

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE **A** Amendment Number _____
A = Add
C = Change
D = Delete

DOCUMENT CODE **3**

COUNTRY/ENTITY **Ghana**

3. PROJECT NUMBER **641-0109**

4. BUREAU/OFFICE **USAID/Ghana AFR 06**

5. PROJECT TITLE (maximum 40 characters) **Contraceptive Supplies**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD) **03 30 89**

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY **85** B. Quarter **3** C. Final FY **87**

8. COSTS (\$000 OR EQUIVALENT \$1 = 050) cedis

| A. FUNDING SOURCE | FIRST FY 85 | | | LIFE OF PROJECT | | |
|----------------------------|--------------|------------|--------------|-----------------|--------------|--------------|
| | B. FX | C. L/C | D. Total | E. FX | F. L/C | G. Total |
| AID Appropriated Total | 2,000 | | 2,000 | 7,000 | | 7,000 |
| (Grant) | (2,000) | () | (2,000) | (7,000) | () | (7,000) |
| (Loan) | () | () | () | () | () | () |
| Other U.S. | | | | | | |
| 1. Centrally funded | 100 | | 100 | 576 | | 576 |
| 2. projects (prev. funded) | | | | | | |
| Host Country | | 248 | 248 | | 1,090 | 1,090 |
| Other Donor(s) | | | | | | |
| TOTALS | 2,100 | 248 | 2,348 | 7,576 | 1,090 | 8,666 |

9. SCHEDULE OF AID FUNDING (\$000)

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | C. PRIMARY TECH. CODE | | D. OBLIGATIONS TO DATE | | E. AMOUNT APPROVED THIS ACTION | | F. LIFE OF PROJECT | |
|------------------|-------------------------|-----------------------|---------|------------------------|---------|--------------------------------|---------|--------------------|---------|
| | | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan |
| (1) PH | 443 | 440 | | none | | 2,000 | | 7,000 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | | | 2,000 | | 7,000 | |

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code _____

B. Amount _____

13. PROJECT PURPOSE (maximum 480 characters)

To increase the voluntary use of safe, effective, and appropriate contraceptive methods by Ghanaian couples.

14. SCHEDULED EVALUATIONS

Interim: MM YY **0 8 7** Final: MM YY **0 3 8 8**

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 941 Local Other (Specify) **935**

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

See attached Mission Controllers Statement.

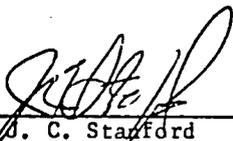
17. APPROVED BY **Thomas P. Juchie**
 Date **Acting**
 Director, USAID/Ghana

Date Signed **02/23/85**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

I have reviewed the proposed methods of implementation and financing for this project, and find them to to be appropriate. Where necessary, adequate provisions have been made for detailed assessments of financial management capabilities. I therefore recommend that you approve this proposed project paper.



D. C. Stafford
Regional Controller
REDSO/WCA

PROJECT AUTHORIZATION

Name of Country: Ghana

Name of Project: Contraceptive Supplies

Number of Project: 641-0109

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Contraceptive Supplies Project for the Government of Ghana ("Cooperating Country") involving planned obligations of not to exceed Seven Million United States Dollars (\$7,000,000) in grant funds over a 4 year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange costs for the Project. The planned life of the Project is 4 years from the date of initial obligation.
2. The Project will assist the Cooperative Country to increase the voluntary use of safe, effective and appropriate contraceptive methods by the Ghanaian population. This will be accomplished by making an adequate supply of contraceptives and other family planning services available to the Ghanaian public on a continuing basis through the existing service distribution networks of the Ministry of Health ("MOH") and through the development of a private sector Contraceptive Social Marketing program on the wholesale and retail level.
3. The Grant Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

A. Source and Origin of Commodities, Nationality of Services:

Goods and Services financed by A.I.D. under the Project shall have their source and origin in the United States, the Cooperating Country, or countries included in AID Geographic Code 941 except as AID may otherwise agree in writing. The supplier of commodities or services shall have the United States or the Cooperating Country as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as AID may otherwise agree in writing, be financed only on flag vessels of the United States or the Cooperating Country, or countries included in AID Geographic Code 941.

B. Conditions Precedent: In addition to the standard conditions precedent, the Grant Agreement will provide conditions precedent in substance as follows:

- (1) Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made except for the assessment referred to below, A.I.D. using project funds will conduct a detailed assessment of the methods for implementing and financing the project, including an assessment of the effectiveness of various methods of implementation and financing in Ghana overall and the level of efficiency of the implementing organization.



