

PD-AAE-023  
Ann: 47145

AN EVALUATION OF  
USAID-ASSISTED POPULATION ACTIVITIES  
IN GHANA

A Report Prepared By:  
JOHN KAREFA-SMART, M.D., M.P.H.  
BEN MAJOR, M.D., M.P.H.  
CAROLE TYSON, Ph.D.  
SAM OFOSU-AMAAH, M.D., M.P.H.  
SAM K. GAISIE, M.A., Ph.D.

During The Period:  
AUGUST 17 - AUGUST 30, 1980

Supported By The:  
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:  
Ltr. AID/DS/POP: 4/2/81  
Assgn. No. 582057

## PREFACE

The members of the evaluation team wish to express their appreciation for the efforts of all the persons with whom they worked or conducted interviews. These persons spared no pains to clarify many problems and to facilitate the inquiries of the team. Special thanks are due to Dr. Morris Weiss and Mr. Ray Martin, of the USAID mission in Accra, and their spouses, who made themselves and their offices available to the team at all times, and to Dr. A.A. Armar and his staff in the Secretariat of the Ghana National Family Planning Program, who made all the arrangements for the team's contacts and interviews. Because of the willingness of everyone in Ghana to assist with the mission, the team was able to complete its tasks even though it did not have enough time to make as thorough an evaluation as these important projects deserve.

The views expressed in this report are those of the authors and should not be attributed to the governments of Ghana and the United States.

## C O N T E N T S

	<u>Page</u>
PREFACE	i
EXECUTIVE SUMMARY	v
General Findings	vi
Recommendations	vii
Conclusions	ix
ABBREVIATIONS	x
I. INTRODUCTION AND BACKGROUND	1
Physical and Social Geography	1
Demographic Background	2
Political Background	5
Currency	6
II. A REVIEW OF THE POPULATION POLICIES OF GHANA	7
III. UNITED STATES SUPPORT OF GHANAIAN POPULATION POLICY	10
Background	10
Objective of Assistance Program	10
IV. THE EVALUATION MISSION	12
Composition of the Team	12
Scope of Work	12
Evaluation of Methodology	14
V. SUMMARIES OF PROJECTS IN GHANA	16
Projects Funded Through U.S./Ghana Bilateral Agreements	
Population Program Support	16
National Family Planning Program Supplies	16
Population Dynamics Program	18
University Teaching of Population Dynamics	18
The Danfa Comprehensive Rural Health and Family Planning Project, 1970-1979	24
Family Planning and Demographic Data Development, The National Demographic Sample Survey, 1968-1969	33

	<u>Page</u>
Projects Funded from Central AID Funds, Directly or Indirectly	
Ghana Fertility Survey, 1979	35
Contraceptive Retail Sales (CRS) Program	37
University Teaching of Population Dynamics	40
Physicians Postgraduate Training in Reproductive Health	41
Family Planning Services	44
Grant to International Planned Parenthood Federation To Support the PPAG	45
Family Planning International Assistance Programs	46
Program for Voluntary Sterilization	50
Support of Teaching and Research in Demography	51
Strengthening International Population Communication and Training	53
Population Information Program: <u>Population Reports</u>	54
AHEA Grants to Ghana Home Science Association	55
Training for Family Planning Managers	56
United Nations Fund for Population Activities	57
Expansion of Postpartum Family Planning Program	60
Family Education Project	61
African Health Training Institutions Project	63
International Development of Qualified Social Work Manpower for Population/Family Planning Activities	66
Participant Training for Population- and Family Planning-Related Activities	67
General Review	70
VI. CONCLUSIONS ON THE GHANA NATIONAL FAMILY PROGRAM	76
General Conclusions	76
Role of the Ministry of Health	77
VII. CONCLUSIONS ON USAID SUPPORT OF POPULATION PROGRAMS IN GHANA	81
Role of USAID Mission Population Staff	82
VIII. RECOMMENDATIONS	85
REFERENCES	87

## **APPENDICES**

- Appendix A: List of Persons Contacted**
- Appendix B: Map of Ghana**
- Appendix C: Demographic Data and Population Factors**
- Appendix D: Sample Summary Report on Acceptors of Family Planning Services, 1978**
- Appendix E: Organization Chart of Ghana National Family Planning Program**

## EXECUTIVE SUMMARY

Ghana became, after Kenya, the second formerly colonial country in Africa to adopt an official policy on population. In March 1969, the Government of Ghana (GOG) published a report entitled "Population Planning for National Progress and Prosperity." This report was the result of a three-year study undertaken by the Manpower Board of the Ministry of Finance and Economic Planning at the request of the National Liberation Council. It includes what is now known as the Ghana Population Policy-- a forthright recognition of the interrelationship between population and general economic and social development and of the "crucial importance of a wide understanding of the deleterious effects of unlimited population growth and of the means by which couples can safely and effectively control their fertility."

The publication of this document constituted a bold change of direction, for the overthrown regime of Ghana's first president, Dr. Kwame Nkruma, had been opposed to any national consideration of population matters. Much credit for the new policy should be given to the quiet pioneering of the Christian Council of Ghana (CCG), which, since 1961, has offered family planning services as part of the family counseling program of its Committee on Christian Marriage and Family Life (CCMFL).

In 1970, the Ghana National Family Planning Program (GNFPP) was established under the direct supervision of the Ministry of Finance and Economic Planning. Its purpose was to coordinate the family planning service activities of the Ministry of Health and the information, education, and communication (IEC) activities of the Ministry of Information.

The United States promptly responded to Ghana's bold new initiative by funding a large number of projects of assistance in population-related programs in both the public and private sectors. In the 10 years covered in this report, approximately \$17 million were appropriated to support 24 projects--5 through the bilateral process and 19 through the central funding mechanism.

A five-member team was appointed to evaluate the contribution of United States assistance to meet the goals of the Government of Ghana. Three members of the team were nominated by the United States and two were selected by the GOG. The American members of the team were John Karefa-Smart, M.D., M.P.H., Department of Preventive and Social Medicine, Harvard Medical School; Ben Major, M.D., M.P.H., an obstetrician-gynecologist in private practice in California; and Dr. Carole Tyson, AID population officer, Washington, D.C. The Ghanaians were Professor Sam Ofosu-Amaah, head of the Department of Community Health, University of Ghana Medical School, and Professor Sam K. Gaisie, a demographer at the University of Ghana.

The team worked in Ghana from August 11 through August 30. It interviewed people in various ministries and private voluntary organizations (PVOs), visited clinics and the University of Ghana, reviewed and upgraded individual projects, and prepared a set of recommendations.

### General Findings

The general findings of the team are as follows:

1. The distribution of U.S. funds, in approximately equal amounts between the two categories of projects (bilaterally- and centrally-funded), is justifiable. The universities and the PVOs were enabled to lend needed support to the larger public programs of the GOG.
2. The projects made approximately equal contributions to the three major objectives: demographic research, training, and information.
3. On a scale of 1 to 5, all the projects scored 3 or above when achievement of objectives was assessed.
4. The Ghana National Family Planning Program, although beset with administrative problems, has weathered the unsettling political and economic disturbances in the country during its lifetime. It can be credited with succeeding in fostering a national awareness of family planning methods.
5. The availability of family planning services and supplies in the regions and especially in rural communities has been limited because of management and transport problems and because collaboration among the ministries has been less than enthusiastic.
6. Large numbers of Ghanaians have been trained both in Ghana and abroad; thus, the capability of Ghanaians to implement programs now and in the future has been greatly strengthened.
7. Prompt and complete reporting is deficient, making it difficult to quantify achievements in terms of persons receiving and using family planning services.
8. With the creation of the MCH/Family Planning Division in the Ministry of Health, which is headed by an enthusiastic senior medical officer, the prospects that the Ministry of Health will accept full responsibility for the provision of family planning services,

including maternal and child care, in all institutions all over the country have been improved.

9. The GOG fully supports the commitment of its predecessors to the national population policy.
10. The U.S. population officer at the USAID mission in Ghana has played an important role as a coordinator and stimulator of activities. His efforts are appreciated by the GOG ministries and PVO officials.

### Recommendations

The recommendations of the team, which were discussed with USAID mission staff and GOG officials, are as follows:

1. The Government of Ghana should give priority to a careful study of the national program to find and implement solutions to the problems which are limiting the program's effectiveness. Such a study should encompass the roles of the Manpower Board, the Ministry of Health, the Ministry of Finance and Economic Planning, and the Secretariat of the GNFPF.
2. AID/W and the AID mission in Ghana should constantly seek to increase the involvement of Ghanaian nationals in decisionmaking in all projects. A Ghanaian should be appointed to serve as a co-director of each in-country project.
3. In its population program and general development efforts, the GOG should be encouraged to focus more attention on the rural areas, where 70 percent of the population resides, and to develop and promote integrated community-based programs, including women's self-help projects.
4. AID support of Ghana's population-related programs should be continued at current or increased levels.
5. In the Ghanaian context, the importance of AID assistance in population, which has required the AID mission to devote considerable effort to coordination, should not be overlooked. The mission's role fully justifies the post of a full-time U.S. population officer who has equal access to AID/Washington, the AID/Ghana mission, and GOG officials.

6. More direct assistance should be given to such PVOs as the Planned Parenthood Association of Ghana and the CCG, which are well organized, have demonstrated their ability to provide acceptable family planning services, and operate cost-effective programs.
7. The effort to fully integrate family planning into maternal and child health (MCH) services has already begun and should be vigorously pursued. No additional financial incentives should, however, be offered to providers in any professional category.
8. The Ministry of Health should assume complete and sole responsibility for the supply and distribution of family planning commodities in the public sector.
9. The demand for a low-estrogen oral pill and the increasing popularity of an acceptable foaming tablet (Neo-Sampon) justify the provision of these commodities in greater quantities.
10. Decisions on pricing should reflect consideration of the low levels of cash income of the majority of rural Ghanaians. The lowest possible prices should be set for a commercial program, and government-provided commodities should remain free.
11. Participating government ministries should pay particular attention to the follow-up of results and recommendations of research projects and workshops as they relate to their programs.
12. Increased reliance should be placed on Ghanaian institutions which already have adequate staff facilities and equipment to undertake in-country training.
13. To avoid difficulties and misunderstandings during project implementation, all financial and other contractual agreements should be fully specified and defined for major participants.
14. AID should continue to support the integrated research programs of Ghanaian universities. These institutions' findings will be much more useful for formulating and implementing socioeconomic development programs and for evaluating action-oriented programs.

## Conclusions

In general, the team believes that U.S. population assistance to Ghana was well deserved, has been effectively used, has contributed significantly to the achievement of the objectives of the GNFPP, and has supported a well balanced mix of programs. This assistance program should be a model for future support in Ghana and other African countries.

## ABBREVIATIONS

AHEA	American Home Economics Association
AHTIP	African Health Training Institutions Project
AID/W	Agency for International Development/Washington
APHA	American Public Health Association
APPLE	Association of People for Practical Life Education
CBD	Community-Based Distribution
CCG	Christian Council of Ghana
CCMFL	Committee on Christian Marriage and Family Life
CEFPA	Centre for Population Activities
CPP	Convention People's Party
CRS	Contraceptive Retail Sales
EIP	Expanded Immunization Program
FLE	Family Life Education
FP	Family Planning
FPIA	Family Planning International Assistance
GHSA	Ghana Home Science Association
GIHCC	Ghana Industrial Holding Corporation
GNFPP	Ghana National Family Planning Program
GOG	Government of Ghana
IASSW	International Association of Schools of Social Welfare
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
ISSER	Institute of Statistical, Social and Economic Research

JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, Attitude, Practice
MCH	Maternal and Child Health
MOH	Ministry of Health
NDSS	National Demographic Sample Survey
NFPP	National Family Planning Program
NLC	National Liberation Council
NRC	National Redemption Council
OB/GYN	Obstetrics/Gynecology
PDP	Population Dynamics Program
PES	Post-Enumeration Survey
PHC	Primary Health Care
PID	Project Identification Document
POP	Population
PPAG	Planned Parenthood Association of Ghana
PROP (PP)	Project Paper
PVO	Private Voluntary Organization
RIPS	Regional Institute for Population Studies
RTI	Research Triangle Institute
SIDA	Swedish International Development Authority
TBA	Traditional Birth Attendant
UCLA	University of California, Los Angeles
UGMS	University of Ghana Medical School
UNC	University of North Carolina
UNDP	United Nations Development Program

UNIDO	United Nations Industrial Development Organization
USAID	United States Agency for International Development
VHW	Village Health Worker
WFS	World Fertility Survey
WHO	World Health Organization
YMCA	Young Men's Christian Association

## I. INTRODUCTION AND BACKGROUND

### Physical and Social Geography

Ghana is situated in Africa, on the sub-Saharan Guinea Coast. Formerly a British colony known as the "Gold Coast," Ghana became an independent republic on July 1, 1957.

Ghana covers an area of 92,100 square miles (238,537 square kilometers). It spreads northward more than 400 miles, from the Atlantic coast at latitude 4°44' north, through the Guineo-Congolian lowland rain forest and the broad-leveled woodland and grassland, just south of the semi-desert region, to latitude 11°10' north. It is bounded on the west by the Ivory Coast, on the north and northwest by Upper Volta, and on the east by the Republic of Togo. The country is divided into four major geographical regions: the humid southeastern equatorial rain forest, which has a mean annual rainfall of approximately 75 inches and a mean monthly temperature that ranges between 79° F and 86° F; the wet, semi-equatorial forest, where the same climatic conditions as prevail in the rain forest are present, except for a more pronounced dry season; the hot savannah woodland, which covers approximately 65,000 square miles of the northern half of the country; and the hot coastal scrub and grassland, which is the driest region in the country, stretching along the coast from Sekondi in the Western Region to Ada in the Volta Region.

Although there are many rivers, none are important for inland transportation, and most of those in the north are dry during the "dry season." The larger rivers--the Volta, Ankokra, and Tano--are only navigable by small craft of shallow draft. The Akosombo Dam on the Volta River has created the largest man-made lake (3,276 square miles) in the world.

For many years, the moist, shady forests and heavy rainfall made Ghana the largest producer of cocoa and an important exporter of timber. Groundnuts, yams, and guinea corn are the principal crops outside the rain forest. There is some cattle-grazing in the semi-desert grasslands in the north.

The climate is tropical, with two distinct seasons: a rainy season, which generally lasts from May to October, and a dry season, which lasts from October to April. The temperature varies little between seasons and ranges in March from a mean maximum of 86° F in the east to 92° F in the north. The relative humidity averages 80 percent, except during the dry harmattan winds in January and February, when humidity is considerably lower.

The country is divided into eight political regions:<sup>1</sup> Eastern Region, Central Region, Western Region, Volta Region, Ashanti Region, Brong-Ahafo Region, Northern Region, and Upper Region.

### Demographic Background<sup>2</sup>

Ghana's population, estimated to be 11,225,000 in 1978, has been increasing in recent years at a rate of about 3.1 percent per annum. This yields a density of 102 persons per square mile.

The rate of population growth, which is higher than that of most African countries, has attracted the attention of demographers and other social scientists since the beginning of the second half of this century.

The Ghanaian population is made up of a large number of ethnic groups. Among the major groups are the Akans, Ga-Adangbe, Guans, Ewe, Gurma, Lobi, Grusi, Central Togo ethnic groups, and Mole-Dagbani.

The Akan-speaking people, who inhabit most of the southern half of Ghana, comprise the Asante-Ahafo, Fante, Nzema-Evalua, Boron (Brong), Akyem, Akuapem, Kwawu, Wasa, Ahanta, and others. The Akans are said to have migrated from the northern part of Ghana to the central and southern parts of the country as a result of pressure from the Fulanis and other northern tribes. This southward movement, believed to have begun around the 15th Century, continued over a fairly long period. Although the Akans are culturally homogeneous, certain cultural and linguistic variations tend to differentiate them from each other. However, they all have a matrilineal kinship system, which is based on a localized lineage organization. The lineage is a branch of a larger unit--the clan--which is a non-localized social entity.

The Ga-Adangbe are found in the southeastern part of Ghana. The Ewes and Akwamus, the Efutu and Awutu, and the Akuapem are their eastern, western, and northern neighbors, respectively. The Ga-Adangbe are made up of two major tribal groups, the Ga and Adangbe, which, in turn, are made up of several sub-tribes. The Ga-Adangbe are said to have migrated at different times and in different streams from the western part of Nigeria. Their kinship system is characterized by patrilineality and patrilocality. The patrilineage is normally administered by the oldest male member of the lineage.

---

<sup>1</sup> See Appendix B.

<sup>2</sup> A comprehensive analysis of demographic conditions in Ghana, contributed by Professor Sam K. Gaisie, is attached as Appendix C.

The Ewe-speaking people occupy a territory stretching southeast of the Volta River to the Republic of Togoland. Tradition has it that the Ewes migrated from Oyo, in western Nigeria, and settled in the southern half of the Republic of Togoland and in southeast Ghana.

The Guan-speaking peoples are scattered over a considerable part of Ghana. They are made up of congeries of culturally heterogeneous groups of people, but most of them speak the Guan language in one form or another.

The Efutu and Awutu in Central Region, the Anum-Boso, Nkonya, and Atwode in the central part of the Eastern Region, and the Gonja and Nchumuru in the southeastern part of Northern Region are all Guan-speaking people.

The Central Togo ethnic groups occupy the central part of Volta Region and spread into the Republic of Togo. The ethnic groups are small in size and, like the Guan, they do not occupy contiguous territory. Avatime, Nyangbo, Tafi, Buem, Akposo, Ntrubu, and Adele are among the major ethnic groups. Their political and social organization is similar to that of the Ewes.

The Gurma comprise several ethnic groups. They live partly in the northeastern part of Ghana and partly in the northern part of the Republic of Togo. The Konkombas are the most numerous among the Gurma. The Mole-Dagbani comprise the Mamprusi, Walba (Wala), Dagaba (Dagarte), Builsa, Nankansi and Grensi, Frafra, Talensi, Kusasi, Namnam, and Mosi. They all inhabit the Northern and Upper regions of Ghana. Their social organization is distinguished by the patriarchal clan and the patrilineal joint family.

The Grusi include closely related ethnic groups who live in Upper Volta and Upper Region of Ghana. Mo, Sisala, Kosena, and Vagala are the main sub-ethnic groups. Their social organization is similar to that of the Mole-Dagbani ethnic groups. Like the Grusi, the Lobi ethnic group is made up of congeries of several ethnic groups who occupy the northern frontiers of the Republic of Ivory Coast, the southern part of Upper Volta, and northwestern Ghana. Birifor, Yangala, Miwo, Lowili, and Lo Dagaba are the main sub-tribes. Among the Birifor patrilineal and matrilineal ties are recognized.

Patrilineal and matrilineal societies in Ghana place a high value on children as a means to perpetuate lineage and as security for old age. They cling to a widely held belief in the importance of perpetuating the line of descent. For this reason, men and women who never marry are not regarded with favor. The Asantes, who live in southern Ghana, have a matrilineal kinship system and honor prolific childbearing. Traditionally, a mother of 10 children will boast of her achievement and be given a public ceremony of congratulations.

