FABRIC OF AFRICA TRENDS REPORT

A Report on Women's Healthcare in Ghana by Philips

March 2013

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I. Introduction

Philips believes that a Healthy Africa begins with Healthy Women, and that Women are the thread that holds the fabric of Africa together, sustaining healthy families. The Philips Fabric of Africa campaign is a multi-year commitment to improve access to healthcare and deliver appropriate, cost effective technology to the African market, with a particular focus on women's health.

With a presence in Africa for over 100 years, Philips has a unique understanding of the complexities of its diverse healthcare environments and a wealth of experience delivering innovative healthcare solutions across the continent. With the increase in prevalence of Non-Communicable Diseases (NCDs) and their anticipated role in the post MDG/2015 landscape, Philips Healthcare believes that health systems strengthening (HSS) initiatives and expanded, sustainable services should be designed to include and meet the increasing needs of women in Africa. The Philips Fabric of Africa Campaign aims to develop meaningful partnerships with local stakeholders to improve healthcare delivery in the areas of maternal and child health as well as NCDs.

The Philips Fabric of Africa Campaign will reflect the post 2015 Millennium Development Goals (MDGs), specifically goals 4[1] and 5[2], focusing on three key areas:

- **Maternal and Child Health**
  In 2010 more women died in pregnancy in Sub-Saharan Africa than anywhere else in the world, with the region accounting for more than half (56%) of the 287,000 deaths recorded globally. [3] Child mortality is also high, with 29% of global neonatal deaths occurring in Africa. [4]

- **Non-Communicable Diseases (specifically breast, cervical & cardiac health)**

  By 2021 more people will die from NCDs in Africa than anywhere else in the world, with an expected death rate of 27% compared to 17% globally. [5] Cervical cancer is the most common form of cancer affecting women in Sub-Saharan Africa, followed by breast cancer.

  Cardiovascular disease is the second most common cause of death in Africa after infectious diseases, accounting for 11% of total deaths. The main causes are smoking, high blood pressure, being overweight and high cholesterol. [6]

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[1] United National Millennium Goal 4 target is to reduce the mortality rate of children under five by two-thirds from 1990 to 2015
[2] United National Millennium Goal 5 target is to reduce maternal mortality rate by 75% from 1990 to 2015
[3] United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Bank, and World Health Organization (WHO), Trends in Maternal Mortality: 1990 to 2010 – WHO, UNICEF, UNFPA and The World Bank estimates. 2012.
http://countryoffice.unfpa.org/uganda/drive/Trends_in_maternal_mortality_A4-1.pdf and United Nations Population Fund (UNFPA). Sub-Saharan Africa's maternal death rate down 41 per cent. New York, United Nations Population Fund. 2012.
[4] World Health Organization (WHO) Regional Office for Africa. The health of the people: the African regional health report. Brazzaville, Republic of Congo: World Health Organization; 2006.
[5] United Nations. *2011 Commitments to advance the Global Strategy for Women's & Children's Health.* New York, United Nations, 2011.
[6] WHO AFROCommission 2012. Addressing the Challenge of Women's Health in Africa *Report of the Commission on Women's Health in the African Region*

- **Infrastructure Rehabilitation and Caregiver Training**

  Poorly equipped medical facilities, inadequate staff numbers and crumbling infrastructure are a serious concern in many corners of the African continent. Appropriate technology and training are important to delivering appropriate and effective care to patients.

  To better understand how healthcare is perceived on the ground, Philips commissioned a one-week qualitative study in Ghana to speak to women[7] and local healthcare workers about healthcare education and real-life experiences of the healthcare system in Ghana. The research team spoke to 70 women aged between 15 and 45 years in urban, semi-urban and semi-rural areas, as well as 5 healthcare providers / policy makers to understand how health and healthcare is perceived by Ghanaian women.

For further information about the Philips Fabric of Africa campaign, please visit: www.philips.com/FabricofAfrica.

II. Key Recommendations

According to the World Health Organization (WHO), NCDs have become some of the leading global causes of death. In 2008, NCDs accounted for nearly two-thirds of global deaths (36 million)[8]. The WHO asserts that the combined burden of these diseases has rapidly increased in low and emerging middle income countries.

In Ghana, NCDs are on the rise but are not yet a current healthcare priority. Communicable diseases are well understood and preventative methods are widely known and used. Women are concerned about health in general and know they need to stay strong to work and look after their families. A move away from eating fresh food and taking regular exercise are seen as issue connected to a modern lifestyle.