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

CAIRO, EGYPT

December 3, 1985

MEMORANDUM

FROM: Shanti Conly, DPPE/PE *SC*

SUBJECT: Evaluation of Helwan Housing Project, Upgrading
Component (263-0066): USAID/Egypt Comments

TO: See Distribution

This evaluation took place in July-August 1984. It was conducted by a five person team led by Sonia Hammam, RHUDO/Tunis. The team leader submitted the final report in August 1985, almost one year after the evaluation.

The report is comprehensive and raises several important issues. Its deficiencies are largely a question of presentation rather than substance. The purpose of this memo is to provide certain clarifications necessary to view findings and recommendations in context; to highlight important findings obscured by the presentation of the report; and to provide an up-date on certain project issues identified for follow-up action in the PES facesheet.

1. Purpose of the Evaluation: The project has two basic components: development of the Helwan New Community (HNC), a sites and services and core unit housing program for an initial population of 35,000; and an upgrading program, including credit for home improvements and small enterprise development, infrastructure and community facilities, in seven existing low-income communities in Helwan area with a combined population of nearly 100,000.

An evaluation of the overall project had been conducted in February 1982 but was considered by USAID to give inadequate attention to the upgrading component. The PES facesheet for the 1982 evaluation recommended further study of the upgrading component's progress. The current evaluation was planned in response to this recommendation, and is limited to the upgrading component. The Scope of Work called for a detailed assessment of the upgrading component's performance in meeting its implementation schedule and its institutional, economic and financial objectives.

2. Cost Overruns: The discussion in the evaluation regarding cost overruns is confusing, since the main focus of the evaluation is on the upgrading component, and the cost overruns are primarily in the other, HNC component. Costs for the upgrading portion of the project, moreover, remain very close to the original estimates.

Based on the March 1984 revised implementation plan, the evaluation projected a cost overrun of \$40 million over the original total project cost of \$160 million. The overruns appear to be in the design, construction and supervision of the HNC. Since the evaluation, UAD and the Joint Housing Projects Agency (JHP) have arranged for L.E. 4 million to be allocated and disbursed to the project from the 1984-85 CIP Special Account allocations towards meeting these overruns. Meanwhile, UAD, the JHP and the technical assistance contractor have begun work on a revised implementation plan that would reduce the estimated cost overruns in the HNC component. As soon as the cost estimates have been revised, UAD and the JHP will determine whether a request for additional allocations from the Special Account is necessary.

3. PACD Extension: The project will probably require a PACD extension. In the evaluation team's assessment, completion of the upgrading component "is likely to be after the first or second quarter of 1987". The current DR/UAD estimate for final completion of both the HNC and upgrading components is December, 1988.

4. Cost Recovery: The report includes an analysis of the potential cost-recovery for the three major elements of the upgrading package, i.e., home improvement loans, infrastructure and land title. The team estimates this potential using varying assumptions regarding affordability, land prices, etc. The major conclusions are:

- Some level of subsidy is necessary to reach the target low-income group, i.e., households below the 60th percentile of national urban household income.
- Project Paper standards for cost-recovery for the upgrading component are probably over ambitious. The Project Paper called for 100% recovery of land value, housing loans at 7% interest, and partial* recovery of infrastructure costs. It appears that households at the median income or below are unlikely to be able to afford Project Paper recovery standards. Cost-recovery expectations should be more directly

*The evaluation team assumed a target of 50% cost-recovery for infrastructure costs.

linked to affordability, and future upgrading programs for low-income groups should probably lower cost-recovery targets.

Any attempt to increase current levels of cost recovery for any one element of the upgrading package (e.g. increasing interest rates for home improvement loans) is likely to jeopardize ability to pay for other components (land title and infrastructure).

Although the upgrading program includes a substantial subsidy, this subsidy is significantly lower than in alternative GOE housing programs. It indicates that low-income groups can afford to pay a greater share of total housing costs than currently demanded of them in traditional GOE shelter programs, and that it is feasible for the GOE to recover a higher percentage of costs than it has in the past.

5. Legalization of land title: At the time the evaluation was conducted, little progress had been made towards the legalization of land title, a critical component to upgrading informal settlements. However, a major recent breakthrough has been the GOE approval of the land-use plans for the upgrading areas. This is the first step towards recognition and legalization of the squatters' land title. The second logical step would be the sale of the land by the authorities to the inhabitants. The JHP will soon begin discussions with the Cairo Governorate and other concerned authorities to expedite the land legalization process and the sale of land on affordable terms to the inhabitants.

6. Expansion of Home Improvement Loan Program: The report views the Home Improvement Loan Program (HILP) as the major success story of the project, and suggests that the appropriate strategy for expansion of this program is to convince commercial finance institutions to invest their own funds in similar loan programs. Some progress has been made in this area; Credit Foncier has recently taken a more active interest in the project. However, it is unlikely that private financial institutions will invest in home improvement loans unless interest rates charged are profitable, i.e. substantially higher than the 7% currently charged under the project. Moreover, until the land title issue has been resolved, alternatives to land title will need to be identified to guarantee the security of loans made by commercial institutions.