In both patrilineal and matrilineal societies, the values placed on children and fertility-related norms have been integrated into the social structures of the societies in such a way that a couple does not feel severely the burden associated with large family size. Although there is a strong desire for large families, the corporate kin groups do not necessarily motivate couples to be highly fertile. They do, however, provide economic and personal support for individuals who adhere to traditional lifestyles. Unlike societies where the nuclear family predominates, the burden of rearing children does not fall directly on the parents.

Among the Asantes, for instance, maternal grandmothers (nana) play an important role in childbearing. Indeed, they are sometimes autocratic in this regard, arguing that a grandchild belongs more to the lineage than to its parents and therefore comes most appropriately under its grandmother's care.

Besides cooperating in rearing and caring for children, members of the lineage participate to a large extent in the contraction of marriage, the most significant institution for achieving the aims and most valued goals of the lineage or kinship group. Given the rules of incest and exogamy, patrilineal groups (e.g., Dagomba, Ewes) can survive only by securing rights over the reproductive powers of women from other groups. Thus, a great deal of importance is attached to marriage, and marriage is so instituted that uxorial and generiticial rights are clearly vested in the husband and his patrilineage.

The high value placed on children in matrilineal societies (e.g., Asante) is related to many aspects of the culture and the localized lineage organization. The ownership of land and other economic property is vested in a lineage or its segment. The ideals and the values implicit in the social organization of the ethnic groups tend to sustain high fertility levels.

Demographic studies at the University of Ghana seem to indicate that the interplay of the lineage structures of the ethnic groups and certain intermediate variables (e.g., low age at first marriage, high proportion of married couples, non-use of contraception during marriage) stimulate high reproduction in Ghanaian traditional societies.

Freedom of worship is guaranteed by the Constitution of Ghana. There is no official state religion, although an estimated 50 percent of the population, who live mostly in Accra, Kumasi, and Sekondi-Takoradi--the "Golden Triangle"--profess to be Christians. Muslims are found mostly in the northern savannah areas. The rest of the population is traditionally animist.

## Political Background

The first president of Ghana following independence was Dr. Kwame Nkrumah. As head of the Convention People's Party (CPP), Dr. Nkrumah ruled Ghana from 1960 until February 1966, when he was overthrown while on a visit to Peking.

The major causes of the 1966 coup were a general decline in the standard of living (partially a result of extravagant capital expenditures) and an increasingly oppressive political atmosphere following the declaration of a one-party state.

A joint military-police junta, the National Liberation Council (NLC), succeeded Dr. Nkrumah. Under the chairmanship of General J. Ankrah, the NLC dissolved Parliament and banned political parties. It remained in power until October 1969. However, in April of that year, Major, later General, A. Afrifa and his colleagues forced General Ankrah to resign because he could not deal with the difficult problems of increasing foreign indebtedness and domestic inflation.

In keeping with an early NLC promise to restore a civilian regime, Ghana held elections in August 1969. Dr. Kofi Busia's Progress Party was declared the winner. At first, a triumvirate non-executive presidency was created and shared by General Afrifa, Major General A. Ocran, and Police Inspector-General J. Hanlley, with Dr. Kofi Busia, a former veteran leader of the opposition in the early years of independence, as prime minister.

Dr. Busia, a sociologist, was unable to cope with the large foreign debt, increasing unemployment, and falling export prices for cocoa. He attempted to solve these problems by expelling foreign Africans, dismissing more than 500 civil servants, and devaluating the currency.

The deteriorating economic conditions led to Ghana's second military coup in January 1972, which was led by Colonel I.K. Acheampong while Dr. Busia was in England. The new junta, again a combined military and police group, was known as the National Redemption Council (NRC). In October 1975, the NRC was replaced by a Supreme Military Council headed by General Acheampong.

Again, a deteriorating economy compounded by drastic reductions in the revenues of cocoa exports and increasing prices for imported oil created large trade deficits and three-digit inflation.

General F.W. Akuffo ousted General Acheampong in July 1978, promising to return the country to civilian rule in 1979.

The alleged corruption of the senior military officials led to yet another coup in June 1979, this time by a 31-year old Air Force officer, Flight Lt. Jerry Rawlings. Within four months, Rawlings fulfilled his promise to return Ghana to civilian rule. (He executed several military officials, including Generals Akuffo, Afrifa, and Acheampong.) Multi-party elections were held in June and July 1979. The elections were won by the People's National Party, led by Dr. Hilla Limann, a 52-year old economist. On September 24, 1979, Dr. Limann was installed as president.

Since Dr. Nkruma was deposed in 1966, the country has enjoyed civilian rule for only 27 months, during Dr. Busia's reign as prime minister.

### Currency

The unit of currency is the cedi, which is the equivalent of 100 pesewas. At the time of this evaluation, the official rate of exchange was  $\text{¢}1 = \text{U.S. } \$2.70$ .

A reliable indicator of the depressed economy is the prevailing black-market rate of one U.S. dollar to 20 cedi.

## II. A REVIEW OF THE POPULATION POLICIES OF GHANA

Throughout his regime, Dr. Nkruma strongly disapproved of any consideration of the effects of rapid population growth on Ghana's economy. He also was opposed to family planning. The results of the 1960 census, however, caused many government officials to become concerned about Ghana's rate of population growth, the urban and rural distribution of the population, the influence of migration, and unemployment.

Soon after Dr. Nkruma was ousted, the military government made a bold departure from Nkruma's position and charged the Manpower Board of the Ministry of Finance and Economic Planning to undertake a study of all aspects of Ghana's population. Three years later, in March 1968, the results of the study were published under the title "Population Planning for National Progress and Prosperity." This document has since become known as the "Population Policy Statement" of Ghana. Its importance cannot be overestimated. Only one other African country, Kenya, has adopted an official policy on population.

The Ghana Population Policy Statement describes the government's intention thus:

. . . recognizing the crucial importance of a wide understanding of the deleterious effects of unlimited population growth and of the means by which couples can safely and effectively control their fertility, the Government will encourage and itself undertake programs to provide information, advice and assistance for couples wishing to limit their reproduction. These programmes will be educational and persuasive and not coercive.

The publication of the policy statement was followed by the establishment in May 1970 of the Ghana National Family Planning Program (GNFPP) and a secretariat. The purpose of the GNFPP is to coordinate the family planning activities of the Ministry of Health and the Ministry of Information. The GNFPP is under the direct supervision of the Ministry of Finance and Economic Planning. Other ministries have been involved in the implementation of the program, including the Ministry of Labour and Social Welfare, the Ministry of Agriculture, and the Ministry of Education.

The pioneering Christian Council of Ghana (CCG), which worked quietly even during the unsupportive regime of Dr. Nkruma, deserves credit for creating an initial awareness of and stimulating concern about family planning. The first marriage counseling clinics to provide family planning information and advice were opened in 1961 by the CCG

Committee on Christian Marriage and Family Life (CCMFL). Credit must also be given to the Planned Parenthood Association of Ghana (PPAG). The founding members of both groups played important roles in the deliberations of the Manpower Board which led to the official publication of "Population Planning for National Progress and Prosperity."

Despite the political upheavals, successive governments, both civil and military, have endorsed the original population policy and have provided administrative and financial support for the GNFP and its secretariat. Most recently, President Limann, in his sessional address to Parliament in November 1979, confirmed government endorsement of the population policy:

. . . We know that Ghana's population is, and will continue to be the nation's most valuable asset. Its protection and the enhancement of its welfare is therefore one of our primary objectives, since population plays a very crucial role in the total development matrix, being both the producer and the consumer of goods and services. Balancing these two aspects of the role of population in our development processes must therefore form an important part of our determination to move ahead.

Our estimated population of 11 million is continuing to grow at an accelerated pace; a growth pattern which has produced a youthful population and brings with it in-built vigour and inherent potential for further growth. As population grows, more services will be needed to ensure that the quality of this most vital national resource is enhanced.

Ghana has recognized the inter-relationship between population and development since 1969. The Population Policy then enacted seems to be sound and will therefore continue to guide our efforts while we look more closely at the relations of population growth and its effects on each of our national development sectors.

My government will therefore take a critical look at our broad population programmes, including relevant research activities in our universities, and introduce appropriate organizational arrangements to ensure that due cognizance is taken of the population element in all our national development efforts.

The 1969 policy statement emphasized the following points:

- Social and economic planning for development requires as an essential component a population policy and program.
- An important goal is reduction of the currently high rates of morbidity and mortality.
- Demographic data must be collected, and research on population is urgently needed.
- Access to family planning information and services is a basic human right of Ghana's citizens.
- There is a need to expand educational and employment opportunities for the female population.
- Regulation of migration requires attention.

To implement the family planning component described in the Population Policy Statement, the government organized the Ghana National Family Planning Program to coordinate the activities of several participating ministries and non-governmental groups. The Secretariat of the GNFP was given the responsibility of channeling external financial support from all sources to implement the various population-related programs. This evaluation, therefore, gives particular attention to the GNFP.

### III. UNITED STATES SUPPORT OF GHANAIAN POPULATION POLICY

#### Background

The United States was one of the first countries to respond to the GOG's bold initiative to enact a forthright and comprehensive population policy. Since 1969, approximately \$17 million have been contributed in support of the 5 bilateral and 19 centrally-funded population-related projects listed in Table 1.

#### Objective of Assistance Program

The principal objective of both kinds of U.S. assistance was to support programs that belong to one or more of the categories of research, training, and the provision of family planning (FP) services. The programs listed in Table 1 were undertaken by several government ministries, by the University of Ghana and the University of Cape Coast, and by a variety of private agencies and organizations.

---

Table 1

GHANA PROJECTS AND ACTIVITIES SUPPORTED BY  
AID/W AND USAID POPULATION FUNDS, 1968-1979

---

- A. Projects funded by USAID through bilateral agreements between the Government of Ghana and the United States:
1. Population Program Support
  2. Population Dynamics Program
  3. Danfa Rural and Family Planning Project (population component only)
  4. National Family Planning Program Supplies
  5. Family Planning and Demographic Data Development
- B. Projects funded centrally from AID/W to agencies and institutions with population-related activities in Ghana:
1. Ghana Fertility Survey
  2. Contraceptive Retail Sales Program
  3. University Teaching of Population Dynamics
  4. Physicians Postgraduate Training in Reproductive Health
  5. Family Planning Services
  6. Grant to International Planned Parenthood Federation (in support of Planned Parenthood Association of Ghana)
  7. Family Planning International Assistance Programs
  8. Program for Voluntary Sterilization
  9. Program Grant to Population Council
  10. Strengthening International Population Communication and Training
  11. Population Information Program
  12. Family Planning Assistance Through Home Economics
  13. Training for Family Planning Managers
  14. UNFPA
  15. Expansion of Postpartum Family Planning Program
  16. Family Planning Education through Adult Literacy Programs
  17. Family Planning Courses in Health Training Institutions, 932-0359 (University of North Carolina)
  18. International Development of Qualified Social Work Manpower for Population/Family Planning Activities
  19. Participant Training in the United States
-

#### IV. THE EVALUATION MISSION

After more than a decade of support, it seemed appropriate to make a comprehensive assessment of total U.S. assistance to Ghana to support the pioneering determination to reduce population growth. Although the decision about this evaluation was made early in 1978, it was not possible to begin the study until August 1980.

##### Composition of the Team

By agreement with the GOG, USAID selected three members of the evaluation team and the GOG selected two. The American team was made up of John Karefa-Smart, M.D., team leader and specialist in public health administration; Ben Major, M.D., medical specialist in obstetrics and gynecology; and Carole Tyson, Ph.D., anthropologist and population specialist. The Ghana government appointed Professor Sam K. Gaisie, a demographer at the University of Ghana, and Professor S. Ofosu-Amaah, M.D., head of the Department of Community Health, University of Ghana Medical School.

On the eve of their departure for Ghana, the three U.S. members were briefed at the AID Population Office in Washington, by the former director of the USAID mission in Ghana, and by officials of the Africa Bureau. The entire team was also briefed on the first working day in Accra by the medical officer, the U.S. population officer, and the acting director of the USAID mission.

##### Scope of Work

The scope of work for this evaluation, on which both governments agreed, was to include, but not necessarily be limited to, the following tasks:

- Review all AID population and family planning assistance from 1968 to present, emphasizing activities in recent years. (This review includes 5 bilateral projects and 20 centrally-funded projects.)
- Make a general assessment of the impact of U.S. aid on Ghana's efforts to implement its official population policy.
- Document the accomplishments of AID-assisted family planning programs and AID inputs and outputs; assess

the extent to which stated outputs and purposes were achieved, the constraints on implementation, the validity of original project designs and strategies, and lessons learned.

- Assess the relevance and effectiveness of types of AID assistance to support the GOG's strategy to reduce the population growth rate; discuss alternative strategies for consideration by the GOG and AID.
- Discuss the quality and relevance of AID-funded population (POP) research and its impact on policy and programs.
- Assess the relevance and impact of AID-funded participant training and in-country training to meet the manpower needs of population and family planning activities; analyze how well training is used.
- Assess the appropriateness of the mix of family planning and non-family planning assistance from AID.
- Assess the appropriateness of the mix of bilaterally-funded and centrally- and regionally-funded assistance.
- Assess the contributions of AID-supported PVOs to the achievement of Ghana's population and family planning goals.
- Assess the appropriateness of types of AID assistance for integrating population and development, as well as family planning and related services, into the GOG's organizational structure.
- Assess the relative effectiveness of AID assistance to different service delivery modalities (e.g., GOG clinics, PVO clinics, commercial distribution, social welfare outreach programs).
- Assess the managerial and administrative capacity of the GOG and of private sector institutions to implement AID POP projects effectively and on time.

It was suggested after the team arrived in Ghana that the team also assist the USAID mission in formulating and drafting a multi-year population assistance strategy statement and in reviewing a project identification document (PID). As the work of the team progressed, however, it became evident that these additional tasks could not be completed in the

time available (three and one-half weeks). Nonetheless, the team did discuss its findings at various stages with the population officer and made informal comments on the main issues that would be addressed in the PID.

### Evaluation Methodology

The team arrived in Ghana on August 11 and remained in the country through August 30. Work began with a meeting with the U.S. ambassador and the Ghanaian ministers (or, in their absence, their deputies) of the collaborating ministries in the Ghana National Family Planning Program. At this meeting the team was briefed on the objectives of the evaluation mission and obtained formal approval of plans to hold discussions with ministry officials who are more directly involved with the program.

The Secretariat of the GNFPF helped to arrange interviews with GOG ministry officials and with the principal officers of voluntary agencies that have received USAID support for family planning programs.<sup>1</sup> Several projects were then assigned to each team member for review. These reviews preceded general discussion by the entire team.

The team had access to the project files in the USAID mission and to a fairly large collection of books, pamphlets, and reports, including earlier evaluations of projects.

The evaluators visited family planning clinics in Accra and Danfa, the Indigenous Medical Plants Research Institute in Manpong, the Danfa Project health center, the Volta River Project hospital at Akosombo, and the Efeea Nkwanta Hospital in Sekondi-Takoradi. They also visited virtually all the sites of centrally-funded projects. Time did not permit visits to other regions.

After completing the primary project reviews, the team discussed each project and prepared a list of general recommendations (see Chapter VII). In analyzing the achievement of objectives, the team graded each project on a five-point scale.

The general recommendations and a summary of the principal findings of the evaluation were first submitted in writing to USAID and GOG representatives. They were then discussed at a meeting convened on the last day of the assignment by the director of the mission.

---

<sup>1</sup> See Appendix A.

A draft report was compiled by the team leader from the written contributions of each member of the team and was circulated for review and comment. The final report incorporates these comments and suggestions.

## V. SUMMARIES OF PROJECTS IN GHANA

It is important to emphasize that USAID was providing population assistance during a time of political upheaval, national unrest, economic instability, and bounding inflation. At the time of the evaluation team's visit, Ghana's economy was still depressed. Because this state of affairs has lasted nearly 14 years, one should consider fully the difficulties under which many projects operated when assessing the achievements described in the following project reviews.

### Projects Funded Through U.S./Ghana Bilateral Agreements

#### *Population Program Support National Family Planning Program Supplies*

The following comments are limited to projects only. (For a discussion of the GNFPP, the program in which these activities are based, see Chapter VI.)

Phase I of USAID population program support to the GNFPP began in 1971. Phase II is scheduled to end in 1981. The purpose of this 10-year project was to develop the primary system of a family planning program that would achieve national population policy goals. The long-range goals were to improve family welfare through family planning and to slow significantly the rate of population growth in Ghana. The aims were to enhance the nation's capacity to provide for socioeconomic growth and to enable each family to improve the quality of life.

The objective of Phase I (1971-1975) was to train Ghanaians and to provide contraceptives to the GNFPP. To date, between 700 and 1,000 persons in various ministries and private organizations have been trained and upgraded in a wide range of population and family planning activities.

The four specific objectives of Phase II (1976-1981) were intensive outreach, intensive rural commercial distribution, motivational research, and in-service training. A subcontract was awarded to Research Triangle Institute in North Carolina to determine what would be the most feasible methodology for extending intensive outreach services to the Eastern and Volta regions. Although RTI completed its research, neither the GNFPP nor the Ministry of Health took further action. Consequently, this part of the project was not initiated. The objective was not achieved for other reasons, too. The project may have been too ambitious from the beginning. The lack of transportation and fuel has become an almost insurmountable problem. Proper management decisions were not made.

The rural commercial distribution program in the Northern and Upper regions also was not undertaken. Again, management, transportation, and fuel problems may have influenced this decision.

The GNFPF requested research proposals, but few of the various ministries and organizations responded. The result has been the underutilization of available resources. (Only a few respondents from the University of Ghana at Legon have used available resources for research.)

One objective of Phase II, multidisciplinary training, was achieved, although some unspent funds were deobligated. Personnel in various ministries were trained, in both Ghana and the United States.

Much of the strategy of Phase II was based on the results of the Danfa research project. That project showed that services and supplies must be delivered to the people; that integrated MCH/FP is most cost-effective in meeting the needs of the people; that outreach is limited to two to five miles from home to clinic; and that concurrent community distribution is necessary.

Since the project began, 194 family planning clinics have been registered, 210,000 new acceptors and 737,000 revisits have been recorded, and 2,357 Ministry of Health nurses and 14 physicians have been trained in family planning. There is a growing interest in the Ministry of Health in fully integrating family planning into maternal and child health and primary health services. USAID has provided most of the contraceptives distributed by the program. But, despite the expansion of services and the development of new outreach activities, targeted levels have not been reached, nor has the demand for services been met.

Total USAID funding for the project was \$4.3 million, of which \$1.3 million were programmed for centrally-funded commodities. To date, \$1.8 million have been deobligated because several components of Phase II could not be initiated.

On the whole, this project has been moderately successful, although it has not attained its targets. In the last 10 years it has, to the credit of the GNFPF, withstood the vicissitudes of successive governments and a deteriorating national economy. Clearly, the project has been hampered by administrative and managerial problems and problems over boundaries. Nonetheless, its basic structure is sound, and the national population policy which guides its activities is excellent.

*Population Dynamics Program  
University Teaching of Population Dynamics\**

Phase I: 1972-1976

The Population Dynamics Program (PDP) was established in 1972 in the University of Ghana "to increase and strengthen the competence of the University of Ghana in research and teaching in the various disciplines and professions related to an understanding of human reproduction, population dynamics, and family planning programs where appropriate, including their relationship to health, economic development, food, land utilization, education and environmental protection."