Lack of education regarding health conditions and diseases, taboos, stigmatization and religious beliefs often prevent women from seeking care for NCDs. Breast and cervical cancers particularly are considered to be a private affair and are not often openly discussed, leading to a delay in early detection, which could impact on care outcomes. Misinformation plays a large part in delaying detection and care,

[7] In the context of this report, women refers to lower-middle and middle class women in the southern part of Ghana
[8] The WHO African Region includes the following countries: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Republic of South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.

as women are fearful of being stigmatized. Ghanaian women are eager for more information about NCDs and women undergoing treatment are anxious to receive more information about their condition, in order to have amongst others the knowledge to explain their condition to others.

Non-Government Organizations (NGOs) and church organizations play an important role in health education, and additionally the internet is quickly increasing in the urban middle class areas but the healthcare focus continues to be mainly on communicable diseases, such as HIV and malaria, and there is often low awareness and misinformation about NCDs.

Following the introduction of the National Health Insurance Scheme in 2003, women feel care has become more within their reach. However, as only certain costs are covered NCDs can often be very expensive to treat and there is now uncertainty about the future for the scheme.

Antenatal care is available but the quality of ultrasound equipment varies greatly. There have been more hospital deliveries since 2003 as they have been free of charge under the National Health Insurance Scheme, however, experience of hospital delivery is not always positive due to perceived harsh treatment by overstretched healthcare workers.

The following report outlines the views and experiences of Ghanaian women and healthcare workers in relation to care. Overall, Ghanaian women are looking for more health education and a more open dialogue in terms of health-related issues. Knowledge of NCDs is low and there is certainly an acknowledgement that more education is needed.

An integrated approach to NCD education and healthcare delivery seems necessary in Ghana. Education of both women and healthcare workers is particularly important to increase awareness of the importance of early detection and treatment and increase survival rates.

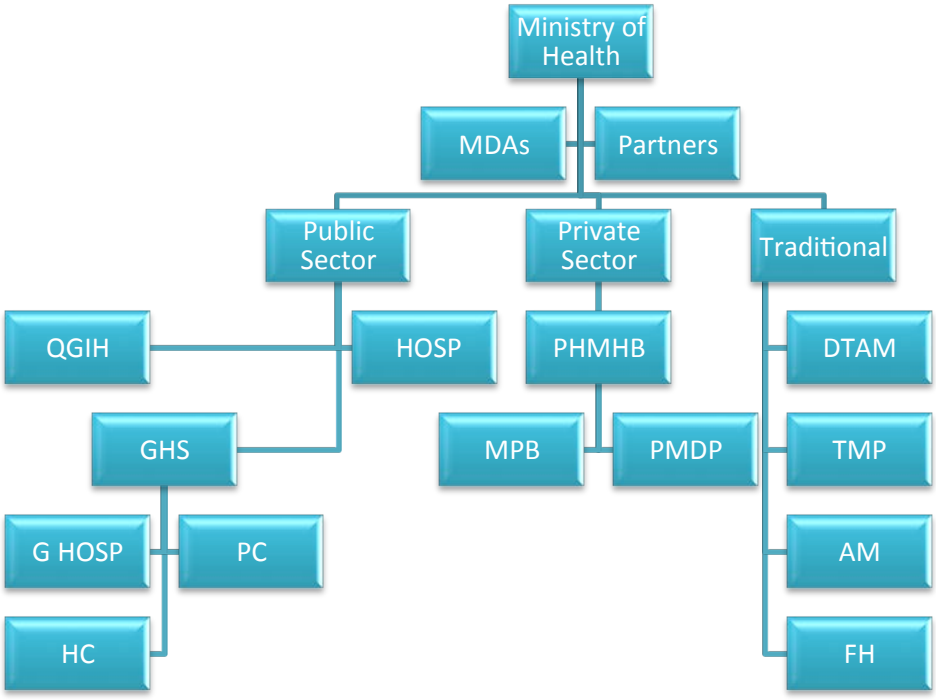
Current healthcare delivery is still mainly basic, curative care. Any proposed improvement should match this reality of limited local facilities and staff. Effective diagnostic and treatment services are of significant importance. Appropriate technology combined with training of staff can result in an increase in survival rates and combat the threat of NCDs.

III. Ghana's Healthcare System

III.a – Health System Organization

The healthcare system in Ghana is organized under four main delivery systems: public, private-for-profit, private not-for-profit and traditional systems. Though the former three are mostly associated with healthcare delivery in Ghana, efforts are being made since 1995 to integrate traditional medicine into the orthodox mainstream (see Abor, P.A.; Abekah-Nkrumah, G., Abor, J., 2008).

