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TECHNICAL ASSISTANCE
FOR REDESIGN OF CONTRACEPTIVE
SUPPLIES PROJECT IN GHANA

by

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TABLE OF CONTENTS

	<u>Page:</u>
ACKNOWLEDGEMENTS	ii
GLOSSARY	iii
TRIP REPORT	1
I. Project Background	1
II. The Team	1
III. The Scope of Work	2
IV. Work Accomplished	3
V. Constraints	3
VI. Issues	4

APPENDICES*

- Appendix A: Scope of Work Proposed by AID/W
- Appendix B: Scope of Work as Amended by USAID/GHANA
- Appendix C: Draft Project Paper
- Appendix D: Persons Contacted in Washington and Tentative Con-
clusions and Recommendations Growing out of
Washington TDY
- Appendix E: Cables Drafted During Assignment
- Appendix F: Information Needed From the Ministry of Health to
Assist in Development of a USAID Funded Project to
Support MCH/FP Activities
- Appendix G: Work Remaining to Be Done
- Appendix H: Persons Contacted in Africa

* The Appendices are copies of the original documents submitted by the consultant.

ACKNOWLEDGEMENTS

The consultant wishes to acknowledge the outstanding logistic support provided by the mission, despite severe constraints including staff shortages, space restrictions, and lack of telephone service and public transportation. He also commends his team members for their competence and flexibility.

GLOSSARY

CCG	Christian Council of Ghana
CDC	Centers for Disease Control
CSM	Contraceptive Social Marketing
DMS	Director of Medical Services
FPIA	Family Planning International Assistance
GIMPA	Ghana Institute of Management and Public Administration
GDO	General Development Officer
GOG	Government of Ghana
HPN	Health, Population and Nutrition
IE&C	Information, Education and Communication
INTRHA	International Training for Health
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communication Services
MCH/FP	Maternal and Child Health/Family Planning
MOH	Ministry of Health
MPH	Master of Public Health
MSH	Management Service for Health
PDO	Project Development Officer
PID	Project Identification Document
PP	Project Paper
PPAG	Planned Parenthood of Ghana
REDSO/WCA	Regional Economic Development Service Office/West and Central Africa
SAWS	Seventh Day Adventist Program
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities

TRIP REPORT

I. Project Background

USAID and the Government of Ghana (GUG) are currently developing a project paper (PP) to update and expand a Contraceptive Supplies Project (641-0109) for an FY 1985 obligation. The project is designed to increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples. To achieve this goal, it contains provisions for making an adequate supply of family planning services available on a continuing basis through (i) the existing service delivery networks of the Ministry of Health (MOH); and (ii) the development of a contraceptive social marketing (CSM) program in the private sector.

II. The Team

The services of International Science and Technology Institute (ISTI) consultant William Bair were requested to complete a three-person team, hired to prepare portions of the PP. The Team, under Team Leader Tom Luche, General Development Officer (GDO), USAID, included in addition to Bair:

- Ralph Susman, independent consultant, management and CSM specialist -- approximately six weeks.

- Michael Dalmat, contraceptive supply management and training specialist, provided by the Centers for Disease Control (CDC) -- two weeks.

The Project Identification Document (PID) had in addition called for the involvement of a training specialist and a financial analyst. While the Team as constituted represented both these skills areas to some degree, USAID decided at the last moment to supplement the training expertise by engaging the following:

- Connie Husman, training specialist from Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), who was in Ghana on another assignment -- one week.

- James Lea, training specialist from International Training for Health (INTRAH), who was diverted to the project en route to another assignment in Sierra Leone -- one weekend.

Two USAID staff members also assisted in the preparation of the PP:

- Joana Laryea, Health, Population and Nutrition (HPN) Assistant -- USAID Foreign Service National direct hire.

- Eugene Rauch, Project Development Officer (PDO) -- Regional Economic Development Service Office/West and Central Africa (REDSO/WCA).

III. Scope of Work

III.1 The Scope of Work proposed by AID/W (see Appendix A) was modified in the field shortly after Bair's arrival as a result of a meeting with USAID Director Roy Wagner, Luche and Susman. The amended Scope of Work (see Appendix B) reduced the level of Bair's involvement in the areas of logistics and contraceptive requirements, which instead were shifted to Dalmat. At the same time, it added two new components. The first was an outgrowth of Bair's review in AID/W of the possible levels of support of cooperating agencies (Appendix B - item [a] and Appendix D) and called for him to review with GOG the support of other donors (see Appendix B, item [e]). The second was an outgrowth of USAID Director Wagner's decision to incorporate CSM activities into the project. In April 1983, AID/W had instructed USAID to support reinstatement of a retail commercial sales program if the GOG were able to provide an acceptable administrative arrangement (see Appendix C, section 3.5.1). Bair learned on his arrival that USAID had decided such an arrangement was possible. Bair was asked to recommend to USAID a schedule of activities for team members and the GOG which would reflect the integrated approach (see Appendix B, item [b]).

III.2 The Scope delineated Bair's responsibility and that of other Team members for the various aspects of the PP. For a variety of reasons, some of the responsibilities shifted in the course of the assignment. The actual delegation of duties is described below:

c)* Organizational Review of MOH. Prime responsibility was assigned to Bair, with the assistance of Susman and the GOG. Bair authored this section of the PP.

c)* Develop a Project Plan of Action. As above, Bair had primary responsibility for this aspect of the PP.

d)* Information, Education & Communication (IE&C) and Training. These were originally to have been drawn up by Bair with MOH's Director of Medical Services (DMS) Joseph Otoo. Instead, the IE&C segment was based on plans drawn up earlier by MOH personnel and Ronald Magarick of Johns Hopkins University/Population Communication Services (JHU/PCS). Meanwhile, the training section, because of the addition of Husman and Lea to the Team and Dalmat's agreement to provide assistance, reflects primarily their work. Dalmat had visited Management Services for Health (MSH) (see V.1.2) on his way, and led in the design of the management training plan.

f)* Development of Information Control System for Contraceptive Sales in the Public Sector Program. As indicated in the Scope of Work, Bair assisted Susman and the GOG in this task.

g)* Contraceptive Needs Projections. As anticipated, these were primarily provided by Dalmat, with assistance from Bair and the GOG.

h)* Development of Budget. This was to have been the prime responsibility of Luche and Susman. Susman agreed to assist with financial planning not only for

* This corresponds to the identification letter in Appendix B, the amended Scope of Work.

the CSM portion but also for the MOH. In view of Luche's unavailability (see V.3) Bair drew up the provisional budget. It was expected that Luche would prepare the final version.

In addition to drafting the PP sections on the MOH, the implementation plan and the budget, Bair prepared much of the initial outline according to the standard AID format. This work included extracting from the PID and modifying as necessary background material on the strategy, policy, social soundness, economic analysis, demographic statistics and the population program. Appendix C represents the PP prepared by Bair. It should be viewed as a working document, which will be modified and completed by USAID/Ghana. The major changes are expected in the CSM portions, the review of MOH financial management, and perhaps funding levels (see VI.3).

IV. Work Accomplished

IV.1 The consultant's itinerary included three phases:

- October 8 - 11: Travel to and briefing in Washington, D.C.
- October 12 - November 7: Travel to and TDY in Accra, Ghana (October 19: Visit port of Tema, Ghana; October 22: Visit Cape Coast, Ghana; October 28-30: Visit Kumasi, Ghana).
- November 8: Travel to and consult with REDSO/WCA Abidjan, Ivory Coast.

IV.2 The Washington briefing offered productive opportunities for contacts with a wide variety of potential support organizations, the results of which are summarized in Section VI. A complete list of persons contacted during the Washington stay is provided in Appendix D.

IV.3 The main parameters of Bair's work in Ghana have been reviewed above (see III). Bair also assisted USAID in drafting several cables (see Appendix E), in drawing up a list of questions on background issues for MOH (see Appendix F), and at the conclusion of the consultancy, in outlining work remaining to be done (see Appendix G). A complete list of persons contacted in the field is provided in Appendix H.

Bair's consultation in Abidjan consisted of briefing REDSO/WCA Director Larry Bond and Dr. James Shepperd (in the absence of Regional Population Officer Clark) on the status of the project design.

V. Constraints

V.1 The major problems encountered during the assignment were that key personnel both from the GOG and USAID were often unavailable due to conflicting responsibilities and that even the Team members did not have the same schedule.

V.2 Three high level GOG officials who would have been invaluable resources were able to spend very little time with Bair. The two MOH Maternal and Child Health/Family Planning (MCH/FP) Directors were away, one for the first two weeks and the other throughout the entire period. In addition, the Director of Medical Services (DMS) Joseph Otoo, although he was extremely helpful, had to leave for Geneva for a week during the critical final period of report preparation. Because of the absence of these officials, Bair had difficulty in eliciting information he needed on the MOH. He used the list of questions he had drawn up (see Appendix F), however, as the basis for seeking information from MOH records and from other sources including the United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activities (UNFPA), and the University of Ghana.

V.3 A number of USAID personnel were also absent or unavailable at key times. Although under normal circumstances the REDSO/PDO would have overseen the consolidation of the various segments of the PP, in this case Rauch was not available until November 1, leaving that task to Bair (see III.3). Team Leader Luche was essentially unavailable during a two-week period while he was mission Acting Director in place of the USAID Director Wagner who had gone to Washington. Because Wagner and DMS Otoo both left prior to the completion of the PP, Bair had to write some portions provisionally, prior to completing his analysis.

V.4 Even the schedules of the three Team members were not entirely synchronized. Team member Dalmat had responsibilities in Nigeria and Kenya that shortened his very effective assistance. Because Susman's stay was longer than Bair's, Susman had not completed the CSM portion when Bair departed and therefore it was impossible for them to review the completed PP together.

VI. Issues

Bair was involved in seeking solutions to a number of issues, some of which remain unsolved. With one exception (see VI.4), however, the PP as drafted represents a consensus of the Team and USAID. The prime issues are summarized below.

VI.1 Involvement of Potential Support Organizations (see Appendix D)

VI.1.1 INTRAH and JHPIEGO. These organizations are expected to play a major role in implementing the training component of the project (see Appendix C, section 3.6.2.3). Bair's contacts in Washington with staff of both organizations helped to lay the basis of their involvement. Acquiring the help of the two consultants (Husman and Lea) representing these two organizations was a logical move, since each could provide first-hand knowledge of their respective organizations in the context of in-country needs.

VI.1.2 MSH and CDC. MOH had requested support from MSH and CDC for the Ghana Institute of Management and Public Administration (GIMPA), which is expected to be responsible for the management training component (see Appendix C, section

3.6.2.2). Both Bair and Dalmat made contacts with MSH prior to their arrivals in-country in an attempt to work out details of these arrangements.

VI.1.3 JHU/PCS. The involvement of JHU/PCS had also been established prior to Bair's arrival in Ghana (see III.2 item d), and the main issue was how to identify local collaborating agencies. This remains to be worked out (see Appendix C, section 3.6.2.4).

VI.1.4 Columbia University and the Center for Development and Population Activities (CEDPA). Bair held exploratory talks while in Washington with Columbia University regarding the possibility of their doing operations research on community outreach and with CEDPA regarding the training of school teachers in family life education. As originally contemplated, these activities were not included as part of the project design, although the possibility remained that they might be initiated part way through the project (see Appendix C, section 3.6.1).

VI.1.5 The Futures Group. Prior to USAID/Ghana's decision to consolidate the CSM portion of the project within the bilateral agreement (see III.1), AID/W had foreseen the centrally-funded Futures Group as the implementing agency for this activity. With the change in plans, it was decided that Futures would remain involved but at the level of providing technical consultation on marketing, program management, advertising, evaluation, logistical support and commodity supplies issues (see Appendix C, section 3.6.2.6).

VI.1.6 Family Planning International Assistance (FPIA). In view of his own and AID/W's interest in supporting the private sector, Bair had discussions with FPIA, which had been providing funding and contraceptives to two private organizations -- the Christian Council of Ghana (CCG) and APPLE. Bair was assured of continuation of this support. In an effort to limit management requirements of the MOH, Bair's PP indicated that consideration of the project's assuming support for these and other private organizations should be postponed until the second year (see Appendix C, section 3.6.1).

VI.1.7 AFRICARE and UNFPA. Bair had preliminary discussions in Washington with AFRICARE regarding their being the agency to procure equipment for the project. In the interest of simplifying administration, however, Bair in the PP indicated that provision of equipment would be left to UNICEF and UNFPA. The latter has a three-year \$666,000 project with Ghana and has already ordered clinic equipment, vehicles and office equipment.

VI.2 Staff

VI.2.1 Population Intern. The issue of whether a population intern would be acceptable to the mission was not solved at Bair's departure. AID/W had offered to provide a recent Master of Public Health (MPH) graduate to assist the MOH with management problems. Bair's review of MOH's management weaknesses convinced him of the value of such assistance. Whether the U.S. Ambassador would agree to this kind of arrangement, however, was not clear.

VI.2.2 Population Officer. Both in the PP (see Appendix C, section 6) and in his discussions with AID officials, Bair stressed the importance of the early assignment of a population officer to support pre-project preparation and project implementation. Although all parties are in accord that the appointment should be made, personnel problems in AID/W appear to be stalling progress.

VI.3 Funding

The level at which the project is to be funded remains an issue. The inclusion of the CSM component, plus the failure of the Japanese Government to provide Neo-Sampoo foaming tablets as originally anticipated (see Appendix C, section 3.6.2.1), together were estimated to represent an additional \$3 million in costs (from \$4 million to \$7 million). AID/W and USAID will need to explore further the availability of funds to cover these new activities.

VI.4 Projected Level of Contraceptives

This was the one area where there was a divergence of opinion among Team members. The projections were based on a careful review by Dalmat of the contraceptives required by the clinics and community outreach to be upgraded in the MOH system and the sales outlets in the CSM portion. Both Bair and Susman were more conservative than Dalmat in their estimate of the MOH capacity to organize the training and management actions in the time planned. Based on the experience of CSM projects around the world, Bair was also more conservative in his estimate of the level of users to be expected of the CSM portion. Some downward adjustments were made. Although Bair still considers the projections somewhat optimistic, he is fully supportive of the plan to go forward with aggressive nationwide marketing for CSM. If the government provides the degree of freedom for the private sector operation that they indicated they would, this could be a very successful venture. Bair is less confident of the ability of the MOH to expand its family planning program given the financial constraints likely to prevail. However, the management training and a strong IE&C program in both the private and public sectors should stimulate considerable attention to family planning. Therefore, it seems prudent to plan for a successful operation and provide the necessary support to achieve it. USAID chose to accept optimistic estimates since there will be several opportunities during the life of the project to adjust the contraceptive shipments or stretch the time. This was agreeable to all.

APPENDIX A

Scope of Work Proposed by AID/W

APPENDIX A

Scope of Work Proposed by AID/W

To assist USAID/Ghana the ISTI family planning technical consultant will develop sections of a revised project paper for USAID/Ghana that:

- A. Reviews Ministry of Health (MOH) administrative, distribution, logistical support, staffing and reporting capabilities in relation to the present and projected contraceptive distribution program;
- B. Reviews procedures for the reporting, control and use of funds generated by the sale of contraceptives donated to the MOH;
- C. Reviews MOH reporting capabilities with special emphasis on the capacity to provide program relevant data which can readily be derived from the distribution chain as it expands;
- D. Contains updated recommendations and strategy on the need for additional IE&C and training requirements in the family planning field for the MOH clinic program;
- E. Contains updated recommendations and strategy on logistics and on the mix and volume of family planning commodities for the MOH clinic program;

It will also be necessary to review and make appropriate recommendations on such key issues as:

- Supply imbalances;
- transport;
- availability and use of appropriate forms;
- contraceptive commodity storage conditions, security;
- accountability at Tema and elsewhere in the MOH distribution chain;
- staffing requirements for an expanded MOH;
- contraceptive program activity.

APPENDIX B

Scope of Work As Amended by USAID/Ghana

APPENDIX B

Scope of Work As Amended by USAID/Ghana

In a meeting October 16, 1984 with USAID Director, Roy Wagner, General Development Officer, Thomas Luche, and Consultant, Ralph Susman, concerning the design of the Contraceptive Supplies Project, it was concluded that Bair's scope of work should be modified. The scope of work should be broadened to include additional elements and focus less on logistics and contraceptive requirements which will be the emphasis of Dalmat's consultancy. A major reason for this was Wagner's decision to include the Contraceptive Social Marketing activity as an integral part of the Contraceptive Supplies Project.

Bair's Scope of Work is as follows:

- a) Consult in Washington with the Africa Bureau, S&T/POP and various cooperating agencies to ascertain the various types and levels of support available to USAID for this project.
- b) Recommend to the USAID a schedule of activities with consultants and GOG leading to revision of the original plan and appropriate sections of the P.P. This is to provide an integrated approach supporting the public sector and private commercial sales of contraceptives.
- c) With Susman and GOG assistance, update the organizational description and review of the management capacity and needs of the MOH/MCH. Develop a project plan of action that provides for Commodity and equipment supply of MOH clinics and outreach points, training and informational programs, mission managed technical assistance through central projects and a commercial retail sales program.
- d) With the GOG develop the basic outlines for training and informational activities.
- e) With GOG review the support of other donors.
- f) Assist Susman and GOG in development of a system for collecting, disbursing and reporting sales of contraceptives to clients in the public sector program.

- g) Assist Dalmat and GOG in estimating contraceptive requirements and developing a list of medical and other equipment to be provided by the project.
- h) Assist Luche and Dalmat in developing the dollar and local cost budget and financial arrangements.

Thomas Luche

Thomas Luche
General Development Officer

Date: 10/18/84

APPENDIX C
Draft Project Paper

APPENDIX C

Draft Project Paper

OUTLINE

Project Summary

List of Acronyms and Abbreviations

1. Project Data Sheet
2. Draft Project Authorization
3. Project Rationale and Description
 - 3.1 GOG Plans and Priorities
 - 3.2 USAID Strategy and Programs in Ghana
 - 3.3 Factors Affecting Project Selection
 - 3.4 Specific Project Problem and Constraints
 - 3.5 Project Objectives
 - 3.6 Project Description
 - 3.6.1 Relation to PID
 - 3.6.2 Project Elements
 - 3.6.2.1 Contraceptives for the Ministry of Health MCH/FP System
 - 3.6.2.2 Contraceptive logistics and service delivery reporting
 - 3.6.2.3 Training
 - 3.6.2.4 Information, Education and Communication
 - 3.6.2.5 Vehicles
 - 3.6.2.6 Contraceptive Social Marketing
4. Cost Estimates and Financial Plan
 - 4.1 Summary and General Considerations
 - 4.2 Budget
5. Implementation Plan
 - 5.1 Implementing Agencies

5.1.1 Public Sector

5.1.2 Private Sector

5.2 Plan of Action

6. Monitoring Plan
7. Summary of Project Analyses
8. Conditions and Covenants
9. Evaluation Arrangements - audit
10. Annexes
 - A PID Approval Message
 - B Log Frame Matrix
 - C Statutory Check List
 - D GOG Request for Assistance
 - E Technical Analysis
 - E-1 Contraceptive requirements
 - E-2 Training Plan
 - E-3 CSM Feasibility and Marketing Plan
 - E-4 Statistical Data, Demographic Analysis
Population Projects in Ghana
 - E-5 Population Policy
 - F Financial
 - G Economic
 - H Social Soundness
 - I Administrative
 - I.1 MOH Organization
 - I.2 Private Sector (CSM) Organization & Capability
 - J Environmental
 - K Waiver Request on Vehicles

Project Summary for Contraceptives Supplies (641-0109)

A. Sector Goal:

To reduce the long term food supply deficit in Ghana, the population growth rate needs to be constrained, thus lessening the demand for food. Reduced birth rates, which contribute to slower population growth and adequate child spacing will also help to improve maternal and infant health.

B. Project Purpose:

The project is to increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples. This will be accomplished by making an adequate supply of FP services available on a continuing basis through the existing service delivery networks of the Ministry of Health (MOH) and through the development of a contraceptive social marketing (CSM) program in the private sector.

C. Expected Achievement/Outputs:

1) Public Sector

One expected achievement of this project is a supply management and reporting system to ensure that a continuous supply of contraceptives will be available to MOH service outlets. A second achievement will be personnel trained in family planning available in all 306 MOH clinics and in all the community health programs being established under the impetus of Ghana's primary health care program. These personnel will be able to provide orals, condoms or foaming tablets on a person's first visit to the clinic and referral if other services are requested. Health brigades will also provide contraceptives at the community level. A third output will be an increase in knowledge and use of contraception by clients due to general informational programs, instruction by all personnel at clinics and health brigades in the community and the ready availability of contraceptive supplies.

2) Private Sector

An expected achievement of the contraceptive social marketing portion of this project is a largely self-financing contraceptive distribution network. A second achievement will be an effective management supply system allowing for significant expansion of the retail sales network resulting in vastly improved consumer access to contraceptives. A third output will be the cadre of trained retailers and marketing staff who can provide improved sales and service to clients throughout the retail sales network. A fourth

output will be increased consumer awareness of available contraceptive products as part of product advertising, promotion and marketing activities. Increased consumer awareness and motivation will stimulate greater product uptake in the commercial retail sales project and at the same time contribute to MOH/Maternal and child health/Family planning (MCH/FP) objectives.

D. Inputs

Funds for this project from USAID will supply scarce foreign exchange for the purchase of contraceptives where Donors have a comparative advantage, \$5.4 million. Additional funds will also be used to provide training aids, vehicles, evaluations and technical assistance, \$1.6 million. In addition, training programs, informational activities, advertising and a storage/distribution system will be supported using AID generated local currency, 30 million Cedis (\$800,000). The GOG will provide local currency funds to support MOH staff and other operating costs of the MCH service delivery program, 50 million Cedis (\$1.2 million).

Acronyms and Definitions

ABS	- Annual Budget Submission
AID	- Agency for International Development/Washington
CBD	- Community Based Distribution
CEDPA	- Center for Development and Population Activities
CDC	- Center for Disease Control (Atlanta)
CHW	- Community Health Worker
CCG	- Christian Council of Ghana
CSM	- Contraceptive Social Marketing
FHI	- Family Health Initiatives
FP	- Family Planning
FPIA	- Family Planning International Assistance
GIMPA	- Ghana Institute of Management and Public Administration
GNFPP	- Ghana National Family Planning Program
GOG	- Government of Ghana
IE&C	- Information, Education, and Communication
IEE	- Initial Environment Examination
IMF	- International Monetary Fund
INTRAH	- International Training for Health
IPAVS	- International Program, Association for Voluntary Sterilization
ISTI	- International Science and Technology Institute
JHPIEGO	- John Hopkins Program for International Education in Gynecology and Obstetrics
MCH	- Maternal Child Health
MOH	- Ministry of Health
MSH	- Management Science for Health
MWIFA	- Married Women in Fertile Age
PNDC	- Provisional National Defense Council
PPAG	- Planned Parenthood Association - Ghana
TBA	- Traditional Birth Attendant
USAID	- United States Agency for International Development
UNFPA	- United Nations Fund for Population Activities
YMCA	- Young Men's Christian Association of Ghana

Definitions:

- Level A - Community Health facilities, usually village level, with TBA's and CHW's (Health Brigades)
- Level B - Health centers, private clinics and MCH/FP centers located at the District level.
- Level C - District Health Administration, e.g. District Medical Officer of Health (DMOH) and District Health Management Team (DHMT) with clinic referral to District hospitals.
- Regions - 10 administrative units in Ghana with lower administrative entities made up of 68 Districts.
- RMOH - Regional Medical Officer of Health in charge of Public Health for the Regional unit, located in each of the 10 Regional capitals of the country.
- Health Brigade - Volunteer group being organized and trained for community health work.

"Manual A" is meant to be used in conjunction with family planning, workbooks in the training of personnel from the Ministry of Health and other agencies. The Manual A covers national policy, rationale for family planning, various contraceptive methods, clinic management, and program evaluation.

"Manual B" is a higher level family planning training and is used by medical and midwifery schools, as well as medical officers, who wish to learn IUD insertion and fitting of the diaphragm.

1. PROJECT DATA SHEET

Gene Rauch

2. DRAFT PROJECT AUTHORIZATION

Gene Rauch

3. PROJECT RATIONALE AND DESCRIPTION

3.1 GOG Plans and Priorities

Ghana's serious economic problems have brought about frequent changes in Government in recent years. In this environment, government goals, plans and strategies have tended to be largely theoretical, with little substantive result. However, even in such an atmosphere, it is clear that the primary development priority is to achieve food self-sufficiency. An economic recovery strategy has been developed. However, the Government has still not adequately linked food self-sufficiency to its other priorities in an effective operational plan.

Nevertheless, the family planning program in Ghana is a priority concern. Since 1969 Ghana has had an enlightened and well-articulated population policy. It recognizes the deleterious effects of rapid population growth on broad economic development and the positive impact of birth spacing on the health of mothers and small children (See Annex E-5 for a full discussion of this policy). Successive governments have continued to accept this policy without major modification. The most recent indications of the government's continuing support for this policy are found in the press release of the Secretary of Agriculture on World Food Day 1984. He includes control of population growth as one of the four essentials for Ghana to develop food security. Similarly, in a recent bulletin, "Health Programmes for 1985 and Related Budget Guidelines", the Director of Medical Services of the Ministry of Health gives prominent attention to family planning in the Maternal and Child Health program. This program calls for distribution of contraceptives by Health Brigades at the community level. The Ministry of Health allocates approximately 30 percent of its maternal/child health budget to family planning services.