As stipulated in a Memorandum of Agreement between the University of North Carolina and the University of Ghana, the objectives of population study programs were to be achieved by awarding fellowships to faculty members and students; funding research projects, seminars, and workshops; publishing monographs; supporting curriculum development; and providing funds to acquire books and other publications. The results achieved by the end of 1976 are described below.

1. Fellowships

The number of fellowships received by Ghanaians and non-Ghanaians is listed below by type.

	<u>Ghanaian</u>	<u>Non-Ghanaian</u>	<u>TOTAL</u>
<u>Overseas</u>			
Faculty	6	1	7
Students	2	2	4
Government Officials	1	-	1
<u>Local</u>			
University of Ghana	15	10	25

---

\* See also separate summary of University Teaching of Population Dynamics, page 40.

2. Research

Forty-three research projects were funded.

3. Seminars and Workshops

Ten seminars or workshops were held in three countries. Seven were held in Ghana, one in Sierra Leone, and two in Liberia.

4. Publications

Five monographs were published with program funds.

Author

Title

A.S. David,  
E. Laing, and  
N.O. Addo (eds.)

Interdisciplinary Approaches to Pop-  
ulation Studies: Proceedings of the  
West African Seminar on Population  
Studies, November 30 - December 4,  
1972

S.K. Gaisie

Estimating Ghanaian Fertility, Mor-  
tality, and Age Structure

S.K. Gaisie and  
A.S. David

Planned Fertility Reduction in Ghana:  
Structural Interrelationships, Poten-  
tial Socioeconomic Impact and the  
Magnitude of the Needed Programs

N.O. Addo and  
J.R. Goody

Siblings in Ghana

J.S. Pobee (ed.)

Religion, Mortality, and Population  
Dynamics

5. Curriculum Development

Program funds were used to support four faculty posi-  
tions at Legon and one position at the University of  
Cape Coast. These faculty were responsible for de-  
veloping a curriculum for population studies.

## 6. Library Acquisitions

A total of 168 books and approximately 750 monographs was acquired. There are no records of books received after 1978. Apparently, there was some confusion over payments to Blackwells Bookshop, in Oxford, England, but this matter was resolved.

A former director of the PDP reported the following non-quantitative achievements of the program:

Four years is perhaps too brief a period to make a comprehensive statement about the achievements and failures of an interdisciplinary program like the one PDP has been experimenting [with] at Legon and in West Africa. PDP started from scratch, and has virtually built up a program from within Legon, with initiative provided by its directors. Several innovative ideas and programs have been developed and are being tried out by PDP in the field of population studies in Africa.

For the first time in the university and indeed in West Africa, an interdisciplinary population program has been developed; this program has modestly succeeded in bringing academic staff from various disciplines to look at population issues from the interdisciplinary point of view. The approach adopted is demonstrated by the extensive disciplinary mix of personnel working on PDP research projects; participants at PDP seminars/conferences; students with PDP fellowships, both local and overseas, etc. The idea is to institutionalize this particular approach of looking at issues which affect socioeconomic development in developing countries, especially Africa.

The PDP has further extended the image of the University of Ghana in the field of population studies. It has cooperated with a number of departments and universities in West Africa in organizing population-related activities, and stimulated the development of population work among individual academics and departments which otherwise were either ignorant about their potential contribution to knowledge about population issues or virtually dismissed the value of interdisciplinary studies in academic work.

Phase II: 1977-1979

The Population Dynamics Program underwent fundamental changes before the 1977-1978 academic year began. In April 1977, the PDP ceased to be an independent program within the University of Ghana and was absorbed by the Institute of Statistical, Social and Economic Research (ISSER). The director of the ISSER became the new director of the PDP. The program is located within the Population Studies Unit of the ISSER. The head of this unit directs the operations of the PDP in close collaboration with the director of the ISSER. Thus, the PDP is one of the projects of the Population Studies Program of the ISSER. It is still referred to as a "program," a term which reflects its original identity as a separately funded activity.

USAID funded the program as a regional activity. The University of North Carolina at Chapel Hill (UNC) played an intermediary role for the past five years. Although that role has ended, the program continues to maintain a working relationship with the university. The rules governing this relationship are contained in a Letter of Understanding, dated February 1980 and approved by the program's Working Committee, between the University of Ghana and the University of North Carolina. (Negotiations over an addendum to this letter, which was requested by AID/Ghana, delayed the signing of the contract between the University of Ghana and UNC.)

The major objective of Phase II was virtually the same as that of Phase I: to develop the Population Dynamics Program at the University of Ghana into an effective institution to promote education, training, and research in population studies in Ghana and other West African countries (see Project Agreement, Population Dynamics Program).

As one of the programs of the ISSER Population Studies Unit, the PDP undertook research in Phase I that resulted in changes in the research orientation of the program.

Population-related activities are important in African countries, for, among other things, these nations need data to formulate and implement socioeconomic development plans. In the light of such needs, the PDP shifted its emphasis from small-scale individual research programs to assistance in developing and funding integrated country projects that would provide useful inputs into various development programs. Thus, since 1977, the major function of the program has been the promotion of integrated research projects.

In Phase II, USAID funds were used to purchase one automobile, and office supplies and equipment, and to finance the activities described below.

1. Fellowships

Overseas fellowships were awarded to one faculty member and eight students from Ghana; local fellowships were awarded to four Ghanaians and three non-Ghanaians for study at the University of Ghana.

2. Research Projects

The following eight research projects were completed:

- Nursemaids and the Pill, by P.O. Olusanya
- Factors Determining Rural-Urban Fertility Differentials in Western Nigeria, by Mrs. Felicia A. Ilori
- A Study of Migration into Selected Capital Cities of Nigeria, by Mrs. Felicia A. Ilori, et al.
- A Survey of Migration into Warri, Bendel State of Nigeria, by Drs. Ita I. Ekanem and A. Adepoju
- Migration into Selected Medium-Sized Towns of Nigeria, by Drs. Ita I. Ekanem and A. Adepoju
- Religions and the Population Debate
- Religious Sects and Attitudes Towards Population Questions in Ghana, by Max Assimeng
- Latent Demand of the "Disadvantaged Group" for Urban Transportation in a Developing Country, by N.J. Garber.

The first and fifth studies are in print; the second, third, and fourth are being evaluated for publication; the sixth is being edited for publication.

The following research projects are in progress:

- Foodcrop Equilibrium and Socio-Demographic Behavior, by Madam T. Loco

- Southeast Repeated Fertility Inquiry, 1978, by Madam T. Loch
- First Generation Rural-Urban Migrants: A Study of Social Mobility and Fertility Behavior, by Dr. A.A. Adewuyi
- Population Dynamics in Rural Development in Nigeria, by Mr. J.A. Abigbola and Dr. A.A. Adewuyi
- Child Survival, Health Services, and Fertility in Nigeria, by Dr. Dan S. Obikeze
- Poverty Research (funding proposed).

### 3. Teaching

The PDP recruited a biostatistician for the 1977-1978 academic year. This person was involved in the biostatistics training course offered by the Department of Mathematics. Student uprisings unrelated to the program prevented the instructor from completing the assignment.

### 4. Seminars and Workshops

The following three seminars or workshops were financed by the program:

- Seminar on Integration of Theory and Policy in Population Studies, January 2-5, 1978.
- Seminar on Population and Development, December 1979 - January 1980. Fourteen papers were presented at this seminar, held at the New Year School of the Institute of Education, University of Ghana. The papers have been edited for publication.
- Seminar on the Role of Population Factor in Rural Developing Strategy. This seminar was held in Monrovia, Liberia, on June 23-27, 1980. Thirty-six papers were presented. These papers are being edited for publication.

*The Danfa Comprehensive Rural Health and  
Family Planning Project, 1970-1979*

History of the Danfa Project: Phase I<sup>1</sup>

In 1964, the University of Ghana Medical School (UGMS) decided that one of its responsibilities would be to train general medical officers to supervise rural health teams. To do this, a demonstration district was needed, not too far from the capital (Accra), where the Department of Community Health could conduct research, training, and service activities. Eventually, the Danfa District was selected and, in 1970, the Danfa Health Center was opened.

To rationally allocate scarce resources to the entire country, the Department of Community Health concluded that rural health information needed to be collected and analyzed more systematically. Furthermore, the department felt that research was required to determine how the family planning services that were mandated by the national population policy could be best implemented in rural Ghana. The Danfa Project was conceived in response to these needs.

External assistance to develop the research component of the Danfa Project was obtained from the United States Agency for International Development. The School of Public Health of the University of California at Los Angeles was identified to collaborate in the project.

The project agreement between the University of Ghana Medical School and the USAID mission to Ghana was signed in April 1970, and the first project paper (PROP) was signed in May of that same year. The PROP indicated that four UCLA staff members were to be assigned to Ghana: a chief of party, who would be responsible for management; an epidemiologist; a family planning/MCH specialist; and a health educator. A health systems analyst was added to the staff in 1973. It was agreed that the Ghana Medical School would be fully responsible for the service components of the project. UCLA was to be responsible principally for providing any assistance with the research components. The university also was to participate in some of the planning and teaching activities of the project.

---

<sup>1</sup> This information was extracted from the Final Report of the Danfa Project, which was jointly published by the University of Ghana Medical School and the UCLA School of Public Health on September 30, 1979.

## Goals and Objectives

The goal (or purpose) of the Danfa Project was to assist in initiating a demonstration rural family health program which would help improve the health and welfare of the people, especially in rural areas. The objectives of the first phase of the project (1970-1975), as outlined in the 1970 project paper, were:

- To investigate the state of the rural community and the factors associated with effective participation in health programs.
- To undertake research into the most efficient means of utilizing available manpower and other resources in the operation of health-post-centered comprehensive rural health services.
- To train doctors, sanitarians, midwives, community health nurses, and other health personnel, both separately and in teams, for their role in rural health work.
- To provide manpower oriented and equipped to handle the problems of the community.

A quasi-experimental research design was adopted at the outset to throw light on the then current controversy about the most cost-effective method of providing family planning services. To test the hypothesis that family planning is best accepted within a comprehensive health care program, the project district was subdivided into the following four areas:

- Area I. In this area comprehensive health care would be provided, including family planning and health education.
- Area II. Here, in addition to the standard services normally given in a rural health post by the Ministry of Health, health education and family planning would be provided.
- Area III. Only standard MOH health post and family planning services would be provided.
- Area IV. This area, in which only standard MOH health post services would be provided, would be a reference area.

In 1975, an external evaluation of the project was carried out. Because migratory movements in the Danfa district were highly unpredictable and because there were widespread socioeconomic differences between the four research areas, the evaluators recommended that the four-area research design be de-emphasized. They also recommended more responsible participation by senior Ghanaian staff and more participant training. These recommendations supported the decision of the GOG in the same year to fully integrate family planning within the Public Health Services.

### History of the Danfa Project: Phase II

The adoption of the recommendations of the external evaluators led to a new project paper and to a two-year extension of the project. The revised objectives of the second phase, which began in January 1976, were:

- To investigate the state of the rural Ghanaian community, concentrating on factors associated with health and family planning behavior.
- To strengthen the institutional capability of the Ghana Medical School to conduct research and to train physicians and other health workers to deliver rural health and family planning services.
- To demonstrate several cost-effective models of health care systems that include family planning as an integrated component suitable to the Ghanaian context.
- To transmit regularly information obtained during project activities to relevant GOG agencies.

#### A. Project Activities

To achieve the objectives and to implement the activities of the project, a team was formed of five researchers from UCLA and 5-10 Ghanaian researchers. Over the years, the project funded the work of 95 research assistants, analysts, data processing staff, vital events registration assistants, health care workers of various categories, and supporting staff.

## 1. Objective One: Investigation

The first two years of the project (1970-1972) were devoted to baseline studies, which provided diagnostic data on the community, a basis for program planning. Five studies were completed.

- All houses in the 200 villages in the project area were mapped and numbered.
- Censuses were taken every six months from 1971 to 1977.
- KAP studies in family planning, child care, maternal health, and health education were conducted. These semi-longitudinal sample surveys were repeated three times at two- or three-year intervals.
- Village health surveys and clinical and epidemiological surveys were made of a probability sample of 8 percent of the total population (approximately 50,000). During the surveys, 4,000 persons in 20 different clusters of villages were clinically examined. This activity, too, was repeated three times during the life of the project.
- Special surveys also were made during the life of the project. These included a malaria survey, a Guinea worm survey, a polio lameness survey, and sero-immunological surveys.

During these studies, project staff gathered and began to analyze detailed data on a rural Ghanaian population that hitherto had not been available. These data yielded considerable information on the state of health of the rural community in Danfa.

## 2. Objective Two: Training

The second objective was achieved by conducting three major kinds of activities: participant training; local on-the-job training, especially of junior research assistants, and the acquisition of equipment, books, and journals; and other logistic support for research and training.

The numbers of persons trained by the end of 1978 are listed by category in the table below.

<u>Category</u>	<u>Approximate Number</u>
Fieldworkers (including research assistants)	460
Medical Students (three-week residence in Danfa Health Center	500
Students from MOH Training Institutions	700
Other University of Ghana Students	640
Participant Trainees in the U.S.	19
Other Local Trainees	50

Twenty Ghanaians, most of whom had worked for some time in the project, received participant training in the U.S. and then returned to the project before settling in the Department of Community Health, elsewhere in the university, or in the Ministry of Health.

Of the 20 trainees, 8 have been appointed permanently to the Department of Community Health. Of the 11 persons who hold the grade of "lecturer" or higher in the department, 5 were sponsored for their public health degrees by the Danfa Project. Another trainee is a senior research assistant, and two are lecturers. Two other persons attended short-term seminars in the U.S. Two physicians who were trained by the Danfa Project may join the Department of Community Health in the near future.

Of those who did not remain with the department, one is now the deputy director of medical services at the MOH; another is in charge of the BARIDEP Project, which is a large rural health research project funded by the World Health Organization and the Swedish International Development Authority (WHO/SIDA). A third is in charge of the WHO Schistosomiasis Unit in the Ministry of Health.

Of the senior staff who participated actively in the project, the majority are now capable of independently conducting and publishing research.

Given equipment from the project, Ghanaian researchers have been able to carry out projects and analyze their findings.

Since 1970, all medical students in the University of Ghana Medical School have been required to spend three or four weeks in the project area as part of their community health clerkship.

### 3. Objective Three: Health Care Delivery Demonstrations

The project has conducted several experiments with health care delivery. For example, it conducted experimental projects in the use of traditional birth attendants (TBAs) and of village volunteers in health campaigns and such programs as the malaria prophylaxis program and the Nutrition Surveillance Project. It implemented pilot programs that train and use village health workers (VHWs). It tested nutrition programs that involve village women's clubs and agricultural extension services to improve agricultural practices and to introduce other nutritious plants into an area. It experimented with the idea of using the same staff at a health center to deliver extended services (i.e., establishing satellite clinics). The project tested an extended mobile family planning program also. In this program, practically every cluster of villages was visited by a health care team at least once every 10 weeks. These visits were in addition to the fortnightly visit to the "permanent" family planning locus.

In addition, the project organized village health committees to participate in village sanitation activities and to help build pit latrines. In another program, it used resident health education assistants in villages. These health workers were involved in the first multiple-antigen mass immunization program in Ghana. The data generated during this effort were useful to the WHO Expanded Immunization Program (EIP).

As a result of the various studies, recommendations were made to eliminate certain drugs from the list of supplies for health centers. In addition, all health workers were trained in family planning, and a manual for this training was developed.

### 4. Objective Four: Information-Sharing

To date, more than 50 journal articles, 30 conference papers, and 11 monographs have been published. More than 500 requests for reprints of the papers on polio lameness have been received from all over the world.

Four manuals have been prepared:

- The Training of Traditional Birth Attendants
- The Training of Village Health Workers
- Family Planning Manual (Teachers' Guide and Students' Book)
- Village Health Survey Manual.

The Ministry of Health has adopted the TBA manual, the manual for village health workers, and the Family Planning Manual, which describes the integration of family planning into health services. To date, over 4,000 copies of the Family Planning Manual have been printed.

The Village Health Survey Manual was used by the WHO Tropical Diseases Research Project in developing a new manual on epidemiological survey methods.

Many members of the department involved in the Danfa Project served on various committees of the MOH Health Planning Unit and assisted in developing a strategy for primary health care (PHC) in Ghana.

The data gathered during the project and all original source documents are available in Ghana. Copies of all tapes sent to UCLA for further analysis and "cleaning" have been returned to Ghana.

Members of the department and other university faculty, both senior- and junior-level staff, continue to use the data. More data are being collected. It is hoped that these data, too, will be analyzed.

Miscellaneous activities related to the project were conducted. Seminars were held with relevant GOG agencies. Staff taught in Ministry of Health programs and served on MOH and other agency committees and participated in the Ghana National Family Planning Project.

An important lesson was learned during the early stages of the project: that it was not worthwhile to use village volunteers to collect data on vital events, because the data which these volunteers collected were inaccurate. The system was changed after 18 months; thereafter, paid registration assistants were used to collect data. This change markedly improved the quality of the data.

Given the changing economic situation and several devaluations of Ghana currency, it is difficult to calculate the real cost of health care in the rural setting. The project depended heavily on transportation. Once the project ended, it was difficult to deliver health services. The Danfa Project was costly; however, given its enormous achievements and their implications for Ghana and many other African countries, the investment was reasonable.

It was difficult to analyze data regularly because the computer available in Ghana during the project had a limited capacity. A voluminous amount of data thus remains to be analyzed.

At one stage, it appeared that the project was straining the capacity of the Department of Community Health. The work of the department was distorted. By instituting participant training, the project relieved some of the pressure on the department.

## B. Impact on GOG Policy

The project demonstrated the effectiveness of integrating family planning into maternal and child health and health service delivery programs. With this project the GOG was able to clarify and affirm its policy on family planning.

The data on the disease profile and health status of the rural population, as well as the strategies to overcome health problems, were useful to the Ministry of Health Planning Unit in drawing up the Primary Health Care Plan.

The participant training program strengthened the teaching and research capability of the Department of Community Health. The department is now able to offer postgraduate studies in public health.

Some of the manuals produced by the MOH (e.g., Family Planning Manual) have been useful in Ministry of Health training programs.

Members of the Department of Community Health and staff of the Danfa Project have served on various GOG committees and have used the experience they acquired during the project.

In general, the Danfa Project has been most useful to the Department of Community Health and to the Medical School of the University of Ghana.

The official report on the Danfa Project has been circulated widely, especially among universities and developing countries.

Following its review of the project, the evaluation team reached three major conclusions:

1. The Ministry of Health and the GOG could continue to use Danfa as a teaching and research site for rural health activities. A special effort should be made to keep this option viable.
2. The data amassed by the project deserve to be analyzed and published.
3. More work should be done on community-based programs. The Danfa Project should be a model for other community-based programs in family planning.
4. The conclusions on the project and the analysis of project data should be made readily available to all GOG departments and ministries concerned with development.

USAID provided \$6.7 million to the Danfa Project. Of this sum, \$6.2 million were part of an institutional development grant to UCLA and \$0.5 million were awarded under a separate contract to the University of Ghana Medical School.

