

What are some of the reasons for this decrease in exclusive breastfeeding? They can only be guessed at and one thing that needs urgently to be done is some form of investigation to confirm this trend and to determine why it is occurring. It is only then that useful measures can be put in place to reverse the situation. There is no doubt that the old traditional obstacles to exclusive breastfeeding are still operating. Mothers are now, perhaps more than ever before being thrust into the role of being the family breadwinners or co breadwinners and therefore are forced to resume work sooner and sooner after delivery, thus making exclusive breastfeeding difficult. The Labour Law of Ghana entitles women to only 12 weeks of paid maternity leave. However many women, even in the formal sector do not get even this and because of the difficulty in obtaining jobs, a woman may not be in a position to complain if she does not get what she is entitled to under the law. The Labour Law further entitles

nursing mothers to 1 hour breastfeeding breaks up to one year after delivery but again few employers make implementation of this possible for their female employees. Even where the employer is willing to grant this, in many places challenges with transportation etc make it near impossible for the mother to go and breastfeed and come back within an hour. Bringing the baby to the workplace may also be difficult and impractical. Thus the regulation is only practicable for the few lucky mothers who happen to live very close to their workplaces.

The threat of easy availability of formula milk preparations has become even more of a challenge than previously. Although these milks are not cheap, they still offer an alternative to breastfeeding for mothers who are having difficulty in breastfeeding and mothers will use what little scarce resources they have to buy them. Despite the passage of LI 1667, Baby milk manufacturers are flouting the laws about the packaging of their products with impunity. Pictures which idealise formula feeding are found on tins of formula throughout the length and breadth of the country and Food and Drugs Board appears to show little if any concern. More and more different "improved" brands are appearing on the market and even special milks such as lactose free milks and special milk for preterm babies are openly sold in supermarkets. The packaging, contrary to law, is becoming more and more enticing and the row in some supermarkets where baby

formula is kept is the most colourful of all and has the most deceptive pictures. The notice on the tins that cautions mothers that "breast feeding is best for your baby's health" is often written in such tiny print and with a choice of colours and backgrounds so as to render it virtually unreadable. Sometimes this notice is written in 2 or 3 languages, ostensibly to make it more widely readable but the result is sometimes that so much text is crammed into a tiny space rendering the text even more unreadable.

Falling standards of education in the country mean that mothers are less and less equipped to be able to read the instructions on the tins of these formula feeds and follow them correctly. Financial challenges make it difficult for mothers to have several feeding bottles that are regularly sterilised or to be able to throw away left over milk as recommended. Many mothers own 2 saucepans, one for the soup and one for the cassava. Which does she use to regularly sterilise the bottles, not to mention the additional cost of firewood or charcoal?Horror stories of filthy, mould encrusted bottles abound. I recently saw a mother at the KATH Cleft Lip and Palate clinic who had prepared her one bottle of over diluted milk at 4am, had come to the hospital, waited for several hours to be seen and as at 3pm was still feeding the baby with that same bottle ofmilk which had been prepared 11 hours before and had been sitting in her hand bag in the scorching sun.

Lack of training means that health workers often are helpless

when confronted with mothers who genuinely want to breastfeed but are facing breastfeeding difficulties. Thus instead of supporting such mothers and helping them overcome the breastfeeding problem, they will often be the first ones to tell them to go and buy formula for the baby. Family members especially grandmothers, who have no positive experience of exclusive breastfeeding will also often put mothers under pressure to add something to the breast milk, be it water, formula or porridge. When a mother is experiencing difficulties, real or imagined, these well meaning but ill informed (and very influential!) older ladies have little experience to fall back on and thus have no help they can offer other than suggest that the mother goes and buys formula.
However there seem to be relatively new and perhaps more subtle challenges to exclusive breast feeding.

On the 13th of May, the online version of Paediatrics published a paper titled "Formula Supplementation May Improve Breast-feeding Rates". This paper looked at long term breastfeeding outcomes of babies given a little formula at birth compared with those not given any formula and concluded that giving a little formula at birth could help exclusive breastfeeding in the long term. Recently another study claimed to have showed that exclusively breast fed babies had more problems with high sodium levels compared to formula fed babies. As medical students we were taught and we continue to teach about "breast feeding jaundice" (jaundice, sometimes with fever resulting from early dehydration when establishment of lactation is delayed). We were also taught that Vitamin K deficiency bleeding is related to breastfeeding. It is almost certain that many of these negative clinical effects are the result of delayed initiation and establishment of lactation and other suboptimal practices, but are being portrayed as if they are normal consequences of the dangerous practice of exclusive breastfeeding. It is important that these subtle seemingly objective scientific studies are interpreted carefully. Dehydration, fever and jaundice with high sodium levels will definitely occur where breastfeeding is not practiced in an optimal way. The response to these studies should be to support mothers more to establish lactation early, rather than to supplement with formula early or, worse still discouraging them from breastfeeding. Indeed a comment made on the paper on early supplementation with formula states

"to evaluate early limited formula objectively, we need protocols that explicitly optimize lactation ... any early limited formula strategy should await these data."