3.2 USAID Strategy and Program in Ghana

The long-run objective of the USAID/Ghana program is to attain food self-sufficiency in the country. However, there are overriding macroeconomic constraints which in the short-run seriously impinge upon the development of an effective strategy to improve the country's food balance. The Mission has developed a response for addressing these macroeconomic problems but this cannot be carried out without substantial GOG success in economic stabilization. (For a discussion of the strategy, see the USAID/G FY 1985 and 1986 ABS.)

Because of this inhibiting macroeconomic environment, the Mission has developed a very modest strategy for attacking the food self-sufficiency problem. Four principles guide the types of activities to be undertaken: (1) they must be essential to

the long-run achievement of the self-sufficiency goal; (2) they must have the potential for at least minor short-run impact even in a hostile environment; (3) they must be implementable, given the realities of Mission staffing and the current absorptive capacity of Ghana; and (4) they must not add to the macroeconomic problems of the country say, by having significant incremental recurrent cost implications.

With these ground rules, the Mission has developed a two-pronged approach to supporting food self-sufficiency aims. One effort will concentrate on developing a viable seed production and distribution capability for basic foodstuffs in Ghana. The other, and the one to which this project is addressed, is to reduce the growth of demand for food by reducing the rate of population growth.

The appeal of the Contraceptive Supplies project is that it meets the four principles for project selection exceedingly well. It is at the heart of the Mission strategy. Although not expected to have a short-run macroeconomic impact, it will certainly have a significant socio-economic impact at the family and community level. Its organization/institution building impact will be substantial. It is expected to re-establish a continuous supply of contraceptives to the MOH clinic system, providing the training and informational services required for its successful functioning. This project will strengthen the family planning component of GOG's growing community based primary health care activities. Additionally, the project will develop a viable system for the commercial (social) marketing of contraceptives in the private sector, substantially increasing the numbers of outlets and building toward self-sufficiency in the future.

Such efforts are a follow-on to previous USAID family planning assistance to Ghana over the past ten years and the Mission's recent Family Health Initiatives Project (698-0662). Although the current project is being designed for a 3-year operational period to measure the USAID and GOG management capability and expansion capacity, consideration will be given in the third year to extending and expanding this project. The requirements for family planning assistance will continue for a considerable period in Ghana as the numbers of women of fertile age will continue to grow. Program success will not diminish the requirements for continuing assistance. With success, the percentage who will seek family planning service of this growing number of women will also increase.

3.3. Factors Affecting Project Selection

3.3.1 Social Considerations (See Annex H)

The policy climate for family planning program development in Ghana is one of the most promising in West Africa. There is a general recognition of the importance of family planning both for demographic and health reasons.

There has been a long tradition favoring "child spacing" within the Ghanaian society. This had some effect on family size limitation but not enough, in the presence of dropping death rates, to be considered a force for reducing the rate of population growth. Traditional practices of "child spacing", separation of couples following child birth and during lactation, have begun to break down, especially with the urbanization of the society and a trend toward more nuclear families. There are some indications that there is an increasing problem of induced abortion, and growing concern of the need to address the problem of adolescent fertility. In discussion with Ghanaians both in Accra and in up-country communities, one often hears the opinion that, while it was difficult to convince couples to use family planning in the past, they are now actively seeking the service. The most common reason given is related to difficult economic conditions, the problems families are having feeding their children and the desire they have for their children to get a quality education.

It appears that social conditions are changing to definitely favor the expansion of family planning services. However, some of the data from the Ghana Fertility Survey add a sobering note as to the level of interest at which this is operating. For example, there is still a considerable expressed desire for a large family. Of the currently married fertile age women living in rural, urban and large urban centers, only 10, 12 and 16 percent respectively, expressed a desire to have no more children. Only after having as many as 5 children did the percentage of those wanting no more exceed 20 percent.

Although private organizations, private practitioners and traditional healers may provide the majority of health services, as many as 30 percent of the population have reasonable access to the public health system. This number is expected to increase as PHC is expanded. There is impressive use of the prenatal, well baby and postnatal clinics, where the family planning services are provided.

At present, the private commercial retail outlets have almost no contraceptives for sale although public demand for the products is considerable. Recent discussions with Government officials by and A.I.D. consultant found the Government to be most receptive to the development and implementation of a retail sales project operating exclusively through the commercial sector. Senior policy officials in the Ministry of Finance and Economic Planning (MFEP) and the Ministry of Health (MOH) were fully supportive of the concept and indicated such a program utilizing the private sector is fully consonant with Government policy.

The people of Ghana are very much a commercial people and this has long been the case. For the most part business enterprises are small, family-run, catering to a client population within a fixed geographic area. Going to a small shop or a kiosk is frequently a social occasion as much as one concerned with making a purchase. The people of Ghana are very relaxed, friendly and gregarious by nature. A trip to a shop or the weekly visit to a village market is an occasion to exchange news with friends and peers about all manner of things especially matters having to do with the family and children.

People in Ghana are not always well informed about family planning, child spacing and contraceptive methods. Nevertheless, there is a general willingness especially among women to listen, ask questions and reconsider existing attitudes. The long standing tradition of social interaction which is a natural part of commercial transaction for the small shop owner and the petty trader provides a promising basis for a commercial retail sales project in Ghana. Pharmacies and many chemical sellers have a tradition of selling contraceptives when they are available and of being asked for their advice on various contraceptive methods. The thrust of this project involving as it does effective marketing, relevant advertising and timely information and training for the retailers is a natural extension of the way in which consumers and retailers interact in day-to-day transactions.

Provision of safe and reliable contraceptive products at convenient locations and at affordable prices will provide Ghanaian couples with the opportunity to regulate family fertility and family size. In the larger context such a project contributes to the important GOG development goals of reducing long term food supply deficits and improving maternal and child health.

3.3.2 Economic Considerations

As noted previously, a major reason for our focus on population is the way in which demographic factors impact upon food self-sufficiency. The other economic reasons for concern with population growth are just as real in Ghana as in other developing countries. Rapid population growth has contributed to the growing numbers of under-employed and swelled the number of children for whom schools must be provided. It has helped to fuel the process of rapid urbanization with all the attendant costs and problems. In addition to the humanitarian concern for poor maternal and child health, it is clear that high birth rates contribute substantially to the high costs of health care, especially during pregnancy, child birth and infancy. Neither the society nor individual families can make the savings and investments required for sustained socio-economic improvement

if the demand for consumption and social service continue to grow with a rapidly growing population. Thus it is essential to make a modest investment in reducing birth rates if other development investments are to produce the desired per capita improvement in the quality of life.

This project will not have a short-term macro-economic effect. The growing labor force and growing number of child bearing women for the next fifteen years are already born. Nevertheless, dealing with the problem cannot be postponed. The inexorable momentum of geometric population growth only makes the problem more intractable with each year of delay. In the meantime, important micro-economic benefits can be achieved. The economic outlook for individual families can be improved with a more well-planned reproductive pattern. The burdens on the health system are immediately reduced when the birth rate begins to fall. Soon thereafter, this impact will be felt on the number of those entering the primary school.

Various alternatives exist for dealing with the problem of high fertility and rapid population growth. The more effective of general development approaches seem to be in the areas of increased levels of education, especially for women; improved roles for women, particularly economic; better distribution of a greater per capita income; and improved maternal and child health. These are all good objectives in themselves and most are being attempted to some degree by the government. However, they are long term in nature and most are made more difficult to achieve in the present economic situation. There is little that can be accomplished in these areas by the expenditure of the limited external resources likely to be available for population programs.

Another alternative could be to utilize the small family incentive/disincentive approach found effective in China. This is not likely to succeed in Ghanaian society which is not organized in a way that would be amenable to the Chinese approach.

The most practical, cost effective alternative at this point appears to be to expand the availability of family planning information and services, utilizing to the maximum extent possible the existing MOH infrastructure for service delivery and developing a system for contraceptive social marketing in the private sector. Community-based distribution will be expanded as the Primary Health Care program of the MOH extends.

3.3.3 Relevant Experience from Other Projects

As described in the Background material (Annex E-4), there has been considerable relevant experience with family planning projects in Ghana. The most instructive are those from the DANFA experiment, the activities of the Planned Parenthood Association of Ghana, the family planning activities of the Christian Council of Ghana and YMCA, the recently expired Retail Commercial Sales Project, and the experience of the GNFPF and MOH in providing family planning services. This PP is based upon those experiences. The most important conclusions follow:

(1) The MOH MCH/FP system can absorb and utilize a continuing and expanded supply of contraceptives.

(2) The MOH logistics system is capable of importing and distributing supplies but this project will need to facilitate continuing improvement in that system. It will require more frequent monitoring, spot checks of inventories, and analysis of commodity flow information by the national and regional staff.

(3) The ongoing training programs of the MOH system produce a considerable cadre of personnel trained in family planning. However, if the new approaches to service delivery are to be carried out (including full supply of contraceptives, more delegation of responsibility to trained auxiliary and community workers, emphasis on family planning service availability every day the clinic is open, better reporting) refresher seminars and on-the-job training will be required. Considerably more attention must be given to management training for all health system personnel whose decisions and performance affect the operations of the MCH/FP program. In the past the MOH has generally been able to provide supervisory and auxiliary personnel for the kind of service contemplated in this project. However, with present economic conditions there has been an increasing difficulty in retaining personnel. Attention must be given to ensure newly assigned personnel are trained in policies and procedures to be fully aware of their roles and responsibilities.

(4) Personnel as trained in the MOH system can provide clinical FP services to a limited client population. However, attention must be given to maximizing the use of outreach workers. The DANFA project especially documented the need to deliver services as close to the home as possible with the participation of community personnel. It is appropriate to begin the public sector portion of the present project with an emphasis on improving the logistics system, providing a full supply of contraceptives and ensuring effective service at the clinic level.

However, this must be used as the basis for further extension to the community, if appropriate coverage levels are to be achieved. This extension to the community can be both through Health Brigades of the PHC program and through retail outlets of the CSM program.

(5) There is currently an unmet demand for family planning services; clients will pay for the services if they are consistently and readily available in a culturally acceptable fashion.

(6) There can be a rapid increase in commercial outlets and product sales when the private sector is given freedom to operate and mobilize a retail network for commercial sale of contraceptives.

(7) Although there is currently a significant unmet demand, project growth and expansion consistent with demographic goals can be fostered by informational activities in both the public sector and through CSM activities. Sales are promoted by advertising and public awareness can be increased through use of the media and through health education.

(8) The MOH is the appropriate organization for program implementation and distribution of contraceptive supplies for the public sector aspect of this project in Ghana. GNFPP will continue to be the policy making body and national coordinator for Ghana's family planning programs. Initial actions of the MOH (under the Family Health Initiatives Project) to directly manage their own supply, their training and family planning service delivery within the MOH system suggests that this shift will improve efficiency and effectiveness of the program.

(9) As demonstrated in the previous project, DANAFCO is a capable and appropriate private sector institution for project implementation.

3.4 Specific Project Problem and Constraints

The project addresses the problem of increasing the availability and use of contraceptives to be provided through the MOH system and private commercial retail outlets.

A major constraint to the MOH system has been the lack of contraceptive supplies and an efficient system for their ordering, warehousing, delivery and reporting. Disruption of supplies, the inability of the GNFPP Secretariat to place supplies in the proper place at the right time, and the breakdown of the reporting system in the public sector family planning projects. Significant progress in resolving these problems has been made even during the last two difficult years. A supply of contraceptives was made available through a regional Family Health Initiatives project and technical assistance in logistics was made available by the Centers for Disease Control (CDC). Considerable improvements in internal supply of contraceptives and record keeping and reporting have been noted. (Refer to CDC Foreign Trip Report, Ghana, March 1984)

Despite the progress in resolving these logistics and reporting problems, the services provided to the public are at a frustratingly low level. One can be most sympathetic to the problems faced by MOH staff in the past two years. Curfews, extreme shortage of petrol and spare parts, low salaries and the real difficulties of securing the bare essentials for personal and family daily living had a most disruptive influence. In many ways it is amazing the FP service continued at all. Yet candor requires the recognition of the present very low level of performance. Many of the socio-economic conditions noted above are now being resolved. However, efforts must be made to supercede the impact they had on FP service delivery.

In terms of the commercial sector for contraceptive sales, a major constraint is the availability of foreign exchange for the importation of commodities. Additionally, there is a requirement for seed capital to reinitiate the packaging, advertising and logistics system that deteriorated in the face of various bureaucratic problems. Obviously full and formal agreement with the GOG to resolve these bureaucratic problems and to allow the private sector to operate freely and effectively is a sine qua non for initiating the CSM portion of this project.

This project expects to address specifically the constraints mentioned above both in the public and private commercial sector. The project will also address three other significant constraints which the PID indicated would remain secondary until the contraceptive distribution and management system were further improved: (in light of performance in actual service delivery in the past two years, these factors now take on even greater significance).

1) Training: Considerable training has been done in family planning over the past ten years but new personnel and personnel shifts require refresher training. Additionally, there are new management procedures and program emphases which must be promulgated.

2) Information, Education and Communication (IE&C): Much effort had been expended in public information programs through the mid-1970's. As a result, the Ghana Fertility Survey indicated that in 1979-80, 60 percent of currently married, fertile age women knew of at least one efficient method of contraception and 44 percent knew of at least one source of supply. (While these rates are low relative to developed countries, they are high for countries in Africa). The converse, however, is that 40 percent of women do not know of any method. The present low levels of family planning services in the MOH clinics are related to many program management issues. However, a break down in public information and awareness has also contributed to the problem.

3) Outreach: Service delivery through clinics is one practical approach at this stage. However, coverage consistent with public health or demographic objectives will require extension beyond the clinics in more community based approaches both in the public and private sector.

3.5 Project Objectives

The sector goal to which this project will contribute is slower population growth; which will improve the food supply/demand balance and contribute to USAID/Ghana's goal of food self-sufficiency. The reduced birth rates and increased child spacing, which will contribute to slower population growth, should also improve maternal and child health.

The project purpose is to increase the voluntary use of safe, effective, appropriate contraceptive methods by Ghanaian couples. Contraceptive use by clients at MOH project sites is estimated to rise from approximately 2 percent of the women of fertile age in 1984 to approximately 6 percent in 1988. The social marketing portion of the project is expected to expand following its initiation to a level of approximately 7 percent of the women in fertile age in 1988. These efforts, combined with activities of various non-governmental organization (NGO's) should bring the contraceptive prevalence rate to approximately 16 percent by that time. This reflects USAID/Ghana's hypothesis that, if an adequate supply of family planning services and contraceptives are available on a continuous basis supported by appropriate training and IE&C, contraceptive use will increase. This is based on three factors: (1) the last 12 years of assistance in this sector by AID in Ghana has resulted in the existence of a distribution system capable of improving and extending to make family planning services more available in the clinics and their surrounding communities; (2) previous experience with CSM demonstrated a rapidly growing commercial demand for contraceptives; and (3) the rapidly rising costs of raising children in Ghana is evident to even rural populations (without a concomitant rise in benefits to the family because of those additional children).

Expected Achievements/Accomplishments

By the end of the project it is expected that the following major accomplishments will have been achieved:

(1) A management supply system will be in place in the public sector permitting the MOH to maintain a full supply of contraceptives at central, regional, and district warehouses and service outlets. This system will provide timely service statistics and commodity flow reports to project managers who will use them for management decisions and for feedback to all implementation levels. Efforts will be concentrated on improving the quality of the existing clinic distribution network, expanding beyond these clinics to the community level. Between 35 and 40 percent of the population should have reasonable access to contraceptives from the service delivery system to be developed.

(2) Personnel who have had Manual Level A (Basic) family planning training will be providing family planning services in all 306 MOH MCH/FP centers. At least 20 additional "Level A" (community distribution) networks will provide advice and non-clinical methods during the last year of the project. In all of the Level B and C centers there will be a person available each day the center is open to provide orals, condoms, or foaming products on a person's first visit. That individual will also be able to refer patients to appropriate centers for an IUD insertion or sterilization if requested.

(3) A largely self-financing commercial distribution system will be in place that can provide a reliable flow of contraceptives and family planning products throughout the established network of retail outlets.

(4) An effective management supply system to strengthen and expand the contraceptive retail supply network will have been developed. There will be a planned and phased expansion of the distribution system including the necessary logistical support required to service an increasing number of retail outlets covering an expanded geographic service area. (See Annex E-3 for marketing plan indicating distribution outlets, sales targets). Over the life of the project this together with the MOH and NGO outlets, should result in 50 to 60 percent of the population having vastly improved access to a range of contraceptives that are reliable, affordable, and available on a regular basis.

(5) Consonant with normal private sector commercial marketing and sales practice, appropriate training and information will be provided on an ongoing basis to marketing staff, retailers including pharmacists, shop keepers, chemical sellers and others who are involved in the distribution and sales network to improve sales and provide better service to clients and potential clients.

(6) An important contribution of the project will be increased consumer awareness of contraceptive methods and products as the result of effective product advertising and marketing activities. The use of effective multi-media advertising coupled with carefully tailored marketing should contribute significantly to consumer motivation resulting in increased sales. A further benefit that can be anticipated from the CSM promotional activities is increased popular participation in MOH MCH/FP and other programs resulting from awareness and attitudinal changes.

(7) By the end of the project, annual levels of contraceptive distribution will reach 13 percent of the women of fertile age who are married (in union). This, together with the expected 3 percent from the PVO programs, will provide an increase in contraceptive use from the 5 to 7 percent MWIFA levels in 1984 to approximately 16 percent MWIFA by 1987. (See Annex E-1 for a discussion of the levels of commodities to be distributed, couple years of protection to be provided and the likely outcome in increased contraceptive prevalence.)

These estimates of growth in levels of contraceptive use are based on the rather conservative estimate of what can be done to improve the productivity of the MOH system with a substantial emphasis on training in the management and delivery of family health services. It depends on increasing information programs and successfully training and organizing village health brigades to deliver family planning information and service. This must be accomplished by a Ministry faced with severe financial and personnel problems. There is considerably more optimism of the speed with which the private sector can be mobilized to provide family planning services if allowed to operate freely and if provided appropriate project resources.

Although the national birth rate will be slow to change, the increased use of contraceptives through this project will affect birth rates in the immediate areas of project concentration. Increase in prevalence will have an immediate impact on the prospects of those couples using program services to postpone or avoid the next birth.

TABLE I: Summary of Access to and Use of Contraceptives

See Attached

ACCESS AND USE OF FAMILY PLANNING SERVICES

	<u>April 1986</u>	<u>April 1987</u>	<u>April 1988</u>	<u>Comments</u>	
A. <u>MOH SYSTEM</u>					
1.1	Outlets (re-trained staff)				
	- Clinics	33	87	141	Total of 282 clinics.
	- Outreach workers	198	522	846	
	- Health Birgade distribution (TBAs, CCAs)	495	1,305	2,115	Adjusted for 30% attriction per year.
	- Employee stores	60	168	276	Adjusted for 10% discontinuation each year.
1.2	Other health centers/posts		249	189	141
2.	Total CYP		56,372	99,025	105,969
3.	Total acceptors		77,890	131,560	138,504
4.	% eligible women using MOH services		3.5%	5.7%	6.2%
B. <u>CSM</u>					
1.	Outlets		2,000	2,750	3,311
2.	CYP (Consumer purchase)		22,308	100,386	156,156
3.	% couples using methods provided by CSM		1.0%	4.5%	7.0%
C. TOTAL CYP					
D. ESTIMATED PREVALENCE					

Source: CDC Consult
M. Dalmat

3.6 Project Description

3.6.1 Relation to P.I.D.

Although the project is somewhat more comprehensive than described in the PID, it is a natural outgrowth of that document and responds to changes which have occurred in Ghana over the past one and half years. For example, it was indicated in the PID (pg 10) "If the GOG produces an administrative arrangement for the private sector which USAID/Ghana finds acceptable, the USAID will gladly support the reinstatement of a retail commercial sales program, in addition to continuing supplying contraceptives through the MOH." Now this is practicable and the mission is able to respond to AID/W instructions (State 088936 April 1, 1983) following PID review, to include CSM in the PP design.

Similarly; the MOH is moving more actively toward community based delivery of family planning through their Primary Health Care emphasis. In the light of conditions which had deteriorated over the past two years was determined that more training, especially in management, information programs and vehicles would be needed for the project than originally contemplated. In order to adjust to the USAID and GOG management requirements of these expanded elements, it was determined to postpone the proposed involvement in this particular project with YMCA, and the Christian Council of Ghana. Consideration of support for the Planned Parenthood Association of Ghana (PPAG) the Seventh Day Adventist program (SAWS), women's development committees and military, church and quasi-government health systems and, possible support considered for women's leadership groups through CEDPA or Operations Research support by Columbia University will be postponed until the second year of the project.

Conditions that have evolved suggest that a close mission control of project inputs and scheduling and use of technical assistance is required to assure project success. In the face of a substantially reduced staff, innovative management arrangements must be found to simplify the mission's task. The project will still require a variety of inputs, especially technical assistance, from different sources. However, the mission management requirements will be facilitated by maximum use of centrally-procured goods and services, including contraceptives. The mission will maintain management oversight of all these centrally-supported activities by participating with the MOH and private sector in the ordering of contraceptives and the scheduling of technical assistance, preparation of work scopes for individual consultations and in-country monitoring of utilization of commodities and services. The mission will provide bilateral funded PIO/Cs and PIO/Ts to draw on these AID/W contracts and cooperating agreements, utilizing AID/W management

assistance and experience in the procurement and coordination of these services. A simple reporting system will be used in which the centrally-contracted agencies will report to the mission in the same timing and format as their central contract. Specific work in Ghana and related expenses will be separately identified in these reports.

3.6.2 Project Elements

3.6.2.1 Contraceptives for the Ministry of Health MCH/FP system

The major support for the MOH is a full supply of commodities; orals, condoms, foaming tablets and IUDs to be provided by AID. UNFPA will be providing other contraceptives. Requests will be coordinated to avoid duplication. It was previously thought the government of Japan would provide foaming tablets but they have supplied vehicles and other drugs to the MOH instead. AID's commodities will be provided as a grant to the Ministry of Health which will be the importing and central warehousing agent.

The distribution system to be used will be the MOH system already in place for other drugs and supplies. It has four levels: National, Regional (10), District (68), and Clinic sites (306). Increasingly the clinics are supervising an outreach program in the PHC approach which has been developed in 25 districts.

The contraceptives are received at the national warehouse at Tema after the MOH has cleared them through customs. The MOH MCH/FP Division, based on experience, clinic use reports and lower-level warehouse stock reports, will make allocations of the supplies to the regions and inform the national warehouse and the regional offices of the allocations. Regional personnel will travel to Tema and pick up drugs and supplies, using vehicles assigned to the region. From the district warehouse to the clinics, supplies will be taken by district nursing personnel as they make their supervisory rounds to the clinics. The distribution system will be considered to be functioning adequately if, at the end of this project, the national warehouse has 12-18 months' supply on hand, the 10 regional warehouses each have 6-12 months' supply on hand, and there is a 4-6 months' supply in each of the 68 district levels. These levels, recommended by the Center for Disease Control (CDC), should be sufficient to prevent stockouts at any level, but modest enough to prevent overstocks and/or the possibility that contraceptives might remain in stock until outdated. Older stocks will be used first, and expiration dates strictly adhered to (roughly 5 years from manufacture date for both pills and condoms).

The MOH Level A family planning training manual establishes the qualifications and training of those who will provide the bulk of the service at the health posts, health centers, and hospital clinics in the program. Personnel will be trained to provide contraceptive information, screen patients for possible side-effects of various methods, dispense orals, condoms and spermicides and refer patients. Special Level B family planning training, including clinical practice, will be reserved for more highly qualified nursing staff. It will enable them to insert IUD's in those centers where available equipment, supervision and medical back-up permit. In community outreach (PHC) programs village workers who are part of the newly organized health brigade program will be trained to provide barrier methods and resupply oral contraceptives. The MOH is reviewing the degree to which trained community workers can be involved in the initial supply of orals. Contraceptives are sold at a price established by the Ministry of Health. This price, well under the market price which prevailed when foreign exchange availability permitted import, will be accessible to the populace. It will also be sufficient to generate significant funds for improving MCH/FP. Priority attention will be given to defraying expenses of distributing personnel, support of training activities and purchase of supplies in support of improved management and supervision. See Section 4 for further discussion of this approach and the shift toward more retention and use of these funds at the level where the contraceptives are sold (including by health brigades). The challenge will be to develop enough reporting for minimum control without creating bureaucratic problems for MOH or USAID.

Voluntary sterilization has not been a part of service delivery of the National Family Planning Program; rather, it is a medical service provided at some hospitals. Referral can be made to centers where qualified surgeons will provide this service on a voluntary basis. The level of demand for this service as stated by the Chief of OB/GYN department of Ghana's Teaching Hospital, Korle Bu, appears greater than previously thought. In a recent study of one thousand women delivering their babies at this hospital, 12 percent are reported as stating they wished a tubal ligation. However, only 3 percent (of the 12 percent) were able to receive this service. More attention is required to expand this service to meet existing demand. Due to the management constraints mentioned above, this, too, will be postponed until the second year of the project. Additional centrally procured assistance may be requested. If such programs are supported, full attention will be given to assure that the services are voluntary and informed consent is documented.

Ghana has chosen to follow WHO and IPPF international standards related to the use of Depo Provera. AID is not providing this drug which, when available, is used for the older, higher parity women.

Abortions are not provided in the MCH/FP program of the Ministry of Health. No AID funds will be provided to support, train or promote abortions. This will be communicated clearly to the Ministry.