Structure of the Health Sector of Ghana[9]



Legend

MDAs: Ministries, Departments and Agencies
GHS: Ghana Health Service
T HOSP: Teaching Hospitals
QGIH: Quasi Government Institution Hospitals
PHMHB: Private Hospitals and Maternity Homes
DTAM: Department of Traditional and Alternate Medicine
GHSP: Government Hospitals
PC: Poly-clinics
HC: Health Centres
MBP: Mission-Based Providers
PMDP: Private Medical and Dental Practitioners
TMP: Traditional Medical Providers
AM: Alternate Medicine
FH: Faith Healers

There are five main levels of care, ranging from community based services, to specialist services in Tertiary or teaching hospitals.

The Ghanaian National Health Insurance Scheme (NHIS) was introduced in 2003 to provide access to adequate health-care regardless of ability to pay. However, the WHO[10] has warned of the possible collapse of the NHIS in 2013 due to structural and organizational inefficiencies, which would significantly impact on healthcare costs and availability in Ghana.

Specialized care is only present in two main cities (Accra and Kumasi), with Community Based Health Services (CHIPS) run by community health officer emerging in rural areas. All of the women who

[9] Source: Accord Health Care in Ghana, March 2009
[10] http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/08/20/000333037_20120820001118/Rendered/PDF/718940PUB0PUBL067869B09780821395660.pdf

participated in the study had access to a health center. However, high patient numbers are common and health center staff interviewed during the study spoke of frustration due to late presentations, the number of patients requiring care, lack of resources and absence of equipment.

Next to the government, churches, collectively known as the Christian Health Association of Ghana (CHAG), [11] play a large role in providing healthcare, providing for around 35% of all healthcare facilities in Ghana.

IV. Ghanaian Women's Views on Health

The women surveyed displayed an acute awareness of the importance of staying healthy in order to work and look after their families. They were often most concerned about the health of children, as they are viewed as not being as strong as adults yet, while men are seen as less likely to contract diseases as they are naturally stronger. The cost of living and a modern lifestyle were the main barriers to healthy living.

'Now we microwave instead of using a charcoal pot but the doctor says it's not good.' [Mother semi-urban area]

'Doctors advise on food but they don't know the expenses of a lady, what if she cannot afford it?' [Mother, semi-rural area]

'Women need to work to take care of themselves health wise, work is the key. We have a good health system but ladies have to wait for their husband for money. I am concerned about women who don't work and who have to ask their men for money to visit the clinic; [Mother, semi-rural area]

Health issues are considered to be a private affair. The women who participated in the study were somewhat reluctant to speak about their body and health issues. Stigmas and taboos play a part in an unwillingness to discuss NCDs such as breast and cervical cancer.

Communicable diseases were the main worry, with malaria and HIV the key concerns. Education around prevention and medication in relation to communicable diseases was very evident and the women were all aware of simple everyday actions they could take. Simple health messages, such as cleanliness and a well-balanced diet were well known, and the women were aware of the medications required to combat common issues.

'*Once in a while you can get malaria but then we'll just buy drugs."* [Elderly lady, semi-rural area]

[11] Website: www.chagghana.org

Non-Communicable Diseases are only starting to appear on their radar but women felt them to be less tangible, there was little evidence of education and communication leading to a low knowledge and awareness level.

"I don't know how to get it but does worry me due to all the ads on TV, I don't know how to avoid it." [Mother, semi-urban area]

'*We're not ready for large scale (mobile)mammography screening yet, people first need to understand what breast cancer is and the importance of screening before they'll use any machine.* [Dr. Beatrice Wiafe-Addai, Consultant Breast Surgeon]

Preventive care is not commonly provided and check-ups were spoken of in terms of a specific disease rather than a general health check. Some women also noted that healthcare workers did not encourage screening and that they had been turned away when they tried to be screened as they were not ill.

V. Women's Experience of Healthcare in Ghana

The women who participated in the study outlined that, initially, they tended to try to solve their health issues through self-diagnosis and treatment with the help of a western or herbal pharmacy prior to seeking professional care. Many people stated that they used both western and traditional medicine and this was a matter of personal choice and often depended on the type of health issue.