It is also worth noting that one of the Co authors of the paper that recommends early supplementation with formula as a way of improving breastfeeding outcomes had served as a paidconsultant for Abbott Nutrition, Mead-Johnson, Nestles, and Pfizer Consumer Products. These companies together produce probably the bulk of the worlds' most recognised brands of infant formula feeds including Lactogen, NAN, SMA, Similac, Enfamil, Goodstart and other popular brands not to mention their derivatives, follow on milks, special milks and formula feeding accessories such as feeding bottles, bottle warmers

etc.

There is definitely a need for good quality formula feeds for the exceptional situations where there are reasons why a baby cannot be breastfed and some of these companies make invaluable contributions to the nutrition of children above six months.

But health workers should not be confused by the jargon.Breast milk is in direct competition with formula feeds. The more babies do exclusive breastfeeding, the less formula feeds will be bought. No one in their right minds promotes theircompetitor. Vodaphone cannot promote MTN, Coca Cola cannot promote Pepsi, Manchester United cannot promote Chelsea and formula milk manufacturers cannot be trusted to promote exclusive breastfeeding.

These subtle, and sometimes even well meaning but misleading pieces of scientific information, if not carefully interpreted, tend to lead health workers to lose confidence in exclusive breastfeeding as the ideal way to feed a baby.

The confusion surrounding the role of breastmilk in the transmission of HIV has further contributed to health worker's confusion and lack of confidence in breastfeeding. The constantly changing position of WHO on this issue has further served to deepen the confusion leaving many nurses and doctors afraid to confidently encourage HIV positive mothers to practice exclusive breastfeeding. To make

matters worse, the confusion in Ghana has extended to Hepatitis B infection with many mothers being incorrectly asked not to breastfeed their babies until they have bought Hepatitis B Immunoglobulin which costs as much as GHC 800 and which many mothers cannot afford. When mothers cannot afford this, they are told not to risk breastfeeding their babies. This is against all the evidence which has demonstrated that Hepatitis B infection is not transmitted through breastfeeding but rather through contact with mother's blood during delivery. This misinformation tends to percolate into the general society, further weakening society's support for exclusive breastfeeding.

The result of all this is that there is a large number of mothers whose own mothers and other older female companions have had no experience with exclusive breastfeeding with which to support them. When they come to the health facilities they meet health workers whose attitudes towards breastfeeding ranges from apathy to sometimes outright hostility and whose knowledge and skills about how to help mothers to breastfeed aresometimes very shaky, health workers whose confidence in breastfeeding has been whittled away by incorrect scientific information concerning fictitious negative effects of breastfeeding.

They then go to traditional healers who tell them that their babies are sick because of a disease in their breasts and that it will be dangerous to breastfeed their babies. Some traditional healers even go as far as to pretend to take maggots from the mothers' breasts.

No wonder with all this going on, that breastfeeding is under threat and the figures are declining, to the immediate and long term detriment of the health and well being of our children.

Breastfeeding, unlike the formula milks, has no powerful rich lobby to support it. Yet the evidence shows beyond doubt that it is best for our babies. Health workers and others who consider themselves advocates for children's health have a duty to arm themselves with the correct information and skills to support mothers to breastfeed and to combat the subtle but powerful undermining of breastfeeding by formula milk manufacturers.

DICUSSION

PAIN, OPIODS AND ADDICTION

Never treats PAIN with the fear of Addiction. Read this. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(01)05322-3/Fulltext

FOA

I have been in and out of Ghana since 09/2010 and I can confidently say PAIN MANAGEMENT is an issue. Acetaminophen or NSAID for patients on admission with Sickle cell disease in severe painful crisis or patients with bad fractures resulting from RTA just to name a few. I think we need a lot of CPDs in Pain Management.

Daniel Akpalu, MD FAAP

VACCINATION (NEW ADDITIONS AND CONCERNS)

My son has been having fever for the past two days now after he had his vaccination at six weeks. My concern is whether it is right to give six weeks old baby 8 vaccines (polio, DPT, HepB, Hib, pneumococcal, Rotavirus) on the same day? I need education from experts in this field, policy makers, paediatricians and all those concern. Thank you.

Ati E.

Fever and sometimes rash are normal after vaccinations. They normally settle by day 3-5.yes these group of vaccines can be given together.