Natural family planning will be taught as one of the contraceptive methods. Most of the in-depth counselling in these methods will be by referral to PVO centers specializing in this approach.

Following is a summary of the contraceptive requirements for the project (See Annex E-1).

Table II: Contraceptive Requirements

Type	Quantity by Calendar year of delivery		
	1985 (000)	1986 (000)	1987 (000)
Public Sector			
Oral (cycles)	1,412	2,289	2,937
Condoms (units)	1,806	6,276	8,104
IUDs (units)	7.6	9.3	8.3
Foaming tablets (units)	10,410	18,096	20,189

Source CDC Dalmat

The above figures provide for a much more rapid growth in outlets and use in the CSM than the MOH system, which has many financial constraints. It also provides a considerably larger buffer stock to assure against stock outs. Clearly the actual shipments for either program will be adjusted to reflect actual program performance.

3.6.2.2 Supply Management

Improvements in the contraceptive supply distribution and management system will continue to be made during this project. This involves reports on a quarterly basis on (1) numbers of clients and contraceptives dispensed at service sites (clinics), passed up the system and aggregated, and (2) reports from the national and regional warehouses to the MOH MCH/FP Division of stocks on hand. In addition, the system involves the production of national reports by the MCH/FP Division of the MOH and their dissemination to donors, and to the regional and district MCH/FP offices. Another expected achievement of this system is the use of such reports in determining future contraceptive needs and appropriate allocations of contraceptives to the regional warehouses, districts, and clinics.

Based on recent work by Richard Monteith, CDC Logistic/Management Consultant, the MOH reporting system has been much simplified from the original to improve collection of only essential data. Monteith's reports from 1983 and early 1984 indicate a slow but continuing improvement in the logistics system. However, the timeliness in reporting, planning and supervision need to be improved. His reports confirm the need for, and recommend the management training component of this project which the MOH has requested through Management Science for Health (MSH) and CDC. See Section 3.5.2.3 and Annex E-2 for more discussion of the management training.

Each quarter, clinics report to the District Public Health Nurse, (who is part of the District Health Management Team), the number of clients seen and the amounts of each contraceptive dispensed. District officers aggregate this data, noting which clinics have not reported. The Regional Public Health Nurses and National Specialist in Charge of MCH/FP then aggregate the data in the same way, noting any District (or Regions, if it were to happen) which do not report. The MOH MCH/FP Division then produces the national quarterly reports from this data. This system was begun just before the Ghana Family Health Initiatives project started. Michael Dalmat, CDC consultant has assessed that in the last five quarters approximately 70 percent of clinics have reported every quarter. By the end of this project, reporting from clinics will be virtually complete, with 90 percent of clinics reporting quarterly on time.

Technical assistance to the MOH (and USAID) concerning the contraceptive supply system and health management training will be provided by CDC under an ST/POP funded RSSA. They will work closely with Management Science for Health (MSH), where six MOH officers have recently been trained as part of a program of continuing MOH health system management improvement.

3.6.2.3 Training

Several kinds of training will be provided under this project both for public sector and private sector leaders.

(a) MPH/FP training for health planners, administrators or health educators who will serve at the regional level. Up to three health administrators or physicians working in the health system and guaranteed a leading position at the regional level or in one of the schools of health training on their return will be selected for training at the MPH level in MCH/FP in a school of Public Health in the U.S. This will only be possible if contractual arrangements can be developed guaranteeing their return. This training is necessary to assure the continued capacity in Ghana to plan for and train personnel for health programs with a public health FP emphasis. It would be more efficient for Ghana to provide the conditions to attract their highly qualified personnel presently overseas to return home. However, this does not seem too likely at the moment.

(b) Short courses, seminars and observation travel for selected leaders and trainers to be trained in the U.S. or third countries. Thirty five person months of training will be provided for approximately 50 persons during the LOP. This update, refresher or specialized training will keep Ghanaians current with advances in contraceptive technology, service delivery modalities, training techniques and informational and communications methods. The kinds of training contemplated include the following:

- family planning clinical skills training in Ibaden, Nigeria
- advanced family health management in Boston or third country
- observation of CBD programs in Latin America, Kenya or Zimbabwe
- women's leadership in development and population activities CEDPA - Washington
- communication skills training for general family planning or adolescent fertility programs - (U.S.)
- evaluation of Family Health and F.P. programs (U.S.) - integrated H.P.N. program delivery Columbia University.

(c) In country training (See Annex E-2 for training plan).

1) Management training will be provided for health administrators and delivery personnel who are associated with decisions and actions in support of the MCH/FP program. This is one of the more ambitious elements of the training program. Its success in achieving both of its two objectives will determine much of the success of the family planning effort in the Ministry of Health. One objective is to improve the general health management capability of the various cadres of health personnel, especially the District Health Team. The other objective is to use this training opportunity to apprise all health personnel of the various aspects of the family planning program, to enlist their support and to prepare them for active involvement in planning for and delivering family planning services. Careful attention will be paid to the latter objective in briefing technical consultants and GIMPA faculty and in planning with Ministry of Health officials who will be developing these courses.

2) Refresher training and basic training will be provided to clinic and community outreach personnel to update skills in delivering family planning information and service.

3) Assistance will be provided to review and revise the MCH/FP curriculum of medical, nursing, mid-wifery schools and community health training institutions. Faculty will be given refresher training in reproductive health and family planning.

It is expected that in the three years of project life there will be trained in-country in the MOH system:

- 20 Central and Regional personnel will receive 120 person weeks training
- 40 Regional and district trainers will receive 200 person weeks training
- 78 tutors will receive 202 person weeks training
- 564 general clinic personnel in the management component will receive 2820 person weeks training
- 171 specialized clinic personnel will receive 686 person weeks training
- 2115 village personnel will receive 2115 person weeks training.

d) The training component of CSM will be discussed in section 3.6.2.6.

JHPIEGO will assist in the review of preservice curriculum and will assist in developing refresher seminars in reproductive health and family planning for faculty of various health training institutions.

INTRAH and MSH will assist the MOH national, regional and district personnel in developing in-service training programs including management and delivery of family planning in the clinic and community.

It is expected that MOH will contract (using project local currency) with the Ghana Institute of Management and Public Administration (GIMPA) to manage and implement the management training component including handling the associated local project costs.

3.6.2.4 Information, Education and Communication (IE&C)

An information, education, and communication program will be developed to assure that potential clients and current users have accurate information upon which to make an informed decision regarding family planning.

Almost all the urban population and up to 80 percent of the rural population are reported to have access to radios. Batteries which were in scarce supply are becoming more available as they are produced in country again. One of the two channels is a non-commercial public broadcasting with time readily available. A network of TV communication that reached to all the regions has deteriorated considerably. There are some indications that it is being rejuvenated. Newsprint is limited in Ghana due to scarcity of foreign exchange so the

circulation of each of the two daily newspapers is down from 250,000 to 75,000. Newspapers are read by all economic levels of the population in large urban areas. The scarcity of printed material makes whatever is available much used by a population said to be 50 percent literate in English. Substantial numbers of community workers are being trained as part of "Health Brigades" at the community level. These are available for inter personal communication emphases.

The IE&C strategy has four major goals:

- o To inform potential clients of the availability of family planning services;
- o To recruit and maintain new clients;
- o To provide accurate information to new and existing clients and combat rumors and misconceptions on FP methods;
- o To educate males about the important family health benefits of child spacing methods.

In order to achieve the above objectives, a variety of activities will be carried out. Possible approaches include:

- o Radio programs on child spacing and family health;
- o Radio and T.V. spots focusing on the availability and health benefits of family planning services;
- o Information materials directed towards males;
- o Newspaper advertisements;
- o Popularized "comic book", or magazine publication for sale to the public
- o Workshops for clinic staff and fieldworkers to ensure proper distribution of materials and proper approaches to inter personal communication;
- o Packets of staff reference materials on family planning. Such materials would include copies of Population Reports, and other materials (films, slides, etc.) available through the Population Information Program/ Population Communication Services at The John Hopkins University.

Because of diverse language groups in Ghana, materials will be prepared in English, Fanti, Ga, Ewe, Nzema, and Dagbani, as may be required.

Specialists from the Johns Hopkins University/Population Communication Services (JHU/PCS) project will collaborate with Ghanaian and U.S. officials in the development of the information/media campaign which will emphasize the health and economic benefits of child spacing. Prior to actual program implementation, JHU/PCS will conduct a project planning mission to work with the Ministry of Health in identifying collaborating agencies to develop and implement the IE&C campaign in the country. Organizations tentatively identified as possible collaborators in this campaign include the Health Education Division of the Ministry of Health, the Planned Parenthood Association of Ghana and the Christian Council of Ghana. JHU/PCS may also call upon its subcontractors, the Academy of Educational Development, the Program for the Introduction and Adaptation of Contraceptive Technology, and Needham Porter Novelli to assist in actual program implementation.

In order to produce many of the materials described above, an advertising agency may be subcontracted by the in-country collaborating organization for the actual development, pre-testing, and production of the materials.

Depending on availability of newsprint, ink, etc. some of these supplies will have to be imported or materials produced outside the country.

All materials developed under the auspices of the program will be carefully designed and tested for cultural and social sensitivity.

The IE&C component of CSM will be discussed in section 3.6.2.6 and in the CSM technical analysis, E-3.

3.6.2.5 Vehicles

Vehicles, equipment and supplies are being provided to the MOH by UNICEF, UNFPA and the Government of Japan. Some unmet needs have been identified for light vehicles to be used for supervision, training and outreach for the MCH activities. Major difficulties in petrol and spare parts availability and maintenance capability preclude heavier involvement in vehicle supply. However, some modest inputs (six light double cab pick-ups) are deemed necessary. Initially these vehicles will be used by the training teams and then will become part of the operational program in the regions. Vehicles will be made available on a grant basis to the public sector with GOG guaranteeing duty free import. MOH assurances of petrol for its vehicles will be obtained.

Vehicles made available to the private sector will be done so outside of this project financing. An agreement will be made with the GOG at the time of project signing to assure the CSM distributing agency has access to FX and licences to upgrade its vehicle fleet.

3.6.2.6 Contraceptive Social Marketing

The Commercial Retail Sales portion of the project will operate through the very straight forward approach of combining private sector commercial know-how with well established social marketing concepts.

The Ghana contraceptive social marketing project plans to make use of the efficiency and experience of a successful Ghanaian commercial distribution organization in order to substantially increase accessibility to a range of contraceptive products. By making use of commercial distribution expertise, such a program is able to rapidly expand the number of service delivery points from which people can obtain regular supplies of contraceptives at affordable prices.

The project will make use of the technical know-how and skills of experienced marketing and advertising professionals in order to increase public awareness about the contraceptive products and their availability. It will also undertake to promote project-related MCH/FP and family health messages such as the encouragement of child spacing. All advertising will be undertaken by local people who are sensitive to the cultural and social values of the community and thus the promotion and information messages will at all times reflect good taste and be consonant with accepted norms and values of the community.

A major departure from traditional clinic based programs will be seen in the rapid expansion of the number and diversity of outlets from which contraceptives may be purchased. Orals, condoms and spermicidal foaming tablets will be provided by AID as a grant under the bilateral program with the Ministry of Health. Contraceptives will be imported free of duty/taxes by the Ministry of Health with onward consignment to DANAFCO, the project's distribution company.

DANAFCO will be responsible for packaging and distributing contraceptives throughout the distribution network in the target areas agreed upon. Staff from DANAFCO will be responsible for marketing and merchandising activities throughout the distribution network including retailer training and orientation.

DANAFCO field staff will be responsible for carrying out regular "shelf audits" throughout the retail sales network in order to (1) maintain sufficient supplies of commodities; (2) provide assurance on proper contraceptive storage, display and use of point of sale materials and (3) provide accurate data on product uptake from which calculations can be made concerning the level of couple years of protection.

The project will utilize various means to increase awareness in all target market locations and especially in small towns and important market villages that have been largely neglected and underserved by all past and present MCH/FP-related programs. Best efforts will be made to translate increased awareness into sales by making a range of reliable and safe contraceptive products readily accessible, affordable and available on a regular basis.

The project will maintain close liaison with the Ministry of Health, Ministry of Finance and Economic Planning and USAID/Accra.

The Futures Group and CDC centrally funded projects will assist with technical consultation on marketing, program management, advertising evaluation, logistical support and commodity supply issues.

4. COST ESTIMATES AND FINANCIAL PLAN

4.1 Summary and General Considerations

This project will help the GOG improve family planning services and contraceptive supplies for three years, at which time consideration will be given to expansion or extension. Contraceptive supplies and other inputs will be provided for the period starting in mid-1985.

In support of family planning in general and this project in particular USAID will provide \$2 million of support from this project in FY 1985 and \$3 million in FY 1986 and \$2 million in 1987 principally for U.S. made commodities and technical assistance. Local currency will be made available in all years from cedis generated from Title One and program support grants total 30 million (\$800,000). Other local costs 48 million cedis (\$1.2 million) will be paid by the GOG from its regular resources. ** (Provisional figures and central supply of \$572,000 not included).

All project funded inputs should be a grant contribution as the GOG is unable to provide the necessary foreign exchange for these inputs. The present economic situation makes it impossible for the GOG to repay these project costs, and the project does not lead to an increase in directly productive activities.

4.2 Budget (PROVISIONAL FIGURES)

A. USAID	<u>Project Funded</u>		<u>Centrally Funded</u>
	\$	Cedis	\$
	(000)	(000)	(000)
Contraceptives and freight for Public Sector	1,953		
Contraceptives and freight for CSM	3,679		
Packaging, advertising & distribution costs CSM	125	8,000	200 (Futures)
IE&C materials & supplies	80	3,000	20 (JH/PCS)
Vehicles & spare parts	90		
In-country training (GIMPA)		7,000	
Training materials & supplies	50		10 (JHPIEGO)
U.S. & third country training	235		
Support for future NGO outreach activities, women's group and military, church and quasi-governmental health systems		5,000	
Evaluation, Surveys and Ops. research		4,000	
Audit	75		
Contingency/Inflation	500	3,000	
Total	6,787	30,000	.225
B. USAID (Technical Assistance)	<u>Project Funded</u>		<u>Centrally Funded</u>
	Trips	Person weeks	\$
			(000)
CDC	14	55	138
ISTI	2	4	12
INTRAH/MSH	18	49	84
JHPIEGO	7	11	36
PCS	9	30	48
FUTURES	20	60	80
Total			212
Total USAID (A&B)			576

C.	Government of Ghana *	<u>Cedis</u> (000)	<u>(Dollar Value @1:40)</u> (000)
	Clinical personnel salaries	32,400	(810)
	Training facilities	3,600	(90)
	Storage and distribution of contraceptives	12,000	(300)
		1,200,000	

* Provisional figures to be further reviewed by USAID.

5. IMPLEMENTATION PLAN

5.1 Implementing Agencies

5.1.1 Public Sector

The implementing agency will be the Ministry of Health and the project will operate under the supervision of the Director of Medical Services (Public Health). Responsibility for implementation will reside with the Maternal Child Health/Family Planning Division of the MOH. There is a trend toward decentralization which will place more responsibility for planning and implementation on the regional and district level.

Review of personnel levels, budgets, and administrative procedures at the national and regional levels has been carried out in the design of the UNFPA project and in this PP. (See Annex I-1). An initial review was made by a JHPIEGO consultant of the staff, student levels, and availability of family planning training aids and materials in the two medical faculties, five schools of midwifery and four schools for community health nursing which will continue to provide the bulk of the pre-service FP training. This provided the background for developing the pre-service portion of the training plan (Annex E-2). Further review of these training requirements will be carried out as part of proposed technical consultation.

These reviews indicate that these institutions are, with considerable difficulty, capable of carrying out the functions required. Technical assistance will be required for logistics and management, curriculum review, training methodology and IE&C. A serious constraint is the economic situation in Ghana which does not permit significant expansion of the MOH budget to increase its activities (or perhaps even to maintain its present staff). A major contribution through the management/in-service training component of the project will be to help the GOG make more efficient use of its resources. Nevertheless, the project must be prepared to bear more of the local costs than contemplated in the PID if the MOH is going to be able to put these new approaches into practice. One element that the PP design does not contemplate is the payment of salaries. As useful as this might be to achieve short run project success, it is considered counter-productive over the long term.

5.1.2 Private Sector

The implementing agency will be the Ministry of Finance and Economic Planning who will contract with DANAFCO Limited as the executing organization to provide all necessary services. A detailed description of the services to be provided by DANAFCO and the respective roles and obligations of the Ministry of Finance and Economic Planning and DANAFCO will be spelled out in a separate agreement to which the Ministry of Health and USAID/Accra will be concurring parties. (See Annex I-2).

DANAFCO Limited will contract with LINTAS, Ghana Limited for the provision of advertising services and with Mr. James Pearce-Biney for the training of retailers.

Responsibility for implementation of all aspects of the marketing plan will reside with DANAFCO.

Both these agencies have a proven track record. The review of their operations confirms they have survived the recent difficult years with adequate capabilities to carry out their responsibilities under this project.

5.2 Plan of Action

See implementation matrix attached

Action Required	1985		1986		1987		1988		Responsible					Implementation			Other					
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	USAID	AID/MPF	HON	ENTRANCE		THP/CD	CD	THP/CD	GINA	
24. Assistant home manager and Refresher training and refresher coordination workshop (2 persons 2 weeks)				X									X		X						X	
25. Phasor District Training (1 person 4 weeks)													Y		X						X	
26. Suburban health subsector															X							
27. Continued District Training and coordination for subsector (2 persons 2 weeks)													Y		X						X	
28. Pre-stress nurse/assistant health workers of "high" priority communities (1 person 2 weeks)													X		X						X	Training Schedule
29. Nurse/assistant health current workshop (2 persons 2 weeks)													Y		X							Training Schedule
30. Training for stress reduction workshop (1 person 2 weeks)															X							Training Schedule
31. Institute of Management of Training for service (2 persons 2 weeks)													X		X							
32. Physician Reproductive Health Extension (1 person 1 month) x 3			X										X		X							Training Schedule
33. Update Physicians Curriculum (1 person 2 weeks)		X											X									Training Schedule
34. Plan Contraceptive Prevalence Survey 2 persons 4 weeks													X		Y							Change Program Status
35. CPS Field Work 2 persons 4 weeks																						
36. CPS Analysis & Report (2 persons 4 weeks) & SOS in Ghana 4 weeks																						Change Program Status
37. CPH Logistics Review (1 person 7 weeks)															X							
38. Financial Audit of CPH and Project Emergency fund cost account																						
39. Mid-term process evaluation (2 persons 2 weeks)																						REDO COC REDO COC
40. Final (out put) evaluation (2 persons 2 weeks)																						REDO COC REDO COC

PUBLIC SECTOR IN-COUNTRY TRAINING PLAN

(See attached flow chart)

A. In-Service Training for Management and Delivery of Family Health Services

The purpose of this component of the project is to revitalize and strengthen the national MOH service system as a vehicle for the delivery of family planning services in the context of family health care (FH/FP). The training focus will be upon service provider teams at the health center (including polyclinics, health centers and health posts) and community-based health brigade levels in at least two districts in each of the country's ten regions.

In three phases, the in-service training plan will (a) strengthen central and regional FH/FP management capabilities, (b) develop nine regional/district training teams (one team will serve both East Upper and West Upper Regions) and (c) provide direct training to health center teams and health brigades in service delivery and related technical skills. Estimated LOP in-service training outputs will include:

- Trainees:
- 20 central and regional personnel trained in FH/FP system management and training methods. (3 weeks)
 - 40 regional/district personnel trained as FH/FP trainers and service providers. (5 weeks)
 - 564 professional and auxiliary health personnel from 54 health centers trained as FH/FP service providers and supervisors. (4 weeks)
 - 2115 health brigade workers (TBAs and other community-based personnel) trained in FH/FP information and motivation and supply distribution. (1 week)
- Products:
- A design for the provision and support of Family Health Services
 - Technical modules for the in-service training of the personnel listed above
 - Other training materials as required

Pre-Implementation Activity

Approximately one month prior to anticipated project initiation, a core group of MOH personnel representing central, regional and district levels will convene at The Ghana Institute of Management and Public Administration (GIMPA), with GIMPA staff and external consultants serving as facilitators. The group will design the national model for FH/FP service delivery and management. The group will also develop a master 3-year plan for the competency-based in-service training necessary to implement the service delivery model. GIMPA will be designated as the major resource institution for in-service training, and a senior GIMPA staff member will serve as operations coordinator.

Phase I: Project Months 01-12

In Project Months 3-4, a 6-week workshop will be conducted at GIMPA by external consultants and GIMPA staff to provide FH/FP management training to 20 MOH central and regional personnel who will have responsibilities for management and evaluation of the project. Update training in FH/FP knowledge and skills will be included. This workshop will produce technical and management modules to be used in training regional, district and community level personnel throughout the project.

In Project Months 7-8, nine regional/district training teams will be trained at regional sites by GIMPA and external consultants. Each team will consist of 1 regional training officer and 4 district-based trainers. Training content in the 5-week workshops will include FP/FH service delivery skills, management/supervision of FP/FH and training technologies. In the process of training the regional/district teams, the staff, outreach, and community workers of 3 health centers will be trained.

In Project Months 9-12, each regional/district training team will train 4 health center teams at the health centers in their respective districts. (This training may take place at a single district site when health center staff deficiencies make training at the health center inefficient.) Training at each of 2 health centers per district will be carried out by each of two 2-member subteams, with the region-based training officer serving as coordinator and resource person. Health center and outreach worker teams will be trained in 5 half-day weeks in topics including FP/FH service delivery skills, health center FH/FP management, and supervision of community-based personnel. Health brigade workers will then be trained by district trainers and health center staff (2 week period) to provide FP services and information in addition to a limited number of other FH services.

During Phase I, inservice training will be provided to 33 health center teams, 198 outreach workers, and 495 health brigade workers.

Phase II: Project Months 13-24

In Project Month 13, 1-week zonal project reviews will be held at selected regional sites. Three regional/district training teams will convene at each site to review their achievements and to identify problems in training design and implementation.

In Project Month 14, a 2-week Phase I Project Review will be conducted at GIMPA. During the first week, the regional training officers, along with the MOH personnel responsible for original design of the FH/FP service delivery model, will assess Phase I progress in the in-service training plan and will revise the training plan as indicated. External consultants will participate as required. During the following week, a National Coordination Workshop at GIMPA will include the regional training officers and key coordinators of the pre-service nurses training, IUD training for nurses and physicians training components of the project for review of coherence and continuity issues and to assure coordination of all training as Phase II begins.

In Project Month 18, training of health center teams by regional/district training teams will resume based upon the national training plan and the training modules, but with revisions made during the Phase I Project Review. During Phase II, training will be provided to an estimated 54 health center teams, 324 outreach workers, and 810 health brigade workers.

Phase III: Project Months 25-36

In Project Months 25 and 26, 1-week zonal project reviews, a 2-week Phase II Project Review and a second National Coordination Workshop will be conducted at GIMPA.

In Project Month 30, training of health center teams will resume. During Phase III, training will be provided to an estimated 54 health center teams, 324 outreach workers, and 810 health brigade workers. At this same time, data collection for end-of-project evaluation will begin under GIMPA administration.

In Project Month 35, an End-of-Project Review will be led by GIMPA, with MOH and USAID participation, to review preliminary findings of the evaluation of training impact and institutionalization and to consider the future of the national FH/FP service and training systems.

B. SPECIALIZED REPRODUCTIVE HEALTH TRAINING FOR NURSE-MIDWIVES

I. Training of Trainers

In project months 3-4, initial training of trainers will take place at a JHPIEGO regional center, probably at the University of Ibadan, Nigeria. Candidates for this intensive training will include a) three teams of three, one team from each of three district health centers identified by the MOH, and b) three teams of three from the midwifery and nurse training colleges at Accra, Kumasi and Tamale. These candidates will participate in the management training in Ghana in addition to receiving this regional training.

This reproductive health training will focus on

A. Clinical skills and knowledge in the selection, patient teaching and management of a) hormonal contraceptives, b) IUDs, c) diaphragm, d) natural family planning and e) referral for sterilization;

B. Detection of high risk patients through history and examination;

C. Identifying abnormalities requiring appropriate or immediate referrals;

D. Establishing clinical standards (equipment, sterile condition, medical backup, etc.) required for insertion of IUDs;

E. Integration of updated knowledge and skills through 1) on-the-job training of others, and 2) integration into pre-service curriculum at various levels of training.

Following this four week course for the 18 candidates, the new reproductive health trainers will return to their respective centers for delivery of FH/FP services and extension of training to other clinic nurses.

In project month 7, approximately three months following the TOT training, a JHPIEGO consultant would visit each training center to evaluate training efforts and coordinate with national and regional MOH continued training efforts in a standard or unified manner. Local clinical sites will be identified. Physician back up will be obtained. Curriculum will be developed. Evaluation or follow-up methods will be identified. Initial in-training efforts are to affect 33 health centers in the first project year and 60 health centers in each year following for a total of 153 in the project's duration.

II. Pre-service Tutor Training

The strategies for expansion of pre-service tutor training will be planned so that 40 tutors are trained during the project. In addition, the Accra tutors will be assigned to a core coordinating committee to plan a 3-4 day workshop/seminar in project months 7-8 for 35 tutors to integrate FP into the pre-service curricula for nurses and midwives. This will include setting standards or levels of knowledge and skill at each level. Recommendations from the workshop will be submitted to the National Council. Additional JHPIEGO consultation is anticipated for this workshop.