'*Sometimes the medicines of the hospital don't work, my grandmother will prescribe herbs then.*' [Mother, semi-urban area]

Public facilities were most often consulted when self medication was not successful and professional care was needed. Private facilities were seen as being accessible only to rich people as they are more expensive. The quality of the healthcare facility was seen as being more important than proximity and, as people are only eligible to receive care from a hospital they are registered with, some would register with a facility further away if they felt the care was better.

"*Women opt for other options until it's too late before they'll arrive in the hospital and when they die they'll blame it on the hospital."* [Dr. Beatrice Wiafe-Addai, Consultant Breast Surgeon]

VI. Awareness and Care in Relation to NCDs

VI.a – Maternal, newborn and child health

According to the United Nations (UN) Inter-Agency[12] report, "Trends in Maternal Mortality: 1990 to 2010", an estimated 287,000 maternal deaths[13] occurred globally in 2010, a decline of 47% from 1990 levels[14/15]. Sub-Saharan Africa (SSA) accounted for 56% of the global total (161,412 maternal deaths) that year. Of the 40 countries with the highest maternal mortality ratios (MMR) in the world, 36 were in Africa [8]. Overall, SSA has the highest MMR at 500 maternal deaths per 100,000 live births in 2010 and is, as a region, not considered by the UN to be "on track" to achieve the MDG 5 target of reducing maternal death by 75% from 1990 to 2015[14,15].

Ghana has been "making progress" toward MDG 5[15]. Between 1990 and 2005, the country's MMR reduced from 740 deaths per 100,000 live births to 503 deaths per 100,000 live births. The MMR then fell to 451 deaths per 100,000 live births in 2008. Despite this drop there have been disparities country-wide in progress. Ghana's Upper East and Northern Regions had some of the highest MMR in the country, with an average of 195 and 141 deaths per 100,000 live births, respectively. The Greater Accra Region's MMR was comparatively low, at 88 deaths per 100,000 live births; however, this reflected an increase from previous years[16]. Ultimately, if the current trend continues, Ghana's overall MMR will be reduced, but only to 340 deaths per 100,000 live births by 2015. Consequently, Ghana is likely to miss the MDG 5 target of 185 deaths per 100,000 live births[17].

The progress on reducing the MMR in Ghana has coincided with the MOH's decision to provide free maternity services to all Ghanaian women along with the introduction of the NHIS. Since the introduction of the new policy in 2003, the number of women delivering in a health facility has increased by 11%. The availability of appropriately equipped rural facilities for emergency obstetric cases as well as difficulties recruiting and retaining sufficient human resources, particularly midwives, have been key challenges for Ghana in meeting MDG 5[16].

On the ground, the women who participated in the study displayed very practical views on pregnancy, labor and delivery. Being pregnant and having a family is simply expected from every woman. In the urban middle class a change in the perception of family size can be seen, it is no longer better to have a lot of children if you can't provide a good quality of life and education. As family planning is more widely available, family sizes are declining.

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[12] Compiled by the World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and the World Bank.
[13] In the *International statistical classification of diseases and related health problems*, 10th revision (ICD-10) (9), WHO defines maternal death as: the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
[14] United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Bank, and World Health Organization (WHO), *Trends in Maternal Mortality: 1990 to 2010 – WHO, UNICEF, UNFPA and The World Bank estimates.* 2012. http://countryoffice.unfpa.org/uganda/drive/Trends_in_maternal_mortality_A4-1.pdf
[15] United Nations Population Fund (UNFPA). *Sub-Saharan Africa's maternal death rate down 41 per cent.* New York, United Nations Population Fund. 2012.
[16] Ghana Statistical Service, Ghana Health Service and ICF Macro, "Ghana Demographic and Health Survey 2008," (2009), p.154.
[17] United Nations Development Programme (UNDP) Ghana. *2008 Ghana Millennium Development Goals Report.* 2010.

So what is the experience of antenatal care and childbirth? Ghanaian women are aware of antenatal care and 85% of women go at least once during their pregnancy, with 60% going four times.[18] However, generally women are at a late stage of pregnancy before they seek antenatal treatment.

'*Women come too late for care for a number of reasons: they wait to see if the pregnancy survives the first 3 months, don't understand the necessity if they had an uncomplicated birth before, cultural beliefs: feel that the spirit of the baby can be taken away if you go to the hospital before 20 weeks so we only see women before 20 weeks pregnant if there is a problem like bleeding.'* [Physician, urban area]

The availability of equipment is a concern for healthcare workers and women are often referred to private care facilities for ultrasound tests, but the quality of scans vary and, if the quality is not good enough, women have to be sent for another one, costing time and money.