*Family Planning and Demographic Data Development:  
The National Demographic Sample Survey, 1968-1969*

This project was designed to provide estimates of fertility, mortality, and other vital rates which could be used in developing population projections and for monitoring other population trends.

Ghanaian demographers tried to estimate fertility and mortality levels, trends, and differentials using data collected during the 1960 Ghana Census and the Post-Enumeration Survey (PES). The vital statistics compiled for the so-called compulsory registration areas were so defective and unreliable that they were of little use. The 1960 PES was the only nationwide exercise which covered such topics as fertility and mortality. PES data on births, deaths, and the age-sex structure of the 1960 population therefore were basic material used to prepare estimates of vital rates for Ghana.

Plausible fertility estimates were derived from special inquiries and, to some extent, censuses; however, because comparable information on mortality was wanting, mortality estimates were imprecise. Although a general mortality level was estimated from PES data on the proportions of surviving children, this estimate was not precise because it was calculated without sufficient information on adult mortality.

Research proposals were submitted to USAID/Ghana for a small-scale survey in selected regions of the country. The survey would concentrate primarily on the rates of mortality for children and adults. The objective was to collect additional information which could be used to improve the estimates derived from the 1960 census and PES data. With the promise of reasonable financial support, the original proposal was redesigned to cover the entire country as a representative sample survey. The scope of the project was also enlarged to include KAP-type questions. USAID provided \$127,934 for the new project, now known as Family Planning and Demographic Data Development.

Concrete results were achieved. The project published The 1968-1969 National Demographic Sample Survey (Vol. 1, "General Report"; Vol. 2a, "General Characteristics of the Sample Population: Demographic and Socio-economic Statistics"; Vol. 2b, "General Characteristics of the Sample Population: Economic Statistics"; and Vol. 3, "General Characteristics of the Sample Population: KAP Statistics") and a detailed analysis of the 1968-1969 National Demographic Sample Survey (NDSS) data, including certain data taken from the 1960 and 1970 censuses and the 1960 Post-Enumeration Survey. The results were published in two volumes: Estimating Ghanaian Fertility, Mortality and Age Structure and Planned Fertility Reduction in Ghana: Structural Interrelationships, Potential Socioeconomic Impact, and the Magnitude of the Needed Programs.

In addition to data from other sources, the vital rates obtained from the National Demographic Sample Survey were used to prepare a set of population projections for the total country and for regions and urban rural areas. Findings were made available to government ministries, national corporations (e.g., State Insurance Corporation, Social Security and National Insurance Trust), university departments, and other research institutions, including the Institute of Statistical, Social and Economic Research and the Regional Institute for Population Studies (RIPS).

The various findings have been useful in reviewing Ghana's population policy and in setting new goals for the National Family Planning Program. Data from the National Demographic Sample Survey have been used by researchers in the Population Studies Unit of the ISSER to prepare several papers.

Projects Funded from Central AID Funds, Directly or Indirectly

*Ghana Fertility Survey, 1979*

The Ghana Fertility Survey, conducted in 1979 and funded by AID, had the following long-term objectives:

- To obtain internationally standardized data on fertility levels and fertility behavior which would aid the development and execution of population programs and projects in Ghana.
- To establish in Ghana scientifically designed machinery for conducting a survey of human fertility levels and behavior, and through this, to increase the nation's capability to conduct fertility and other demographic survey research.
- To obtain for Ghana the data on fertility behavior required for social, economic, and health planning and for evaluating the nation's family planning program.

The immediate objectives were:

- To collect for Ghana a body of reliable data on fertility levels and trends.
- To obtain information on the relationship between socioeconomic factors and fertility levels.
- To provide data on the regional and urban and rural variations in fertility levels and related aspects of behavior.
- To ascertain women's knowledge of and attitudes toward family planning and family size.

The instruments used to collect the basic data included the World Fertility Survey (WFS) Core Questionnaire, Mark I, for high fertility countries; a module on factors other than contraception affecting fertility; and selected sections of the Family Planning Module.

USAID provided \$218,181 for this fertility survey.

The sociopolitical and economic conditions which prevailed in the country during the period of field work (e.g., shortage of petrol, the lack of vehicles, rains, delays in payment for services of field staff, etc.) increased the difficulties normally associated with such a survey.

#### Impact on Government of Ghana Population Policy

The survey has materially improved the demographic research skills of Ghanaian workers. Its impact on the government's population policy can be correctly determined only after the collected data have been prepared for analysis and the results have been assessed.

*Contraceptive Retail Sales (CRS) Program*

A three-year contract was awarded in July 1976 to Westinghouse Electric Corporation (Health Systems Division) to "design a system for the commercial distribution of contraceptives" and "to establish a distribution system in order to significantly increase the commercial availability of contraceptives and to reach the majority of urban and rural fertile age couples in Ghana." AID provided the contraceptives at no cost to both the contractor and the Government of Ghana. The project manager did not arrive in Ghana until June 1977. The project was originally intended to be completed in June 1979, but its implementation was delayed. It was extended twice at no additional cost, first to January 1980, and then to March 31, 1980.

The advertising contract for the project was awarded to LINTAS Advertising Agency, Ghana. The packaging and printing was contracted to DANAFCO, Ltd. Following market research and tests of packaging and brand names, the sales operation began in December 1978.

In May 1979, the AID mission proposed to the GNFPP that a meeting be scheduled to review the program and long-range plans. It suggested three options, based on a review of successful CRS programs in other countries: complete or nearly complete public sector management; complete or nearly complete private sector management; or some combination of the above options.

The American Public Health Association (APHA) conducted an evaluation for AID in December 1978. The evaluators recommended that "after the contract period, the GNFPP continue to act as overseer and policy maker but delegate [the] daily operation to organizations which have the structure, experience, and private sector skills necessary for smooth functioning... Coordination would be best achieved through liaison between the designated GNFPP counterpart and an experienced project manager based at DANAFCO or the chosen distributor. Physical presence at the headquarters of the distributor will enable the product manager to carefully monitor product packaging and movement and will provide a familiar setting for project-related business contacts. To ensure a smooth transition, this person should be hired from the private sector well before January 1980."

As the project continued, most of these recommendations were implemented, although Westinghouse was not phased out and no Ghanaian was appointed to be product manager.

The annual and end-of-contract reports of the project manager reveal that, despite difficulties and delays, the objectives of the program were achieved. The advertising program contributed to widespread acceptance of the idea of contraceptives, and within 12 months more contraceptives were sold through the distribution system than had been given away by the

GNFPP since its inception. Demand seems now to exceed supply. Also described in the project reports are the following achievements:

- Advertising

As demonstrated by sales, the contract with LINTAS to handle media and other public advertising was successful.

- Packaging and Distribution

A contract with DANAFCO to package, print, and distribute all retail sales products was implemented satisfactorily.

- Sales

Four products were successfully sold through normal retail channels at all levels. The cumulative sales at the end of the first 12 months (January 1, 1979 - December 31, 1979) were as follows:

PANTHER Plain Condoms	1,395,600 Units
SSS Colored Condoms	520,080 Units
FLORIL Oral Contraceptive	104,106 Cycles
CORAL Foaming Tablets	293,820 Units

Average monthly sales were as follows:

PANTHER Plain Condoms	116,300 Units
SSS Colored Condoms	43,340 Units
FLORIL Oral Contraceptive	8,668 Cycles
CORAL Foaming Tablets	146,910 Units (2 months sales only)

Given January 1980 sales, one might predict that these average monthly sales would not only continue, but also increase.

The project manager estimated that sales income at the end of the project will be the equivalent of more than U.S.\$50,000 at the current rate of exchange.

Staff encountered three major problems in implementing the project.

1. Civil service procedures were applied in selecting and remunerating project personnel. This prevented the recruitment of the most suitable and experienced persons.
2. The project was too closely identified with the GOG.
3. The administration of the GNFP Secretariat was over-centralized and hindered the extension of the sales program to remote areas.
4. Delays in making decisions affected important matters.

#### Impact on FP Policy

By increasing the availability of contraceptive methods selected by users and by maintaining motivation through suitable advertising, the CRS achieved results which will undoubtedly effect changes in attitudes toward widespread contraceptive use. The program conformed with the principles of persuasion, not compulsion, and free choice as advocated in national family planning policy.

The successes of the retail sales program are due, to a large extent, to the wise use of advertising. This suggests that a consistent, steady, and culturally acceptable advertising campaign should be continued, and that the emphasis should be on the concept of family planning and the promotion of the available products.

*University Teaching of Population Dynamics*

This project was essentially a continuation of the bilaterally-funded Population Dynamics Program (PDP; see page 18). The University of North Carolina received central funds to provide project-related services to the University of Ghana. A faculty member who was recruited by UNC was unable to complete his contract.

*Physicians Postgraduate Training in Reproductive Health*

This project, funded in 1979, provided postgraduate training for Ghanaian physicians at two U.S. universities: Johns Hopkins University and Washington University Medical School.

Professor K.K. Bentsi-Enchill of the University of Ghana Medical School nominated, with the approval of the AID mission in Ghana, Ghanaian obstetricians and gynecologists in the MOH for postgraduate training abroad. A selection committee at Johns Hopkins University reviewed the curriculum vitae of the nominees and, depending on class size and available space, offered each physician a place in the next or subsequent class.

The training consisted of four weeks of intensive didactic reviews of reproductive biology and endocrinology, basic demography, and teaching methods, or two weeks of instruction in infertility studies. Homework was assigned, and physicians were expected to give presentations on relevant subjects, and, in particular, subjects that applied to situations at home. Air transportation to and from Baltimore, Maryland, was provided for the participating physicians. At the time of the evaluation team's visit, four physicians had attended the courses.

It was expected that after completing the course, physicians would be able to maintain (and upgrade where applicable) their proficiency in all the teaching and technical aspects of reproductive health and infertility and thereby enhance their ability to provide efficient and cost-effective service in their specialty.

A review of the course content and of the comments of four participating physicians indicates that the course is relevant and does achieve its objectives. Although some of the subject matter and technical procedures (e.g., microsurgery on the fallopian tube) are not relevant in the Ghanaian context, the evaluation team believes that a knowledge of such procedures is useful and in fact necessary to the well trained specialist, wherever he resides or works.

The program's impact on the government's population policy has been minimal; the rate of population growth has not been reduced significantly. Nevertheless, direct benefits accrue to the population served by physicians trained in reproductive health.

The procedure followed at Johns Hopkins University was also followed at Washington University Medical School. No other details are available on the status of this contract.

### Training in Laparoscopy

Johns Hopkins University received a \$118,000 grant to conduct a program in laparoscopy. The objective of the program was to train surgeons to perform laparoscopic tubal sterilizations. One aim of this method of fertility control was to reduce the rate of population growth in Ghana. Another objective was to facilitate the diagnosis of infertility.

The course consisted of two weeks of didactics, including movies and actual observation of laparoscopic procedures. The physicians then returned to Ghana. There they spent another week at either Korle Bu or the Police Hospital performing the procedure under supervision. Subsequently, two instructors in laparoscopy (one from Nigeria and one from El Salvador) visited Ghana and toured the local hospitals where the newly trained laparoscopists were practicing following the week of in-country training. The two instructors observed technique, reinforced training where applicable, and helped solve technical problems or problems with equipment. A Ghanaian technician was sent to the United States to learn how to sterilize, maintain, and repair equipment.

Since 1977, when the program began, 13 Ghanaian physicians have been trained and 9 laparoscopes have been sent to various hospitals around the country. The physicians were selected from various MOH hospitals with the concurrence of the GNFPF Secretariat.

The doctors all learned the technique well and were able to demonstrate the expected, and varying, degrees of proficiency. The only technical problems observed in Ghana were equipment breakage, electrical failure, and adaptation of the couplings of the French-manufactured carbon dioxide canisters to the American-made laparoscopic units. Equipment was provided for tubal sterilization by electrical cauterization (fulguration) and tubal occlusion with a silastic rubber ring (fallope ring).

The doctors were favorably impressed with their training and with the new method of fertility control. They are performing a minimum of two or three laparoscopic procedures a month. As many as 20 laparotomies a month are being performed at Korle Bu. The majority of procedures (80 percent-90 percent) seem to be for diagnostic laparoscopy (only occasionally related to infertility) rather than for tubal sterilization. Although training in laparoscopy has increased and although the diagnostic capabilities of doctors have probably improved as a result, this training has had little effect on fertility reduction in Ghana, because of pervasive philosophical repugnance to, and cultural prejudice against, sterilization.

It is clearly evident that the ability to perform laparoscopy is an important and valuable medical skill; in Ghana, however, the procedure has not been a significant fertility reduction tool. Nonetheless, the

value of laparoscopic training is unquestionable. It would seem that a sufficient number of Ghanaian surgeons have become experienced enough that training can be done locally in the future.

The experience gained from this project suggests that, in the future, physician-training should be limited to the type and quality of training that cannot be offered in Ghana and that financial support for laparoscopic training abroad should be transferred to other areas of population-related education and training. The Ghana government should now organize and deploy a local laparoscopic training unit for in-country and regional trainees.

*Family Planning Services*

In the early 1960s, AID began to provide funds to the Pathfinder Fund, a U.S. institution engaged primarily in family planning activities. Pathfinder distributes educational materials and literature to family planning programs throughout the world and assists innovative family planning projects.

The aim of the Pathfinder project is to enhance understanding of the methodology for delivering family planning services and to deliver such services more efficiently.

In addition to receiving information, education, and communication (IEC) materials from the Pathfinder Fund, several Ghanaians have participated in a seminar, organized by Pathfinder and held in Sierra Leone in September 1980, on the use of non-physician personnel to deliver family planning services.

It is difficult to quantify the extent to which objectives have been achieved, but results have been positive. There have been no known negative or counterproductive effects. For example, pelvic models and, in some areas, breast models purchased with project funds have been effective tools for teaching and training both physicians and non-physicians.

The program's impact on Ghana's population policy will be directly proportional to the number of fieldworkers and other paraprofessionals recruited for multidisciplinary training in family planning and maternal and child health.

AID's total financial contribution to this Pathfinder Fund project is not known.

*Grant to International Planned Parenthood Federation  
To Support the PPAG*

AID/W makes grants to the International Planned Parenthood Federation (IPPF) which, in turn, provides most of the support to the Planned Parenthood Association of Ghana (PPAG). In 1979, the IPPF gave PPAG a cash grant of \$331,187 to supplement the \$127,100 in local PPAG income from fees and fundraising. The GOG, through the GNFPF, made a grant of £50,000 (\$18,400) to the IPPF in 1979.

With a national staff of 207 employees, the PPAG operates 30 clinics, 50 percent of which are in rural areas. Approximately 1,000 volunteers are deployed throughout Ghana. In each region there is at least one regional coordinator, two midwives, clinic staff, support staff, and fieldworkers. There is at least one fieldworker who can provide contraceptives in every community served. Although visits by clinic staff may be as infrequent as every two weeks in the most remote communities, professionals do serve on local PPAG councils and committees. Many of them devote only a few hours each month to advisory service. The PPAG once trained fieldworkers for the GNFPF, and it is involved currently in GNFPF information and education activities. The GNFPF has funded, wholly or partly, several PPAG-sponsored seminars.

As a private voluntary organization, the PPAG is one of the cooperating agencies of the GNFPF. It holds a seat on the National Family Planning Council and on the Program Advisory Committee. The GNFPF's completed acceptor statistics date only to October 1978; apparently, both before and since 1978, the PPAG has been responsible for approximately 50 percent of the new users of contraceptives in the country. For the first six months of 1980, for example, the PPAG recorded 61,796 new users of contraceptives. The majority of these new users chose foaming tablets, which are gaining in popularity. Pills and condoms were the second and third choices of contraception.

PPAG authorities believe that they have been successful in achieving the objective of assisting the GOG in implementing Ghana's population policy.

The evaluation team strongly recommends that AID consider giving continued and increased direct financial or technical assistance to private voluntary organizations such as the PPAG and CCG. These organizations have demonstrated high levels of success per dollar in educational, outreach, and contraceptive-distribution programs.

*Family Planning International Assistance Programs*

AID funds were used by Family Planning International Assistance (FPIA) to support the programs of the Christian Council of Ghana (CCG), the Young Men's Christian Association (YMCA), and the Association of People for Practical Life Education (APPLE).

A. Christian Council of Ghana

The Christian Council of Ghana, organized 51 years ago, advises and provides services to member churches. Approximately 50 percent of Ghana's population are members of these churches. In the early 1960s, the CCG became concerned that sterile marriages often led to divorce and that the lack of birth control affected family health, making it difficult for parents to care properly for children.

The Committee on Christian Marriage and Family Life (CCMFL) was established to provide adequate counseling and family planning services to families in need of assistance. The first CCMFL clinic was opened in Accra in 1961. The CCG thus became the first organization in Ghana to become actively involved in family planning and to have a catalytic role in the development of Ghana's national family planning (FP) program. Its early involvement also helped to legitimize family planning, because the organization routinely offered reproductive health counseling, including the diagnosis and treatment of infertility, to parents, youth, families, students, and couples. It is important to note that, from the beginning, the project was an entirely Ghanaian effort. Ghanaians motivated other Ghanaians to seek family health education, including family planning. From 1971 to 1978, the CCMFL reports show an increase in known contraceptive users, from 5 percent to 20 percent. The CCG has had managerial and administrative problems which caused the FPIA to cease temporarily the funding for the CCG program.

Each CCG clinic is manned by part-time or volunteer fieldworkers, a receptionist, family counselors, and a physician (less regularly). Each clinic is open for service Monday through Friday, from 8:30 a.m. until 4:30 p.m.

Family planning commodities are provided by clinics at the following government-controlled prices:

<u>Commodity</u>	<u>Price</u>
Oral Contraceptives	1 cycle for 20 pesewas
Neo-Sampon	1 tube for ₦1.00
Intrauterine device	1 for ₦1.00
Emko Foam	1 Bottle for 50 pesewas
Condoms	Package of 3 for 10 pesewas

The CCG's commodity distribution system is separate from and independent of the GNFP's system, and it operates efficiently. Neo-Sampon is scarce, as the Christian Council has recognized. It is hoped that the GNFP's need of this commodity will be met when the contraceptive retail sales project is in full operation. The present demand for Neo-Sampon far exceeds supply.

CCG clinic reports are sent monthly to the GNFP Secretariat.

The objectives of FPIA assistance to the CCG are as follows:

- To provide FP services to 7,000 new users by opening spot clinics, deploying mobile clinics, and extending clinic hours to evenings and weekends.
- To provide FP services to 16,000 continuing users.
- To conduct an IEC effort (30 film presentations, two pamphlets for rural areas, home visits by fieldworkers).
- To provide marriage and FP counseling to 15,000 couples.
- To provide and broadcast 16 television programs and periodic, rapid spots.
- To conduct 80 family life education (FLE) sessions for approximately 20,000 participants.
- To conduct for 800 teachers three in-service seminars on instruction in sex education and NFP parenthood.

Another program of the CCG Committee on Christian Marriage and Family Life which has received AID support through FPIA is Community-Based Family Planning Service.