His is a silo-in question. It does not need a policy maker but any member in this group.

Anyway, my question I will ask you is ''who gave the vaccines and has that vaccination combination been administered to other kids before?'' If the answer to my question is yes, please tell me the outcome/ impact and I will help you to draft a brief for your child's situation.

FOA

This is the new immunization policy in Ghana and all children go through this. As for the impact, i will not be in the position to tell now.
Ati E

There is a team monitoring this and they follow up on Adverse Events but your complains for now are normal reactions. Some ethnic groups especially for religious and other reasons avoid vaccinations n that has been a reason amongst others why some diseases are still hanging around. There may be individualized reasons why people cannot receive some vaccines like allergy to eggs and influenza vaccine etc etc but in this case it was about your child who had fever which is normal immunologic response implying your child is rather healthy.

Purely from vaccination point of view it is possible to combine some vaccines. Few exceptions will be when immunoglobulins are given with live vaccines which may render the vaccine less effective. But how is your child who for me is the topic for my response. The MOH surveillance team can handle the rest. Good morning.

How is baby? Hope your son is doing fine. The penta vaccine (DPT, Hep B & HiB) has been around for some time now and the Pneumococcal and Rota vaccines were introduced a year ago. They are safe to give to a 6 week old. A child having a brief fever sometimes with irritability could happen after a shot. Be reassured.

However you said he has had the fever for 2 days, with the assumption you have given an antipyretic (eg. paracetamol), if the fever is still persistent then I recommend you see a Paediatrician, as there is a possibility of an underlying cause, which may in no way be related to the vaccine. Unfortunately your son cannot talk.....he cannot say daady do not worry it is my ear, tummy....).

A thorough examination of baby will surely allay your anxieties. I wish you, mummy and baby well, and may the sweet hand of Jesus be upon him. Amen!

Best Wishes, BB

Now,
I think we can't tell for a fact the impacts of the new vaccines added and Emma's worry may go beyond the days of the lives of some of us. In such a situation of doubt, can one decides to enjoy the benefits from the externalities of the vaccination on other children and so therefore, deny his children from the vaccinations?

Emma, please don't worry for the vaccination is going to save your child(ren) from diphtheria, influenza, whooping cough, POLIO, yellow fever and measles. The child is unlikely to die from hepatitis B which has been prevalent in certain parts of Ghana on accounts of the usage of one blade for designing their tribal marks and also cutting most umbilical cords. The impact of vaccination on your child is to enable him to become a good economic material for our sinking economy (with lots of functional illiterates).
Or were you afraid of the fever with a colour yellow?
Wishing your child strong and a health of "no fever" after vaccination. Please, try to make sure that the needles used are clean (? injection abscess with fever).

FOA

WHITE PAPER ON MARKET PREMIUM

-FYI, the white paper on market premium
http://media.myjoyonline.com/docs/201304/GOV%27T%20WHITE%20PAPER%20ON%20MARKET%20PREMIUM%20GUIDELINES-1.pdf

Sey F.

Hi Dr. Sey,
Thanks for attaching the white paper for all to see.

But tell me, what does all that English mean? And what are we to expect if government is the one to determine it and again, do so considering its own ability to pay? Somebody help me here.

Nii Obodai
Hmm, this is getting quite interesting. So is this the outcome of the extensive job evaluation by the numerous consultants who were paid for work done? By my understanding government can freely get up one day and say your skill is no more in scarcity by its understanding or that there is not even a pesewa for any market premium. Let's remember our basic salaries have been reduced and not even with the conversion difference will we get to where we would have been on the old salaries. Will this be the reason why they are not talking about 2013 market premium arrears? And interestingly article 71 holders are untouchable. God help Ghana!

K. Boamah Boateng

The white paper makes very interesting reading.
I agree it Looks like a kneejerk reaction with the aim to end all the agitation.

Is there a way we can opt out of this and just take our Salaries for our 40 hours and our employer can determine what this white paper is proposing.

FOA

Hi K. Boamah,
Hmmm....I agree perfectly with your sentiments!!

I read through and through this Government White Paper (i think it should better be called Government Black Paper) and I have come to the following conclusion that this is:

- An ambush by government and abuse of power
- A knee jerk reaction based on emotions
- A document not thought through; it had been hurriedly crafted to solve a problem today but its future ramifications have not been considered at all.

An example as you rightly pointed out is that if say in 5years government decides that doctors are no longer considered essential and that our numbers are enough, then what happens to the salary figures? The market premium will be scrapped and what then remains as salary??

In fact the Government "Black" Paper is not scientific, it had made useless the work done by consultants using our taxes and it was based mainly on sentiments/emotions!!!!!