C. SPECIALIZED REPRODUCTIVE HEALTH TRAINING FOR PHYSICIANS

In project month 5, a 3-day symposium for 50 gynecologists in issues of reproductive health will be conducted at GIMPA in Accra. This symposium will concentrate on:

- 1) new directions in family health care in Ghana
 - a. community-oriented family health care
 - b. Family planning - its impact in Ghana
 - c. CBD
 - d. family planning in medical education
- 2) PID, diagnosis, treatment - infertility, preventive measures
- 3) Laparoscopy as a diagnostic and therapeutic instrument

It is intended to coordinate this symposium with the national professional organizations so as to reactivate annual continuing education seminars for Ghanaian gynecologists. This initial seminar will represent coordinated efforts of gynecologists from Korle-Bu and Police Hospital with MOH. Subsequent annual seminars will be planned at this first seminar.

The convening of gynecologists will also be used for observation of model clinics in Accra, discussion of common concerns, and activation of a practical, community-oriented curriculum for medical training.

Pre-service, curriculum modifications for medical students is anticipated to occur with consultive and educational materials from JHPIEGO - Since there are only two institutions, both with JHPIEGO fellows as chairman, estimated cost of materials includes approximately \$5,300.

JHPIEGO will provide the requisite technical consultation for this portion of the training. In addition to this participation as part of the Bilateral project, JHPIEGO will continue to provide centrally funded support to train physicians and operating theater nurses in laparoscopy.

Source - Michael Dalmat, CDC
James Lea, INTRAM
Connie Husman, JHPIEGO
W. D. Bair

CSM Feasibility and Marketing Plan - Susman

Financial - Rauch

STATISTICAL DATA, DEMOGRAPHIC ANALYSIS AND (a)
BACKGROUND ON POPULATION PROJECTS IN GHANA

A. Statistical Data^{1/}

a. Population of Ghana (1982)	12,943,000 ^{2/}
b. Land Area of Ghana	240,175 sq. km.
c. National Pop. Density per sq. km. (1982)	53 ^{2/}
d. Number of Localities in Ghana (1970)	
- under 100	35,974
- 100 to 1000	10,512
- 1000 to 5000	1,148
- 5000 to 20,000	112
- 20,000 to 50,000	17
- over 50,000	6
e. Crude birth rate (1981)	48.3 ^{2/}
f. Crude death rate 1950 - 1955	30.7
g. Crude death rate 1975 - 1980	19.1
h. Population Growth Rate (1982)	3.2 ^{2/}
i. Total Fertility Rate (1981)	6.7 ^{2/}
j. Infant Mortality (less than 1 year) (1981)	101 ^{2/}
k. Maternal Mortality Rate	5-15 per 1000
l. Life Expectancy at Birth (1981)	49.9 years ^{2/}
m. Estimated Population under age 15, (1981)	5,647,000 ^{2/}
n. Population Per Physician (1975)	11,227
o. Population Per Hospital Bed (1975)	695
p. National Per Capita Income	\$250

(All data is 1980, unless otherwise indicated).

1/ Data from the Ghana Fertility Survey, collected in 1979.
(All data is from this source unless otherwise stated)

2/ Data from the ALLDATA Currently Available on Ghana report. Published by Economic and Social Data Services Division, Development Information Utilization Service, Bureau for Science and Technology, Agency for International Development, October 5, 1982.

a) The information in this section, prepared for the P.I.D., has been reviewed and considered sufficiently current to be adequate for this PP. The 1984 census was taken in March but no data has been published. Some of the provisional figures have been used in estimating marketing targets for the CSM portion of the project. Although Population Reference Bureau estimates a 1984 population of 14.3 million, the unofficial census figure show 12 million. Pages E-8, E-9 and E-10 have been slightly modified to reflect the most recent family planning use data available and to reflect that the Ghana Family Health Initiatives Project (\$500,000), Regionally funded by ARF/RA, has provided contraceptives to Ghana for the past 2 years. It also notes the consideration of another PHI support for TRA training.

B. Demographic Analysis^{1/}

The rationale for the GOG's population policy in 1970 was that "the size of our present population does not pose immediate problems for us. However, the rate at which the population is increasing, will very certainly create serious social, economic and political difficulties before the turn of the century. If we want to alter the rate of growth, even marginally, in two decades time, we must initiate action now".

The policy emphasizes quality of population rather than quantity of population. It recognizes that birth rates need to be brought down to parallel falling death rates; otherwise "the children of the next few generations will be born into a world where their very numbers may condemn them to life-long poverty". The adverse effect of high fertility on the health of mothers and children and the difficulties posed by unregulated migration are also discussed.

Ghana's 1969 policy parallels in many respects the provisions of the World Population Plan of Action adopted at Bucharest in 1974. The principle elements of Ghana's policy include (1) population policy and program as organic parts of social and economic planning in development activity, (2) reduction of morbidity and mortality, (3) demographic data collection and population research, (4) access to family planning as a basic human right, (5) expanded opportunity for female employment and education, and (6) regulation of migration. To coordinate the prominent role given to family planning in the policy, the GOG established in 1970 the Ghana National Family Planning Program.

According to the 1970 census, about 70% of Ghanaians live in rural areas. Urban population, however, is rapidly increasing. According to one estimate, Ghana's two major cities, Accra and Kumasi, experienced growth rates of 22% and 39%, respectively, from 1966 to 1970. Such explosive urban growth posed serious problems since health and other social services, as well as infrastructure are increasingly strained to meet the needs of urban dwellers, many of whom arrive without the skills necessary to compete in an already tight employment market.

^{1/} Data for this section comes primarily from Prof. S.K. Gaisie, Demographer, University of Ghana, Legon and may be dated. The Mission anticipates that the Contraceptive Supplies project (641-0109) P.P. will be able to utilize more recent data which is now becoming available from the 1979 Ghana Fertility Survey.

Ninety-nine percent of the population is African; the remainder are of European, Asian or Middle Eastern extraction. In 1960, foreign immigrants (mostly from neighboring African countries) composed 12.3% of the population. The Alien Compliance Order of 1969 required immigrants without necessary papers to leave Ghana. The precise effect of the Order on population growth is unknown; however, demographers assume that the once considerable impact on population growth as a result of foreign immigration from neighboring countries has been reduced.

Of the indigenous population, 40% belong to the Akan ethnic group, 12% are Ewes, 12% Mole-Dagbani, 10% Ga-Adangbe and about 5% Grusu. The remainder belong to the Guan, Gurma and Central Togo groups. Over 100 separate subgroups and corresponding dialects exist in Ghana; ethnic boundaries are ill-defined and most parts of the country are ethnically mixed. English is the official language in Ghana and is more prevalent in urban (primarily southern) areas where colonial influence was stronger.

Forty-five percent of the population are Christian. Thirty-eight percent are traditionalist (animist) and 12% Muslim. Seven percent claim no religious affiliation. A relatively high proportion of Christians are in the southern part of Ghana.

In 1970, over 43% of Ghanaians had attended school, a marked and rapid increase from the 1948 level of 4%. The increase was particularly noticeable in urban areas and among males. The majority of rural adults have not received formal education. The Education Act of 1961 made elementary education free and compulsory. In 1969, government expenditure for public education amounted to about 21% of the government's total expenditure budget. Growth of middle and secondary education has not been as rapid, and a lack of secondary level facilities makes it difficult for many to continue education at that level.

In 1980 Ghana's population was estimated to be 11,570,000. The last official census, however, was in 1970 and it will be 1983 before a new census can be mounted. It is estimated that the population has been increasing in recent years at a rate of about 3 percent per annum. Migration from rural to urban areas create increasing problems in urban areas, and there is a growing demand for public services which the GOG is currently unable to provide financially.

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.

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 approximately 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.

Mortality

In the early 1960s, the estimated crude rate was 23 per thousand population and the infant mortality rate was 160 per thousand live births (Gaisie, 1976). By the late 1960s, those figures had declined to approximately 19 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. 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 since World War II and through the early 1950's indicate a slow decline in mortality and a relatively rapid decline immediately thereafter (Gaisie, 1976; 220ff). Gaisie estimates that Ghana's expectation of life at birth was approximately 35.3 years in the 1940s. Life expectancy rose to nearly 40 years in the late 1950s, and then rose again to approximately 48 years in the late 1960s and early 1970s. These figures indicate substantial downward trends in mortality.

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 11.6 million. 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 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. Gaisie estimates that the population expanded at a higher rate in the 1960s, approximately 2.7 percent per year, and, by the 1980s, has now increased to slightly more than 3 percent per year. It is 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.

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 population projections 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 the year 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 the year 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. A reduction of nearly 57 percent by the year 2000 will still generate a population of nearly 18 million.

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 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 say, 36 percent by the year 2000 is possible only if fertility declines more than 50 percent between 1975 and the year 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; 83-98). 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.

C. Population Project History

In spite of Kwame Nkrumah's lack of support for family planning, the results of the 1960 census caused many GOG officials in the government to become concerned about Ghana's population growth rate, the urban and rural distribution of the population, the influence of migration, and unemployment.

Soon after Dr. Nkrumah was ousted in 1966, the new military government made a dramatic departure from Nkrumah's position. The Manpower Board of the Ministry of Finance and Economic Planning was charged to undertake a study of all aspects of Ghana's population. In March, 1968, the study results 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. Ghana became, after Kenya, the second country in Africa to adopt an official policy on population.

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

"...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 on 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 was to coordinate the family planning activities of the Ministry of Health and direct supervision of the Ministry of Finance and Economic Planning. Other ministries involved in the implementation of the program included 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. Nkrumah, deserves much of the credit for creating an initial awareness 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 local IPPF affiliate. 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."

Phase I of the USAID population program support project to the GNFPF began in 1971. Phase II ended in March, 1982. The purpose of this multi-year project was to develop the primary system of a family planning program which would achieve goals enunciated in the national population policy. These 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 its quality of life.

The objective of Phase I (1971-1975) was simply to train Ghanaians and to provide contraceptives to the GNFPF. The four specific objectives of Phase II (1976-1982) were intensive outreach, intensive rural commercial distribution, motivational research, and in-service training. For example, 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 GNFPF nor the Ministry of Health took further action due to transportation and petrol problems, and lack of proper management decisions.

The rural commercial distribution program in the Northern and Upper regions also was not undertaken. Again, management, transportation, and petrol problems influenced this decision. In the area of demographic research, the GNFPF requested proposals, but few ministries and organizations responded. The result was that funds available for this effort were underutilized.

Basically only one objective of Phase II, i.e., multidisciplinary training, was achieved, although some unspent funds even for this aspect were deobligated. Personnel in various ministries were trained, in both Ghana and the United States. In fact, almost half of all projects undertaken included a wide array of training components. For example, nearly 1,000 Ghanaians received specific training in demography, laparoscopy, family planning management, communication, and similar disciplines. Thus, a large corps of trained Ghanaians was

created to provide family planning services: A comprehensive IEC program was also initiated. In addition, "training of trainers" was undertaken and all nine Regions provided in-service training in family planning to MCH and other nursing staff. More than 4,000 graduates of nursing schools received family planning training. A high-level seminar for practical nursing officers and heads of nursing schools was held to discuss ways to integrate MCH/FP and nutrition into the primary health care strategy for Ghana.

It is important to realize that much of the strategy of Phase II training was based on the results of the Danfa research project. That project indicated that services and supplies must be delivered to the people; that integrated MCH/FP is the 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.

The Mission believes that the mix of past projects was appropriate for that period primarily for two reasons: First, when USAID began to provide population assistance, a critical mass of trained manpower did not exist. Secondly, before AID-funded IEC programs were initiated, there was a little demand in pro-natalist Ghana for contraceptives.

Since the project began, 306 new family planning clinics have been registered, and 210,000 new acceptors and 737,000 revisits recorded between 1970 and 1976. Acceptor reports are very sketchy after 1978 due to the fact that GNFPP no longer was able to collect acceptor data. However, data is now becoming available from the MOH which together with the CCG and PPAG appear to be serving from 4 1/2 to 5 percent of the women of fertile age.

There is now growing interest in the MOH in fully integrating family planning into maternal and child health and primary health care services. It would also appear that the MOH is now in a position to ensure that family planning services are offered at all government health institutions. The MCH Division of the MOH has been reactivated and its responsibility is to fully integrate family planning as part of overall MOH services throughout the country. The staff are under the direction of a senior medical officer.

Over the past 12 years AID 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 GNFPP 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.

The table below summarizes total USAID population assistance to Ghana during the past years:

AID POPULATION ASSISTANCE TO GHANA, FY 1968-1979 FUNDS

Bilaterally-Funded

Family Planning and Demographic Data Development, FY 1968-1970 funds	\$240,000
National Family Planning Program Supplies, FY 1971-1972 funds	350,000
Population Program Support, FY 1971-1978 funds	2,750,000
Danfa Rural Health and Family Planning Project, FY 1970-1978 funds (\$1,577,000 health funds also provided)	4,335,000
Population Dynamics Program, FY 1977-1978 funds	600,000
Subtotal	<u>\$8,275,000</u>
Centrally or Regionally-Funded (estimated)	9,300,000
GRAND TOTAL	<u>\$17,575,000</u>

The most recent USAID assistance was through the Ghana Family Health Initiatives project which provided \$500,000 of contraceptives for the MOH/CCG/YMCA program during the period 1/83 through 6/84. At this time consideration is being given to Ghana as one of the sites for a Regional FHI (698-066.24) support for TBA training. This would be quite supportive of the objective of this contraceptive supply project.

USAID has provided most of the contraceptives distributed by the program. To date approximately 10 percent of the population desire to use contraceptives and there is a reasonably large number of people who understand modern contraception. However, despite the expansion of service and the development of new outreach activities, targeted levels have not yet been reached, nor has the demand for services been met. Therefore, family planning efforts in Ghana, based on the Population Program Support objectives of Phase I and Phase II, still have yet to be achieved. However, it is important to emphasize that USAID was providing population assistance during a time of political upheaval, economic instability, and rampant inflation. In this difficult environment, one can say that the GNEPP should be given credit for having at least maintained the government's population policy framework in spite of changes in governments and a deteriorating national economy.

POPULATION POLICY IN GHANA RELATED TO FAMILY PLANNING

Ghana has traditionally had one of the more positive approaches to population policy and Family Planning in West Africa.

The Ghana Population Policy Statement of 1969 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 programs will be educational and persuasive and not coercive."

This policy has been built on a rationale similar to statements expressed in the conclusions of the Parliamentary Conference on Population and Development held in Nairobi July 6-9, 1981 and attended by 60 Parliamentarians from approximately 30 African countries:

"Family Health which is basically concerned with human fertility, reproduction and growth and development addresses a variety of problems, the most important of which are high fertility, maternal age, the number of children at each stage of maternity and birth spacing, as well as high infant and young child mortality related to the above mentioned causes and to malnutrition, poor environmental sanitation and communicable diseases."

This emphasis is underscored by the Paper presented for that conference by Dr. Fred Sai, a prominent Ghanaian physician. Excerpts follow:

* FAMILY PLANNING

A problem which needs to be more seriously addressed in Africa is family planning. Family planning is not the same as population control, though family planning methods can help with population regulation. Family planning is a powerful tool for reducing mortality and improving the health of mothers and children. Family planning should have the following aims and objectives:

1. To enable women to postpone child bearing until they are at what is biologically and socially the most suitable age for child bearing.

2. To enable women to space their children at no less than two-year intervals, preferably 3 to 4-year intervals to enable adequate lactation and breast feeding of the child, adequate weaning and adequate replenishment of the mother's nutrients level.
3. To enable women to stop child bearing when they have had the desired family and certainly when their age is 35, after which the problems of bearing children become so very much more serious than in the younger ages.
4. And family planning should also be able to help with the problems of infertility and be involved in programmes such as counselling and preventive services."

"If family planning programmes are to succeed, and really be implemented properly, then they should be involving the consumers, i.e. the women and the fathers, even more than they have done in the past. Family planning programmes that are oriented and based on medical prescription can certainly do no more than reach the elite. It is necessary that all the other programmes mentioned, and particularly those of family planning, become a social concern of the community at large so that they can be undertaken in such a way that all community resources can be used and the medical services will become a back up force for the programmes."

These relationships, though stated for that conference in continent-wide terms are particularly relevant for Ghana according to the document of the Ministry of Health, "Review of the Maternal Child Health and Family Planning Programmes (MCH/FP) in Context of the Primary Health Care (PHC) system in Ghana." (Boohene, 1980)

"Maternal, Child Health and Family Planning Services are made up of all the programmes that bear on the health and social well-being of mothers and their children with the ultimate objective of safeguarding the full potential of the next generation of citizens of a country."

The estimated population in 1980 is 11,573,812 (Gaisie)^{1/}. The infant mortality rate is about 122 per thousand live births. The life expectancy is about 48 years. The birth rate is about 48 per thousand population (Gaisie). Maternal Mortality Rates (M.M.R.) 5-15 per 1,000 (births), and the crude death rate 19/1,000 (population) (Gaisie). Growth rate is about 3% per year.

"The estimated population for 1985 is 13,547,991 (Gaisie); this shows an increase of two million in the population within five years (1980-1985). This in actual terms increases the pressure on developing health services which interpreted into action means quadrupling of institutions, facilities, personnel and expenditure at the very least."

^{1/} Prof. S.K. Gaise, Demographer, University of Ghana Legon.

The stated actions of this program as found in the referenced document of the MOH include:

"The staff at a static (fixed) center has the obligation to provide adequate MCH/FP services for the population living within five kilometers radius of the institution. Whenever the transportation system and the staffing structure permits, a Health Station should also provide field MCH/FP services for up to 10 nearby villages with a population of 200 and above.

"Health Center/Post (Health Station) has the obligation to provide the following minimum types of activities daily:

- immunization
- growth monitoring (weighing)
- antenatal
- intrapartum
- postnatal
- family planning
- nutrition and health education
- curative"

In describing the activities of the MCH center, which essentially is Level B of the health system, the following programs are identified as obligatory:

"Maternal Health Care - Obligatory

- antenatal with immunization
- post-natal with immunization for the newborn
- family planning
- TBA and midwives inspection

"Child Welfare Programmes - Obligatory

- immunization
- growth monitoring
- health and nutrition education"

Thus GOG population policy and the rationale and policy of the Ministry of Health for delivery of family planning services is further clarified in the following excerpts from the MOH level "A" training manual most relevant for the personnel and activities of this project.



REPUBLIC OF GHANA

MANUAL 'A'

FOR HEALTH WORKERS AND SERVING PERSONNEL & BASIC AND AUXILIARY
NURSING SCHOOLS

MATERNAL CHILD HEALTH/FAMILY PLANNING DIVISION
OF THE MINISTRY OF HEALTH

AND

DANFA COMPREHENSIVE RURAL HEALTH AND FAMILY
PLANNING PROJECT—DEPARTMENT OF COMMUNITY
HEALTH—UNIVERSITY OF GHANA MEDICAL SCHOOL

II. NATIONAL AND MINISTRY OF HEALTH FAMILY PLANNING POLICY

Objectives.—At the end of this section the trainee should be able to:—

1. Discuss the major aspects of the Ghana Government's official policy statement on Population Planning.
2. Explain the steps the Ministry of Health is taking to integrate family planning into all MCH services.

Lesson Content

1. Government Policy

The population of Ghana is the nation's most valuable resource. Although Ghana is not over-populated now its welfare is being endangered by the rate of population growth. This is occurring because the death-rate is falling rapidly whereas the birth-rate has continued at one of the highest levels in the world. As a result Ghana is now producing more children than it can comfortably provide for in terms of education health care, and jobs.

In order to assure the highest quality possible for its population the Government of Ghana in 1969 decided that there would be a national population policy and programme that would be developed as organic parts of social and economic development and with close linkage to the national health programme.

The policy is to support means to reduce the still high rates of illness and death, a desirable end in itself and one that must be pursued along with measures to reduce high fertility. Recognising the crucial importance of a wide understanding of the bad effects of unlimited population growth, and of the means by which couples can safely and effectively control their fertility, the Government encourages and itself undertakes programmes to give information, advice and assistance to men and women who wish to space or limit their reproduction.

2. Ministry of Health Policy

A. It is the policy of the Ministry of Health that Family Planning is an essential part of maternal and child health and is an important factor in the attainment of social wellbeing.

B. Training

1. Family Planning should be incorporated into the curricula of all health training institutions at the appropriate level depending on the functions of the personnel on completion of studies.
2. In-service training in family planning should be given to all health personnel according to their level of training. The ethical and religious persuasion of the health workers being trained in the promotion and delivery of Family Planning services should be respected.

D. Co-ordination

The person in charge of MCH services in an approved institution is to be the co-ordinator for family planning services.

E. Personnel

All health workers who have obtained training in family planning should deliver family planning services.

F. Services

Family Planning services shall be offered in conjunction with other health services (e.g. child care, maternity care, T.B. care, etc) in all Ministry of Health approved institutions (e.g. Health Centers, Health Posts, etc.)

Family Planning services to be provided will be:

1. *Education*—for both men and women on family planning.
2. *Motivation*—for the acceptance of a method.
3. *Selection*—of a method under guidance.
4. *Prescription*—of method chosen, and
5. Follow-up and /or referral of clients.

G. Bank-up

Each health facility will provide care for problems associated with or arising from the use of family planning methods. Staff should consider it their duty to see to all such problems whenever approached: either dealing with it themselves or referring it to other health facilities. A satisfactory referral system should include:

1. Prior arrangement with the nearest capable health facility.
2. Ministry of Health workers feeling free to refer cases to voluntary agencies or other clinics when necessary and also accepting referrals from these.
3. Mechanisms for feedback on findings and treatment to the referring facility.

H. Reporting

A report on family planning activities is expected in the quarterly MCH reports of all workers giving family planning services including:

1. Number of staff delivering the services.
2. Number of people motivated.
3. Number of people accepted.
4. Number of people referred.
5. Number of acceptors for each method.
6. Number of revisits.

Exercises

1. Prepare a discussion that you will lead with your colleagues on the Ghana Government's population policy.
2. Prepare a talk you will deliver to a health center staff explaining how the Ministry of Health plans to integrate family planning into MCH services.

III. RATIONALE AND MOTIVATION FOR FAMILY PLANNING

Objectives

At the end of the training programme the health worker will be able to:

1. Demonstrate an awareness of the health benefits of family planning.
2. Demonstrate an awareness of the effects of rapid population growth.
3. Demonstrate an awareness of the advantages of family planning to the family and the nation.
4. Motivate men and women to accept family planning.

Lesson Content

Objective 1

At the end of this section the health worker will be able to demonstrate an awareness of the health benefits of family planning by listing at least three health benefits of family planning to the mother and at least three health benefits to the child.

When men and women practise family planning, they use various methods to ensure that they have the number of children they want when they want them. There are several reasons why it is a good idea for men and women to adopt family planning:

A. First, there are health benefits to the mother

1. Every pregnancy carries the risk of death. Thus, the fewer the number of pregnancies the fewer times she will be put at the risk of death.
2. The risk of death is greater when the interval between pregnancies is less than two years. Thus, family planning can ensure a proper interval and reduce this risk.
3. The risk of death is greater for pregnancies in older women (over 35 years) or of high parity (6 or more pregnancies). Thus, again family planning can ensure that these women do not become pregnant if they don't wish to.
4. In Ghana many women die each year from septic abortion which they have sought in order to avoid an unwanted pregnancy. These women can avoid unwanted pregnancies through family planning practices.
5. Women who have too frequent pregnancies get nutritionally deprived and age more rapidly. Therefore, adequate spacing will allow the mother to regain her nutritional status.
6. The mother will have enough time to recover physically and emotionally after every pregnancy.

B. There are also health benefits to the child:

1. Adequate spacing will help to ensure a healthy foetal development
2. The risk of malnutrition due to premature weaning will be avoided.
3. The risk of infant death is less when the interval between pregnancies is more than two years, the mother less than 35 years of age and of parity less than 6. Thus family planning can ensure these lower risks.
4. The mother will have time to help with the child's intellectual development.
5. The mother will have adequate time to bring the child to health facilities for adequate preventive and curative care.

Objective 2

At the end of this section the health worker will be able to demonstrate an awareness of the effects of rapid population growth by listing at least three disadvantages in countries with rapid population growth.

Effects of Rapid Population Growth

Disadvantages of rapid population growth in a country include:

1. Difficulty in raising standards of living or family income because a constantly larger number of people must be fed, clothed, and housed.
2. Difficulty in providing enough food for the rapidly expanding population.
3. Difficulty in providing social amenities such as schools, water and medical care for the expanding population.
4. Difficulty in providing jobs for the expanding work force.
5. Crime and social unrest may develop in crowded urban areas.
6. Environmental pollution, especially in crowded urban areas.

Objective 3—Advantages

At the end of this section the health worker will be able to list at least three social and economic benefits of family planning to the family and at least three to the nation:

(a) A family who practises family planning will be able to:

1. Spend greater portion of its income to educate each child.
2. Allow the mother to have more time to work and supplement the family income.
3. Save money to afford better housing and generally improve the standard of living of the family.
4. Save money for the future; for retirement.

(b) A country where family planning is being practised will be able to:

1. Save some of its national income to expand industry and agriculture.
2. Provide enough food for the population and perhaps some for export.
3. Provide sufficient jobs for its workers.
4. Provide adequate social amenities such as schools and medical care.
5. Control environmental pollution.

Objective 4

At the end of this section the health worker will be able to motivate men and women to accept family planning.

Sub-objective A

At the end of this section, the health worker will know how to reach men and women in need of family planning.