This program, which received an AID grant in 1979, will use satisfied users to provide community-based family planning services to new contraceptors. Fifty-five satisfied contraceptive users and 45 family counselors will be recruited and trained to motivate prospective users and to expand services in four regions. Audiovisual material will be developed, produced, and distributed in three national languages. The goal is to reach almost 7,000 new contraceptors and to resupply 10,000 continuing contraceptors.

Because this project began last year, it is not possible at this time to assess its achievements or to determine the impact it has had on national population policy.

#### B. National Council of Ghana/YMCA

In 1979, a grant of \$44,624 was awarded to the National Council of Ghana/YMCA for family life education and counseling for youth. An additional grant of \$64,754 was made in 1980. The major objectives of the grant were:

- To provide IEC through the mass media and additional written materials.
- To distribute 504,000 condoms to 7,000 males and 1,008 bottles of foam to 1,000 females. To date, 7,000 young people have been contacted and 1,000 have been referred to clinics in five regions (Greater Accra, Central, Ashanti, Western, and Eastern).

#### C. Subgrant to the Association of People for Practical Life Education

A subgrant was awarded in June 1980 to the Association of People for Practical Life Education (APPLE). APPLE, a Ghanaian private voluntary organization, was founded by two members of the Peoples' Education Association. It operates in the Brong-Ahafo Region. APPLE received a grant from USAID for general development activities. The grant also supports work with mother-and-daughter clubs.

The objectives of the AID subgrant were to:

- Train 12 health/FP workers.
- Develop IEC materials for the semi-literate and illiterate population.
- Offer family planning services to 3,720 new acceptors.

FPIA grants to Ghana can be broken down as follows:

<u>Organization</u>	<u>Grant</u>
Christian Council of Ghana, CCMFL, 1973-1977	\$237,778
CCG, Community-Based Services, 1979	29,410
YMCA National Council, 1979 and 1980	109,378
APPLE, 1980	<u>30,150</u>
TOTAL	<u>\$406,716</u>

The team believes that these grants have been and are being used effectively to accomplish the objectives of the GNFPF.

*Program for Voluntary Sterilization*

Two physicians (an MOH supervising physician and a Korle Bu staff physician) received assistance enabling them to attend the Fourth International Conference on Voluntary Sterilization in Seoul, Korea, May 7-10, 1979. Financial support was also given for a seminar on the promotion of surgical contraception to enhance FP programs in Ghana. This seminar, which preceded the conference in Seoul, was organized by the department of Obstetrics and Gynecology of the Ghana Medical School and the National Family Planning Secretariat. It took place in Accra on April 6-7, 1979. The pros and cons of sterilization as they relate to the patient, the physician, and operating room staff were discussed. Male sterilization was superficially discussed, as was the maintenance of endoscopic instruments. Most of the 35 participants and observers thought the seminar was worthwhile but none recommended that the presentation be repeated.

Neither of the two seminars appears to have had any impact on the implementation of the government's population policy. It is apparent that demand for male sterilization in Ghana is extremely low at this time.

*Support of Teaching and Research in Demography*

This program, supported by an AID grant to the Population Council, was intended to be a "pre-institutional development" activity in teaching and research in demography in the Department of Sociology. Between 1973 and 1976, two courses in technical and substantive demography were offered to 14 final-year honor students.

It was decided that the "data collection technique will be of the form of the combination of surveys, i.e., an initial inventory of the population covering the socioeconomic background, followed by continuous registration of vital events, and follow-up surveys each year." The baseline census was taken in April 1974. The registration of vital events dates from the reference date of the baseline census. Follow-up surveys were conducted annually from 1975 to 1977. In addition to the 1974 baseline census data, completed census forms for 1975 and 1976 were coded in the Cape Coast office with the help of a graduate assistant, and Dr. Jain took the coded data to Canberra for analysis (see Morton-Williams, 1977;3). Among the data conveyed to Canberra are the following:

- 1974 survey data (from 5 files, on tape)
- 1974 and 1975 registered vital events (on tape)
- Coding sheets of 1975 and 1976 follow-up surveys
- Coding sheets of 1975 and 1976 vital events
- Information on births and deaths from registrations of vital events recorded during 1975 and 1976 surveys (These similar data (and data from the 1977 survey) will be matched and the number of events missed by both systems will be estimated.)
- Data from the 1976 PES on a 5 percent random selection of houses recorded on the original (1974) census form. (This information on the members of 335 households will be processed in Canberra.)

The Department of Sociology, University of Cape Coast, retains the original information sheets from registrars, the survey forms, and the informants' and registrars' diaries.

The following activities were supported by the grant:

1. Teaching

Fourteen Ghanaians benefited from the teaching program in demography offered before their final-year examinations. Two continued their studies at the University of Ghana and Australian National University and eventually received a master's degree in demography. They are now teaching demography in the sociology and geography departments of the University of Cape Coast, but they plan to complete doctoral dissertations when funds become available.

2. Research

Data have been collected and are being analyzed at the Australian National University, Canberra. This activity has been going on since 1977.

A visiting mission from the Population Council noted that, although the grant to the University of Cape Coast was an "institutional development grant," it was being used to support research, and not to establish the university as a site for demographic teaching and research. Although a program in demography has been established in the University of Cape Coast, it does not provide a solid foundation for demographic research. This may be because all senior personnel connected with the project have departed.

USAID contributed \$61,791 to support this program from 1973 to 1978.

The major difficulties cited by program staff were academic commitments of faculty and heavy and prolonged rains in June, which created poor conditions for travel and hampered data collection.

*Strengthening International Population Communication and Training*

In July 1980, the University of Chicago, in collaboration with the GNFPP, offered an in-country seminar at the University of Ghana on information, education, and communication. Eight courses were given in a four-week period to Ghanaian planners, administrators, mass communicators, person-to-person communicators, and communication researchers. Sixty-three Ghanaians were assisted by a number of Ghanaian and non-Ghanaian resource persons.

A grant of \$15,000 was made by AID to the University of Chicago for this seminar.

Seminars of this kind, which emphasize skills in motivation for family planning by appropriate IEC, should achieve impressive results if they are conducted in other regions of the country.

*Population Information Program: Population Reports*

Free copies of Population Reports\* are sent to approximately 558 Ghanaians representing a wide spectrum of interests and professions in a range of institutions and private practices: medical schools, universities, hospitals, government agencies, police, military, etc. Each issue of Population Reports emphasizes one topic in the general area of population. Recent issues have covered prostaglandins, family planning programs, oral contraceptives, law and policy, laparoscopy and minilaparoscopy, and cultural traditions affecting family planning.

The number of Ghanaians who read the publication is not known. It would be difficult to conduct an accurate poll of readers.

---

\* A periodical published by The Population Information Program, The Johns Hopkins University.

*AHEA Grants to Ghana Home Science Association*

The Ghana Home Science Association (GHSA) has 300 home economists and teachers as members. In 1973, the American Home Economics Association (AHEA) provided the first of several grants to the GHSA. These AHEA grants, provided by AID, financed the following activities:

- A curriculum development workshop (1974), including publication of the report, "Workshop of Family Life Education."
- An African regional workshop (April 1976).
- A five-day curriculum change workshop (1980). This workshop, for organizers of home economics projects, was attended by three participants from each of nine regions (secondary school teachers).
- A rural community project for youth at Danfa, sponsored jointly by the GHSA, the IPPF, and the AHEA (1977). Weekly meetings were held for farmers and traders (women) at a village given special consideration by the GHSA. Members became interested in organizing a parent-teacher association.
- A research project to evaluate family life education. The AHEA contributed approximately \$1,500 for the evaluation. Two publications resulted from this project: "A Comparative Study of Adolescent Pregnancy, U.S.A. and Ghana" (Cross) and "A Cultural Perspective on Attitudes and Values."
- A "Spark Plug Workshop" (to be continued in 1981). Between 1973 and 1980, the AHEA contributed \$19,567.

These grant-supported activities appear to have been moderately successful. Relations between the GHSA and the AHEA have been difficult because of the lack of communication and misunderstandings about each other's role and concerns. The evaluation team recommends that AHEA assistance be continued only after these grants and the ability of the GHSA to implement the objectives have been evaluated in depth.

*Training for Family Planning Managers*

Thirteen Ghanaians were sent to the Center for Population Activities, in Washington, D.C., for training in the management of family planning programs. This training, lasting approximately four weeks, took place between 1976 and 1979. Those who were trained now occupy such positions as deputy director of medical services, regional coordinator of the GNFP, and district medical officer.

The training appears to have had a beneficial impact on the implementation of Ghana's national population policy; the managerial and administrative capabilities of the trainees who now hold responsible positions have been improved.

*United Nations Fund for Population Activities*

The United Nations Fund for Population Activities (UNFPA) was created in 1967 by the Secretary-General of the United Nations as a trust fund financed by voluntary contributions from member governments and private philanthropies. The fund is administered by the administrator of the United Nations Development Program (UNDP), who appoints the director of the Fund.

Member agencies of the U.N. system are designated as executing agencies of activities financed by the Fund in requesting countries. It is estimated that the United States has contributed approximately 27 percent of the UNFPA budget in the last five years.

In Ghana, four projects were financed by the UNFPA during the period under review. These were:

- Registration of Vital Statistics
- The 1980 Decennial Census
- The Regional Institute for Population Studies
- Production of Oral Contraceptives (UNIDO).

From 1977 to 1979, the UNFPA contributed \$225,000 to support these programs, each of which is described below.

1. Registration of Vital Statistics

The UNFPA has provided training fellowships to Ghanaians for study abroad, financed the services of an expert adviser in the Bureau of Statistics, and supplied several vehicles.

The project, which began in 1976, was to have been completed in 1981. The GOG requested a two-year extension. To date, the request has not been approved.

2. The Decennial Census

A decennial census was scheduled in 1980. Despite active preparation, the census is now expected to be conducted in 1982.

Two fellowships have been awarded to Ghanaians for training in the Bureau of the Census in the United States. Census supplies, equipment, and several vehicles will be supplied as needed.

3. The Regional Institute for Population Studies (RIPS)

This inter-country project is designed for all English-speaking member countries of the U.N. in Africa south of the Sahara. It is located in Ghana at the University of Ghana. Ghana does not, therefore, receive direct assistance.

Training in demography and population is given to students from the countries served, including Ghana. The institute shares an ISSER-based library, supported by the Population Dynamics Program. Both institutes share lecturers and encourage cross-attendance by students.

Following a review of the project, the evaluators recommended that:

- The ISSER and RIPS be encouraged to cooperate more closely. Both institutes should be assisted in developing a joint publications program.
- Both institutes need a modern computer to process the valuable data that are being collected. This matter should be given urgent attention.

4. Production of Oral Contraceptives

This project, which should have been supported by the United Nations Industrial Development Organization (UNIDO), was not finalized. Negotiations were begun with the Pharmaceutical Division of the Ghana Industrial Holding Corporation (GIHOC) for assistance in designing a system for the local production of oral contraceptives. Because of the many internal difficulties at the GIHOC, the GOG chose not to reply to a proposed list of possible contractors, and the UNIDO dropped the project.

A review of the contraceptive retail sales project suggests that a study should be made of the advantages of local production of the popular foaming tablets and oral pills.

*Expansion of Postpartum Family Planning Program*

This centrally-funded project, begun in 1969 and terminated in 1972, was sponsored by the Population Council and instituted at three hospitals: Korle Bu (Accra, 1969), Effia Nkwanta (Sekondi-Takoradi, 1971), and Komfo Anokye (Kumasi, 1971). The aim of the program was to increase the acceptance of family planning by offering FP services to women after delivery or abortion, a time when, it is presumed, women are most likely to be motivated to accept FP, because they are still in the hospital. Ministry of Health hospital staff who provide ob/gyn services with the assistance of a cadre of motivators were recruited to provide family planning services. It was felt that the prospective clients would be more receptive to known and trusted staff and therefore be more likely to accept FP services. The full range of family planning services, including postpartum insertion of IUDs (a controversial issue at the time), was offered.

Although the program achieved its objective of increasing the number of persons introduced to family planning (some of whom would not have returned later for family planning assistance), the continuation rate appeared to be no better than that of others recruited at other times. A final blow was dealt to the program when an ethical question was raised about the payment of honoraria to staff who provide family planning services, which are a part of ob/gyn services.

AID contributed \$150,200 to this project. The principal contribution of the project to GNFPP objectives was stimulation of interest in family planning among personnel in the Ministry of Health.

*Family Education Project*

This Ministry of Social Welfare project was supported by funds from World Education, under contract with AID/Washington.

The purpose of the project was to develop an integrated approach to improving family life in Ghana by combining the development of vocational skills, home economics, and family health planning with the improvement of life in the home and the teaching of literacy.

The project was conceived by two Ghanaians from the Ministry of Social Welfare who had attended a seminar on family life education in Nairobi, Kenya, in 1972. After several visits to Ghana, in 1973 and 1974, and following a workshop in Ghana in June 1974 on materials development for family planning, the Ghanaians submitted a project proposal. The proposal was approved first by the GNFPF in November 1974 and then by USAID/Accra.

In February 1975, a two-year work order was finally issued to World Education. At this stage, the project was described as a "pilot project to shed light on the efficiency and effectiveness of adult education as a vehicle for promotion of family planning." The objectives of the project were:

- To plan and implement a program that integrates adult literacy and family life education and that will meet the needs of rural adults for family planning, occupational skills, nutrition, recreation, and civic life.
- To demonstrate the feasibility and effectiveness of such a program.
- To be a model for future expansion and integration into the adult education program of the Department of Social Welfare and Community Development.

Adult classes in two districts were held for the first six months of 1975, and a list of 50 topics to be covered was developed.

In November 1976, World Education requested that the termination date be extended from February 1977 to June 1977. An additional sum of \$14,544 was awarded, bringing total contributions to \$93,744.

At the same time, agreement was reached on proposals for a new and enlarged three-year project (July 1977-June 1980). The objectives of the extended project were:

- To introduce functional literacy materials in Akwapim-Twi, Akim-Twi, and Fanti to 1,100 adults.
- To introduce the same materials in a fourth language to an additional 300 adults.
- To establish and administer a self-help fund of U.S.\$38,000 in four districts.
- To establish and administer a revolving fund of \$7,000 in one of the four districts.
- To conduct 12 workshops in adult education techniques and strategies.
- To train 155 volunteer adult education "facilitators."
- To establish 25 non-formal educational field sites.

Among the activities made possible by the grant were the following:

- Field lectures covering 50 topics were developed and translated into three languages.
- Field staff and volunteer leaders ("facilitators") were trained.
- Demonstration classes were conducted in two farming regions and one fishing region.
- Materials were produced and printed for use in extending the program.
- Plans were developed to expand the program to three other regions.

A preliminary report on the first years of the project was prepared by World Education. It indicates that limited transportation has resulted in limited outreach by field staff and trained facilitators.

If this project were integrated at the village level with the primary health care program of the Ministry of Health, transportation and supply problems might be solved.

World Education contributed \$93,744 from 1975 to 1977, and \$304,500 thereafter. Of these amounts, only \$45,000 were put into the self-help fund and the revolving fund.

*African Health Training Institutions Project*

The objectives of the African Health Training Institutions Project (AHTIP) were to:

- Increase the capability of health professionals in selected African countries to provide family planning services.
- Help heads of African health training institutions recognize the importance of family planning and maternal and child health and nutrition to professional education and health service programs.
- Enhance training in family planning at health training institutions by upgrading knowledge of family planning and teaching methodology through:
  - the development of teaching materials, especially self-instructional teaching materials;
  - participant training, especially in the U.S.; and
  - seminars and workshops in selected countries and among regional groups.
- Encourage regional meetings of teachers of health institutions to exchange ideas on curricula.

The AHTIP conducted the following activities in Ghana:

- A workshop for 23 teachers from 11 MOH nursing schools was held at the University of Ghana in June-July 1974.
- A workshop for 15 participants from four MOH nursing schools was held at the University of Ghana in January 1977.
- A workshop was held at the University of Ghana Medical School in April 1976 for teachers in the departments of community health, child health, obstetrics and gynecology and for Ministry of Health personnel (physicians,

nursing-tutors, health educators, nutritionists). Twenty-five participants, 23 of whom worked in self-instructional units, attended this workshop.

- Seminars were held in Nigeria, Kenya, and North Carolina for teachers from Ghana.

The AHTIP contributed \$80,000 to the workshops.

The Consultative Group on Nursing, Midwifery and Allied Health Professions was organized. The group held its first meeting in Accra in 1974. Annual meetings were held thereafter.

A consultant in curriculum design was retained for the University of Ghana Department of Nursing.

### Achievements

The three workshops in Ghana involved many persons who are in teaching positions in the medical school, Korle-Bu, Nursing Department of the University of Ghana, and at least 14 other health training institutions. They all learned about teaching methods, and most tried to design self-instructional units.

To the benefit of the medical school, some teachers produced self-instructional units, became aware of the availability of other units elsewhere in Africa, and began to use the units with their students. Many of the teachers in the medical school had been exposed to developments in this field at a successful meeting in Accra in 1973. The meeting was arranged by the Association of Medical Schools of Africa and the Carolina Population Center program, a precursor of the AHTIP.

The AHTIP's relationship with the Nursing Department and its sister institutions in Ghana appears to have been intimate and useful. A member of staff of the Nursing Department had been a liaison person for the AHTIP in Ghana, and the head of the department is a member of the AHTIP Consultative Group on Nursing, Midwifery and Allied Health Professions, which meets once a year in different African countries.

Details of AHTIP-sponsored participant training of Ghanaians in the United States were not available to the evaluation team.

The trainees in the Department of Nursing helped to integrate the clinical practice of family planning into the tutors' course.

The workshops resulted in the production of a manual, "A Topical Outline for the Teaching of Family Health," which many teachers of family health in Ghana consider to be useful.

The evaluators listed three criticisms of this project:

1. AHTIP efforts in Africa were diffuse because too many countries were involved.
2. Much time was required to edit the self-instructional units.
3. Not enough copies of these documents were made available, even to the authors.

#### Impact on GOG Policy

The AHTIP helped the Nursing Department to improve the teaching of family planning at Legon. Because teachers from training institutions were involved in the effort, courses in family planning were integrated into the curricula of Ministry of Health training institutions sooner than expected.

*International Development of Qualified Social Work Manpower  
For Population/Family Planning Activities*

This project was funded through a grant to the International Association of Schools of Social Welfare (IASSW). The IPPF also collaborated in the effort.

A sub-regional workshop on family welfare, a component of development, was held at Legon on February 4-8, 1976. Thirty persons from four African countries attended the workshop.

A pilot workshop for social welfare supervisors was held at Greenhill from September 26 to October 2, 1976. Co-sponsored by the GNFPF, this workshop was designed to improve supervisors' understanding of their role in family planning and to help them acquire skills. Twenty-four persons attended this workshop.

An IASSW conference was held in Puerto Rico and Jamaica. It was attended by senior-level social workers from Ghana.

Not enough documentation is available to justify an objective evaluation of the impact that this project has had on the objectives of the GNFPF program.

*Participant Training for Population-  
And Family Planning-Related Activities*

This effort combines both bilaterally- and centrally-funded assistance. The award of some fellowships was controlled by the GNFPP Secretariat; other fellowships were awarded after consultation with the GNFPP. The GNFPP was not involved in any way in the award of Danfa Project fellowships.

In general, USAID funds covered the costs of training, but in bilaterally-funded projects, the GOG paid the travel costs of Ghanaians trained in the United States.