Just thinking aloud.....GMA executives, I suggest we let our lawyers have a look at this BLACK paper and if there is a merit, we should start heading to court for the sake of workers of Ghana after the present struggle.

Innocent

Dear Innocent!
The market premium has always been my bone of contention with the Single Spine, as it clearly appeared to be a variable highly influenced by prevailing market conditions. The government of the day has just confirmed my fears. The situation is reminiscent of the ADHA. It's become something they cannot handle anymore, , since everyone is clamoring for it, so they have come out with this "explanatory" White paper.
In my opinion, it's not just this White Paper that was poorly thought out. It's the entire spine that has pathological fractures!
Frankly, it appears that what we really need to chase after is an improved base pay, so that the market premium becomes icing on a real cake, not sugar icing on a cardboard cake! (Sweet, but largely inedible and of no nutritive value at all!) I am told that the conversion difference payment will partly solve the problem, as it takes us back to pre SSSS levels. I sincerely hope so. I just don't know whether it will take into account promotion, # of years since qualification or inflation. They have been known to cause us to retrogress a few levels in the past.

As an essential service our salaries and allowances should reflect our essentialness to society, just like the Article 71 office holders' apparent importance is reflected in theirs!
As for their being untouchable, I clearly heard the President say that the National Constitution Review Commission has recommended that Article 71 holders be placed on our now shaky and fragile Single Spine, during his National Thanksgiving Service speech. He also called for a round table discussion on salaries. I hope it's true. I really wouldn't want a Pinnochio situation to evolve! Rhinoplasty is quite expensive, I believe!

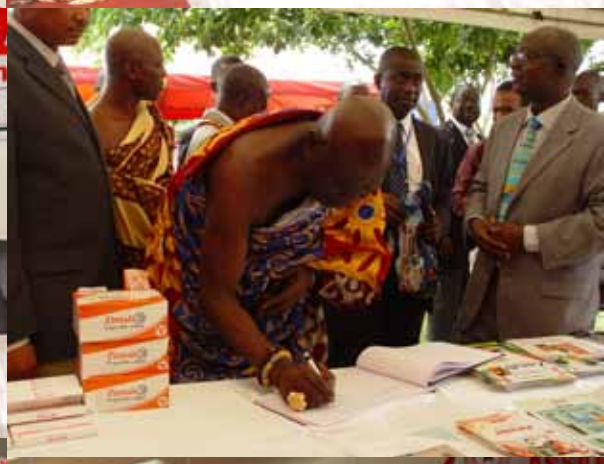
If they are for real, though, these moves might be the surgery that could repair the spine once and for all. It would require a very delicate touch, or else the Spine will completely break, with irreversible damage to the cord, resulting in, paraplegia, quadriplegia or worse! Let's pray the orthopedic surgeon and neurosurgeons work together well!

I for one can hardly wait until a referendum is called to amend the 1992 Constitution!

In the mean time, let's learn our lesson well, and make sure that future negotiations focus on improved base pay with associated good pensions, and not allow ourselves to be distracted and misled by seductively veiled and perfumed Sister Marketina Premiumson, whose true nature is only revealed after she has made you wild on sultry promises, has you on a leash, has led you a merry dance, spent your time and money, then runs off to her pimp (Bro Government), leaving you with empty pockets, a battered face, bruised ego and a !
Good night everyone!
God bless our homeland, Ghana and GMA

Edwina Addo Opare-Lokko

Pictures from 54th Annual General Meeting



Pictures from 54th Annual General Meeting

Pictures from 54th Annual General Meeting










Pictures from 54th Annual General Meeting

Living Longer, Retiring Later?

Not having enough money to enjoy your extended retirement is like getting a free pass to Disneyland only to be told you can't go on the rides and have fun!

Increased life expectancy is a cause for celebration. But who is going to pay for the party?

Retirement... It's a wonderful and rewarding time of your life. Finally, after years of honing your career, working hard and raising a family, this life stage is about having the time and resources to pursue the things you enjoy.

Rather pleasing then that these golden years are lasting longer than ever before. Each new generation of New Zealanders is living longer than the last. In fact, the length of time you can expect to live after reaching age 65 has nearly doubled in the past 100 years.

For example, if you were aged 65 in 2011, you can expect to live on average another 20 years if you're a male, and more than 22.3 years if you're a female1. And the trend continues - 44 per cent of males and 52 per cent of females born in 2011 will live to 100!

So, with more time to relax in retirement, and consequently more money required to fund the laid back lifestyle, who's covering the cost? No wonder then there's increasing debate over whether the entitlement age for NZ Superannuation should be lifted. It's a brave move made by many governments already, with countries such as the United Kingdom, Singapore and our neighbour Australia announcing plans that over the next decade or so the age of government pension entitlement will gradually increase, and means testing introduced. For countries facing severe austerity

measures, such as Greece, Spain and Portugal, this decision has been a no brainer.