'An ultrasound is free but booked in advance for months so we need to refer them to the private clinics just outside of the hospital. The only problem is that the quality of the scan varies, so we try to advise them where to go but we cannot advertise one clinic over the other, we need to be independent.' [Physician, urban area]

Due to an increase in antenatal ultrasounds, women tend to know their due date and can plan ahead, resulting in more hospital deliveries. Location and quality of care were the two main concerns expressed by the women who participated in the study. Hospital deliveries are typically guided by nurses and most clinics and hospitals have large wards where women deliver at the same time. Women who had experienced a hospital delivery spoke to harsh treatment of nurses and midwives, who are under pressure to treat a high number of patients. Men are not permitted in the ward so it can be a lonely experience in contrast to a home birth with a Traditional Birth Attendant who will personally guide the delivery and the family of the woman will be there to assist afterwards.

'The midwife told me to hurry up, as she didn't have time, she left my sister and me with the baby.' [Mother, semi-rural]

VI.b – Breast Cancer

Ghanaian women are at risk of developing breast cancer 10 to 15 years earlier than their counterparts in developed countries. The average age of breast cancer detection in Ghana is 43 years and a study on breast cancer in Ghana indicated that out of over 47,000 women screened nationwide and confirmed with the disease, 55% of those diagnosed were in the pre-menopausal stage and 45% were in the post-menopausal stage. Juliana Azumah–Mensah, Minister of Women and Children's Affairs, announced during a press briefing on the Breast and Cervical Cancer Fund in 2011 that the prevalence rate for breast cancer in Ghana was between 0.41% and 1.11% among women between 15-80 years while women aged 35 to 45 years were most affected[19].

[18] Report on the determinants of antenatal care use in Ghana.:https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CD0QFjAB&url=http%3A%2F%2Fciteseerx.ist.psu.edu%2Fviewdoc%2Fdownload%3Fdoi%3D10.1.1.132.7628%26rep%3Drep1%26type%3Dpdf&ei=z39JUbetlorWPbangYAF&usg=AFQjCNE-6Cy81HMiHtbgyI9mqgv_kEahRw&bvm=bv.44011176,d.ZWU

[19] Kogevinas, M., N. Pearce, M. Susser, and P. Boffetta, eds. 1997. *Social Inequalities and Cancer*. IARC Scientific Publications 138. Lyons: IARC Press.

Women in Ghana have primarily linked the disease to superstitious beliefs and, in that regard, efforts have been made to raise awareness of the disease and teach Ghanaian women that it is curable. In 2010 alone, 2,062 women were diagnosed with the disease in Ghana[20]. According to GLOBOCAN, Ghana is ranked 10th among countries burdened with the disease in Africa, with a breast cancer incidence rate in the country of 25.8% (2,062 cases) and a related mortality rate of 16.6% (1,144 deaths)[21].

Having expressed an awareness of the disease, the women who participated in the study expressed concern that there were no clear guidelines about how to prevent it, unlike the more well-known communicable diseases.

'I don't know how to get it but does worry me due to all the ads on TV, I don't know how to avoid it.' [Mother, semi-urban area]

'No it is not that we don't worry about breast cancer, we do not worry about it very much because we abide by what the nurses tell us to do [self-examination] *when we go to the hospital.'* [Mother, semi-rural area]

'*At the moment there is some awareness but the issue is how to convince women to take prompt action.'* [Dr. Beatrice Wiafe-Addai, Consultant Breast Surgeon]

The women also admitted that there is a taboo around breast cancer, it was a private issue and not to be discussed in public.

'We need to take prompt action as soon as they are diagnosed to prove that this disease is curable and survivable, only then we can remove the fear surrounding breast cancer.' [Dr. Beatrice Wiafe-Addai, consultant breast surgeon]

Breast cancer organizations try to help in breaking down taboos and avoiding stigmatization:

'We write letters to the loved ones of the patient: "this is what your loved one is going through.' [Breast cancer organization Accra]

Knowledge of breast cancer screening was mixed amongst those who participated in the discussions. If there is free screening provided by an NGO or a church, women were likely to attend out of curiosity, but self-examination was not common. Breast cancer care is not reimbursed under the NHIS scheme, and specialists stated that they found it difficult to obtain funding. This naturally results in low levels of detection.