The objective of participant training was to improve the knowledge and skills of personnel already engaged in population-related work, and especially those in USAID-financed projects.

Table 2 identifies the categories and numbers of trainees.

Length of Training

Of the 166 Ghanaians who received participant training abroad, 118 persons (71 percent) attended seminars and workshops lasting less than 22 weeks (most ranged from 1 week to 20 weeks; modes, 6 weeks and 13 weeks). Twenty-five persons (15 percent) attended courses lasting from 39 to 52 weeks. Of these, 17 attended one-year degree programs. Twenty-two persons (13 percent) spent 65 to 115 weeks abroad. Five spent 160 weeks abroad, and one person was away for 218 weeks. Eight persons were away for less than 8 days. Nine persons received more than one fellowship.

Present Status of Trainees

The team ascertained that at least 71 (nearly 43 percent) of all trainees now hold jobs in Ghana that directly or indirectly relate to the objectives of their training.

Achievements

In the early days of the national program, the trainees from participating ministries or departments of the State who were selected returned to play insignificant roles in efforts to achieve national goals. Some

---

Table 2  
PARTICIPANT TRAINING ABROAD  
(1969-1978)

---

<u>Category</u>	<u>Number</u>	<u>Percentage</u>
Health Professionals*	61	36.7
Demography, Statistics, Social Sciences, and Data Processing	40	24.1
Information, Education, and Communication	26	15.7
Home Science, Social Welfare, and Agriculture	21	12.7
Administrative and Legal Personnel	16	9.6
Unknown Status	<u>2</u>	<u>1.2</u>
TOTAL	<u>166</u>	<u>100.0</u>

---

\* 22 Physicians  
39 Other Health Professionals

---

projects were highly successful, however, because staff were selected carefully.

In the past five years, selection has improved, and many of those who are trained now play a role in the program, either as providers of services or as teachers. Earlier, problems arose because some Ghanaian institutions did not know what was expected of them in the national program. Doubtless, many senior-level persons felt pressured to attend seminars. Moreover, if a role was not clearly defined, or if a program was not envisaged or initiated, a returning trainee might have found no immediate use for his or her newly acquired knowledge and skills.

#### Impact on GOG Policy

It appears that almost everyone in a senior position in the national program, either in the GNFPP Secretariat or in the participating agencies, has taken advantage of some training in the U.S.

The participant training scheme has been a significant component of the USAID contribution to Ghanaian population programs, for it has strengthened the capability of manpower infrastructure to provide adequate and good services.

The next objective should be to ensure that various institutions at all levels are capable of providing much of the training in Ghana.

There is a need to develop centers in Ghana for training and research in the clinical aspects of fertility control and in IEC. This program should match the training program in demography. Through its contribution to the training of Ghanaians in these fields, USAID has established the foundations for such a development effort.

## General Review

Table 3 summarizes the total USAID population assistance to Ghana during the period under review.

The actual amount spent on population programs is somewhat less than the figure shown in Table 3 because well over \$130,000 were deobligated in FY 1976 and 1977. Because of unspent population funds (\$340,000) from previous years, there were no budgetary provisions for population programs in the 1980 USAID budget.

The evaluation team's review of both centrally- and bilaterally-funded projects revealed many management problems. These problems, in addition to the continuing, unsettled state of the national economy and political unrest, may have had a significant effect on the country's ability to absorb the budgeted assistance (the current mix is approximately 50 percent for each of the two categories of funding).

Following individual review, the projects were classified into categories of population-related activity. The categories were "Demography," "Family Planning Services," and "Family Planning IEC." Each category was further subdivided into three component activities: research, training, and service. Table 4 illustrates this classification.

In reviewing this classification, a reasonable conclusion is that United States assistance has been fairly evenly spread among the three main kinds of activities to serve the objectives of reducing the rate of growth and improving the general health of Ghana's population. Not all the projects had service-related components, but this does not mean that the provision of family planning services, which was the principal task of the GNFPP, was neglected. However, it does indicate that a significant number of persons should be trained to provide services and information and that Ghanaians should be sensitized to the benefits of child-spacing, as well as other FP services.

The team would have been able to confirm the effectiveness of the services that are being provided had it had access to reports from the various family planning clinics. For reasons not clear to the team, the GNFPP has compiled no reports since 1978.

The team decided to assign a numerical value to each objective of each program as a measure of its achievement. This exercise, like any value-grading system, is both objective and subjective. It is useful in this evaluation because it provides a comparable and relative assessment of the achievement of objectives.

Table 5 is a list of grades for each project.

Table 3

AID POPULATION ASSISTANCE TO GHANA, FY 1968-1979

Bilaterally-Funded

Family Planning and Demographic Data Development, FY 1968-1970	\$ 240,000
National Family Planning Program Supplies, FY 1971-1972	350,000
Population Program Support, FY 1971-1978	2,750,000
Danfa Rural Health and Family Planning Project, FY 1970-1978 (\$1,577,000 health funds also provided)	4,335,000
Population Dynamics Program, FY 1977-1978	<u>600,000</u>
Subtotal	\$ 8,275,000
Centrally- or Regionally-Funded (estimated)	8,800,000
GRAND TOTAL	<u><u>\$17,075,000</u></u>

Table 4  
GHANA POPULATION PROJECTS BY FUNCTION

Projects	Demography			Family Planning			Family Planning IEC		
	<u>R</u>	<u>T</u>	<u>S</u>	<u>R</u>	<u>T</u>	<u>S</u>	<u>R</u>	<u>T</u>	<u>S</u>
<b>Bilateral</b>									
B1					X	X		X	X
B2	X	X		X	X		X	X	
B3	X	X	X	X	X	X	X	X	X
B4						X			
B5	X	X		X			X		
<b>Centrally-Funded</b>									
C1	X	X					X		
C2						X			X
C3	X	X							
C4					X				
C5					X				
C6					X	X		X	X
C7					X	X		X	X
C8								X	
C9	X	X							
C10								X	
C11									X
C12								X	
C13						X		X	
C14	X	X	X						
C15				X		X			
C16								X	X
C17					X			X	
C18								X	
C19		X			X			X	
<b>TOTAL</b>	<u>7</u>	<u>8</u>	<u>2</u>	<u>4</u>	<u>10</u>	<u>7</u>	<u>4</u>	<u>13</u>	<u>7</u>
<b>Code:</b>	R = Research T = Training S = Services								

Table 5  
PROJECTS GRADED BY ACHIEVEMENT OF OBJECTIVES

Project Number	A. Bilaterally-Funded Projects	Grade					
		1	2	3	4	5	NG
1, 4	Population Program Support; National Family Planning Program Supplies				+		
2	Population Dynamics Program					+	
3	Danfa Rural and Family Planning					+	
5	Family Planning and Demographic Data Development						+
B. Centrally-Funded Projects							
1	Ghana Fertility Survey						+
2	Retail Contraceptive Sales Program				+		
3	University Teaching of Population Dynamics					+	
4	Physicians Postgraduate Training in Reproductive Health				+		
5	Family Planning Services (Pathfinder Fund)						+
6	Grant to IPPF (Support to PPAG)						+
7*	Family Planning International Assistance (Grants to YMCA)						+
8	Program for Voluntary Sterilization						+
9	Program Grant to Population Council (University of Cape Coast)				+		
10	Strengthening International Population Communication and Training						+
11	Population Information Program						+
12	Family Planning Assistance Through Home Economics					+	
13	Training for Family Planning Managers (CEFPA)		+				
14**	UNFPA						+
15	Expansion of Postpartum Family Planning Program (Population Council)					+	
16	Family Planning Education Through Adult Literacy Program					+	
17	Family Planning Courses in Health Training Institutions					+	
18	International Development of Qualified Social Work Manpower						+
19	Participant Training (Airlie Foundation, AHEA, Downstate, Harvard, Johns Hopkins University, University of Chicago, Ford Foundation, IPPF, Pathfinder, Population Council, UNFPA, WHO, Meharry University)						+
TOTALS		0	1	7	5	3	8

Code: 1 - Program Objectives Not Achieved  
 2 - Program Objectives Poorly Achieved  
 3 - Program Objectives Moderately Achieved  
 4 - Program Objectives Well Achieved  
 5 - Program Objectives Very Well Achieved  
 NG - Not Gradable. A score of NG was given when the objective achievements were not quantifiable or impossible to assess. Some programs with more than one objective or part were scored only on the results of parts completed (e.g., numbers 8 and 15) or on the collective results of several objectives.

\* Only two of four projects were started.

\*\* Only four of five projects were started.

An analysis of the scores, by number and percentage of projects which earned a particular grade, is given in Table 6.

Only one project, the Training of Family Planning Managers Project, received a "2," which indicates poor achievement of objectives. Excluding the eight projects which the team decided not to grade (see explanation in Table 5), the projects all scored a "3" ("moderately achieved") or higher, indicating general satisfaction with the moderate successes of these programs.

---

Table 6  
SCORE GRADES BY NUMBER AND PERCENTAGE

---

<u>Project Grade</u>	<u>Number of Projects</u>	<u>Percentage of Projects</u>
5	3	12.5
4	5	20.8
3	7	29.1
2	1	4.1
1	0	0
Not Graded	8	33.5

---

## VI. CONCLUSIONS ON THE GHANA NATIONAL FAMILY PROGRAM

### General Conclusions

To the credit of the Secretariat of the GNFP and its executive director, the program survived the many political upheavals and uncertainties in Ghana which followed its initiation. It is generally agreed that the support provided by the program has contributed significantly to the widespread knowledge and awareness of contraception in Ghana.

Initially, the GNFP organized the training of nurses and other family planning workers from the MOH and private voluntary agencies. These GNFP trainees deserve credit for whatever measure of success has been achieved in the delivery of family planning services. The MOH is now in charge of programs for nurses, nurse-midwives, and other health workers. It has incorporated training into the regular curricula of MOH training schools.

Lack of efficient management, problems in procuring and distributing supplies, and the uneven and unenthusiastic collaboration of certain divisions of participating ministries have resulted in the inequitable distribution of contraceptive supplies throughout the country. This means that more supplies are available in some areas than in others.

A majority of the individuals who were interviewed by the evaluation team believes that serious problems have arisen because of the organizational structure and management of the program. They note especially problems in organizing and managing the Program Advisory Committee, the National Advisory Committee, and the Government Services Unit. For example, the coordinating functions of the Manpower Board and the Secretariat of the GNFP overlap. These functions should be sorted out and clearly delineated. (The current organization chart of the GNFP is attached as Appendix E.)

The predominant emphasis on family planning in the national program seems to account in part for the lack of enthusiasm and confusion of ideas among the collaborating ministries. Most think that family planning services should be provided by the Ministry of Health, although all the ministries are expected to contribute to the implementation of the national population policy. One effective way to exact these contributions might be to include the word "population" in the name of the national program. For example, the national program might be renamed the Ghana National Population Program (GNPP) to reflect the emphasis on population.

The National Advisory Council and the Program Advisory Committee meet infrequently. This is a problem, as is the composition of the groups. The original intention was that the most senior professional

heads of the various ministries would serve as members of the Executive Committee of the program. This seems to have been thwarted, however, when the Advisory Committee was substituted for the Executive Committee. The result was that junior representatives from the ministries attended the few committee meetings that were called. A return to the original structure should be considered.

Another problem is the considerable misunderstanding and disputes about the role of the Ministry of Health in providing family planning services and controlling the supply and distribution of contraceptives among MOH staff. This misunderstanding might be clarified if a medical services director from the Ministry of Health were appointed to the staff of the GNFPF.

All these problems may be attributable to the national unrest and circumstances that are beyond the control of the persons involved. They must, however, be solved to ensure the fulfillment of the objective of the program: to reach the majority of the people of Ghana who reside in the rural areas. The team urges the GOG to take urgent steps to find solutions to these problems.

#### Role of the Ministry of Health

It is clear from the documents that describe the origins of the Ghana National Family Planning Program that the Ministry of Health was to be entrusted with the following responsibilities:

- the training of health personnel in the Family Planning Program;
- the motivation of clients by health workers; and
- the delivery of family planning services in MCH clinics, hospitals, and other MOH institutions.

Family planning services were offered at 54 MOH clinics. These services included free advice and consultation on FP methods, sterilization, and infertility problems and the provision of contraceptive methods at nominal charges. The contraceptive methods included:

- Contraceptive pill. Only one brand (combination) is available. There is a need to add more brands, including a low-estrogen pill for those who are nursing and prefer to be on the pill.

- Intrauterine device.
- Vaginal foam tablets and spermicidal creams.
- Condoms.
- Long-acting hormonal contraceptives by injection (Depo-Provera).
- Sterilization (in maternity hospitals).
- Referral of patients for infertility management.
- Motivation of patients and clients for FP through individual and group talks and discussions.
- Recruitment and follow-up of women for FP during antenatal, postnatal, and child welfare sessions and through home visits.

Within a short time staffing problems in the GNFP Secretariat and the disturbing effects of political upheavals combined to create a lack of enthusiasm among MOH officials for family planning activities.

The senior medical officer at the MCH/FP Division recently reported that "there is a ferment in the Ministry of Health MCH/FP Division to grapple with the issue of family health as it relates to contraception and infertility." The government supports the Ministry of Health in its determination to establish a creditable family planning program. This indicates that the government is aware of the country's population problems, that it recognizes the importance of family planning services to the health and socioeconomic development of mothers and children, and that it is committed to tackling population issues.

One indication of results achieved is total attendance at government MCH/FP clinics, which increased from 19,871 in 1970 to 197,200 in 1976. In 1976 there were 31,800 new acceptors and 165,400 revisits for consultation reviews and routine supplies of contraceptives.

New record forms developed by the Research and Evaluation Unit of the GNFP were introduced in June 1978. With these forms it will be possible to calculate continuation rates.

The Ministry of Health is taking steps to ensure that it is represented adequately at the various GNFP committee meetings. This was a problem in the past. The MOH now will be represented regularly and at

the highest possible level, especially on the Program Advisory Committee, which appears to be a key to the successful participation of the ministries in the GNFPF.

The team was informed that the MOH is anxious to extend the primary health care system to communities outside the present public health care system.

The MCH Division of the Ministry of Health has been reactivated. Its responsibility is to fully integrate family planning into MCH services. The staff are under the direction of a senior medical officer.

The GNFPF vigorously tackled training by integrating family planning into the curricula of all MOH training institutions. By the end of 1979, more than 4,000 graduates of nursing schools had received family planning training.

In addition, "training of trainers" has been undertaken and all nine regions have provided in-service training in family planning to MCH and other nursing staff. A high-level seminar for principal nursing officers and heads of nursing schools was held to discuss ways to integrate FP/MCH and nutrition into the proposed primary health care program for Ghana. It would appear that the MOH is now in a position to ensure that family planning services are offered at all government health institutions.

The following constraints still handicap the program:

- Lack of vehicles, especially for decentralized MCH/FP services in the districts and for supervision from the headquarters in Accra.
- Bottlenecks in the supply of contraceptives and other family planning commodities. To ease these bottlenecks, the MCH/FP office in Accra, the GNFPF, and the MOH Pharmacy Division should meet for discussions.
- Budgeting problems between the GNFPF and MOH MCH/FP.

It is generally agreed that Ghanaians have a fair level of knowledge of family planning methods, that the government is aware that rapid population growth is a threat to both family health and national development efforts, and that the practice of contraception is undoubtedly increasing, given the popularity of the recently introduced foaming tablets and reports of the retail sales of contraceptives. It is disturbing, however, that little progress has been made in documenting the effects of the GNFPF on fertility rates.

Most of the program's activities are still conducted in the "golden triangle," a heavily populated area linking Accra, Kumasi, and Sekondi-Takoradi.

The GOG must give a much higher priority to the nationwide implementation of the population policy and to the removal of the administrative and logistic obstacles that prevent the effective extension of the program to all parts of the country, but especially to rural areas.

## VII. CONCLUSIONS ON USAID SUPPORT OF POPULATION PROGRAMS IN GHANA

For 12 years the USAID program of population assistance was the primary mechanism of support for implementing Ghana's forthright national population policy. Almost half of all projects undertaken have included a wide array of training components. For example, nearly 1,000 Ghanaians received training in demography, laparoscopy, family planning management, communication, and similar disciplines and are thus prepared to effectively provide family services in Ghana. A large corps of trained Ghanaians has been created, and an effective IEC program has been initiated. The country is now ready to extend services to all regions and to conduct additional population-related research.

The mix of projects has been appropriate for two reasons. One, when USAID began to provide population assistance, a critical mass of trained manpower did not exist. Two, before AID-funded IEC programs were initiated, there was little demand in pro-natalist Ghana for contraceptives. The mix, now concentrated in the development of more refined demographic data for development planning and more widely provided FP services, has been evolving properly to meet the country's needs.

Several projects have been duplicative and are not very effective. Many gaps remain to be filled. A greater coordinating role by AID/Ghana is therefore indicated.

AID has provided an impressive volume and range of assistance totaling roughly \$17 million. This support has been divided almost equally among 5 major projects funded by bilateral agreements and 19 projects funded indirectly from central AID funds.

AID funds supported eight types of population-related activities:

- The National Family Planning Program received budget support for several years.
- The NFPP received funds for a contraceptive distribution program.
- AID supported short-term U.S. training for approximately 125 persons.
- Local training for several thousand health workers and other health personnel was financed with AID assistance funds.

- The Population Dynamics Program at the University of Ghana was established with AID funds.
- Support was provided to establish a contraceptive retail sales program.
- Population studies and family planning research were funded with AID monies.
- AID supported the population and family planning activities of private voluntary organizations.

Some funds had to be deobligated because they were not used. The evaluation team does not believe that funds were not used because Ghana reached its capacity to absorb external financial assistance but because of management problems in the collaborating ministries and delays caused by red tape, personality conflicts, and failure to make prompt decisions. These problems must be eliminated so that continued financial assistance at current or increased levels will be used fully to extend the gains achieved in some parts of Ghana to all other areas.

An examination of Table 7, which compares total U.S. economic assistance with U.S. population assistance, should correct a mistaken impression (heard by the team in some quarters) that excessive amounts of U.S. funds have been spent on population programs in Ghana. The total of \$8.04 million of bilateral aid and the \$8.80 million of centrally-funded population assistance amounts to only 7.5 percent of the \$225.1 million allocated as bilateral economic assistance.

#### Role of USAID Mission Population Staff

The team had several opportunities to observe the work of the Population Office of the USAID mission and that office's relationship with GOG officials and the offices of health in the government, especially the GNFPP Secretariat, and voluntary agencies.

The Population Office is responsible for:

- Keeping the U.S. Ambassador and the USAID mission director fully informed about the progress and status of population assistance projects.
- Preparing briefs for high-level discussions with GOG officials.

Table 7  
 COMPARATIVE TABLE OF USAID BILATERAL ASSISTANCE TO GHANA  
 (\$000s)

<u>Fiscal Year</u>	<u>Total Bilateral Economic Assistance to Ghana</u>	<u>Bilateral Population Assistance*</u>	<u>Percent of Total Population Assistance</u>
1968	34.6	0.13	0.3
1969	24.7	0.12	0.4
1970	31.2	0.79	2.5
1971	22.1	0.64	2.8
1972	15.1	0.65	4.3
1973	24.4	1.03	4.2
1974	6.0	1.44	24.0
1975	7.5	0.96	12.8
1976	22.6	0.61	2.6
1977	13.4	0.81	6.0
1978	12.2	0.73	6.0
1979	7.4	0.13	1.8
1980	<u>3.9</u>	<u>0.00</u>	<u>0.0</u>
	<u>225.1</u>	<u>8.04**</u>	<u>3.57</u>

\* Includes centrally-funded contraceptives.