BABY BOOMER TSUNAMI

In the not too distant future, one in four New Zealanders will be aged 65 or over – how can any government and its already squeezed, diminishing team of tax payers afford to fund the lifestyles of well over a million retirees? It's becoming increasingly obvious that New Zealanders (and indeed most other nationalities) must take responsibility for their own financial support come retirement. Even the Commission for Financial Literacy and Retirement Income has said there are no guarantees when it comes to receiving NZ Super, stating this welfare benefit 'may be different in years to come in terms of how much you can get, when you can get it2, and who can get it'.

NO WORRIES OR NO FRILLS?

Already, there's plenty of evidence which indicates today's retirees living on the state pension are struggling. According to a recent study which looked at the cost of living a healthy but basic lifestyle at retirement, a single person renting a home needs $453 a week and a couple require $590 – both figures considerably greater than the current pension entitlement of $333 a week and $511 respectively.

So how much extra is needed to help close the gap? Assuming a couple want to live off the 'average' NZ income in retirement they would require a net income of around $45,000 to $50,000 per annum (including NZ Super). Let's say they were going to live for 20 years in retirement (but remember this is increasing every few years), they would require income in addition to NZ Super of about $22,000 per annum. To achieve this they would need to have accumulated a retirement nest egg from which to live off of approximately $420,000 . This doesn't take into account any unexpected healthcare costs or provisions for children.

SIZING UP THE OPTIONS

For many, this nest egg may well come from an inheritance, Kiwi Saver and/or an investment portfolio. For others not so fortunate (or forward thinking), it means a serious rethink of plans. Perhaps working past 65 is an option, or further reducing living costs in order to set aside some for the future, or downsizing the family home to release equity.

The important thing is to understand what your own personal situation will be like, and if you do need to do something about it, act now before it's too late. An Authorised Financial Adviser can recommend a plan to help you decide the best way forward for your own financial circumstances, giving you a better chance to retire (and celebrate your longer living) in style.

WILL YOU BE LIVING A 'NO-FRILLS' RETIREMENT?

Will you be living a 'no-frills' retirement or will you have 'choices'?

ECB is heading in the right direction

Will you be living a 'no-frills' retirement or will you have 'choices'?

By Murray Harris, National Investment Manager, Spicers

Last week the New Zealand Retirement Expenditure Guidelines1 were released. The report is based on research by the Financial Education and Research Centre, a joint initiative by Westpac and Massey University to improve New Zealander's knowledge, attitudes and behaviour towards money matters. The report was commissioned by Workplace Savings NZ, a not-for-profit membership organisation which focuses on the issues which affect the workplace retirement savings industry in NZ.

GOLDEN YEARS MAY BE NOT SO GOLDEN

The results are both interesting and worrying. Using Statistics

NZ's Household Economic Survey to generate household budget data, plus a survey of 517 retired households, the report reveals some sobering facts about the cost of living in retirement and the sort of lifestyle retired New Zealander's are enjoying.

The report covers two geographic groups of retirees. The Metro group, main centres such as Auckland and Wellington; and the Provincial group covering regional New Zealand. Households have been separated into a one-person household and two-person household i.e. a retired couple. This represents approximately 96% of all retired households.

The expenditure levels of these households has been designated as either 'No Frills' – which is a basic standard of living that includes few, if any, luxuries; and the 'Choices' budget – which represents a higher standard of living that includes some treats or luxuries. Housing related costs have been excluded from the expenditure because of the variable nature of this for households e.g. renting, versus paying a mortgage, versus being mortgage free.

NO-FRILLS LIVING EQUALS FEW TREATS IN RETIREMENT

The numbers will be startling for some readers no doubt. The cost of living (excluding housing costs) on a No-Frills budget for a one-person retiree household in a metro centre is $113.38 per week; the same household on a No-Frills budget in a provincial centre spends a similar amount of $113.22.

A two-person retiree household on a No-Frills budget costs $241.35 in a metro centre and $244.24 per week in a provincial centre.

Remember, a No-Frills budget is one with few, if any, treats or luxuries. The report shows these households spend very little or next to nothing on items such as alcohol, restaurants, recreation or travel.

Isn't one of the reasons we look forward to retirement is so we have more time to do the things we enjoy and to treat ourselves to a few luxuries like more travel and holidays after years of hard work? That does not seem to be the case for those living on a No-Frills retirement!