There are many situations where the health worker comes into contact with men and women who may be in need of family planning. Some of these situations are:

1. Child welfare clinics
2. Post-natal clinics
3. Ante-natal clinics
4. Out-patient clinics
5. Hospital wards
6. Home visits
7. Women's groups, religious groups and other society meetings
8. Group discussions and health talks
9. Waiting rooms
10. Talks with friends.

How people can be reached

In every community there are "Opinion leaders". These leaders are often turned to by the people for advice on particular subjects and may be different people for different subjects. Opinion leaders on the subject of family planning could be sought, then educated and motivated about family planning. They would then help spread the information.

There are also a few people who have a great deal of power in every community and people often do what these people tell them to do. Examples of such people are chiefs and other village leaders, village representatives, rich people and people who have a lot of workers under them. Such men and their wives can easily help spread information. However, a health worker should not associate himself completely with such powerful people nor give them special favours or else the poor masses will lose trust in them.

Another way of reaching the people is through personal influence. With this, each person that hears about family planning confides in at least one other person. The subject spread easily through this method. The health worker might encourage this flow of information by suggesting to people to discuss the subject with their friends, relatives, spouses and neighbours.

Human nature is such that people are interested in discussing anything that might make their own sex life more rewarding. When you discuss family planning openly and naturally, people will be encouraged to express their natural curiosity thus making them understand the subject better.

Furthermore, the idea that family planning can help people solve some of their family problems can motivate them to accept it. If a man's immediate problem is about his wife's health then telling him that family planning will help may make him adopt it. Really, find out their family problems and tell them how family planning can help solve those problems.

Sub-objective B—Communication

At the end of this section, the health worker will know how to communicate the message of family planning to men and women.

There are several methods through which the family planning message could be communicated to men and women. Some of these are:

1. Individual counselling during contacts with people in appropriate places.
2. Home visits to discuss family planning.
3. Holding public meetings about family planning.
4. Conducting family planning discussion groups.
5. Working through organizations, "opinion leaders" and "influential people" in the community.

The health worker in these situations acts as the link between the radio, newspaper, television, written articles in magazines and the ordinary man and woman who wants to learn about family planning. Visual aids and role playing situations could be used to explain things further to men and women.

Sub-objective C—Helping men and women accept family planning

At the end of this section the health worker will know how to help men and women to accept family planning.

The following are ways in which the health worker can help men and women to accept family planning:

- 1 Teaching the facts about family planning; It is obvious that if people do not plan their families, they will usually have large families which might lead to many family problems. Health and socio-economic benefits of family planning would be lost. To help people accept family planning, the health workers should tell them facts about the methods involved, how the methods work and the advantages and disadvantages of each method. Furthermore, they should be told the health and socio-economic benefits gained by the family and the nation.

2. **Motivating people.** A person will have to be motivated to accept family planning. This means that he must feel the need for the advantages derived from family planning. To be motivated he must understand the benefits that family planning will bring him and his community and recognize the benefits as desirable. Try to find out the needs and wishes of the people and then help them see how family planning can help them meet these needs. Really, you must try to weaken the motives for having large families whilst strengthening the motives for having small families.
3. **Promoting trust, confidence and belief in family planning.** If a person does not believe what he is taught he will not adopt it. It is up to you to present your information in such a way that people believe and trust you. You must be unhurried in your approach. You must try to answer their questions honestly and completely and make them feel you are responsible and understanding. Do not exaggerate the advantages of family planning, practices and tell them frankly about the disadvantages of the various methods. Patience and good knowledge of family planning will help promote trust.
4. **Dispelling fears and rumours about family planning:** Listed below are a few fears and rumours and how to dispel them:
 - (a) **Fears of permanent damage to health from prolonged use of the pill, IUD or other contraceptives.** Many couples often fear that the use of pills, IUD or injections for a prolonged period will cause permanent damage to their health. Some of these fears are:
 - (1) Fear of cancer
 - (2) Fear of sterility
 - (3) Fear of damage to vital organs or of fatal circulatory disorder
 - (4) Fear of body disfiguration
 - (5) Fear of migration of the IUD
 - (6) Fear of loss of sex drive
 - (7) Fear of deformed children in case of accidental pregnancy.

Solution to the Problem

Often these fears are not untrue but are distortions, exaggerations or a wrong interpretation of medical problems. The only solution to the problem is telling the people the truth. The health worker can help by reaching them in their homes or community and telling them the truth. The people should be told that there are some contraindications for the contraceptives but family planning personnel make sure that clients have none of the contra-indications before prescribing the methods.

- (b) **Fears of the short-term side-effects of the pill and IUD.** There is often exaggerated, distorted and untrue information about the short-term side-effects of the pill and the IUD. The side-effects include:
 - (1) Discomfort
 - (2) Skin pigmentation
 - (3) Effects on milk supply
 - (4) Weight gain
 - (5) Growth of body hair.

Solution to the Problem

To solve this you can help replace exaggerations and wrong information with facts. Admit the existence of side-effects and teach them how to deal with these side-effects.

- (c) **Inadequate communication between husbands and wives about ideal family size, spacing, contraceptive methods, whether to practise family planning, and infidelity.**

Inadequate communication is an obstacle to the acceptance of family planning and may be due to:

- (1) Sex shyness
- (2) Lower social position of wife
- (3) Traditional behaviour—where there is less communication between husbands and wives, and husbands make the major decisions alone.
- (4) Traditional behaviour—where it is unusual for couples to discuss in advance the number of children wanted and their spacing.

Solution to the Problem

There could be a campaign geared towards the promotion of husband—wife communication for family planning. Tell them it will be better if they discuss problems of child rearing and took decisions together. They should also try to discuss in advance the number of children wanted.

Furthermore, there is no scientific evidence that women who practise family planning are more likely to be unfaithful. Argument contrary to this can be used to disprove such rumours—some of the arguments are:

- (1) If a woman is happy in her marriage she is less likely to be attracted to other men. A woman whose husband keeps her pregnant all the time, overworked getting old and ugly before her time, is tempted to run away. The younger she is, the greater the temptation. If you have a young bride, one of the best ways to keep her faithful and loving is to space your children.
 - (2) There are many ways to avoid pregnancy. If your wife wants to have an affair with another man, she knows how to avoid pregnancy without necessarily using a modern method or the man may use something. Don't blame family planning if you are unable to keep your wife's affections at home.
 - (3) Most men who suspect their wives of infidelity probably have an unhappy marriage on other grounds. One party or the other is probably tired of the marriage and showing displeasure. Usually a man suspects infidelity only if the marriage is in trouble.
- (d) *Negative influence of peers and elders.*—Many couples do not adopt family planning because they believe persons whose opinions they value most will disapprove of it.

Secondly, there may be group pressure against adopting family planning in many societies. Thus men and women may not be free to adopt family planning even if they want to.

Solution to the Problem

- (1) Appeal to the entire group to consider their attitude.
- (2) A group discussion with a skilled leader can help solve the problem.
- (3) Convince men and women that once they start practising family planning they will gradually overcome the pressure.
- (4) An individual who practises family planning despite the pressure can be used to influence the others.

(e) *Anxieties about contraceptive failure.*—One of the major problems is about women who, though they are using a family planning method, become pregnant. This leads to anxieties since one does not know what will happen.

Solution to the Problem

- (1) Try and convince the people that the methods are not 100% reliable. Though some are more reliable there could still be accidents.
 - (2) Emphasize that the accidents are rare with proper use of the method
5. *Making family planning socially acceptable.*—Before a person adopts family planning there is often the feeling of making sure that some of the people he respects will not disapprove of it. Thus it is better to talk with influential people or opinion leaders in the community and convince them about family planning first before including other people. Encourage open discussion of the subject to make it socially acceptable.
 6. *Helping people decide in favour of family planning.*—A person must feel that family planning is a good thing before he adopts it and you as the health worker can help him. You can help him decide in favour of family planning by showing him how the use of a method is linked to other things he desires like good education and maternal health. A suggestion that they discuss family planning with their spouses and closest friends will be of big help since such informal discussions can easily change people's minds.
 7. *Helping people apply the family planning message to themselves so they realize that it is up to them to obtain family planning supplies and use them*
The people must be made to feel that if they are to have the benefits of family planning they must seek out the supplies from village health workers, family planning clinics, health centers or pharmacies.
 8. *Making sure that men and women continue using family planning methods successfully.*
They must be made aware that they must continue to use the methods faithfully and to get more supplies before the old ones are finished, otherwise accidental pregnancy will occur.

Exercises:

1. List 3 health benefits to the mother and to the child as a result of practising family planning.
2. List 3 disadvantages of a rapid population growth to any country.
3. List 3 social and economic benefits of family planning to the family.
4. List 3 social and economic benefits of family planning to the nation.
5. List 5 situations where the health worker comes into contact with men and women who may need family planning.
6. Discuss 3 ways through which men and women can be reached for motivation.
7. List 5 situations during the course of your work with patients where it would be appropriate to introduce the subject of family planning with patient.
8. List 4 ways in which the health worker can help men and women to accept family planning.
9. In your home community who will serve as an opinion leader for family planning?
10. Prepare talk about F.P. that you might give to assembled villagers in a village near your place of work.
11. Prepare your approach to motivating a woman to accept family planning in the health service you are now working in. You will be asked to motivate such a woman in a role playing situation.

Financial - Rauch

Economic Analysis

Review of the economic considerations of this project concluded:

(1) In the public sector the lowest cost service delivery modality consistent with administrative and cultural constraints is being utilized. Using the MOH drug distribution system to carry contraceptive supplies will not increase total distribution costs since it is presently under-utilized. Reorganizing the delivery model in existing clinics will improve efficiency and bring additional personnel into family planning delivery without increasing costs.

Greater emphasis on CBD programs can be more cost effective in the future but is not practical at this time. First, the MOH must more fully utilize its present MCH/FP system. It will have difficulty in expanding the current logistics and supervisory network to include greater expansion of CBD than is planned until the clinical system becomes fully functional. In the MOH system, this project emphasizes the lowest cost technology (orals, condoms, foam) requiring the least training and equipment. These services can be provided by community health nurses and health brigade. Services can be increased with very little additional cost.

(2) In the private sector the implementation of a contraceptive social marketing project is a highly cost-effective manner to expand contraceptive use. The efficient use of commercial distribution and marketing resources creates the opportunity for (a) rapid product outreach at low cost; (b) moderate overhead costs; (c) reliable resupply to sales points at low cost; (d) moderate costs for expanding product awareness; and (e) steady build up of sales compared with other program modalities.

(3) The costs of external inputs are relatively inexpensive to achieve the results expected. It is impossible to make a meaningful analysis of the local costs of the project to compare with similar projects in other countries. Also, to disaggregate the cost of family planning as part of the MCH program is difficult, although the MOH estimates that 30 percent of MCH work is devoted to family planning.

We have looked at the Couple Years of Protection expected and related it to the value of U.S. foreign exchange. U.S. inputs of approximately \$7.5 million will be utilized to produce approximately 540,216 Couple Years of Protection during the life of this three-year project. This cost of \$14 per CYP in external assistance appears reasonable in the light of conditions in Africa.

(4) The recurrent cost considerations for the GOG are minimized as few additional personnel are to be added; no new

facilities are to be constructed; cost recovery elements are included through patient charges; management training should lead to the more efficient use of resources and reductions in birth rates will diminish the rate of growth in demands on the health system.

(5) This minimal investment by the U.S. government in family planning builds on past USAID population efforts over the last 12 years. It is a cost-effective use of development resources. This is particularly true at this time when it is difficult in Ghana to achieve results with other developmental efforts. It will remain true throughout our future development assistance relationship to Ghana, when actions to reduce population growth rate will enhance the impact of other projects on the quality of life and when reductions in population growth will reduce the problem of long-term dependency.

In addition, the Mission has reviewed the papers presented by Speidel, Gillespie, Bertrand, Blumfeld, Nortman and Ojeda at the International Conference on Cost Effectiveness and Cost Benefit at St. Michaels, Maryland, August 17-20, 1981. Additionally, we have reviewed two reports of APHA contracts:

- Economic and Social Benefits of Family Planning to Guatemala: Horlacher, 11/19/79, and
- "A Cost-Benefit Analysis of the Proposed Jamaican Family Planning Project."

The papers from the Cost Effectiveness Conference provide information from other country programs that confirm our conclusion that the cost of service projected in the PP is within the range of average costs of other programs. The two APHA reports confirm our conclusion that the long-term socio-economic benefit of reduction in fertility has already been more than adequately justified in countries similar to Ghana based on their state of development. We are aware of some of the recent literature suggesting that with human resources as essential as they are to development, efforts to slow their growth may be uneconomic. Our contention is that, human rights and health reasons aside, this position could only be considered when a society is marshalling and using its resources in a reasonably efficient way which produces economic growth in balance with population growth -- a condition not prevailing in Ghana's current economy. When additional hands cannot be engaged effectively in production, the demands they place on society are greater than the contribution they make.

Obviously, one could seek more precision. However, we believe the benefits in reducing social investment costs, alleviation of rapidly growing requirements for food, shelter, and energy, and lessening the pressure for more jobs so clearly outweigh the relatively modest cost of a family planning program that additional analysis of a cost-benefit nature is not necessary.

Social Analysis^{1/}

Ghanaians have traditionally desired large families, as reflected by one of the highest fertility rates in the world. The Danfa baseline KAP survey confirmed that, at the time it was carried out, the desired completed family size was still quite large. The mean number of desired children for men was 9.8 and for women 6.6 children. Nevertheless, there were indications of a change in attitude towards control of fertility. Whereas studies conducted in 1965 showed that only 8% of women in the Accra rural area approved of family planning, 72% of the Danfa baseline sample expressed approval. Knowledge about family planning had also increased with 65% of respondents reporting knowledge of the pill. However, use of modern family planning methods was minimal. Only 7% of couples reported ever using a modern method previously. The most common source of information about family planning was reported to be word of mouth from friends and relatives in the village (72%).

Sociocultural patterns are undergoing rapid transition in rural Ghana and, therefore, a number of factors associated with fertility and contraceptive behavior were investigated by the Danfa project.

MARITAL PATTERNS

The Danfa project investigations indicated that marriage in the survey area is a fluid relationship with stages of mutual consent and marriage by customary rites. Cohabitation by mutual consent is generally the initial marital state, and is normally followed within a few years by customary rites. Under 2% of marriages were formalized by civil registration or church services.

Remarriage rates are high among women during their reproductive years and among men at all ages. Of those ever married, 49% of men and 40% of women had been married two or more times. Almost all Ghanaian women marry at some time. By age 25, over 90% are married, and by age 40, 99%.

Marital instability was found to lower a woman's fertility performance but to increase the final number of children a man produces. Polygamy was also associated with reduced fertility performance in the woman.

The mean age at first marriage for women was 18.4 and for men 25.2 years. Increased age at first marriage of women was associated with lower fertility. The survey showed that the percentage of women marrying before age 20 had not been falling in recent years. In fact, early marriage was reported more frequently in the age group below

^{1/} Much of the data in this section is taken from the Danfa Project Final Report, UCLA and UGMS.

30 years than over 30 years. About two-thirds of ever-married women below age 30 were married by age 20. If it is actually occurring, a decrease in the median age at first marriage would be a factor tending to increase fertility rates. Although increased age at first marriage was associated with lower fertility, it was also associated with decreased polygamy and decreased marital instability. This suggests that the full impact of an increase in the age at first marriage on lowering fertility might not be realizable.

AGE AND SEX

In the Danfa Project district the age of menarche has been steadily diminishing over the past decades due to better nutritional status of young girls. The Danfa baseline KAP survey showed that the average woman reported menarche at 15 years, was married at 18 and had her first pregnancy that same year.

In the 1972 Danfa baseline Family Planning-KAP survey, males in the Danfa Project district desired an average of 9.8 children and females an average of 6.6 children. Both males and females in the younger age group wanted fewer children. However, both age and sex relate to other factors such as education (males, and particularly young males, are better educated throughout Ghana), and marital patterns. There was no sex preference among women but men desired three sons for every two daughters.

There was little sex differential in approval of family planning found in the Danfa baseline KAP survey with 72% of both males and females reporting approval. While reported knowledge of family planning was extremely high among respondents in the Project's baseline survey, their use of common modern methods was low--only 5% of females and 19% of males had practiced some form of contraception before Project activities were introduced.

EDUCATION AND FERTILITY

Education has long been recognized as a major sociocultural change agent. Educated persons are generally more mobile, with a greatly increased chance of exposure to innovative ideas such as limitation of family size.

Education is highly regarded throughout Ghana; the effort to educate all children has received greatest attention in the south. Not surprisingly, level of education was found to be related to reproductive behavior and attitude in the Project's baseline survey. The more educated the respondent, the more approving was that respondent toward smaller families. However, only after middle school level is attained do respondents exhibit a desire for fewer children and a significantly higher level of approval of family planning. Since these more highly educated persons may also tend to migrate to urban areas it is difficult to predict whether improved opportunities for rural education will affect future attitudes about family planning.

RELIGION

The Danfa Project's baseline KAP confirmed a relationship between religion and reproductive behavior. Christians who composed 51% of the sample were more supportive of smaller families than Muslims or traditional believers. Christians also had the highest level of approval of family planning (74%) of the religious groups. However, religion and educational levels are believed to be interrelated in Ghana: much of the education in Ghana has been sponsored by the Christian churches, and Christians exhibit higher levels of education than other groups. The Church Council of Ghana has also been actively supporting family planning activities since 1960.

OCCUPATION

While the net effect of husband's occupation on his family size desires has not been found to be significant, the data revealed a significant relationship between occupation of the wife and number of children desired by her. But a wife's reproductive norms are lower only when she is engaged in non-farming occupations. Thus, if employment opportunities outside the home are provided to the women, this might bring about a change in their attitude toward large families, which may be instrumental in lowering the actual fertility levels.

PARITY AND NUMBER OF LIVING CHILDREN

Danfa baseline and subsequent KAP studies have found a significant relationship between number of living children and additional children desired. The more children a couple has, the less likely they are to want additional children, such that 39% of women with five or six children want no further children. Also, the net effect of infant and child loss was positive and significant on the desired number of children. Female approval of family planning was fairly uniform irrespective of the number of their pregnancies.

ETHNICITY

The Danfa Project population is comprised mainly of Ga, Ewe and Akan tribes. In the 1972 baseline survey, the only ethnic differentials noted were in family planning use by females under age 30. Ewe and non-Ghanaian women in this age group reported only half the use of contraceptives as that reported by Ga and Akan respondents. The Ewe's and non-Ghanaians are more recent arrivals in this area, are chiefly engaged in subsistence farming, and generally hold more traditional attitudes than the Ga and Akan.

OTHER FACTORS

Some women, unfortunately, find that they are unable to have any children. It was found that 2% of women in the Project district suffer from primary infertility; that is, by age 45 they are unable to conceive even once. Another 4% suffer from secondary infertility. They are able to conceive but are unable to produce a live birth by age 45. A high percentage of the infertility results from tubal scarring due to pelvic infections. For many of these women infertility is a life-long curse since the society places such a high regard on a woman's ability to bear children. In traditional Ga culture infertile women were often scorned and ridiculed and, although this is probably diminishing, it still represents a heartbreaking problem for most.

Danfa demographic studies have shown that the average woman has seven or eight live births by the end of her child-bearing years. One or two die in early childhood leaving her with five or six living children. The mean birth interval is about 30 months. Breastfeeding is practiced in almost all cases and lasts for about 16 months if a pregnancy does not supervene, in which case the woman usually abruptly weans the child. In one Project survey of non-acceptors, it was found that abstinence only lasts five months. An examination of acceptor registration forms containing information about pregnancies occurring before starting family planning showed that the risk of conception after a live delivery is at least 10% by 12 months, 33% by 18 months and 50% by 24 months. The result is a fertility rate among the highest in the world with three of every ten women aged 20-40 delivering a child each year.

TRADITIONAL CONTRACEPTIVE PRACTICES

In spite of a very pronatalist tradition, there were many situations in which couples have tried to limit their fertility. The most common reason was to ensure an adequate spacing between births. Although women may not have been aware of its anti-fertility effect, breastfeeding has been, and still is, the most important child-spacer in countries such as Ghana because of the anovulatory effect of lactation hormones. Abstinence (after childbearing) was another method and, although it may now have only minimal impact because it occurs early when the anovulatory effect of lactation is strongest, it may have been more important formerly in the Danfa Project district and may still be in other parts of Ghana and West Africa where it is continued for longer periods.

The next most common method of contraception used traditionally has been rhythm. In a recent Project study rhythm was used in 18% of all birth intervals. However, ideas of what constituted the "safe period" of the menstrual cycle varied widely and two-thirds of traditional midwives interviewed gave times for safe period that fell wholly or partly into what is scientifically considered to be unsafe periods.

Despite this, respondents in the Danfa survey reported rhythm to be rather effective, with an accidental pregnancy rate of only 8 per 100 women-years use. It may be worthwhile to investigate in greater detail the nature and impact of rhythm and other traditional methods of fertility control in rural Africa.

Withdrawal is used only rarely but abortion is not uncommon and 4% of Danfa acceptors reported that they sought abortion for pregnancies occurring after the start of contraception. Illegal abortion performed by untrained personnel is a major problem in rural Ghana and is one of the leading causes of death on the Gynecology Wards of Korke Bu Hospital.

MOTIVATING FACTORS OF ACCEPTANCE

It is commonly assumed that birth spacing for better child health is the most common motivating reason for the acceptance of family planning in Africa. In fact, two-thirds of Danfa female acceptors did say that they accepted in order to space births but one-third said they accepted either to delay their first pregnancy or to stop having children entirely. However, the health of the child was not the most common reason women gave for using contraceptives. Rather, it was to protect their own health. The second most common reason was freedom to work or study, and to have an older child to help look after the next baby. Health of the child was only the third most common reason given.

The most common reason for family planning acceptance given by male respondents was the improvement and preservation of the health of their children. The next most important reasons were prevention of an unwanted pregnancy for freedom to work or study followed by preservation of the health of the mother. Better ability to educate the children was the fourth most common reason given by both men and women.

The integration of health with family planning services undoubtedly assists in increasing the acceptability of family planning in Africa. The Danfa project indicated that in the test Area I where a comprehensive health care program was provided (having all services, including family planning, similar to a primary health care approach using outreach workers), the acceptance rate was 18 percent. In Area II where health education, family planning, and other MOH services were based primarily on a clinic setting, the acceptance rate was 9 percent of the population.

This proposed project has a combination of both clinic (MOH) and outreach (Christian Council and YMCA). Based on the Danfa experience, it is the Mission's view that refilling the pipeline

for these two programs should see an increase in acceptor rates from the present 6-8 percent to roughly 11 percent by 1986. The eventual development of a national primary health care program, having family planning and outreach to the Level A (village) level would hopefully further increase acceptor rates to the 18 percent recorded in Area I of the Danfa project area by 1990.

At this time the USAID Mission is anticipating a follow-on project which will include a component for outreach to the level A (village) clinics as well as commercial retail sales activity primarily for urban areas of Ghana through private sector resources.

Implementing Agencies -- MOHA. Ministry of Health1. Description:

Following is a description of the salient features of the nationwide health system for which selected family planning inputs are to be provided by this project. The impression should not be that these services will be provided in a vacuum. They will be part of the Ministry of Health system of MCH care. Some of the problems that are encountered in the system include inefficient bureaucratic procedures, lack of supplies, shortage of funds, and low salaries and morale. Yet it does maintain a network of facilities that continues to provide substantial patient services.

In 1980, throughout the system there were reported:

307,754 - persons hospitalized (1977)
 6,431,470 - outpatient consultations
 691,933 - attendance at prenatal and well
 baby clinics
 41,590 - post natal consultations
 83,920 - deliveries in hospital and centers

The following excerpt from a UNICEF report indicates the magnitude of the system:

The Government Health Services

"The Government is by far the largest provider of health services ... "

Table XI.48: Health Institutions and Beds

<u>Institution</u>	<u>1976</u>	<u>1978</u>	<u>1981</u>
Regional Hospital	9	9	9
District & Quasi			
Govt. Hospitals	51	51	58
Mission Hospitals	34	34	31
Mines & Co. Hospitals	16	16	16
Psychiatric Hospitals	3	3	4
Leprosaria	6	6	6
Health Posts &			
Centres	118	120	230
Beds and Cots	16,871	17,305	20,582

Source: Ministry of Health.

"Table XI.48 indicates that the developments over the last 20 years have been in the direction of health centres and health posts as was recommended by the Brachott Report , but as will be demonstrated later this does not mean that enough resources had gone into rural health. Indeed, the modernisation of the urban hospitals had been a major constraint."

Source UNICEF Ghana
Situation Analysis of Women
and Children July 1984

There are in this system 10 Health regions, each comprised of from three to ten districts - a total of 68 districts nationwide. (One recently formed region and 3 new districts don't appear in all the statistics following).

In most districts there is one or more medium size (100 beds +) hospitals (a total of 105 nationwide). These are run directly by the Ministry of Health (54), Quasi-governmental agencies (18) or by a missionary group (31) linked in some way to the Ministry system. This Level C of attention is responsible for curative, preventive and promotive health activities in the district. A full range of family planning services are available at this level as supplies permit.