\*\* Centrally-funded population assistance projects received an additional estimated \$8.00 million during these years.

- Maintaining up-to-date records and files of project reports and correspondence on all population projects.
- Monitoring all population projects.
- Providing liaison with the Secretariat of the GNFPF, with local representatives of other external donors, with project directors and officials of the private voluntary organizations that are receiving assistance, and with officials in the secretariats of GOG ministries that participate in the GNFPF.
- Assisting the USAID mission director in keeping AID/Washington fully informed of current developments, including formulation of population policy, changes in the emphases of GOG and PVO programs, and other relevant matters that influence future planning.
- Developing new population and population-related projects and monitoring the progress of current activities.

The team believes that any action that might be interpreted as downgrading the importance of USAID population assistance to Ghana should be avoided. The high-level coordinating and interpreting functions of the population officer will be compromised if they are assigned to a locally recruited person who does not have equal access to GOG officials, USAID mission staff, and AID staff in Washington.

The full effects of a decade of U.S. population assistance cannot be quantified at this time for many reasons. First, far-reaching changes in human behavior, such as those required to fully embrace family planning practices, cannot be effected in a single decade. Second, the political and economic upheavals in Ghana during the decade under review have made it difficult for all the variables which affect population changes to exert their normal influence. Third, although successive governments in Ghana have repeatedly declared their support for the original population policy, such long-range issues as population have not received as much attention as short-range problems resulting from political, social, and economic instability.

## VIII. RECOMMENDATIONS

The following general recommendations for the entire AID assistance program were prepared after each project was reviewed. Because several projects have been completed and others are in various stages of implementation, the team did not consider it useful to offer specific recommendations for individual projects.

1. The Government of Ghana should give priority to a careful study of the national program so that the problems which are limiting the program's effectiveness can be solved. Such a study should encompass the roles of the Manpower Board, the Ministry of Health, the Ministry of Finance and Economic Planning, and the Secretariat of the GNFPF.
2. AID/W and the AID mission in Ghana should constantly seek to increase the involvement of Ghanaian nationals in decisionmaking in all projects. A Ghanaian should be appointed to serve as a co-director of each in-country project.
3. In its population program and general development efforts, the GOG should be encouraged to focus more attention on the rural areas, where 70 percent of the population resides, and to develop and promote integrated community-based programs, including women's self-help projects.
4. AID support of Ghana's population-related programs should be continued at current or increased levels.
5. In the Ghanaian context, the importance of AID assistance in population should not be overlooked, for it requires the AID mission to devote considerable effort to coordination. The mission's role fully justifies maintaining the presence in Ghana of a U.S. population officer who has equal access to AID/Washington, the AID mission in Ghana, and GOG officials.
6. More direct assistance should be given to such PVOs as the PPAG and the CCG, which are well organized, have demonstrated their ability to provide acceptable family planning services, and operate cost-effective programs.

7. The effort to fully integrate family planning into maternal and child health services has already begun and should be vigorously pursued. No additional financial incentives should, however, be offered to providers in any professional category.
8. The Ministry of Health should assume complete and sole responsibility for the supply and distribution of family planning commodities in the public sector.
9. The demand for a low-estrogen oral pill and the increasing popularity of an acceptable foaming tablet (Neo-Sampoon) justify the provision of these commodities in greater quantities.
10. Decisions on pricing should reflect consideration of the low levels of cash income of the majority of rural Ghanaians. The lowest possible prices should be set for a commercial program, and government-provided commodities should remain free.
11. Participating government ministries should pay particular attention to the follow-up of results of and recommendations for research projects and workshops that relate to their programs.
12. Increased reliance should be placed on Ghanaian institutions which already have adequate staff facilities and equipment to undertake in-country training.
13. To avoid difficulties and misunderstandings during project implementation, all financial and other contractual agreements should be fully specified and defined for major participants.
14. AID should continue to support the integrated research programs of Ghanaian universities. These institutions' findings will be much more useful for formulating and implementing socioeconomic development programs and for evaluating action-oriented programs.

REFERENCES

- Aryee, A.F. and Gaisie, S.K. Fertility Implications of Contemporary Patterns of Nuptiality in Ghana, 1979.\*
- Gaisie, S.K. "Aliens: How many left Ghana before the 1970 Census and How many gave false Declarations in the Census." In Economic and Social Affairs. Vol. I, No. 4, October 1975.
- . Estimating Ghanaian Fertility, Mortality and Age Structure. Population Studies No. 5. Chapel Hill: University of North Carolina, 1976.
- . Population Projections for Ghana. Ghana: Institute of Statistical, Social and Economic Research, University of Ghana, 1978.\*\*
- Gaisie, S.K. and David, A.S.. "Planned Fertility Reduction in Ghana: Structural Interrelationships, Potential Socio-Economic Impact and the Magnitude of Needed Programmes." Population Studies No. 6. Ghana: University of Ghana, Legon, 1974.
- Gaisie, S.K. and de Graft-Johnson, K.T. Population of Ghana. World Population Conferences. CICRED, 1976.
- Gil, B. Immigration into Ghana and Its Contribution in Skill (Mimeographed). Accra, Ghana: Census Office, 1962.
- Keyfitz, N. "The Impact of Modernization." In Approaches to the Science of Socio-Economic Development, ed. P. Lengyed. Paris, 1971.
- Ministry of Economic Planning, Accra, Republic of Ghana. Five-Year Development Plan 1975/76 - 1979/80 Part II. Ghana Publishing Corporation, Accra-Tema, 1977.

---

\* In print.

\*\* Unpublished.

**APPENDICES**

**Appendix A**  
**LIST OF PERSONS CONTACTED**

Appendix A  
LIST OF PERSONS CONTACTED

Ministry of Finance and Economic Planning

Dr. Amon Nikoi, Minister of Finance and Economic Planning  
Mrs. M. Chinery-Hesse, Chief, Economic Planning  
Mr. R. W. Kwami, Acting Director, Manpower Board  
Mr. J. Y. Owusu, Census Coordinator

Ghana National Family Planning Program Secretariat

Alhaji Imolo Egala, Chairman, NFP Council  
Dr. A. Armar, Executive Director  
Mr. S. K. Kwafo, Deputy Director  
Mr. H. Ofori, Chief of Information  
Mr. H. K. Acqvaye, Assistant Director  
Mr. C. Addo, Director of Training  
Mr. W. Amponsah-Nketia, Commercial Distribution

Ministry of Health

Mr. M. P. Ansah, Minister of Health  
Dr. G. Beausoleil, Director, Medical Services  
Dr. Y. Aboagye-Atta, Deputy Director, Medical Services  
Mr. I. K. Boateng, Principal Secretary  
Dr. E. Boahene, Director, MCH  
Mr. Osei-Tutu, Head, Pharmacy Board

Mr. Bruce, Deputy Head, Pharmacy Board

Mrs. Hornsby-Oddoi, Chief Nursing Officer

Mrs. Akita, Department of Post-Basic Nursing, University of Ghana

Ministry of Information

Dr. J. S. Nabila, Minister of Information

Mr. J. Ampah-Kwofie, Deputy Minister

Mr. Martin Tay, Deputy Director

Mr. Marshall, Deputy Director

Ministry of Education

Dr. R. Owusu-Bempah, Deputy Minister

Mr. S. K. Apreku, Deputy Minister

Mr. Hesse, Principal Assistant Secretary

Ministry of Social Welfare

Mr. Sai, Principal Secretary

Mr. H. Asamoah, Director, Social Welfare

Mr. V. Fletcher, Welfare Officer

Planned Parenthood Association of Ghana

Mr. E. Kwansah

Mr. D. Azu

Christian Council of Ghana

Mr. D. Dartey, Executive Secretary

Mrs. Agnes Hughes

Korle Bu Hospital

Professor D. A. Ampofo, Head, Department of Obstetrics and  
Gynecology

University of Ghana

Professor K. Twumi-Barima, Director, Institute of Statistical,  
Social and Economic Research (ISSER)

Professor E. Laing, Department of Botany

Professor Schraft Hanson, Department of Classics

Mrs. Nsarkoh, Department of Home Science

Mrs. Krumeckpor, Research Fellow, ISSER

Mrs. A. Akiwumi, Nursing Department

Dr. C. Okonjo

Professor K. Dickson

University of Ghana Medical School

Dr. Bentsi-Enchill, Sekondi-Takoradi

Dr. D. Ampoto, Korle Bu Hospital

Ghana Home Science Association

Mrs. F. Sai

Mrs. J. Kwawu

USAID

Mr. I. Coker\*

Dr. D. Hess, Acting Mission Director

Dr. M. Weiss, Chief, Health and Population

Mr. R. Martin, Population Officer

LINTAS, LTD.

Mr. J. Obetsebi-Lamptey

DANAFA

Mr. F. Boosteen

U.S. Embassy

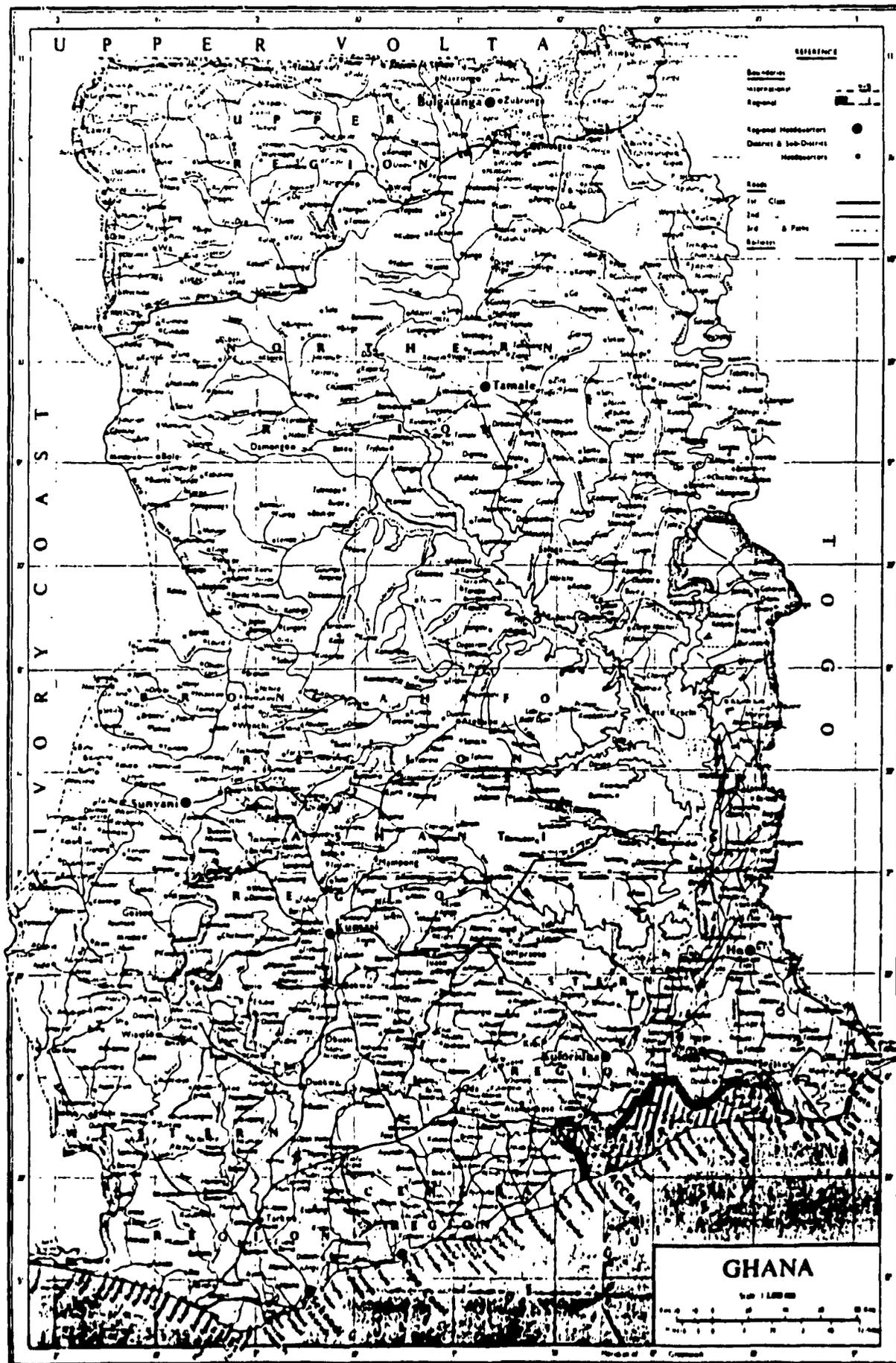
Mr. T. Smith, Ambassador

---

\* Formerly director in Washington.

**Appendix B**  
**MAP OF GHANA**

# ADMINISTRATIVE



Published by the Survey of Ghana, 1977  
Copyright Reserved

Compiled, Printed and Photographed  
by the Survey of Ghana in 1977

21

**Appendix C**  
**DEMOGRAPHIC DATA AND POPULATION FACTORS**

## Appendix C

### DEMOGRAPHIC DATA AND POPULATION FACTORS\*

#### Introduction

Following independence, census-taking in Ghana improved rapidly. The 1960 census exemplified improvements in techniques, objectives, and scope. The second census of the Republic of Ghana was taken in March 1970. The results are still being processed. These censuses have provided a solid foundation for most of the demographic studies undertaken in Ghana. Unfortunately, however, little progress has been made in the collection and compilation of vital statistics.

The status of population data and vital statistics is relatively low. In most cases, the analyses of the dynamics of population growth in Ghana are based on estimates. Nevertheless, the available demographic data throw some light on demographic developments in the country. These developments--changes in total population size, rate of growth, fertility, mortality, and migration--are discussed below.

#### Nuptiality and Fertility

Marriage is still universal, or near universal, especially for females. Although females tend to marry younger, males marry at older ages, which explains the wide disparity in age-at-marriage. Though several forms of marriage have been introduced into society, the customary form of marriage is still the most popular. The incidence of polygamy has not changed significantly, and a substantial proportion of husbands live with their wives in the same house. All these variables seem to influence or have some effect on fertility.

There have been some changes in the proportions of ever-married and currently-married females younger than 30 years, particularly among 15-19-year-olds and 20-24-year-olds. The decrease in the proportion of married persons in these age groups is reflected in the reduction of the contributions of the younger generations to total marital fertility rates. These changes in nuptial age patterns are largely attributable to a substantial increase in the number of females who attended school in the inter-censal period (1960-1970) following the implementation of Section 2

---

\* The information in this appendix was provided by Professor Sam K. Gaisie, M.A., Ph.D.

of the Education Act (No. 871; 1961). Nevertheless, the evidence suggests that the level of fertility has remained constant (Aryee and Gaisie, 1979).

Fertility is high and seems to have stabilized at high levels. The birth rate has been estimated at 50 per thousand population and the total fertility ratio is between 6.7 and 7.0. The most plausible estimate is that every Ghanaian woman of reproductive age will bear, on average, 6.9 children and will replace herself with approximately 3.4 daughters, two of whom will survive to become mothers. In other words, a woman in the present generation will be represented in the next generation by two women.

The high fertility level indicated by the total fertility ratio is also reflected in the completed family size. Figures on completed average family size show that fertility in Ghana is as high as or higher than fertility in Latin American and Asian countries, and apparently it is higher than that of some other African countries (Gaisie, 1976; 84ff).

### Mortality

In the early 1960s, the estimated crude death rate was 23 per thousand population and the infant mortality rate was 160 per thousand live births (Gaisie, 1976). By the late 1960s, these figures had declined to approximately 19-20 and 133, respectively. The data from the 1971 Supplementary Enquiry show that infant mortality declined further to 122 per thousand live births at the beginning of this decade. These figures conceal significant variations between regions.\* The urban death rate, 14 per thousand, is approximately two-thirds the rural rate. The urban rate is lower than the rural rate: 98, as compared to 161 per thousand live births (Gaisie, 1976; 298). Estimates based on the 1971 Supplementary Enquiry suggest that urban and rural infant mortality rates declined to 84 and 100 per thousand live births, respectively, in the late 1960s and early 1970s.

The estimated values of life expectancy indicate a steady decline in mortality since the early 1940s. The available figures suggest a slow decline in mortality since World War II and through the early 1950s and a relatively rapid decline immediately thereafter (Gaisie, 1976; 220ff). The author estimates that Ghana's expectation of life at birth was approximately 35.3 years in the 1940s. Life expectancy rose to nearly 40 years

---

\* Estimated crude death rates range from 8-10 per thousand in the Accra Capital District to 25-27 per thousand population in the Upper Region. In the 1960s, the regional estimates for infant mortality ranged from 56 in the Accra Capital District to 192 in the Upper Region.

in the late 1950s, and then rose again to approximately 47 years in the late 1960s and early 1970s. Between 1940 and 1970, it declined from 0.42 years per year to 0.62 years per year. These figures indicate substantial downward trends in mortality.\*

### Migration

The existing statistics show that there is considerable internal migration from one locality to another in Ghana. The four types of internal migratory movements have been identified as rural to rural, rural to urban, urban to urban, and urban to rural. It has been noted that "although the rural to rural movements are the most numerous, the most significant is the rural to urban movement" (Gaisie and de Graft-Johnson, 1976; 38ff).

Birth statistics, which have been used as a proxy for migration data, indicate clearly that there is considerable movement of the population of Ghana. Estimates based on the matrices of birthplace by place of enumeration show that most of the regions lose populations through migration to the regions of Greater Accra, Brong Ahafo, and Ashanti. It has been observed that "migration in Ghana tends to be of the labour type and Greater Accra with its concentration of government ministries and industrial establishments tends to attract large population. The Ashanti and Brong Ahafo Regions also, due to the cocoa farms, tend to attract migrant farm workers" (Gaisie and de Graft-Johnson, 1976; 69).

International migration has also been estimated for Ghana. In 1960, 12.3 percent of the total population were immigrants and approximately 96 percent of the foreign-born immigrants came from neighboring African countries: Togo, Upper Volta, and Nigeria. Approximately 86 percent of the immigrants were unskilled laborers, semi-skilled laborers, traders, etc. By 1970, the proportion of the foreign segment of the population had decreased to about 6.6 percent. One could say that the enforcement in 1969 of the Aliens Compliance Order was largely responsible for the sharp decline in the number of foreign nationals. However, the knotty problem confronting demographers at this moment is the number of foreign nationals who declared themselves to be Ghanaians in the 1970 census (Gaisie, 1975; 17ff).

---

\* Regional differentials indicate, however, that life expectancy in the Upper Region was between 30.0 and 32.5 years by the end of the last decade; life expectancy in the Greater Accra Region was approximately 56.0 years.