NZ SUPERANNUATION PAYMENTS OF LITTLE HELP

Of course you need to factor in NZ Superannuation payments to these budgets. A single person living alone receives $348.92 per week in NZ Super. A couple receives $536.80 per week.2Deducting the living costs outlined above from these payments leaves approximately $235 - $295 per week. But, that is before housing costs. Massey University research in May 2012 showed the median weekly rent ranged between $350 - $440 per week in metro centres, and $200 - $335 across the rest of NZ.

A single person living alone on NZ Super only, in provincial NZ, and living a No-Frills retirement will have a small excess of approximately $36 per week after covering living and housing

costs (if renting at the low end of the rental scale).

A couple living solely on NZ Super in provincial NZ, in the cheapest rental accommodation will also have a small weekly surplus($92 per week), but NZ Super alone will not cover living and housing costs for any other groups of retirees on a No-Frills budget.

Of course the news is better for those living in their own home with no mortgage. The maths works out better. But in Spicers experience, many retirees are still paying off their mortgages. The report highlights that even a small mortgage of $50,000 on a 5 year term would cost around $220 per week to service, at current record low floating interest rates.

MORE ENJOYMENT WITH CHOICES

So what about those retirees living on a Choices budget? A Choices budget is one with a few luxuries and treats like a restaurant meal now and again, a bottle of wine with the groceries, and some holidays.

The report shows that a one-person household in a metro centre on a Choices budget spends $349.78 per week; or $349.76 in a provincial area. A two-person household costs $761.56 in a metro centre; and $693.83 in a provincial centre.

You can work out the maths for yourself from the information above on housing costs and NZ Super payments. But it's clear that NZ Super alone would not cover the living and housing costs for any retired household living a Choices retirement, even if they were mortgage free!

Still time to retire with Choices
Clearly those retirees living a Choices retirement have made provisions for their retirement over and above what NZ Super provides them. They may have saved and invested well while working to ensure they could enjoy the retirement they wanted. It's all about choices in more ways than one.

So how much is enough? And how can you ensure you achieve it? If you're not sure of the answer then don't hesitate to seek some qualified financial advice from a Spicers adviser so you can ensure that you get to make the choices you want in your retirement.

Jokes!

SURGERY BILL

A well-known rich businessman's wife broke her hip. The businessman got the best orthopaedic surgeon in town to do the operation. The operation went well, and the surgeon sent the business man a bill of of $5000. The businessman was outraged at the cost, and sent the doctor a letter demanding an itemized list of the costs. The doctor sent back a list with two things: 1 screw- $ 1
Knowing how to fix it- $4999
Total- $5000 total.
The businessman never argued

SUBSPECIALIZATION

What kind of job do you do?" a lady passenger asked the man sitting beside her.
"I'm a naval surgeon," he replied.
"Goodness!" said the lady, "How you doctors specialize these days! The last time a co-passenger said he is a breast surgeon"

TOUGH TREATMENT

An old lady fell down the stairs and broke her leg. The doctor put it in a cast and warned her not to walk up and down the stairs. The leg was slow in healing. Finally, after six months, the doctor announced it was all right to remove the cast.

"Can I climb the stairs now?" asked the old lady.
"Yes" answered the doctor.
"Oh, I'm so glad," she smiled.
"I'm sick of standing on a chair and then jumping through the window all these months to enter my room"

FROM LAGOS TO BANGKOK THROUGH CHENNAI
TIME TO REVIEW OUR TRANSPORT SYSTEM

PART II

Following from the 54th Annual General Conference Edition, I have been called upon to complete this article.

Walking down the streets of Kumasi and Accra, I see our version of tricycles which are "abused" most of the times contrary to the manufacturer's specification/intention and this becomes a strain on our limited medical resources. The pictures tell their own stories.

Funnily, most motorbikes in Kumasi are not licensed and those which are officially licensed have only the rear license plate-why? Those who have helmets hang them at the back of their vehicle for POLICE inspection ONLY.

OUR PROBLEM AS A NATION

When is the OPPORTUNE TIME to take decisions or enforce the laws?

Oh we are getting to Christmas - so allow
JANUARY - Oh we have just come out of Christmas - so allow

FEBRUARY - Oh valentine time - so allow
MARCH / APRIL- Easter and also the rains are about to start - so allow

MAY - African Union Day - so allow
JUNE - Don't you know it is Kutawonsa (hard time month) – so allow
JULY - Ramadan – so allow
AUGUST - Eid-Ul-Fitr - so allow

SEPTEMBER - Founder (s) day - so allow
SEPTEMBER Rainy season - so allow
OCTOBER -Eid-Ul-Adha - so allow

OCTOBER/NOVEMBER - Oh we are getting to another Christmas so allow and so the cycles of ALLOWS and INDECISIONS continues unabated and if we are in an election year then there is MAXIMUM WAHALA.