Within each district there is one or more Level B health centers and/or health posts located in a village of several thousand population and serving an immediate population area of about 20,000 - 25,000. These centers have 5-8 maternity beds, several consultation rooms and some housing for staff. There are approximately 306 of these centers functioning. They are staffed by a medical assistant, nurse mid-wives, enrolled nurses, community health nurses and environmental health inspector assistants. They provide services at the facilities and in the community. Many of the staff have been trained in family planning. Some educational, motivational activities are carried out with limited teaching aids. Contraceptives have been made available at this level sporadically by GNEPP in the past. Generally, those facilities designated health posts are smaller, do not have maternity beds and have fewer staff headed by community health nurses. Worthy of note in this system is what appears a marked separation of functions in many centers. There are "General Health Services" and "MCH" (including FP and nutrition sections). One person is designated as "The Family Planning Nurse" and often F.P. services are not available in her absence. One of the objectives of the MOH's management training is to break down this distinction and create a team approach to service delivery.

In 25 districts through the health system (at least one in each region) the Ministry has initiated outreach activities by Level B staff working with village health workers working at community (Level A). This is based on the Danfa and BARIDEP experiences. There also are several simple "Community Clinics" established by the village authorities in each PHC District. A variety of promotional, preventive and simple curative services will be provided by the village health worker and the traditional birth attendant. Recently the PNDC's program for health mobilization has begun to organize Health Brigades to expand the Group of Volunteers at the community level engaged in self-help community improvement, sanitary and health education activities.

LOCATION OF HOSPITALS, CLINICS AND HEALTH POSTS AND THOSE PROVIDING F.P.

Region	No. of Districts	No. of Hospitals	No. Hospital providing F. P.	Total No. clinics centers posts	No. clinics providing FP				Outreach facilities providing FP	Private maternity providing FP
					Urban health centers	Rural health centers	MCH center	Health post		
Greater Accra Region	3	12	12	26	7	2	2	12	60	79
Volta Region	8	15	15	46	-	9	7	21	72	13
Western	5	16	16	31	2	5	10	6	-	12
Eastern	9	15	15	49	-	9	17	15	45	22
Central	8	12	12	37	1	2	9	20	-	-
Ashanti	10	11	11	42	2	11	8	5	51	53
Brong-Ahafo	8	10	10	29	-	8	6	12	34	-
Northern	7	6	6	20	-	6	5	8	10	5
Upper East	3	-	-	-	-	1	3	4	6	-
Upper West	4	8	8	26	-	2	2	3	35	-
Total	65	105	105	306	12	55	69	106	313	184

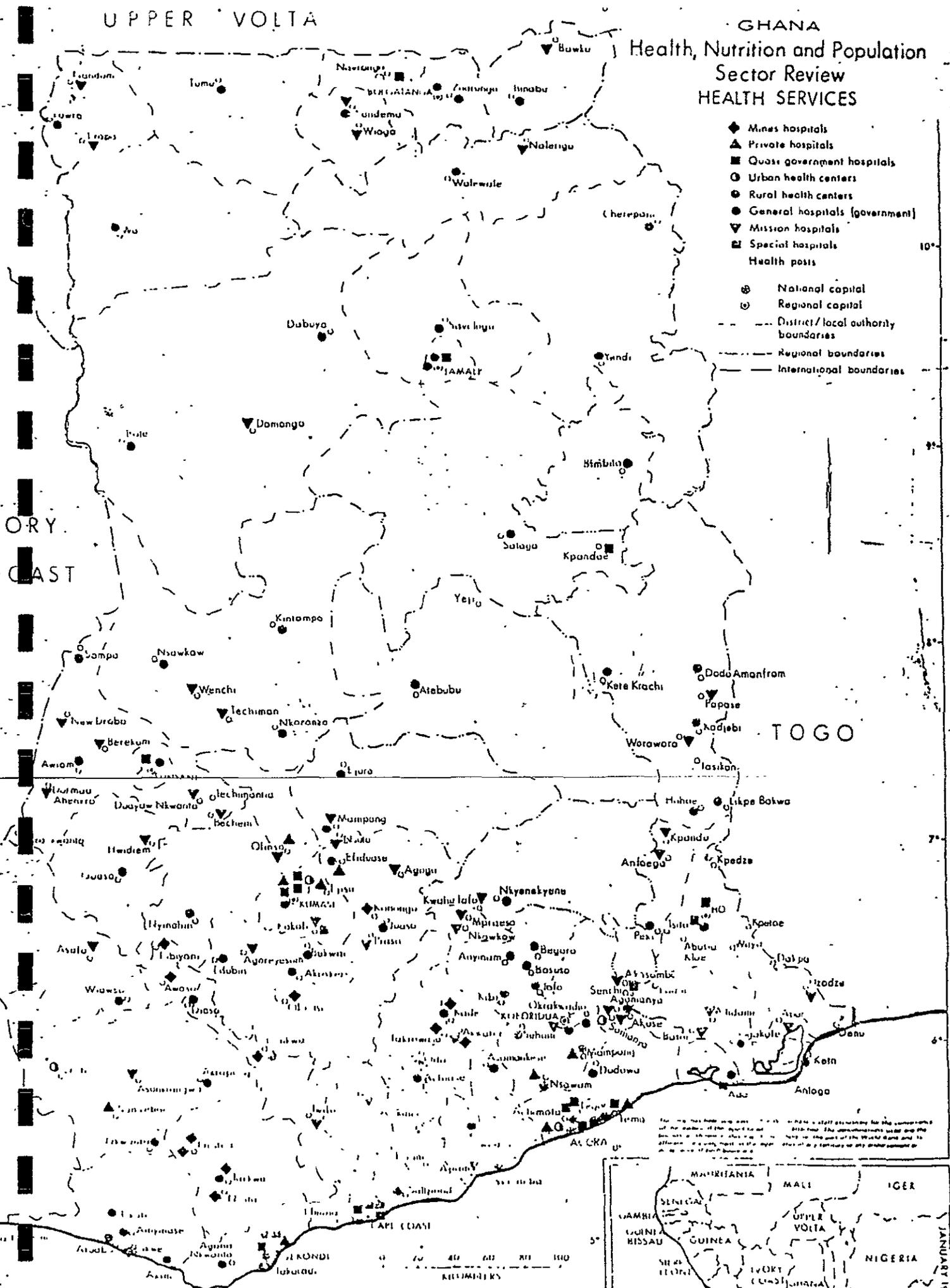
Health, Nutrition and Population Sector Review HEALTH SERVICES

- ◆ Mines hospitals
- ▲ Private hospitals
- Quasi government hospitals
- Urban health centers
- Rural health centers
- General hospitals (government)
- ▼ Mission hospitals
- Special hospitals
- Health posts

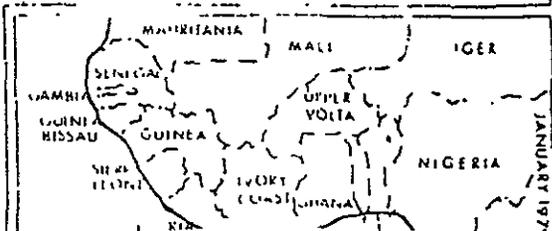
- ⊕ National capital
- ⊙ Regional capital
- - - District/local authority boundaries
- - - Regional boundaries
- - - International boundaries

ORY
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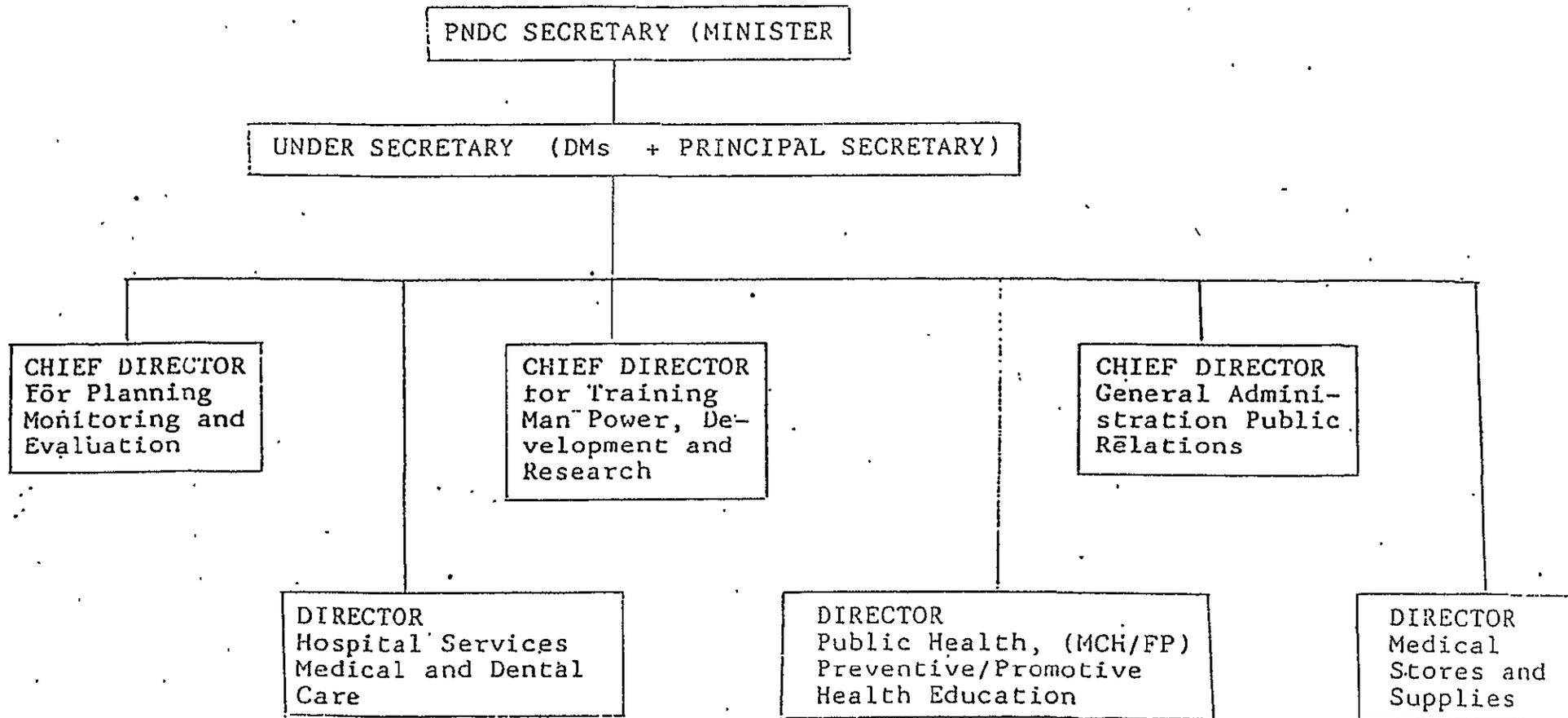
The map was prepared by the Health Services Section of the Ghana Statistical Service. The data were collected from the Health Services Section of the Ghana Statistical Service and the Health Services Section of the Ghana Statistical Service. The map is a generalization of the data and does not represent the views of the Ghana Statistical Service.



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KILOMETERS

PROPOSED ORGANIZATIONAL STRUCTURE - M.O.H.

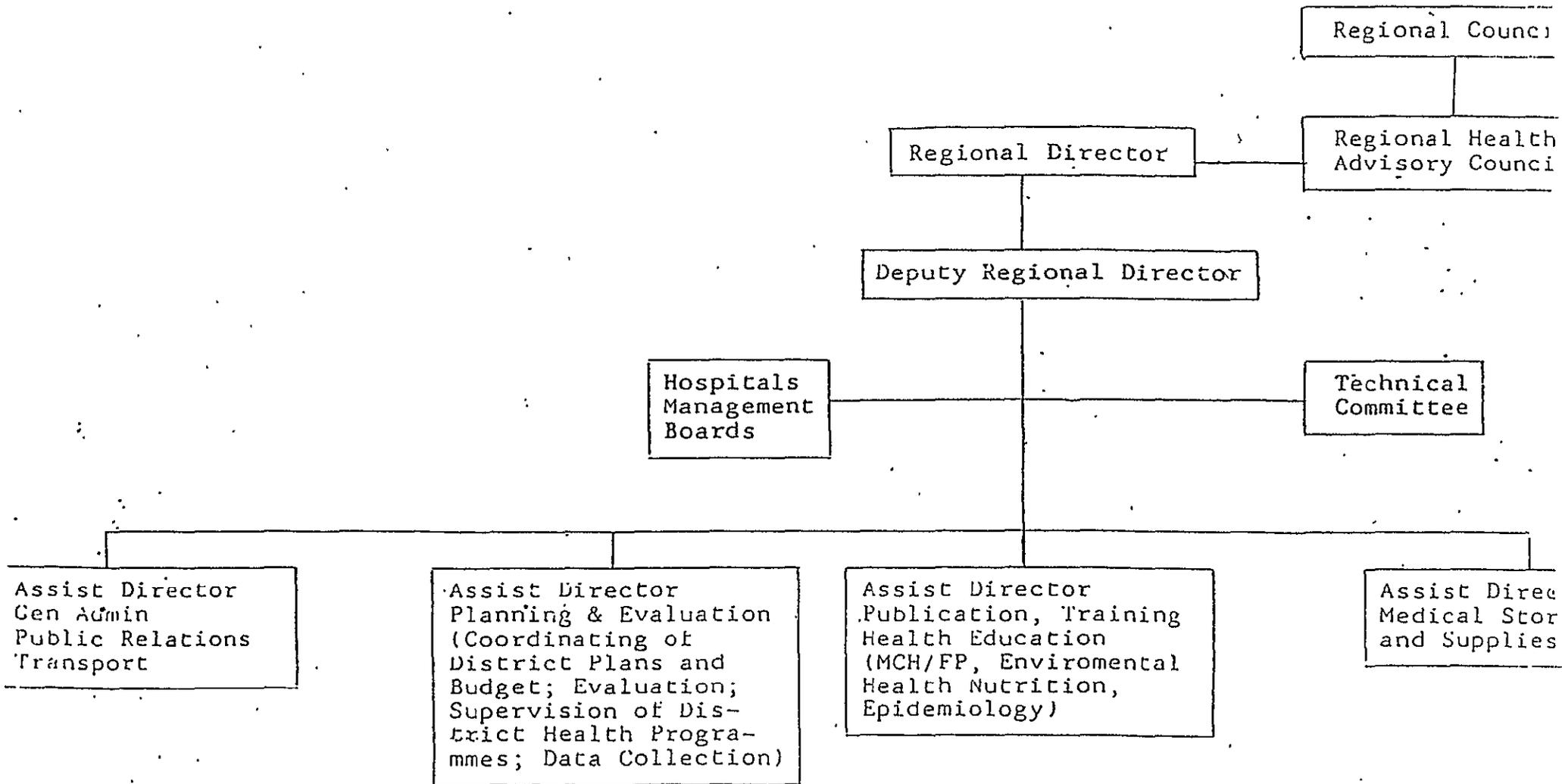
Annex I-4



SOURCE: UNFPA

ORGANIZATIONAL STRUCTURE AT REGIONAL LEVEL

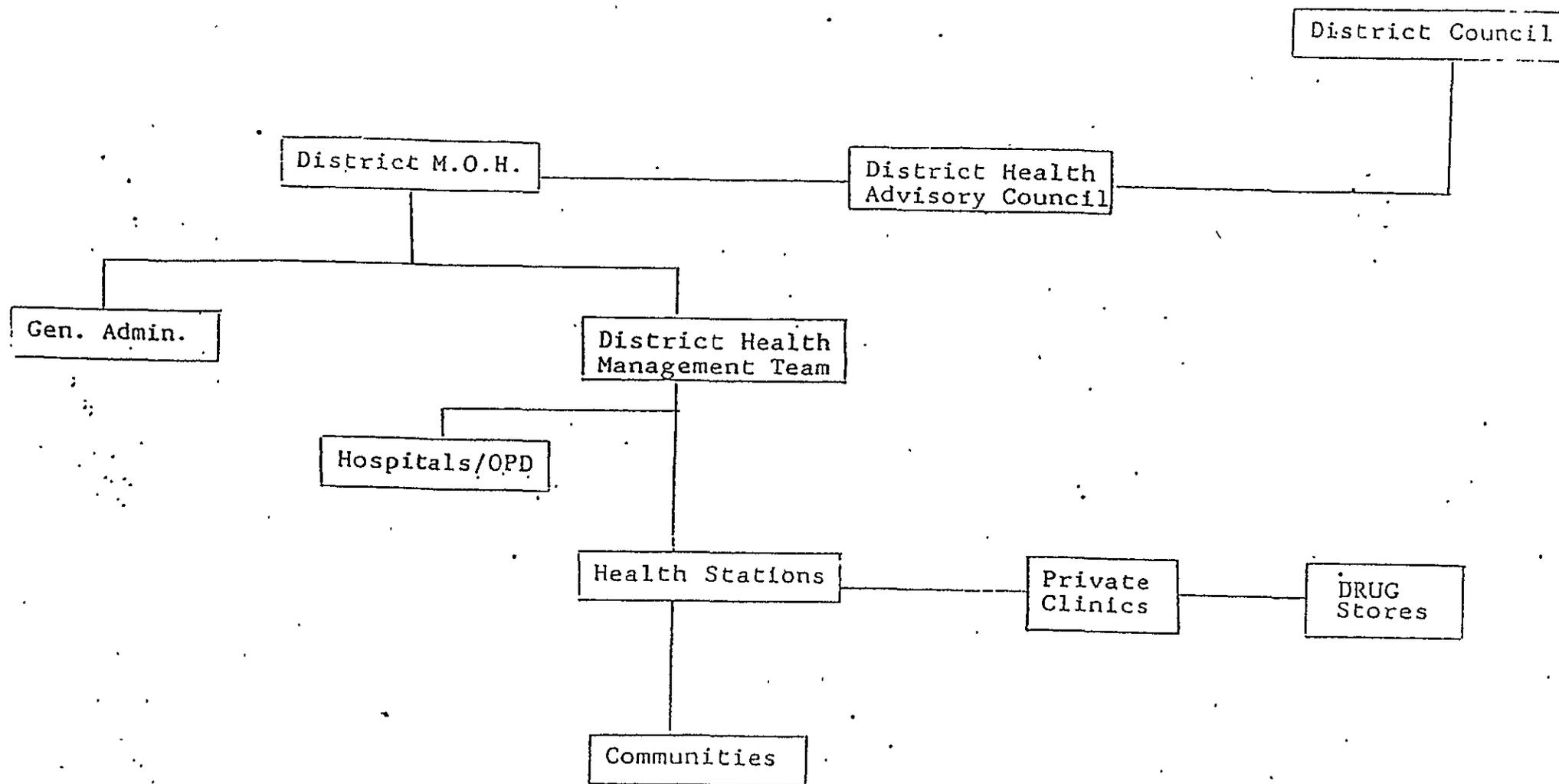
Annex I-1



SOURCE: UNFPA

ORGANIZATIONAL STRUCTURE AT DISTRICT LEVEL

Annex I-4



2. Resources Available to MCH/FP Family Health Programs

a. Budgetary Resources

Following, for illustrative purposes, is a summary statement of GOG budgetary support for the MCH/FP program based on the 1980-81 budget, the most recent disaggregated information available. It is imprecise as some accounts overlap and different definitions of what is included in MCH/FP would give different answers. Since the Family Health Program now is to include MCH/FP and Nutrition those accounts are both included below. Expenses for the Epidemiological division (current Exp. \$ 14,397,000 year), which provides immunization supplies for the MCH program is not included. Neither is General Administration which totals \$ 103,851,000 of which \$ 95 million provides equipment and supplies for the system. (The GOG budget is developed by Region and Central Administration but is not disaggregated for the following tables):

- 10 -

(1) MCH/FP and Nutrition Operating Budget 1980-81 MOH

(Cedis 000's)

	<u>MCH/FP</u> 000¢	<u>Nutrition</u> 000¢	<u>Total</u> 000¢
1) Personnel	4,474	1,142	5,616
2) Travel and Transport	825	334	1,159
3) General Expenditure: (stationary, printing training, etc.)	289	118	407
4) Maintenance, repair and renewal	25	23	48
5) Other current expenditures (fuel, health education conferences, drugs and stoves, etc)	585	303	891
6) Total	6,299	1,920	8,219

(2) Capital Expenses 1980-81 MOH

7) Construction	475	145	620
8) Plant, equipment Furniture, Vehicle	173	132	305
9) Total	648	277	925

Source MOH budget document

(3) Operating Budget 1980-81 - 1984

<u>Year</u>	<u>Total MOH</u> <u>allocation</u> (000) Cedis	<u>Total MCH/FP</u> <u>allocation</u> (000) Cedis	<u>MCH/FP</u> <u>as percent</u> <u>of total</u> <u>Percent</u>
1980/81	340,452	6,299	1.8
1981/82	523,469	10,309	2.0
1983	608,216	14,825	2.4

Source MOH/Planning
October 1984

- 11 -

MOH officials state that in previous years the Ministry could depend on receiving 90 to 100 percent of the money budgeted, (usually at a level of 7-9% of the National Budget). However, in recent years the percentage of the budget actually received has dropped significantly. It is estimated that in 1983 the MOH only received 70 percent of its budget. In October of 1984 all discretionary expenditures were frozen, suggesting to MOH officials that 1984 will produce less than 70% of the budget. Thus, even though the budget has increased each year since 1980/81, the actual allocations have not been sufficient even to keep pace with inflation.

In an unpublished article, "Health Policies", Dr. K.P. Nimo of the Ghana Medical School Department of Community Health reviews what has happened to the purchasing power of the MOH budget since 1970:

Health Expenditure

"The per capita expenditure on health has been reduced in real terms from a high of 6.36 cedis in 1974 to 65 pesewas in 1982/83, i.e. to 10% of its 1974 value as shown in column 5 of Table XI.9.7. All the figures have been adjusted for the cost of living index." (based on 1963 = 100, Old Series. CBS)

Table XI.9.7

The M.O.H. Budget 1970 - 1981 and Inflation

<u>Year</u>	<u>M.O.H. Budget '000's</u>	<u>% of National Expenditure</u>	<u>Per Capita cedis (X)</u>	<u>Per Capita cedis (XX)</u>
1970/71	34505	7.1	4.03	4.03
1971	34026	6.4	3.85	3.53
1972	41965	7.4	4.60	3.82
1973	71223	9.4	7.57	5.36
1974	103279	8.9	10.64	6.36
1975	112095	9.3	11.19	5.16
1976	125414	10.3	12.42	3.66
1977	183745	9.8	17.22	2.35
1978	239630	9.1	21.71	1.71
1979	349630	7.5	30.76	1.57
1980	407130	7.6	34.71	1.18
1981/82	596649	8.1	49.30	0.77
1982/83	678216	6.7	54.69	0.65

Sources: M.O.H. Planning Unit/Min of Finance
 X - Adjusted for Population growth
 XX - Adjusted for population growth and cost of living index

Another reality that is clear from the MOH budget is the very high requirement placed on the system by curative care, largely in the hospitals. Dr. Nimo's analysis came from the 1975-76 budget but there is little reason to believe the situation is much different today.

Functional Allocation Analysis of the
1975-76 Health Budget (5)

Central and Divisional Headquarters	-	3%	
Medical Care (hospital based)	-	79%	
Korle-Bu Hospital	-		(22%)
Other Hospitals	-		(57%)
Public health	-	12%	
Training	-	6%	
			100%

Source: Planning Unit MOH . - by Dr. Nimo - Ghana Medical College

The Ministry reminds us correctly that budget percentages don't tell the whole story of program emphasis. The MOH staff may put as much as 50% of their time on preventive health activities. The curative activities are also higher cost budget items than many of the relatively inexpensive preventive approaches. Nevertheless, one would like to see Public Health and MCH/FP receiving more than their respective 12% and 2.4% share of the budget.

As a result of the financial crunch, there is a virtual standstill or even digression in terms of achieving the progressive objectives expressed by Ghanaian health leaders. Vehicles are sidelined for lack of spare parts or petrol. Supervision is sketchy. In-service training is inadequate. Basic equipment and supplies are lacking and the whole system shows the results of several years of stress.

There are, however, some bright signs. One, of course, is the resilliance and tenacity of many of the dedicated health personnel who are working under very difficult conditions to keep the system functioning. This is impressive and is presumably one of the reasons why large numbers of mothers continue to come and bring their children to the centers for prenatal, post natal, and child welfare sessions as well as for medical attention.

Most recently UNICEF, which has been a major supporter of the MCH program, has made large shipments of drugs and equipment for the health centers and posts. The Government of Japan has provided \$2 million in trucks to rebuild the logistic system and \$2 million in basic drugs. UNFPA support is expected soon for training, equipment and contraceptives.

The Ministry is reviewing its fiscal policies in ways that will alleviate some of these problems. For example, it expects to change its policies regarding charges for services to clients. Presently the charges for all services are so low as to produce no significant financial recovery. Additionally, that which is collected in the hospitals is returned to the general treasury and is not then available for hospital financing. Both these policies may be changed toward more realistic charges to clients and toward retaining at least part of the money collected by the health institution for its use. The 1985 MOH budget being developed is said to contain provision for substantial salary increases. Whether this will be possible to achieve in the face of the country's economic conditions remains to be seen.