### Population Size and Rate of Growth

At the beginning of 1921, Ghana had a population of just over 2 million. By the first quarter of 1960, the population had increased to 6.7 million, more than tripling in those 40 years. The population thereafter continued to expand at an accelerated rate and by 1970 reached 8.5 million. At this time, it is estimated to be 11.3 million (Gaisie, 1978). The indigenous population is estimated to be 10.2 million (Gaisie and David, 1974; 141). As these figures show, the population more than quintupled in 56 years.

One of the significant features of Ghana's population is the rate of growth. Although data for the early part of the century are not reliable, the recorded figures indicate that Ghana's population has been growing at a relatively high average annual rate since 1921: 3.2 percent between 1921 and 1931; 2.8 percent between 1921 and 1960; and 2.7 percent between 1960 and 1971 (Gaisie and de Graft-Johnson, 1976; 7). The author estimates that the population expanded at a higher rate, approximately 2.7 percent per year, in the 1960s and, by the 1980s, increased to 3 percent per year. It is now estimated that the rate of growth will increase to 3.2 between 1980 and 1985. This increase will be attributable primarily to the decline in crude death rates.

The rapid growth of Ghana's population is attributable to a constant high fertility rate, a declining mortality rate, and an inflow of immigrants from neighboring African countries. The influence of the migration factor was, presumably, weakened considerably in late 1969 and early 1970 following enforcement of the Aliens Compliance Order. One must recognize that the number of aliens who returned to Ghana after January 1972, when the government changed hands, cannot be estimated from existing information on international migrants, particularly from data on migrants from neighboring countries. Nor can we estimate the number of Ghanaians who have been migrating from other African countries in recent years.

Notwithstanding the imbalance between fertility and mortality rates, which are largely responsible for the rapid increase in the size of the population, a review of projections of the population of Ghanaian origin shows that, in the absence of any changes in the level of fertility, the 1960 population will have doubled by 1982, a period of less than 25 years, and that by the year 2000 there will be nearly four Ghanaians for every Ghanaian in 1960. Even with a 28 percent reduction in fertility by the year 2000, the population will have more than tripled by the end of the century, implying that there will be three Ghanaians in 2000 for every one in 1960. Even if Ghana is able to reduce the fertility rate by as much as 50 percent between 1985 and 2000, the population will more than double in the next 26 years unless there is an immediate marked decline in fertility, an unlikely prospect. Slight changes in the fertility

level will not have any significant effect on the size of the future population. The important issue is the rate at which fertility will decline once the process begins. Note that a reduction of nearly 57 percent by the year 2000 will generate a population of nearly 18 million, nearly twice the 1970 estimated population of Ghanaian origin (10.2 million) (Gaisie and David, 1974; 141ff).

### Population Structure

Crucial to the socioeconomic development of a country are changes in the age structure of the population and labor force participation.

#### A. Age Structure

The most striking feature of the Ghanaian population is its extreme youthfulness. The proportion of children under 15 years is more than 45 percent. There are, moreover, indications that the Ghanaian population is becoming more youthful. High dependency rates obviously accompany such a youthful population. It has been projected that Ghana's population will become much younger in the next 20 years and that a marked transformation of the age structure will occur only if fertility declines steeply in the next several years. For instance, a reduction in the proportion of the population under 15 years to less than 40 percent (i.e., 36 percent) in the year 2000 is possible only if fertility declines more than 50 percent between 1975 and 2000.

Given the age structure, one can conclude that the prospects for growth are high and that the population will continue to increase beyond the year 2000. It is important to remember that the immediate benefits of declines in fertility are always relatively small and that the population is bound to grow for a considerable length of time before the rate of growth drops substantially. It has been estimated that, with an immediate fertility decline to replacement level in developing countries, the population would increase 66 percent before growth ceases (Keyfitz, 1971; 83-89). Thus, even if Ghana's fertility were to drop to replacement level in 1990, her population would continue to grow until the middle of the 21st Century. Because population change is dynamic, its effect on development would not be felt for a long time.

#### B. Size and Growth of the Labor Force and Related Problems

Ghana's labor force, 2,772,026 in 1960 (1,677,058 males and 1,045,968 females), increased to 3,331,618 in 1970 (1,859,395 males and

1,472,223 females). It grew approximately 2.5 percent each year during the decade. This is a high rate of growth with far-reaching implications for employment, unemployment, and under-employment. It is important to bear in mind that an annual high growth rate of 2.9 percent of the total population causes the labor force to grow at a more rapid rate. Thus, if the estimated growth was 3.0-3.2 percent of the total population between 1975 and 1980, the labor force would grow 2.7-3.0 percent annually in the same period. (Gaisie and de Graït-Johnson show that Ghana's labor force would reach 4.2 million by the end of 1980.)

The demand for new jobs depends on changes in the demographic structure of the growing population and the spatial displacement of that population. It has often been argued that one of the social and moral obligations of a responsible government is to provide productive employment for the adult males and females in the working-age population. Indeed, this has even been a goal specified in some national plans.

Unemployment in Ghana in both 1960 and 1970 was 6.0 percent per annum. It was projected that a constant annual rate of 6.0 percent would yield an unemployed population of approximately 252,000 by 1980 unless a concerted effort was made to create more jobs. The modern sector of the economy has a "low absorptive capacity . . . to provide employment opportunities for existing unemployed as the new additions to the labor force" (Republic of Ghana, 1977; 377). Thus, the successful resolution of the unemployment problem will depend on the performance of the economy in the short run and on changes in current demographic conditions in Ghana in the long run. Massive increases in the labor force would mean that the number of jobs would have to increase at least 3 percent annually to stave off under-employment and unemployment. The rapidly growing labor force would require extra capital for equipment and to train the additional workers so that the level of output per worker in the existing labor force, whose productive capacity even now needs considerable improvement, would be maintained. One must recognize also that to educate and train the much-needed high-level and middle-level personnel, a huge expenditure of public funds over a considerable length of time is needed. "Inadequacy of training, paucity of qualified instructors and physical facilities for practical training" are some of the bottlenecks which were identified in the Five-Year Development Plan 1975/76 - 1979/80 (Republic of Ghana, 1977; 337).

There is a need to examine the influence that demographic variables have on employment policies in the context of development objectives. Meaningful planning requires that objectives be defined in relation to the ultimate beneficiaries of development (i.e., the people). The numbers and characteristics of the population are, therefore, important determinants of policy objectives, which can be defined only in relation to actual and estimated future values of demographic variables. By varying the numerical values of demographic variables and by observing the required changes in the types and levels of policy instruments for achieving given objectives, alternative sets and levels of policies may

be identified and that policy which most reduces the pressure on increasing employment can be selected. It is equally important to examine the effects of employment policies and programs on demographic variables. These policies and programs may be considered to be a part of population policy both in terms of growth and distribution of population.

**Appendix D**

**SAMPLE SUMMARY REPORT ON ACCEPTORS OF  
FAMILY PLANNING SERVICES, 1978**

SAMPLE SUMMARY REPORT ON ACCEPTORS OF  
FAMILY PLANNING SERVICES, 1978

1.0 Completeness of report submission.

The Secretariat received reports for the month of July, 1978, from 81 hospitals and clinics providing family planning services (a total of 156 have ever reported and a total of 193 have registered with the National Family Planning Programme). Thus, 52 percent of those hospitals and clinics that have ever reported to the unit have submitted reports on time. The figures represent 42 percent of the total number of registered clinics.

2. In the month of July, 1978, there were 3,644 acceptors of family planning services of all kinds (late reports are not included).

2.1	<u>Agency</u>	<u>Number of Acceptors</u>	<u>Percentage Distribution Of Total Acceptors</u>
	MOH	1,011	28
	PPAG	2,131	58
	CCG	369	10
	Other	<u>133</u>	<u>4</u>
	TOTAL	<u><u>3,644</u></u>	<u><u>100</u></u>
2.2	<u>Region</u>		
	Western	258	7
	Central	1,119	31
	Greater Accra	1,185	33
	Eastern	442	12
	Volta	206	6
	Ashanti	205	6
	Brong Ahafo	101	2
	Northern	99	2
	Upper	<u>29</u>	<u>1</u>
	TOTAL	<u><u>3,644</u></u>	<u><u>100</u></u>
2.3	<u>Method</u>		
	P111	1,396	38
	IUD	128	4
	Other	<u>2,120</u>	<u>58</u>
	TOTAL	<u><u>3,644</u></u>	<u><u>100</u></u>

CLINIC ACTIVITY BY AGENCY AND REGION JULY, 1978

AGENCY	Total No. Clinic (a)	Total No. Clinics ever Reported (b)	Total No. Clinics Reporting (c)	Total No. In Acceptance (d)	% Distribution of Acceptances (e)	% Clinics Reporting		Average Acceptors Per Clinic (h) = (d) ÷ (c)
						Total Enrol. (f) = (a) ÷ (a)	Total Ever Rec. (g) = (d) ÷ (b)	
F.O.H.	51	77	40	1011	23	43	51	25
F.P.A.G.	53	34	19	213	53	50	55	112
C.C.G.	12	23	8	59	19	66	61	46
OTHER	52	52	24	153	4	25	43	9
TOTAL	158	186	91	534	100	41	51	44

REGION

VICTORIA	27	23	10	253	7	37	50	25
CENTRAL	13	29	3	119	31	23	50	573
CANTON AREA	45	53	23	1253	53	55	65	47
EASTERN	57	29	12	442	12	49	60	36
WEST	18	18	6	23	6	33	33	31
AGENCY	31	23	19	203	6	61	75	10
INDIA	12	11	1	101	2	8	9	101
OTHER	22	9	3	99	2	25	33	33
OFFICE	5	5	2	29	1	40	40	14
TOTAL	158	186	91	534	100	41	51	44

REGION	In Acceptance		% Distribution	
	JULY 1978	JUNE 1978	JULY 1978	JUNE 1978
HILL	1395	651	53	25
I.U.D.	188	152	4	4
OTHERS	2120	2471	50	71
TOTAL	3644	3577	100	100

D-2

106

SUMMARY REPORT ON CLINIC ACTIVITIES BY METHOD, AGENCY

AND REGION - JULY 1970

	NEW ACCEPTORS JULY, 1970				Total Revisits	Total Visits	NEW ACCEPTORS CUMULATIVE JULY '70 - July 1970				Total Revisits	Total Visits
	LCCP	PILL	OTHER	TOTAL			LCCP	PILL	OTHER	TOTAL		
<b>REGIONAL TOTAL</b>	126	1396	2120	3644	13524	17160	25010	126948	90429	242395	920460	1162055
<b>BY AGENCY</b>												
MINISTRY OF HEALTH	69	779	163	1011	2030	3041	12601	58572	20449	99502	310553	410055
F.P.A.C.	26	302	1723	2151	9141	11572	7209	46512	47020	100741	432056	533597
CHRISTIAN COUNCIL	24	126	219	369	633	1052	3412	15663	10048	25711	99067	121778
OTHER	9	109	15	138	570	703	1716	11529	4912	16441	69904	86425
<b>BY REGION</b>												
EASTERN	13	160	85	258	1390	1656	2390	14718	12365	29473	91921	119739
CENTRAL	1	150	968	1119	1009	2120	1630	9775	11420	22033	82427	100260
GREATER ACCR.	67	246	672	1135	3904	5009	10068	26833	33322	72220	269554	341325
EASTERN	4	381	57	442	804	1246	2403	17608	12547	32650	114995	147633
VOLTA	14	87	105	206	310	546	2023	8465	6153	17441	51017	68458
ASHEANTI	19	100	6	205	1010	1215	3629	29662	9702	43078	176192	219265
BRONG AHAFO	-	101	-	101	5	106	776	9061	1427	11264	40529	55793
DORTCHIAN	4	75	20	99	4961	5060	701	6950	2741	10592	72000	83192
UPPER	6	16	7	29	93	122	510	1871	672	3050	13400	16533

107

COMPARISON OF NEW ACCEPTORS, JULY, 1977 AND JULY, 1978 WITH YEARLY AVERAGE

MONTH	No. of Clinics Reporting	Total New Acceptors	P I L L		I. U. D.		O T H E R		Average No. of New Acceptors Per Clinic
			No.	%	No.	%	No.	%	
JULY, 1977	93	2746	1221	44	140	5	1385	50	30
JULY, 1978	81	3644	1396	38	128	4	2120	58	45
<u>12 MONTH AVERAGE</u> AUGUST, 1977 TO JULY, 1978	86	2600	1139	46	161	7	1298	47	31

70

REGIONAL DISTRIBUTION OF ACCEPTORS BY AGENCY AND PERIOD - JULY, 1978

REGION	TOTAL NO. OF REGISTERED CLINICS	TOTAL NUMBER OF CLINICS REPORTING THIS MONTH	NEW ACCEPTORS							
			Total Number	% Dist.	PILL		I. U. D.		OTHER	
					No.	% Dist.	No.	% Dist.	No.	% Dist.
<b>WESTERN</b>										
H.C.H.	13	5	112	43	99	62	2	15	11	13
P.P.A.G.	4	4	125	48	45	28	11	85	69	81
C.C.G.	1	-	-	-	-	-	-	-	-	-
OTHER	9	1	21	9	16	10	-	-	5	6
<b>TOTAL</b>	<b>27</b>	<b>10</b>	<b>258</b>	<b>100</b>	<b>160</b>	<b>100</b>	<b>13</b>	<b>100</b>	<b>85</b>	<b>100</b>
<b>CENTRAL</b>										
H.C.H.	8	1	-	-	-	-	-	-	-	-
P.P.A.G.	5	1	1101	93	132	88	1	100	968	100
C.C.G.	-	-	-	-	-	-	-	-	-	-
OTHER	-	1	18	2	18	12	-	-	-	-
<b>TOTAL</b>	<b>13</b>	<b>3</b>	<b>1119</b>	<b>100</b>	<b>150</b>	<b>100</b>	<b>1</b>	<b>100</b>	<b>968</b>	<b>100</b>
<b>GREATER ACCEL</b>										
H.C.H.	17	10	268	23	111	45	42	63	115	13
P.P.A.G.	12	8	714	60	65	26	10	15	639	73
C.C.G.	4	3	172	15	50	20	10	15	112	13
OTHER	12	4	31	2	20	9	5	7	6	1
<b>TOTAL</b>	<b>45</b>	<b>25</b>	<b>1185</b>	<b>100</b>	<b>246</b>	<b>100</b>	<b>67</b>	<b>100</b>	<b>872</b>	<b>100</b>

109

REGIONAL DISTRIBUTION OF ACCEPTORS BY AGENCY AND METHOD - JULY, 1973

REGION:

EASTERN	TOTAL NUMBER OF REGISTERED CLINICS	TOTAL NUMBER OF CLINICS REPORTING	NEW ACCEPTORS							
			Total Number	% Dist.	P.I.L.L.		I. U. D.		O T H E R	
					No.	% Dist.	No.	% Dist.	No.	% Dist.
H.C.H.	14	5	284	64	273	72	1	25	10	18
P.P.A.G.	0	5	124	28	80	21	1	25	11	77
C.C.G.	-	-	-	-	-	-	-	-	-	-
OTHER	8	2	34	8	28	7	2	50	3	5
<b>TOTAL</b>	<b>30</b>	<b>12</b>	<b>442</b>	<b>100</b>	<b>381</b>	<b>100</b>	<b>4</b>	<b>100</b>	<b>57</b>	<b>100</b>
<b>V O L T A</b>										
H.C.H.	12	2	34	17	30	34	1	7	3	3
P.P.A.G.	-	-	-	-	-	-	-	-	-	-
C.C.G.	5	4	172	83	57	66	13	93	102	97
OTHER	1	-	-	-	-	-	-	-	-	-
<b>TOTAL</b>	<b>18</b>	<b>6</b>	<b>206</b>	<b>100</b>	<b>87</b>	<b>100</b>	<b>14</b>	<b>100</b>	<b>105</b>	<b>100</b>
<b>ASHANTI</b>										
H.C.H.	12	12	151	74	134	74	17	90	-	-
P.P.A.G.	7	-	-	-	-	-	-	-	-	-
C.C.G.	1	1	25	12	19	11	1	5	5	83
OTHER	11	6	29	14	27	15	1	5	1	17
<b>TOTAL</b>	<b>31</b>	<b>19</b>	<b>205</b>	<b>100</b>	<b>180</b>	<b>100</b>	<b>19</b>	<b>100</b>	<b>6</b>	<b>100</b>

1/10

REGIONAL DISTRIBUTION OF ACCEPTORS BY AGENCY AND METHOD - JULY, 1973

REGION:

BROAD AGENCY	TOTAL NUMBER OF REGISTERED CLINICS	TOTAL NUMBER OF CLINICS REPORTING	NEW ACCEPTORS							
			TOTAL NUMBER	% Dist.	PILL		I. U. D.		OTHER	
					No.	% Dist.	No.	% Dist.	No.	% Dist.
H.O.H.	6	1	101	100	101	100	-	-	-	-
P.F.A.G.	-	-	-	-	-	-	-	-	-	-
C.C.G.	1	-	-	-	-	-	-	-	-	-
OTHER	5	-	-	-	-	-	-	-	-	-
TOTAL	12	1	101	100	101	100	-	-	-	-
NORTHERN										
H.O.H.	4	2	32	32	15	20	-	-	17	85
P.F.A.G.	4	1	67	68	60	80	4	100	3	15
C.C.G.	-	-	-	-	-	-	-	-	-	-
OTHER	4	-	-	-	-	-	-	-	-	-
TOTAL	12	3	99	100	75	100	4	100	20	100
UPPER										
H.O.H.	3	2	29	100	16	100	6	100	7	100
P.F.A.G.	-	-	-	-	-	-	-	-	-	-
C.C.G.	-	-	-	-	-	-	-	-	-	-
OTHER	2	-	-	-	-	-	-	-	-	-
TOTAL	5	2	29	100	16	100	6	100	7	100

New Acceptors Reported by Ghana National Family Planning Program

	<u>Total</u>	<u>Pills</u>	<u>IUD</u>	<u>Other</u>
7/70 - 6/71	20,473	6,886	5,693	7,894
7/71 - 6/72	25,406	12,159	3,492	9,755
7/72 - 6/73	32,063	18,102	2,963	10,998
7/73 - 6/74	31,386	18,333	2,683	10,368
7/74 - 9/74	9,013	4,644	716	3,655
FY 75 (10/74 - 9/75)	32,609	18,467	2,421	11,721
FY 76 (10/75 - 9/76)	30,389	17,521	2,832	10,036
FY 77 (10/76 - 9/77)	32,471	18,513	2,376	11,582
FY 78 (10/77 - 9/78)	<u>32,490</u>	<u>12,988</u>	<u>1,797</u>	<u>17,705</u>
	246,302	127,615	24,873	93,714

**Note:** The accuracy and completeness of GNFP official reports is limited. Many family planning clinics do not report. Users through private medical personnel and the commercial program are not included. The data include an unknown amount of double counting due to users switching methods or clinics. From 7/70 - 9/78, 52% of new acceptors chose the pill, 10% IUD and 38% other, which includes, foam, condom, depoprovera, etc.

Blertia, USAID/HFW  
11/27/79

112

Appendix E  
ORGANIZATION CHART OF  
GHANA NATIONAL FAMILY PLANNING PROGRAM

**ORGANIZATION CHART  
GHANA NATIONAL FAMILY PLANNING PROGRAMME**