Oh Ghana! The time to ACT is NOW

Kwabena Opoku-Adusei

IS SODZI SODZI "T", THE ALEX FERGUSON OF GMA?

I dedicate the entire sports column to my colleague, friend and brother Dr. Sodzi-Sodzi Tettey.

He has decided to hang his boots after a long dedicated and selfless service to the mother association, Ghana Medical Association.

The question I cannot answer is if this self imposed retirement is temporal or permanent, but at least for the next two years he will not be part of the Executive Committee of the Ghana Medical Association.

His contribution to the establishment of the Focus Magazine cannot be over emphasized.

It would have been lovely to simply write about some kind of sports that he is or was actively engaged in.

This is however next to impossible because Sodzi had never been able to successfully done any sporting activity. His interest is very much limited to "ampe" which I thought was the preserve of young Ghanaian women.

He had previously tried his hands o lawn tennis only to fail miserably.

Sometime ago, I was excited to learn that he was preparing to run in a Milo Marathon, but when the time came for the actual event, I learnt with great disappointment that he was unable to participate. This was because his doctors, including Dr. Ernest Yorke of Korle bu Teaching Hospital, had found Sodzi to be seriously out of shape and hence was not given the green light to run.

I have watched Sodzi from a distance and had always believed that with his zeal, stubbornness and tenacity, he would have been a fine boxer. Certainly now, age is not on his side and hence my decision not to push him to pursue this line of sports.

He probably would have been a better boxer than Floyd Mayweather who carefully chooses his opponents and still continue to disturb the ears of the world by claiming to be the best pound for pound boxer ever to have graced the boxing world. I still maintain that that Iron Mike Tyson and Julio Caesar Chavez were better boxers than this loud mouth Floyd Mayweather. The supporters of Mohammed Ali, am sure will be shouting for attention as well.

Never mind, Sodzi may have been on this list had I seen him in his youthful days and given him my expert advice to pursue this noble sport of boxing.

The decision of Sodzi not contest again in the upcoming GMA elections as an Executive Committee member of the Ghana Medical Association came as a surprise to many and their reaction was similar to that of the football fraternity when Sir Alexander Chapman Ferguson announced to the world his retirement as the manager of arguably the most successful English football club in the shape of Manchester united.

Sir Alex Ferguson was the longest serving manager of Manchester united. He served for more than twenty six years, winning over

38 trophies including 13 English Premier League and 2 UEFA Champions League titles.

His replacement, David Moyes, former Everton Manager, is gradually turning Manchester United into a mid table team. Well, may be posterity is the best judge.
From me, the question is who takes over from Sodzi as the Vice President of the Ghana Medical Association. Did he pick his replacement silently…..

Jokes!

MEDICATION ERROR

A patient, during a two week follow-up appointment with his cardiologist, revealed he was having trouble with one of his medications.
"Which one?", asked the doctor.
"The patch," he replied.
"What is the problem?" queried the doctor.
The patient replied, "The nurse told me to put on a new one every six hours and I've run out of places to put it!"
The doctor had him quickly undress and discovered what he hoped he wouldn't see . . .
The man had over fifty patches on his body!

The medication now carries new instructions that includes removal of the old patch before applying a new one

FUNNY HUMAN EQUATIONS

Human = eat + sleep + work + enjoy
Horse = eat + sleep + work

Therefore:
Human = Horse + enjoy

Therefore:
Human - enjoy = Horse

In other words, A Human that doesn't know how to enjoy is a Horse.

NO CLUES

As the doctor completed an examination of the patient, he said, "I can't find a cause for your complaint. Frankly, I think it's due to drinking."

"In that case," said the patient, "I'll come back when you're sober"

BONES AND DOGS

Doctor: Did you know that there are more than 1,000 bones in the human body?

Frank:Shhh, doctor! There are three dogs outside in the waiting room!

DELIVERY MATTERS

"Just relax", the hospital staff kept telling Frank, but it was to no avail. Frank's wife was in labor and he was very nervous. After what seemed like a week, to both Frank and the hospital staff, a nurse came out with the happy news, "it's a girl", she cried. "Thank God, a girl", said Frank, "at least she won't have to go through what I just went through!"...

BE POLITE

A pediatric nurse often has the painful job of giving injections to the children. One day upon entering the examining room to give a shot the little girl starting screaming "NO! NO! NO!"
"Mellissa" her mother scolded, "that is not polite behavior!"
At that the girl continued to scream "NO THANK YOU! NO THANK YOU! NO THANK YOU!"...