7. USAID Replication: Based upon USAID experience to date, the upgrading component - and in particular the HILP - is an important, potentially replicable, alternative model for

urban low-income housing programs, because it reduces the subsidy substantially from traditional GOE housing programs, and takes advantage of individual initiative and private sector construction capabilities to meet community needs in informal settlements. USAID has included a new shelf activity in this area for possible future funding.

Distribution:

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USAID/EGYPT
MID-PROJECT EVALUATION REPORT
COMMUNITY UPGRADING COMPONENT
HOUSING AND COMMUNITY UPGRADING FOR LOW INCOME EGYPTIANS
(Project 263-0066)

Prepared by:

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Final Report Date: July 1985
Evaluation Conducted: August 1984

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Acronyms and Definitions

| | |
|---------|---|
| ABS | - Annual Budget Submission |
| AID/W | - 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 |
| FFIA | - 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 |
| MFEP | - Ministry of Finance and Economic Planning |
| 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.
- Health Brigade - Volunteer group being organized and trained for community health work.

1. PROJECT RATIONALE AND DESCRIPTION

1.1 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 security. An economic recovery strategy has been developed. However, the Government has still not adequately linked food security 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 service.

1.2 USAID Strategy and Program in Ghana

The long-run objective of the USAID/Ghana program is to assist the Government of Ghana attain food security. 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 (see Economic Analysis, Annex G), the Mission has developed a very modest strategy for attacking the food security 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 difficult 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 macro-economic 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 security 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. 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 immediately 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.

1.3 Factors Affecting Project Selection

1.3.1 Social Consideration (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. In traditional society with high death rates, these practices held down the rate of population growth. However, with the urbanization of the society and a trend toward more nuclear families, these traditional practices, such as separating couples following childbirth and during lactation, have broken down. Now, however, economic conditions have led to increased desire for modern family planning. Ghanaian parents feel they are not able to feed or school their children adequately. High abortion rates and concern about adolescent fertility are also indications that there is an increasing problem. High fertility practices are still prevalent, however. 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.

As recently as 1979-80, the Ghana Fertility Survey found that there is strong support for large families. 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 only 30 percent of the population have reasonable access to the public health system, this number is expected to increase as Primary Health Care is expanded. There is impressive use of the prenatal, well baby and postnatal clinics, where the family planning services are provided. Therefore, this strategy would seem to reach a reasonable number of people.

Moving into the private sector, however, would expand the program considerably. 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 an A.I.D. consultant found the Government to be most receptive to the development and implementation of a retail sales program operating exclusively through the commercial sector. Senior policy officials in 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.

1.3.2 Economic Considerations

As noted previously, a major reason for our focus on population is the way in which demographic factors impact upon food security. 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 labor force and growing of child bearing women for the next fifteen years are already born, and increase in number each year. 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. Program options vary from more general to quite specific. The more effective of general development approaches seem to be in increasing 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 cannot be adequately addressed by the limited external resources likely to be available for population programs.

At the other extreme is 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.

What research studies have shown to be most effective is the expansion of family planning information and services, in the context of improving socio-economic development. This project, using the MOH structure, moving into the private sector, and anticipating community-based distribution of contraceptives, would most closely approach that ideal.

1.3.3. Relevant Experience from Other Projects

As described in the Background material (Annex E-4), family planning projects are not new in Ghana. These include 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 GNFP 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 improve 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.

(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 but will have no involvement in any aspect of direct implementation or financial management. 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.

1.4 Specific Project Problem and Constraints

This project expects to address specifically the constraints of lack of contraceptive supplies and efficient distribution in the public sector and lack of commodities in the private sector.

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 GNFPF Secretariat to place supplies in the proper place at the right time, and the break-down 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 Center for Disease Control (CDC). Considerable improvements in internal supply of contraceptives and record keeping and reporting have been noted.

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 reinstate 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 necessity for initiating the CSM portion of this project.

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, new program strategies and personnel shifts require refresher training. Additionally, there are new management procedure 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.

3) Outreach: Service delivery through clinics is one practical approach at this stage but reaches only 30% of the population. 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.

1.5 Project Objectives

The sector goal to which this project will contribute is slower population growth, which will relieve demand pressure in agricultural production and facilitate economic recovery. The reduced birth rates and increased childspacing will 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.

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 decision 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.)

1.6 Project Description

1.6.1 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 O88936 April 1, 1983, Annex A) 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. Deterioration over the past two years lead to the need for more training, especially in management, information programs and vehicles than originally contemplated. In order to adjust to the USAID and GOG management requirements, the project was simplified. Activities with the Christian Council of Ghana were deferred for the project period. 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.