'Malaria, TB, malnutrition and HIV/AIDS are the acute diseases so they get a lot of attention and thus money.' [Dr. Beatrice Wiafe-Addai, Consultant Breast Surgeon]

Ghanaian women with breast cancer often do not seek help in time, generally through a combination of being ashamed and unaware that treatment could save their lives. A lot of the time it is too late to save a patient by the time they seek healthcare, which leads to a belief that breast cancer leads to death.

[20] GLOBOCAN Commission Report 2012, p34
[21] International Agency for Research on Cancer. *GloboCan 2008 – Cancer Fact Sheet.* http://globocan.iarc.fr/factsheet.asp

'If I talk about my experience, people want to touch the wound, it opens their eyes when I tell them that I survived.' [Breast cancer survivor, urban area]

"We need outreach programs for awareness creation and clinical screening, multiple visits are necessary as education is a dynamic process. People are still reporting with late stage presentations. This underlines the importance of the continuance of education. If women come in too late surgery is not possible or helpful anymore but only palliative care could be offered. We want to turn the idea of the diagnosis breast cancer being equal to death around and show that if you detect it early and take prompt action you can be cured. There are a lot of survivors who help in giving awareness talks and share their stories, we have people who are ready to volunteer their services but such people need to be assisted to do what they can do to help other women. For example Palsa (the Piece and Love survivors association) is ready to offer peer support assistance, especially to newly diagnosed women to help them comply to treatment." [Dr. Beatrice Wiafe-Addai, Consultant Breast Surgeon]

VI.c – Cervical Cancer

According to GLOBOCAN 2008, Ghana's cervical cancer incidence rate was 39.5% (3,038 cases) and its mortality rate was 27.6% (2,006 deaths)[22]. Dr. Peter Baffoe, a Gynecologist at the Bolgatanga Regional Hospital, said that 90% of cervical cancer cases associated with women in Ghana could not be treated in the country's health facilities because of the advanced stage of the disease at the time of screening[23]. *"Most of the cases we get are so advanced, they are in a stage where you are not able to cure,"* he said, adding that the country does not have enough capacity to treat very advanced conditions. While he noted that radiotherapies were available in Kumasi or Accra, he stressed the importance of early cervical screening for prevention[24].

The study showed that, as with breast cancer, cervical health is a taboo subject and women felt a bit uncomfortable discussing it. Once again, there were many misconceptions as to the cause of the disease.

Women are looking for more education in relation to cervical cancer

"Women should be more open and share their problems, only then they can be diagnosed and treated on time." [Mother, semi-urban area]

"Teach us about cervical cancer, we don't know that much about it." [Mother, semi-urban area]

At the moment there are only a few screening possibilities and resources to treat cervical cancer in Ghana. The government is aware that it will need to put facilities in place before screening and education programs can start.

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[22] Globocan 2008. www.globocan.iarc.fr
[23] GNA. *90 per cent of Cervical Cancer cases cannot be treated.* VibeGhana.com. 2012. http://vibeghana.com/2012/05/16/90-per-cent-of-cervical-cancer-cases-cannot-be-treated/
[24] N-Janjerborr Jalulah, William. *Ghana: Practice Safe Sex to Prevent Cervical Cancer - Gynaecologist Advises Women.* AllAfrica.com. 2012. http://allafrica.com/stories/201205220307.html

"There is no national policy on screening, we only do opportunistic screening. MOH has a policy on V.I.A. (Visual Inspection with Acetic Acid) not pap smear. They do screen for other diseases like eye problems, blood pressure, but not for cancer as it is not considered to be a number one problem." [Physician, urban area]

VI.d – Heart Disease

In 2008, the WHO reported that mortality from CVD and diabetes in Ghana was at a rate of 343.5 deaths per 100,000 women. When compared to the other selected countries, women in Ghana showed a higher estimated prevalence of daily tobacco smoking, at 1.7%. Additionally, an estimated 35.2% of women in the country had elevated blood pressure, 34.9% were considered overweight, and 19.8% registered raised cholesterol levels[25].

Heart disease was not commonly known amongst the Ghanaian women interviewed. The women surveyed were of the opinion that stress and negative emotions were a possible cause of heart disease, while stroke was also mentioned.

"Too much thinking can give you heart disease or high blood pressure." [Mother, semi-urban]

"You'll get heart problems if you easily get annoyed." [Young woman, semi-urban area]

"If you are angry it will affect your heart." [Elderly lady, urban]

[25] World Health Organization (WHO). *NCD Country Profiles-2011*. Geneva, World Health Organization, 2011. http://www.who.int/nmh/countries/en/index.html