FELLOWSHIP AWARD

Prof. Francis Adu-Ababio

AWARD OF MERIT

Dr. Sodzi
Sodzi Tetteh

Dr. Rita
Larsen-Reindorf

Dr. Titus
Beyuo

55th ANNUAL GENERAL CONFERENCE

Theme: "Cancers - Emerging Trends"

Under The Distinguished Chairmanship Of The President Of GMA

Venue: Tyco City Hotel, Sunyani, Brong Ahafo Region

TUESDAY, NOVEMBER 5, 2013

Arrival & Registration of National Executive Council members at Tyco City Hotel

WEDNESDAY, NOVEMBER 6, 2013

National Executive Council meeting at Tyco City Hotel
Arrival & Registration of general members at Tyco City Hotel

THURSDAY, NOVEMBER 7, 2013:
SCIENTIFIC MEETING – AT TYCO CITY CONFERENCE HALL

08:00-08:30	Arrival and registration of participants
08:30-08:35	Opening Prayer
08:35-09:20	Presentations by Pharmaceutical Companies
SESSION I:	CHAIRMAN: Dr. Timothy Letsa (Regional Director of Health Services, BAR)
9:30 – 10:00	Overview of Cancers in Ghana - Dr. (Mrs.) Maame Pokuah Amo-Addae Public Health Practitioner and DDHS, Shama District
10:00-10:30	Prostate Cancer - Dr. J. E. Mensah, Department of Urology, Korle Bu Teaching Hospital, Korle Bu, Accra
10:30-11:00	Paediatric Cancers - Dr. Lorna Awo Renner, Department of Child Health, Korle Bu Teaching Hospital, Korle Bu, Accra
11:00-11:30	New HIV Policies and Guidelines - Dr. Angela El-Adas, Director-General, Ghana AIDS Commission
11:30-12:00	Presentation by Food & Drugs Authority - Pharmacovigilance Dr. Stephen K. Opuni
12:00-12:20	Snack Break

SESSION II: CHAIRMAN: Dr. J. B. Fordjour
(Obst & Gynae Specialist, Regional Hospital, Brong Ahafo)

12:30-13:00	Breast Cancer	-	Prof. Joe-Nat Clegg-Lamptey, Department of Surgery, Korle Bu Teaching Hospital, Korle Bu, Accra
13:00-13:30	Cervical Cancer	-	Dr. Frank Ankobea, Department of Obst & Gynae, SMS/KNUST, Kumasi
13:30-14:00	Cancer Registry in Ghana	-	Dr. Baffour Awuah, Radiation Oncologist, Komfo Anokye Teaching Hospital, Kumasi

14:00-14:20 Discussions

14:20-14:30 Wrap Up and Closing of Session

14:30- 15:30 LUNCH BREAK

16:00-18:00 GAMES / FOOTBALL MATCH

19:00-21:00 COCKTAIL

FRIDAY, NOVEMBER 8, 2013
OFFICIAL OPENING CEREMONY AT TYCO CITY CONFERENCE HALL

07:00-08:30 Registration continues

08:45- 09:00 Opening Prayer

09:00-10.00 Presentation by Pharmaceutical Companies
Time with PZ Cussons

10:00-13:00 Official Opening Ceremony

Welcome Address I - Chairman, GMA, Brong Ahafo Division,
(Dr. Kofi Amo-Kodieh)

Welcome Address II - Brong Ahafo Regional Minister

Fraternal Messages - MC

Conference Address – President, GMA – Dr. Kwabena Opoku-Adusei

Cultural Display

Address: Special Invited Guest, Minister of Health, Hon. Sherry Ayittey

Address: – Guest of Honour, Cardinal Peter Appiah-Turkson

Keynote Address: Special Guest of Honour – Prof. James Ephraim
(Vice Chancellor, Catholic University, BAR)

In attendance: Omanhene of Sunyani Traditional Area – Nana Bosoma Asor-Nkranwiri II

Presentation of Awards

Vote of Thanks

Closing Payer

GROUP PHOTOGRAPHS

OPENING OF EXHIBITION – Hon. Minister of Health and Special Guest of Honour

13:30-14:40 LUNCH BREAK

FRIDAY, NOVEMBER 8, 2013 – AFTERNOON SESSION

15:00-17:00 AGM OF GMA PENSION FUND
19.00-21.00 COCKTAIL

SATURDAY, NOVEMBER 9, 2013 – ANNUAL GENERAL MEETING

08:00-09:00 Registration of Participants
Presentations by Pharmaceutical Companies

09:00-10:00 Electoral Presentations
10:00-17:00 GMA Business Session and Voting

19:00-TDB: DINNER DANCE AND SWEARING –
IN OF NEW EXECUTIVES AT TYCO CITY

SUNDAY, NOVEMBER 10, 2013, AT TYCO CITY HOTEL

9:00-10:00: Press Conference on Conference Communiqué
10.00-11.00 Brunch & Departure
End of 55th Annual General Conference