Without some movement in this direction, it is hard to see how the Ministry can continue to hold its staff and make operational improvements. However, it is not clear how much can be achieved in the short run. It is likely the Ministry of Health will be faced with severe financial constraints throughout the life of the project. It is clear that AID does not intend to move strongly into the broad health sector. It can expect to have only marginal influence on these circumstances which will be difficult for the GOG to alter. Under these conditions a decision to go forward with the project requires:

- 1) limited expectations of the level of financial support from the MOH and no expectation of increased personnel;
- 2) willingness to provide for more of local costs than might be normally considered, especially those like training and production of informational material which can be considered investment costs and not necessarily recurrent;
- 3) insistence on least cost approaches as well as dependancy on community volunteers and the private sector for an increasing share of the responsibility for extending family planning services to the population; and
- 4) realistic expectations in terms of project output. The public sector portion of the project can be more than a "holding action". However, this portion cannot do more than improve the quality of services within the existing clinic services with some expansion at the community (PHC) level.

b. Personnel Resources

The following are the personnel resources available in the system to manage the program and deliver the Family Health program services:

Program ManagementHeadquarters (Accra) (MCH/FP)

<u>Type</u>	<u>Number</u>
Physician	1
Deputy Director, Nursing Services	1
Principal Nursing Officer	1
Senior Nursing Officer	1

All Regional Medical Offices (RMOH)
Located in each of the 10 Regional Capitals

<u>Type</u>	<u>Number</u>
Principal Nursing Officer (Public Health)	10
Regional Medical Officer	10
Physician for MCH (Accra)	1

All District Medical Offices (DMOH)
Located in all 65 districts of the country
(District-wide Level and below)

<u>Type</u>	<u>Number</u>
Senior Nursing Officer	49
Nursing Officer	95
Public Health Nurses	84
Community Health Nurse	1,467

Source: MOH 1981

c. Services Delivery for Family Health

<u>Type</u>	<u>Number in service at all levels of MOH now</u>	<u>Number Trained in MCH/FP 1975-80</u>	<u>Number Currently in Training for MCH/FP</u>
Prof. Nurse Midwives	4,000 <u>1/</u>		250
Public Health Nurses	216		30
Auxiliary Nurses Midwives	218		244
Community Health Nurses	1,467		160
Medical Assistants (some MCH)	350		40
Total	6,251 <u>3/</u>	4,833 <u>2/</u>	724 <u>3/</u>

Source: MOH - 1981

- 1/ There are 8,230 in total system
- 2/ Includes all health personnel trained in F.P. not just those trained for the MCH/FP program
- 3/ Those specifically working in or being trained for the MCH/FP program.

At the time of the PP design, the MOH was not able to provide complete updated information regarding the actual status of personnel in the system. According to reports from regional officers, hospitals and clinics visited, there has been a considerable exodus of personnel, especially at the mid-level. The UNICEF report indicates, for example, that in 1981 there were 1665 physicians in Ghana. In April 1984, there were 817 (464 government, 91 NGO and 262 private). Out of 10,600 nurses of all categories, 900 left in 1982.

Although many physicians have reportedly left the system to work in other countries or in private practice, the University hospitals at least are reasonably well staffed with physicians. Physicians were never in good number in the rural areas and that has not improved. Midwives have also left the system. Over half

of the graduating classes of doctors and midwives are reported to be leaving the government services. The common reason stated for this exodus were the very low salaries and the lack of proper working conditions. Other categories of nurses do not have the same flexibility.

Apparently, the lower level personnel in the rural area have remained more stable as they have been provided accommodations at the health centers. Indeed personnel shortages did not seem as much a problem in the health centers visited as did the condition of basic equipment, shortage of supplies and communication aids, and appropriately maintained physical surroundings.

In addition to the problem of declining numbers of health personnel in the MOH system, their geographic distribution and the multiplication of categories adds to the difficulty. For example, in 1984, 41 percent of the physicians are in Accra. The two teaching hospitals in Accra and Kumasi employ 30 percent of all the physicians in the country. The distribution of nurses is apparently not quite so heavily skewed to the urban areas but follows a similar pattern. One can note from the following table that of the 9671 state registered nurses (SRN), enrolled nurses (EN), public health nurses (PHN) and community health nurses (CHN) now in the MOH system 3197 or 33 percent are located in the greater Accra region and the two teaching hospitals.

Distribution of Nurses by Region

	SRN	EN	PHN	CHN	TOTAL
Korle Bu					
(Teaching hospital)	686	538			1224
Greater Accra Region	481	517	70	215	1283
Eastern Region	380	872	31	164	1447
Volta Region	247	669	15	59	990
Central Region	188	452	21	99	760
Western Region	178	429	10	68	685
Komfo Anokye					
(Teaching hospital)	338	429	10	68	685
Ashanti	200	234	20	116	570
Brong-Ahafo	85	600	16	79	780
Northern Region	145	405	16	79	780
Upper East	95	251	8	71	629
Upper West	49	152	6	60	234

Source MOH Planning 1984

- 17 -

There are an additional 518 nurse midwives, 142 midwifery superintendents, 447 staff midwives and 217 enrolled nurse midwives in MOH facilities (Source:UNICEF) not included in the above figures. Their distribution may be even more skewed toward the urban areas.

The proliferation of categories of health personnel has created problems in clarifying roles and job descriptions, developing health teams, supervision and training. For example there are Public Health Nurses, Midwives, State registered Nurses, Enrolled Nurses, Community Health Nurses, Nurse-midwives and Medical Assistants. Most have their own professional association, seek to maintain their role to a level of international standards and carefully guard their prerogatives.

In summary, we see a general health system which has made considerable progress over the years in extending its services throughout the nation and toward the community level. Despite policy pronouncements favoring public health and preventive care it has not superceded the demands of hospital and curative care. Since its peak per capita expenditure on health in 1975, there has been a steady decline in (deflated) MOH per capita expenditure. The 1983 level was only 1/10 of that of 1974. This financial condition has contributed to heavy personnel exodus which aggravates the problem of maldistribution of personnel, the proliferation of personnel categories and the compartmentalized roles in service delivery. The physical plant is in disrepair; vehicles are sidelined; health institutions are under equipped; the health information system has broken down and in many places the morale of an intelligent, well trained and good humored staff is sadly sagging. The UNICEF report states the results as follows: "...it has been demonstrated that Ghanaian health status has stagnated since the mid-1970's. Infant mortality rates have not changed. Other health indices have also remained the same, or have deteriorated, for instance, the nutritional status of children. Health care coverage of the population had peaked at above 25% to 35% over-all and still favored the Urban areas."

The MOH recognizes these problems and is marshalling its own resources with some new and enthusiastic leadership to deal with them. There is a favorable policy climate for a stronger emphasis on family planning. UNICEF continues its strong support; Japan has increased its assistance; and the UNFPA has initiated support for the MCH/FP activities. One must be realistic, but there are sufficient signs of improvement to allow some cautious optimism for measured progress. All of the above, however, underlines the need for capable technical assistance, training and information programs and local cost financing if this modest family planning effort is to be effective in this environment.

LOCATION OF MOH HOSPITALS, CLINICS AND HEALTH POSTS
HAVING FAMILY PLANNING

NO.	REGION	DISTRICT	HEALTH INSTITUTION
1	Greater Accra	Accra City	Military Hospital Korle Bu P.M.L. Ridge Hospital Achimota Kaneshie P/C Maamobi P/C Mamprobi P/C Ussher MCH/FP Labadi P/C Adabraka P/C Dansoman P/C Korle-Gonno P/C Police Hospital FP Unit
		Tema	Tema Gen. Hospital Tema UHC Urban Health Center Ashiaman H/P Obom H/P Danfa H/P - Medical School Tema Newtown H/P
		Dangbe	Ada Health Centre Ningo H/P Sege H/P Kasseh H/P Dodowa H/P Prampram H/P
2		Eastern	Tetteh Quashie Hospital Nsawam Hospital Nsawam MCH Hospital Center Mampong MCH Akropong MCH Aburi MCH Adukrom H/P Okrakojo H/C
		Kaoga	Somanya MCH
		Kraboa Coaltar	Suhum Hospital Suhum MCH Center Asuboi H/P

REGION	DISTRICT	HEALTH INSTITUTION
Eastern Region	Birim.	Akim-Oda Hospital, New Birim H/P Achiase H/C Aboabo H/P Akim-Oda MCH Asene H/P
	Kwahu	Atibie Hospital Atibie MCH Center Pease H.P. Obo MCH Center Nkyenkyene H/C Donkorkrom H/C Nkwatia H/P Abeɔifi H/P Nkawkaw MCH Center
	West Akim	Asamankese II/C Kade H/C Pramkese II/P Takorasi H/P Osenase H.P.
	New Juabeng	Koforidua Hospital Koforidua MCH Center Jumapo H/P Efiduase H/C
	Manya-Krobo	Akuse Hospital Akuse MCH Center Asesewa H/C Atua Hospital Krobo-Odumasi MCH Center Kpong MCH
East-Akim.	Kibi Hospital Kibi MCH Center New Tafo Hospital Asafo H/P Osino H/P Aɔedwa H/P Anyinam H/C Bososu H/C	

D.	REGION	DISTRICT	HEALTH INSTITUTION
	Central	Twifu-Heman-Denkyira	Dunkwa Hospital Dunkwa MCH Center Diaso H/P Kyekyeware H/P Oponso H/P Twifu-Prasu H/P
		Mfantseman	Saltpond Hospital Saltpond MCH Center Anomabo H.P. Essuehyie H/P Abora H/P Abankraba H/P Otum H/P Otum MCH
		Agona	Agona Swedru H/C
		Bremen-Ajumako	Bremen-Asikuma MCH Brakwa H/P Bisease H/P Odobeng H/P Nkwantanum H/P Anyan-Abaasa H/P
		Gomoa Ewutu-Efutu	Winneba Hospital Winneba MCH Apam MCH Bawjiase H/P Gomoa-Oguaa H/P Senya-Beraku H/P
		Assin	Assin Fosu MCH Assin Bereku H/P Assin Manso H/P Fantse-Nyankomase H/P
	Volta	Anlo (Keta)	Keta MCH Hospital Anlo Afiadenyigba H/P Anyako MCH + H/P Alakple H/P Tegbi H/P Anloga H/C + MCH

No.	REGION	DISTRICT	HEALTH INSTITUTION
	Volta	<p data-bbox="560 378 649 409">Hohoe</p> <p data-bbox="560 472 592 504">Ho</p> <p data-bbox="560 934 738 966">Kete Krachi</p> <p data-bbox="560 1207 649 1239">Tongu</p> <p data-bbox="560 1365 665 1396">Kpandu</p> <p data-bbox="560 1564 673 1596">Jasikan</p>	<p data-bbox="966 378 1291 441">Hohoe Govt. Hospital Hohoe MCH Center</p> <p data-bbox="966 472 1477 903">Ho Community Health Nursing Sch. Ho MCH Center Ho Hospital Kpetor H/P Kpedze H/P Ave Dakpa H/P Tsito H/P Adaku Waya H/P Abulia Agove H/P Vane H/P Abulia Kloe Amedzofe H/P E.P. Social Center</p> <p data-bbox="966 934 1299 1165">Kete Krachi MCH Hosp. Banda H/P Katanga Hosp. Tutukpene H/P Adidome E.P. Hosp. Tokwano H/P Dormanbu H/P</p> <p data-bbox="966 1207 1250 1333">Adidome E.P. Hosp. Mafi-Kumase H/P Podoe H/P Sogakofe H/C</p> <p data-bbox="966 1365 1193 1533">Kpandu H/C Have H/P Peki MCH Peki Dzake H/P Wusuta H/P</p> <p data-bbox="966 1564 1234 1837">Worawora MCH Kadzebi H/C Likpe Bakwa H/C Ahamanso H/P Jasikan H/P Baika H/P Dodi Papase Hosp. Dodo Amanhan H/C</p>

NO.	REGION	DISTRICT	HEALTH INSTITUTION
6	Brong Ahafo	Brekum-Jaman Wenchi Goaso-Ahafo Techiman Nkoranza/Kintampo Sunyani Dormaa-Ahenkro	Sampa H/C Wenchi Meth. Hosp. Yeji H/C Nsawkaw H/P Subinso H/P Atebubu H/C Goaso H/C Akrodie H/P Kukuom H/P Akyerensu H/P Gyedu H/P Hwidiem MCH Techiman MCH Tanoso H/P Kintampo H/C Nkoranza H/C Yefri H/P Nkoranza Hospital Sunyani Hospital + MCH Center Nsuatre H/P Techimantia H/P Bechem MCH Center Chiraa H/C Yamfo H/P Duayaw-Nkwanta MCH Basel Mission Hospital Dormaa Ah H/C Wamfie H/P
7	Ashanti	Kumasi City Council	Manhyia H/C Suntresu H/C Old Tafo H/C MCH Center KAH (Komfo Anokye Central Hosp.) Chirapatre H/C Military Hospital

NO.	REGION	DISTRICT	HEALTH INSTITUTION
		Offinso	St. Patrick's Hospital (FP) Nkensansu H/C Akomadan H/P Boaman H/P Offinso MCH Center
		Asante-Akim	Juaso H/C Agogo Agogo Hospital Konongo H/C Dwease H/P Prasu H/P
		Sekyere	Ejura H/C Kwamang H/P Kofiase H/P Effiduase H/C Kumawu H/P Mampong Hospital (Ashanti) Mampong MCH Tetram H/P
		Ejisu/Bosomtwe Amansie	Ejisu MCH Achiase H/P Bekwai Hospital Bekwai MCH Center Manso Edubia H/C Dunkuraa H/P
	Ashanti	Kwabre-Sekyere	New Asenomase H/P Abuabugya H/P Aboaso H/P
		Adansi	Ashanti Gold Fields Mines Hosp. Obuasi MCH Center Akrokerrri H/C
		Atwima Ahafo-Anno	Nyinahin H/C Nyinahin Town Clinic Mankranso H/P Teppa H/P
	Upper	Kassena/Nankani	Navrongo Hosp. + MCH Kandiga H/P Chiara H/P Pagala H/P

NO.	REGION	DISTRICT	HEALTH INSTITUTION
	Northern	Sissala	Walembela H/P Tumu H/C
		Kusasi	Bawku Hospital Binaba H/C Garu H/P Widana H/P
		Wa	Wa Hosp. + MCH Daffiama H/P Jang H/P Wechem H/P Cherepong H/P
		Bulsa	Sadema H/C
		Frafra	Bolgatanga Hosp. + MCH Presby Mobile Clinic Tongo H/P Bolga H/P
		Lawra	Lawra MCH Jirapa MCH Nandom MCH Duori H/P Han H/P
		Western Dagomba	Sakasaka MCH Center Regional Hospital Tamale Savelugu H/C Kumbungu H/P
		Eastern Dagomba	Yendi Hospital Chereponi H/C Gushiegu H/P Sabuba H/P
		Mamprusi	Walewale H/C Pesempe H/P Bunkpurugu H/C Gambaga H/C
		West Gonja	Damongo MCH Daboya H/P Game Reserve H/P
		East Gonja	Salaga Hospital

No.	REGION	DISTRICT	HEALTH INSTITUTION
	Northern	Bole Nanumba	Bole H/C Tinga H/P Kambol H/P Bimbila H/C <u>303</u>

Private Sector Capability - Susman

Annex J

IEE - Rauch

Annex K

Waiver - vehicles and non competitive procurment DANAFCO

Susman/Rauch

Annex L

Draft Letter of Agreement MOH (MFFEP) and DANAFCO

Susman

APPENDIX D

Persons Contacted in Washington
and Tentative Conclusions and Recommendations
Growing Out of Washington TDY

APPENDIX D

Persons Contacted in Washington
and Tentative Conclusions and Recommendations
Growing Out of Washington TDY

SUBJECT: Consultancy for International Science and Technology
Institute - to assist in design of Contraceptive
Supplies Project for USAMD Ghana October 8 thru
November 15, 1984 - W.D. Bair

A) Washington October 9-11

1) Persons contacted:

Lawrence Eicher - Acting Chief AFR/TR/POP

Don Reilly - Acting Chief AFR/TR

Charles Gurney - Chief AFR/TR/HN

Julius Cole - Chief AFR/CWA

David Walsh - AFR/Ghana Desk

Glen Cauvin - AFR/DP

Anne Aarnes - Chief S&T/POP/IT

Andrew Wiley - S&T/POP/IT

Marilyn Schmidt - S&T/POP/IT

Marschal Rothe - S&T/POP/IT

Elaine Murphy - S&T/POP/IT

John Burdick - S&T/POP/AFR/NENA

Carl Hemmer - S&T/POP/UNFPA

Betty Case - S&T/POP/D

Don Newman - Chief S&T/POP/Commodities

Richard Cornelius - S&T/POP/Demography

Jack Lawson - S&T/POP/Demography

Gene Rauch - REDSO/WCA PDO (Telephone)

Connie Husman - JHPIEGO *

Ethna Johnson - JHPIEGO

Robert Smith - FUTURES

Betty Ravenholt - FUTURES

Mary Worstel - FUTURES

see pg. 9 for acronyms

Don Ruschman - FUTURES

Phil Claxton - FUTURES

Susan Saunders-Academy for Educational Development

Michael Dalmat - CDC

John Alden - PRITECH (Telephone)

Katherine Crone - MSH (Telephone)

Elizabeth Preble - International Science & Technology Institute

Betsy Stephens - International Science & Technology Institute

Rhonda Steppe - International Science & TEchnology Institute

Ron McGarrick - Johns Hopkins PCS

Phylis Piotrow - Johns Hopkins PCS

Dan Weintraub - FPIA

Alan Alemian - AFRICARE

Lynn Knoff - INTRAH

Peggy Curlin - CEDPA

James William Masoki - UNFPA/Ghana

Joycé Holfield - Consultant assisting AID/Nigeria

Don Laro - Columbia University (Telephone)

Gene Weiss - Columbia University (Telephone)

2) Tentative Conclusions and Recommendations growing out of Washington TDY.

a) AFR desk (Walsh) says PID approved for authorization in field and should stay in field unless substantial change (like go beyond \$5 million or add health money). PD may want to bring PP back to AID/W but Desk will oppose that. Walsh suggest leaving LOP as open ended as

possible so extension after 3 years easy. DP (Cauvin) doesn't see any problem if fund requirements increase somewhat.

- b) AFR/TR/POP (Eicher) encourages go forward with both contraceptive Supplies project (bilateral) and Contraceptive Social Marketing (Centrally funded) but keep them separate except as part of overall strategy. Later found from FUTURES and S&T/POP that contraceptives for CSM should be provided out of the bilateral. Eicher concurs in private sector emphasis in PP to degree possible to support Ghana Christian Council, APPLE, PPAG and possibly SAWS. He supports interest in using MSH for management training.
- c) With S&T/POP/IT, INTRAH and JHPIEGO, concluded that, subject to Mission and GOG interests, INTRAH could provide In-Service training assistance especially for paramedicals and JHPIEGO could provide assistance with revision of curriculum and pre-service training for physicians and nurses - training of tutors. INTRAH could provide about \$80,000/year T.A. out of central project and in-country costs should be paid by bilateral - Same of JHPIEGO - Husman, JHPIEGO and Lea of INTRAH available late October early November. INTRAH and JHPIEGO cooperation in Nigeria is relevant experience for Ghana.
- d) With S&T/POP/IT and Johns Hopkins PCS concluded PCS can provide TA directly or thru Academy Ed. Development in

IEC and could handle project funds of up to \$500,000 for informational component. Both they and FUTURES agree contract with local publicity firm would be preferable. Cross over with CSM project could be facilitated by AED which is sub contractor for both FUTURES and PCS. PCS experience with IEC materials development for Nigeria should be relevant for Ghana. McGarrick (PCS) will work with Miss Assan to sketch out IEC outline while she's at Hopkins.

- e) Joyce Holfield confirms the ease (to date) of establishing project with AFRICARE for provision of clinic equipment for Nigeria. This may be a good way to take the burden off USAID/Ghana and GOG if clinic equipment is to be part of the bilateral. AFRICARE is interested.
- f) Confirmed with FPIA they will continue to support APPLE and Ghana Christian Council but they recommend against the inclusion of YMCA.
- g) Especially with strong AID/W support for private sector, it will be useful to explore more support for APPLE, GCC, PPAC and SAWS in PP design.
- h) FUTURES (and AID/W) very supportive of CSM project if conditions with GOG (and GNEPP) appropriate. At present FUTURES contract requires resident advisor which they will provide along with much of financing (centrally provided) for project. Contraceptives should be funded from

bilateral. Susman considered excellent consultant for analysis of Ghana situation and general project design. If it appears USAID wants to go forward, FUTURES would send staff person, Messick, for finalization.

- i) MSH is interested in the management training component. U.S. or third country training can be PIO/P funded. MSH TA can be thru IQC or possibly through buy-in to PRITECH contract (Ann Tinker from S&T Health was not in town to confirm the mechanism but MSH confident it should not be difficult). Gurney is supportive. Desk will be agreeable if it doesn't mean back-door start-up of "health" activities. It must be sufficiently part of the population project to justify spending population funds for it. CDC is interested in working with MSH support of GIMPA. Dalmat will stop in Boston on way to Ghana to discuss with MSH.
- j) With growth of local costs requirements for training and IE&C, availability of cedis to project becomes increasingly important.
- k) UNFPA has 3 years project with MOH for \$666,000. They have ordered clinic equipment, vehicle and office equipment. They are urging GOG to expend this year's money soon on national seminars and \$100,000 of contraceptives that will be ordered as soon as they know what we will provide. Masoki says Japanese govt is also providing

vehicles but he doesn't know about Neo-Sampon (we should contact).. Mr. Alfred Mubanda is new UNDP Representative to contact and Masoki will visit from N.Y. in few weeks. Dr. Otoo is UNFPA contact with GOG which will facilitate coordination.

- 1) S&T/POP/IT (Elaine Murphy) is willing to work with Mission and GOG to provide a Population Intern (recent graduate of Michigan MPH program) to assist project (not a Mission employee) at no cost to project. If conditions permit, this could be real help to project. While not of direct assistance to USAID, this could facilitate management requirements.
- m) Using central projects to procure TA (contact Betty Case about simple PIO/T incremental funding) and cooperative agreement with AFRICARE for equipment should further facilitate Mission Management.
- n) USAID Pop position is still considered essential, and has been advertised. All personnel matters are bogged down at the moment, this position among them.
- o) Columbia University is interested in doing some operations research similar to Nigeria project in Ghana. This should not be initiated until later in project. It would be a way of helping MOH get out of clinics and into community with Contraceptives. It could also focus on private

sector (GCC, SAWS, PPAG and/or various women's groups.

- p) Additional efforts to move toward Community Based Distribution (CBD) could be facilitated by increased support to private sector, observation travel to Kenya and Zimbabwe, support for Ghanaians at Columbia University June course.
- q) Plans for contraceptive prevalence survey should be included in PP as part of evaluation. Dalmat will check with CDC their interests. Cornelius and Lawson said it could be included under the new Central project just awarded to Westinghouse. TA could be funded centrally-local costs by project (\$50,000).
- r) Consideration could be given (later in project if absorptive capacity is demonstrated and depending on Nigeria results) for contract (about \$500,000) with CEDPA for project to train school teachers in family life education similar to Nigeria approach).

TO BE DONE FOR P.P.

- a). Up date organizational description and management capacity/needs of MOH/MCH and plan of action for expansion of service delivery - Bair/Susman/Otoo
Travel to observe system in operation - Bair/^{SUSMAN}Dalmat/MOH
- b) Develop system for collection/disbursement of funds from sale of contraceptives - Susman/Bair/Otoo

- c) Outline of I.E.C. program -- Bair/Otoo
- d) Outline of Training Program -- Bair/Otoo
 - 1) Preservice & curriculum development for physicians.
Training of tutors, nurses
 - 2) In-service training
 - 3) Management training
 - 4) U.S. and third country training
- e) Review support of other donors - (UNFPA, FPIA, IPPF, Japanese) -- Bair
- f) Review private sector possibility - PPAG, GCC, SAWS, -- Bair
- g) Review of logistics system and update of contraceptive requirements -- Dalmat/Luche/MOH
- h) Medical equipment -- Dalmat/Bair/MOH
- i) Budget \$ and Cedi and financial arrangements - GOG contribution -- Luche/Dalmat/Bair
- j) Overall strategy including Public and Private sector on bilateral as well as the independent CSM -- Bair/Susman
- k) P.P. design - AID requirements, check list, log frame etc. -- Rauch/Luche

- INTRAH Centrally funded program for paramedical training in family planning - University of North Carolina
- JHPIEGO Centrally funded project with Johns Hopkins training physicians and nurses in family planning
- JOHNS HOPKINS PCS Centrally funded project - population communication service - for Information Education and Communication (IEC)
- FUTURES Private organization on contract to AID for development of contraceptive Social Marketing (CSM)
- CEDPA Center for Development and Population Activities- Private organization for leadership and women's training
- UNFPA United Nations Fund for Population Activities
- FPIA Family Planning International Assistance - international arm of Planned Parenthood U.S.A. large grant from AID largely for family planning service delivery emphasizing private sector

APPENDIX E

Cables Drafted During Assignment

UNCLASSIFIED
AID 10/25/84
A/DIR:TLUCHE
GDO:WBAIR
NONE
AID3 CHG DCM, CHRON

AMEMBASSY ACCRA
SECSTATE WASHDC
INFO AMEMBASSY ABIDJAN

ADM AID

FOR EICHER, AFR/TR/POP
ANNE AARNES, S&T/POP

ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

SUBJECT: REQUEST FOR CONSULTANTS IN MANAGEMENT OF
- FAMILY HEALTH PROGRAMS - GHANA CONTRACEPTIVES
- SUPPLIES PROJECT

REF: ACCRA 07654

1. IN COORDINATING MEETING WITH MOH, UNICEF AND UNDP REPRESENTING UNFPA OCTOBER 23 IT WAS DETERMINED THAT USAID SHOULD BE THE LEAD SOURCE FOR PROVIDING TECHNICAL CONSULTATION FOR TRAINING IN THE PRIMARY HEALTH CARE/MATERNAL CHILD HEALTH/FAMILY PLANNING PROGRAM.

2. A MAJOR COMPONENT OF THE TRAINING PROPOSED IS A LONG RANGE EMPHASIS ON IMPROVING FAMILY HEALTH PROGRAM MANAGEMENT WITH A STRONG FAMILY PLANNING COMPONENT. THIS IS TO BE JOINTLY IMPLEMENTED BY THE MOH AND THE GHANA INSTITUTE OF MANAGEMENT AND PUBLIC ADMINISTRATION. FOR THIS LONG RANGE EFFORT DR. JOSEPH OTOO, DIRECTOR OF MEDICAL SERVICES OF MOH, HAS SPECIFICALLY REQUESTED TECHNICAL ASSISTANCE FROM MANAGEMENT SCIENCES FOR HEALTH (MSH).

3. ANOTHER ACTION WILL BE THE REVIEW AND UPDATING OF REPRODUCTIVE HEALTH/FAMILY PLANNING CURRICULUM OF THE VARIOUS HEALTH INSTITUTIONS ALONG WITH REFRESHER TRAINING IN THESE SUBJECTS FOR THE FACULTY AND THOSE

J. J. Otoo
25/10

235 1

A/DIR

GDO

PROVIDING SPECIALIZED CLINICAL SERVICE, WE EXPECT JHPIEGO WILL PROVIDE ASSISTANCE FOR THIS AND WE WILL BE DISCUSSING THIS WITH CONNIE HUSMAN THIS WEEK.

4. A THIRD COMPONENT WILL BE IN-SERVICE TRAINING FOR PHC/MCH/FP SERVICE PERSONNEL ESPECIALLY IN THE TECHNICAL COMPONENTS OF SERVICE DELIVERY. INITIAL EMPHASIS WOULD BE TRAINING FOR PERSONNEL OF THE ~~15~~ 25 PHC DISTRICTS WHICH ARE RECEIVING SUBSTANTIAL UNICEF ASSISTANCE. HOWEVER, SOME ELEMENTS OF THE TRAINING PROGRAM WOULD SOON BE NATIONWIDE. IT IS EXPECTED THAT INTRAH WILL PLAY THE LEAD ROLE IN TECHNICAL ASSISTANCE THROUGH TRAINING OF TRAINERS AND ASSISTING WITH AT LEAST THE INITIAL SERIES OF IN-COUNTRY TRAINING COURSES AT THE DISTRICT LEVEL. THIS WILL BE DISCUSSED FURTHER WITH JIM LEA WHEN HE VISITS GHANA.

5. AN ESSENTIAL EARLY STEP IN THE TRAINING DESCRIBED ABOVE, ESPECIALLY THAT OF PARA 4, IS CLARIFICATION OF THE SERVICE DELIVERY MODEL TO BE UTILIZED AT THE HEALTH CENTERS AND HEALTH POSTS. FOR SEVERAL YEARS THERE HAS BEEN CONSIDERABLE DISCUSSION IN GHANA OF PHC, PREVENTIVE CARE, INTEGRATION OF SERVICE, AND DECENTRALIZED MANAGEMENT OF THE HEALTH SYSTEM. HOWEVER, HEALTH PERSONNEL AND THE HEALTH SYSTEM CONTINUES TO FUNCTION IN MANY PLACES IN THE OLD CENTRALIZED, COMPARTMENTALIZED FASHION SEPARATING CURATIVE FROM PREVENTIVE MCH STAFF AND WORK. F.P. FOR EXAMPLE IS ONLY PROVIDED IN MANY PLACES BY SELECTED INDIVIDUALS IN SPECIAL SESSIONS. IF F.P. IS TO BE INTEGRATED EFFECTIVELY INTO THIS SYSTEM, CONSIDERABLE EFFORT MUST BE MADE TO MAKE IT A PART OF THE RESPONSIBILITY OF ALL HEALTH PRACTITIONERS AND AVAILABLE AT ALL TIMES. DR. OTOO WISHES TO DEVELOP A MORE PRECISE DEFINITION OF THE PREFERRED SERVICE DELIVERY MODEL TO BE USED AS THE BASIS OF THE TRAINING PROGRAM. THE MOH PLANS TO HAVE THE SIX TRAINEES WHO RECENTLY ATTENDED THE MSH COURSE WORK TOGETHER FOR THIS PURPOSE. THEY HAVE REQUESTED THAT TECHNICAL CONSULTATION BE PROVIDED FROM MSH, INTRAH OR POSSIBLY CDC TO HELP THEM WITH THIS TASK AND THE FURTHER ELABORATION OF THE TRAINING PLAN REQUIRED TO MAKE THE MODEL FUNCTIONAL.

6. THE SCOPE OF WORK FOR THE TWO CONSULTANTS FOR FOUR WEEKS IN JANUARY/FEBRUARY 1985 WOULD BE TO ASSIST

CLASSIFICATION

IN THE SEVERAL FUNCTIONAL AREAS OF FAMILY HEALTH AND PHC AS WELL AS MANAGEMENT SKILLS AND UNDERSTANDING WILL BE REQUIRED.

8. REQUEST AID/W ASSISTANCE IN RECOMMENDING CONSULTANTS AND DETERMINING SIMPLEST WAY OF FINANCING, WHETHER IT BE USING PD AND S FUNDS, ISTI, INTRAH OR CDC. SINCE BOTH MSH AND INTRAH ARE EXPECTED TO ASSIST WITH THE FOLLOW-ON TRAINING, PREFERENCE WOULD BE TO USE THEIR SERVICES IN THIS INITIAL CONSULTATION. IF NECESSARY GOG CAN USE WHO CONSULTANT FUNDS TO PAY FOR THIS SERVICE. PLEASE ADVISE EXPECTED COST. BRIMS##

9. USAID request \$4T/pop to make CDC DACMAT'S services available ~~in the US~~ upon his return ~~to the US~~ to brief ~~there~~ and assist ~~there~~ as possible for organizing this consultancy. ~~on the ^{particular} technical and the overall objectives of the management / in-service training program ~~to follow~~ of which this was a key engagement.~~

DACMAT has played a key role in designing the management training component of the mission would appreciate his continuing involvement in its planning and/or implementation.

Tel 10/29

VZCZCGNA *
 RR RUEHC
 DE RUTAGN #7829 301 **
 ZNR UUUUU ZZE
 R 270913Z -OCT 84
 FM AMEMBASSY ACCRA
 TO SECSTATE WASHDC 3046
 BT
 UNCLAS ACCRA 07829.

CLASS: UNCLASSIFIED
 CHRGE: AID 10/26/84
 APPRV: A/DIRTLUCHE
 DRFTD: GDO:WBAIR:VTO
 CLEAR: NONE
 DISTR: AID3 CHG DCM
 CHRON

ADM AID

E.O. 12356: N/A

SUBJECT: POPULATION: CONTRACEPTIVE SOCIAL MARKETING

REF: (A) STATE 318338, (B) STATE 312545

1. MISSION APPRECIATES THE FUTURES GROUP (TFG) INTEREST AND SUPPORT.

2. AT THIS TIME GOOD PROGRESS IS BEING MADE WITH DR. RALPH SUSMAN'S ASSISTANCE IN DEVELOPING CSM COMPONENT AS INTEGRAL PART OF THE BILATERAL CONTRACEPTIVE SUPPLIES PROJECT (641-0109). IN OUR OPINION NEEDS FOR TA IN PROJECT DESIGN BEING ADEQUATELY ADDRESSED IN THIS FASHION. CLEARLY SUSMAN'S CONSULTATION DRAWS ON PREVIOUS ASSISTANCE SUPPLIED UNDER TFG SPONSORSHIP.

3. PROJECT 641-0109 DESIGN CALLS FOR USE OF FUTURES IN SUPPLYING CONTINUING TA AND OTHER ASSISTANCE WITHIN SCOPE DESCRIBED REF B.

4. ISSUES REQUIRING IMMEDIATE ATTENTION BETWEEN USAID AND TFG STAFF PERSONS ARE THE FOLLOWING:

--A) RESIDENT ADVISOR

--B) THE NEED FOR DOLLAR AND LOCAL COST FINANCING FOR THE CSM PORTION OF THE GHANA ACTIVITY OUT OF THE CONTRACEPTIVE SUPPLIES PROJECT AND THE MOST EFFICIENT MEANS OF APPLYING THESE FUNDS TO THE FUTURES SUPPORTED ACTIVITY.

--C) THE MANNER AND DEGREE OF USAID INVOLVEMENT IN THE MANAGEMENT OF FUTURES ACTIVITIES IN GHANA.

5. THE ABOVE ISSUES OBVIOUSLY INVOLVE THE AID/W PROJECT MANAGER AS WELL AS TFG AND USAID. MISSION DIRECTOR WAGNER IS IN AID/W AND WE THINK IT WOULD BE BEST TO HANDLE THESE ISSUES WITH HIM RATHER THAN TFG TRAVELLING TO GHANA AT THIS TIME.

6. BASED ON RESULT OF CONVERSATIONS PARA 5 MISSION WILL FURTHER REVIEW NEEDS FOR CONSULTATION WITH FUTURES AND NEEDS FOR TA. TFG TRAVEL TO GHANA EARLY IN CY 1985 MAY BE THE MOST APPROPRIATE. BRIMS

→ Blair / Susman
 → Joanne

VZCZCGNA *
 PP RUEHC RUEHAB
 DE RUTAGN #7654 293 **
 ZNR UUUUU ZZH
 P 191112Z OCT 84
 FM AMEMBASSY ACCRA
 TO RUEHC / SECSTATE WASHDC PRIORITY 2952
 INFO RUEHAB / AMEMBASSY ABIDJAN 3218
 BT
 UNCLAS ACCRA 07654

CLASS: UNCLASSIFIED
 CHRG: AID 10/19/84
 APPRV: DIR:RWAGNER
 DRFTD: GDO:WBAIR:BBJ
 CLEAR: GDO:TCLUCHE
 DISTR: AID3 CHG A/DCM
 CHRON

ADM AID

AID/W S&T/POP/IT, ANNE AARNES
 AFR/TR/POP, LAWRENCE EICHER
 S&T/HEALTH, ANN TINKER
 ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

SUBJECT: DESIGN OF CONTRACEPTIVE SUPPLIES PROJECT
 (641-0109) - GHANA

1. MOH HAS STRONG INTEREST IN MSH PARTICIPATION IN MANAGEMENT COMPONENT OF INSERVICE TRAINING. BASED ON MEETINGS HELD IN BOSTON AT REQUEST OF AFR/TR, DALMAT, CDC, REPORTS MSH AGREEMENT IN PRINCIPLE TO ASSIST MOH AND GHANA INSTITUTE OF MANAGEMENT AND PUBLIC ADMINISTRATION. IT IS LIKELY THAT SOME OF LOCAL COSTS OF THIS TRAINING IN GHANA TO BE SUPPORTED BY UNFPA UNDER RECENTLY APPROVED F.P. PROJECT MANAGED BY UNDP/GHANA. MISSION WILL COORDINATE WITH UNDP/UNFPA.

2. SIMPLE CONTRACTING MECHANISM FOR PROCURING MSH SERVICES ESSENTIAL TO LIMIT MISSION MANAGEMENT REQUIREMENTS. PRESUME MISSION USE OF HEALTH IQC IS ONE POSSIBILITY.

3. DESIGN CONSULTANTS HAVE ALSO EXPLORED POSSIBILITY OF INTRAH AND JHPIEGO INVOLVEMENT IN TRAINING; THE FORMER FOR IN-SERVICE TRAINING FOR CLINICAL AND COMMUNITY F.P. SERVICE DELIVERY AND LATTER FOR PRE-SERVICE CURRICULUM REVISION, REFRESHER TRAINING FOR TUTORS AND SPECIALIZED REPRODUCTIVE HEALTH TRAINING. IT APPEARS THESE TWO ROLES ARE SUFFICIENTLY SEPARATE AND INTRAH AND JHPIEGO COOPERATION EXPERIENCE SUFFICIENT THAT THIS WOULD NOT POSE MAJOR COORDINATION PROBLEM FOR MISSION OR GOG.

4. ONE OF THE ROLES FOR MSH IS FOR LIMITED U.S. AND THIRD COUNTRY TRAINING FOR SELECTED GHANAIAN OFFICIALS OF MOH AND GIMPA. THIS CAN BE HANDLED WITH NO DIFFICULTY THROUGH PIO/PS. THE OTHER ROLE FOR MSH WOULD BE IN ASSISTING GIMPA AND MOH IN DEVELOPING CURRICULUM AND IMPLEMENTING TRAINING PROGRAM IN PROGRAM PLANNING, MANAGEMENT AND EVALUATION FOR CLINICAL AND COMMUNITY BASED F.P. SERVICES.

5. TO MEET ESSENTIAL REQUIREMENTS TO SIMPLIFY BOTH

UNCLASSIFIED

ACCRA 7654

MANAGEMENT AND COORDINATION, MISSION REQUESTS AID/W TO INQUIRE OF INTRAH AND MSH IF MSH SERVICES CAN BE PROVIDED UNDER A SUB-CONTRACT WITH INTRAH FOR THE IN COUNTRY TRAINING REQUIREMENTS. WE WOULD CONCEIVE OF THIS BEING A JOINT INTRAH/MSH EFFORT (WITH CDC INPUT) TAKING ADVANTAGE OF THE RESPECTIVE STRENGTHS OF EACH INSTITUTION. PLEASE ADVISE ALL THAT THIS IS MERELY AN INQUIRY FOR INFORMATION AT THIS STAGE, HOWEVER MOH IS FULLY SUPPORTIVE OF THIS.

6. WOULD ALSO APPRECIATE YOUR INQUIRING UNEPA/NY ATTITUDE TOWARD COLLABORATIVE TRAINING VENTURE WITH UNEPA FUNDING LOCAL COSTS AND AID PROVIDING T.A. AS DESCRIBED.

7. PLEASE ADVISE ASAP. BRIMS

BT

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ACCRA 7654

APPENDIX F

Information Needed From the Ministry of Health (MOH)
to Assist in Development of a USAID Funded
Project to Support MCH/FP Activities

INFORMATION NEEDED FROM THE MINISTRY OF HEALTH
(MOH) TO ASSIST IN DEVELOPMENT OF A USAID FUNDED
PROJECT TO SUPPORT MCH/FP ACTIVITIES

1) A copy of MOH organogram showing where MCH/FP fits in.

E (1/2)

A staffing pattern for the MCH/FP Division with short job description of lead positions. Please indicate any plans for staff expansion. *Plus region x also list level under MCH supervision*

E (1/2)

How many positions are established for physicians, nurses, auxiliary nurses, other service delivery personnel at the National, Regional, District and local level? How many of these positions were filled (by category) in 1983?

4) Total cedi budget; Amount Allocated; Actual expenditure of MOH for 1981, 82, 83.

5) Total cedi budget; amount allocated; actual expenditure of MCH/FP Division 1981, 82, 83.

6) Please indicate any additional funds (cedis) which have become available at the regional, district or local level for the health system in 81, 82, 83.

7) What is the total MOH and the MCH/FP budget for 1984? What is requested for 1985?

8) What is the vehicle fleet available to the Ministry of Health - How many are assigned, of what type - at national, regional and district level? On average what percent of vehicles are operational? What is the procedure for maintenance and repair? *How is patrol allocated to regions and made available to users?*

9) List the various institutions for training health personnel and their locations. What is the approximate number of faculty at these institutions and how many students graduate each year with what type of training? (Give information for each institution if available or a total figure if details are not available). What percentage of the graduates are employed by the Public Health System?

10) What are the kinds and number of various types of institutions which deliver health care (e.g. hospitals, health centers - health posts)? Describe briefly the services provided at the health centers and lower levels of service delivery and the types and number of health personnel requested to staff these delivery points in the 1985 budget. *How many of each type of institution (e.g., hospitals, health centers, health posts) are currently providing services for women and children?*

- 11) Briefly describe the function and authority and give number of the administrative levels of the health system. What are the number and staff assigned and how are these administrative levels financed?
- 12) What progress was made in establishing PHC districts between 1981 and 1983? How many districts are functioning with village health workers selected, trained and supplied? What are the plans for expansion in the 1985 budget?
- 13) Are there plans for other initiatives to involve the community groups in health service delivery? Will they include family planning? *Health Brigade*
- 14) Have there been any recent standing order revisions or administrative notices sent to Regional or District offices regarding family planning service delivery or logistics and reporting for contraceptives?
- 15) See Chart Attached.
- 16) Please indicate the levels and types of assistance you have received or expect for the MCH/FP program from other donors such as UNICEF, UNFPA, Government of Japan and others - 1984, 1985, 1986.
- 17) Could you provide a brief statement of the MOH objectives in maternal child health/family planning stated in terms of:
 - a) program emphasis
 - b) coverage expansion (numbers of facilities offering service % of children and women in fertile age served by categories of service) - *Are there regions to be emphasized?*
 - c) training (kinds of training, % of target group, numbers of trainees) -
 - d) Information, Education and Communication - types of activity (quantify if possible, number of participants, posters, Radio spots, etc. - % of population to be reached) - *Are there regions to be emphasized?*
 - e) management improvements; i.e. efforts planned or underway to strengthen management effectiveness in areas of planning, logistics, supervision and evaluation.
 - f) new initiatives in service delivery, training or information programs

OT/O
over

** A more detailed plan for training and IEC will be needed. Here we just want the general objectives stated,

- 18) Provide a more detailed outline of the training program objectives, locations and personnel involved in training and the numbers and types of trainees.

A) Management Training

1. What are the specific objectives especially as they relate to primary health care, maternal/child health and family planning.
2. What faculty at GIMPA will be involved?
3. Will tutors from the MOH or other institutions also be used?
4. How will the courses be financed?
 - a) What resources are available to GIMPA from their regular budgets,
 - b) Will MOH make additional payments?
 - c) Are other donors involved in supporting GIMPA activities?
5. How many GIMPA faculty or MOH personnel should attend U.S. or other country MSH training?
6. How many and what kinds of MOH personnel do you expect to be trained in Ghana by GIMPA in 1985-1986.
7. How much and what kind of technical assistance will be required from MSH in Ghana (person months in 1985, 1986).
8. Is there a cooperative role for the Center for Disease Control in management training and can GIMPA provide assistance to the MOH in the actual management of the contraceptive supply activities?

B) Pre-Service Training

1. Do you require assistance for revising curriculum in reproductive health and family planning for:
 - physicians
 - mid-wives
 - nurses
2. What types of in-country refresher training should be provided for faculty of medical schools, mid-wife-schools, nurses? How many persons of what type should be included in 1985 and 1986?

C) In-Service Training

How many

- 1. Who is responsible for in-service training of MCH/FP of service delivery personnel in the MOH. Is there a cadre of personnel whose main responsibility is training?
- 2. How are the various health training institutions and faculties involved with the in-service training?
- 3. What facilities are there in Ghana where the patient case load is sufficient to use for the training program in family planning

Number

- 4. What kinds and numbers of personnel require MCH/FP in-service training of what duration in 1985 and 1986,

<u>Type personnel</u>	<u>Number</u>		<u>Duration of Course</u>
	<u>1985</u>	<u>1986</u>	
Trainers			
Midwives			
Nurses			
Auxiliary Nurses			

- 5. How will the travel and per diem costs of trainees be funded - What MOH resources are available?
- 6. What kind of assistance is required for the in-service training?
 - Training materials (what kind) _____
 - Consultants for training trainers? _____
 - Other? _____
- 7. What kinds and numbers of personnel require what kind and duration of training outside of Ghana?

19) Information, Education and Communication

- a) What are the specific objectives of the IEC program as related to MCH/FP (What kinds of message to achieve what purpose with what audience)?
- b) What media do you expect to use, e.g.:

- Radio
- TV
- Posters
- Pamphlets
- Community gathering
- Home Visits
- Other

- c) What IEC program related services could be contracted for to professionals operating in the private sector?
- d) What trained personnel resources are available in the MOH to undertake IEC activities?
- e) What financial resources or other (such as free radio time) are available to the MOH for I.E.C.?
- f) What will be required to expand the I.E.C. program -
 - External technical consultation
 - private firm assistance
 - materials development (of what kind and number)
 - Supplies (paper, ink, etc.)
 - financial assistance

20) What are the equipment requirements for the project?

21/

a) Clinical:

<u>Type equipment</u>	<u>Number and kinds of health facilities Where Required</u>	<u>Total Number Needed</u>	
		<u>1985</u>	<u>1986</u>

b) Office equipment:

<u>Type</u>	<u>Locations Where Required (Identify)</u>	<u>Total Needed</u>	
		<u>1985</u>	<u>1986</u>

c) Transport:

	<u>Locations Where Required (Identify)</u>	<u>Total Needed</u>	
		<u>1985</u>	<u>1986</u>

Supervisory vehicles specifically for FP program

Vehicles needed
for community
outreach

Motorcycles

Bicycles

APPENDIX G

Work Remaining To Be Done

APPENDIX C

Work Remaining To Be Done

November 7, 1984

Bair, Rauch, Susman

Status of PP preparation - Contraceptive Supplies (641-0109)

Thomas Luche, A/DIR

Attached is a draft of much of the body of the PP and several annexes. The following remains to be completed. Please refer to the PP outline -

<u>Section to be completed</u>	<u>Person</u>
1. Data Sheet	Rauch
2. Draft Project Authorization	Rauch
3. Needs more in various section on CSM	Susman/Rauch
3.6.2.5 Add Specifications to Vehicles	Rauch
4.2 Budget - Provisional figures have been developed but this needs more work	Susman/Rauch
5.2 Plan of Action a matrix has been developed that needs some more info on CSM	Susman/Rauch
5.3 Pre implementation - Section needs added to outline	Rauch
7. Summary of Project Analysis - not written	Rauch
8. Conditions & Covenants - Not written	Susman/Rauch

Annex A

PID Approval-cable use PID/PP guidance cable and recent cable back to AID/W	Rauch
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Annex B

Logframe - in process	Rauch
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Annex C

Statutory check list - in process	Rauch
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Annex D

GOG request	Rauch/Susman/Luche
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Annex E-1

Contraceptive requirements
Drafted by Dalmat being typed

Rauch

Annex E-3

CSM Feasibility and market plan
(in process)

Susman

Annex F

Financial to be done when more info
available - will include discussion
of use of funds from contraceptive
sales

Rauch/Susman

Annex G

Economic - The attached is weak

Rauch

Annex I-2

Private Sector (CSM) organization &
capability (in process)

Susman

Annex J

IEE

Rauch

Annex K

Waiver request for vehicles and non-
~~competitive procurement of DANAFCO~~
(Add-to-outline)

Susman/Rauch

Annex L

Draft letters of agreement - MOH
(MFEP) and DANAFCO (Add to outline)
(in process)

Susman

APPENDIX H

Persons Contacted in Africa

APPENDIX H

Persons Contacted in Africa

Persons Contacted in Africa - William D. Bair

Roy Wagner	Director USAID
Thomas Luche	General Development Officer - USAID
Joana Laryea	Health, Population, Nutrition Assistant
Eugene Rauch	Project Design Officer - REDSO/WCA
Ralph Susman	Consultant
Connie Husman	JHPIEGO
Michael Dalmat	CDC
James Lea	INTRAH
Arch Book	Director CIDA
Steve Glovinsky	UNDP
Taylor Andrews	UNDP
Glen Howell	SAWS
Dennis Caillaux	UNICEF
Robert Jackson	Assembly of God Publishing Company
Dr. Joseph Otoo	Director of Medical Services - MOH
Dr. Adamafio	Deputy DMS
Dr. William Osei	Director Maternal and Child Health - MOH
Ms. Victoria Assan	Director of Family Planning - MOH
Ms. Elizabeth Dadzie	Director MCH/FP Greater Accra Region
Dr. Sekyiamah	Principal Secretary Ministry of Finance and Economic Planning
Mrs. S. A. Ababio	Assistant to Coordinating Secretary PNDC
Hans Rothe	Industrialist on board of Ghana Institute of Management and Public Administration
Dr. Kumoji	Director of private Kumoji Hospital
Jacob Obetsebi Lamptey	Lintas Ltd (publicity firm)
Peter Hasford	Lintas
Mr. Quansah	Executive Secretary Planned Parenthood of Ghana (PPAG)
Mrs. Agnes Hughes	Acting Director Christian Family Program Christian Council of Ghana
Mr. Quarshie	Acting Director YMCA

Ms. Florence Ashitey

Professor Klufio

Warehousemen of Central

Medical Stores, TEMA

Mr. Yankey

Several pharmacists Cape Coast

Dr. (Mrs.) Hayfon Benjamin

Chief Nursing Officer

Family Planning Nurse

Medical Superintendent &

Chief Matron

Dr. Djang

Dr. Marty

Mr. J. K. Boadu

Mr. Sackitey

Mr. D. N. Gyamfi

Dr. James Shepperd

Lawrence Bond

Dr. George Jones

Anthony Bilecky

Sr. Nursing Officer Korle Bu University
Hospital, Accra

Chief OB/GYN Department Korle Bu Hospital

PPAG Director Cape Coast

Regional Medical Officer of Health, Kumasi

Manhyia Polyclinic, Kumasi

Manhyia Polyclinic, Kumasi

Komfo Anoyke University Hospital, Kumasi

OB/Gyn specialist Komfo Anoyke University
Hospital, Kumasi

Chief OB/GYN Department Komfo Anoyke
University Hospital, Kumasi

Assistant to Manager DANAFCO, Kumasi

Empire Pharmacy, Kumasi

Bikkai Pharmacy, Kumasi

Health Officer REDSO/WCA

Director REDSO/WCA

Director Regional Projects REDSO/WCA

Procurement Advisor REDSO/WCA