Mission management requirements remain essentially the same. Even though reduced in scope, the project will still require a variety of inputs, especially technical assistance, from different sources. Mission efficiency can be improved through maximum use of centrally-provided goods and services. Mission input will be required to specify needs and timing, scopes of work for technical assistance and consultants and preparation of PIO/C's and PIO/T's. 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.

TABLE 1.5

ACCESS AND USE OF FAMILY PLANNING SERVICES

| | April 1986 | April 1987 | April 1988 | <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 Brigade distribution (TBAs, CCAs) | 495 | 1,305 | 2,115 | Adjusted for 30% attrition per year. Adjusted for 10% discontinuation each year. |
| - Employee stores | 60 | 168 | 276 | |
| 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 | 78,680 | 199,411 | 262,125 | |
| D. ESTIMATED PREVALENCE from Project | 4.5% | 10.2% | 13.2% | |
| E. PREVALENCE From NGO | 2.4% | 2.4% | 2.4% | |
| F. Estimated Prevalance from all Sources | 6.9% | 12.6% | 15.6% | |

1.6.2. Project Elements

There are five separate, though mutually reinforcing, elements to this project:

- . contraceptive inputs into the Ministry of Health MCH/FP system;
- . improvements in the MOH contraceptive distribution and management systems;
- . staff training to improve institutional efficiency;
- . information, education and communication efforts for intended beneficiaries; and
- . a contraceptive social marketing network.

1.6.2.1 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 2.0 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 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 | | |
|----------------------------|---------------------------------------|----------------------|----------------------|
| | <u>1985</u> (000) | <u>1986</u> (000) | <u>1987</u> (000) |
| Public and Private 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 |

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.

1.6.2.2 MOH Contraceptives Distribution and Reporting

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 contraceptive 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 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 warehouse, 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 needs 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 1.6.2.3 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.

1.6.2.3 Illustrative MOH Training

Several types of training could be provided under this project to support both the management and technical capability of the MOH to achieve project purposes. The exact training modules will be developed and pretested at an expert workshop at the beginning of project implementation; however the major training components will be:

In-country training for:

- . Management and Delivery of Family Health Services
- . Reproductive Health for Nurse-Midwives
- . Reproductive Health for Physicians

U.S. and Third Country training for:

- . MPH/FP for Health Planners, Administrators
- . Seminars and Observational Travel for FP leaders and trainers

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

(1) Management training will be provided for health administrators and delivery personnel of the MCH/FP program. 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 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 of family planning services.

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

It is expected that in the first three years of the project the following will have received training under the two topics above:

20 central and regional personnel will receive six weeks training in the technical and management modules to be used in training regional, district and community personnel throughout the project.

40 regional and district trainers will receive five weeks training in FP/FH service delivery skills, management/supervision of FP/FH and training technologies.

564 general clinic personnel (4 in each of 141 clinics) will receive five half-day weeks of training in FP/FH delivery skills and supervision of community-based personnel.

846 MOH outreach and 2,115 volunteer health regional workers will receive one week in FP/FH service delivery.

The training plan is built upon the logical hierarchy of training of trainers (TOT) from the central to community level. Project Year One will be devoted to designing, testing, implementing and evaluating the delivery services training to be fully implemented in Years Two and Three. The distribution of district and community level training over time will be:

| | <u>Project Year</u> | | | <u>Total</u> |
|--------------------------------|---------------------|----------|----------|--------------|
| | <u>1</u> | <u>2</u> | <u>3</u> | |
| Health Center/Clinic Personnel | 132 | 216 | 216 | 564 |
| Outreach | 198 | 324 | 324 | 846 |
| Health Brigade | 495 | 810 | 810 | 2,115 |

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. The national delivery service and management training will be reviewed and evaluated annual during a National Coordination Workshop to be conducted by GIMPA.

(3) Assistance will be provided to review and revise the MCH/FP curriculum of medical nursing, and midwifery schools and community health, reproductive health and family planning. JHPIEGO will assist in the review of pre-service curriculum and will assist in developing refresher seminars in reproductive health and family planning for faculty of various health training institutions.

Under this section of the training plan, 50 gynecologists will receive short-term training (three days) in reproductive health (Annex E-2-C) and 75 nurse-midwives will receive training in integrating FP into the nurse-midwife curricula.

It is expected that MOH will contract (using local currency) with GIMPA to manage and implement these training components including handling the associated local project costs.

(b) MHP/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 MHP 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.

(c) 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 and modalities, training techniques and informational and communications methods. The kinds of training contemplated include the following:

- . family planning clinical skills training at the JHPIEGO regional center in Ibadan, Nigeria
- . advanced family health management in the U.S. or in a third country
- . observation of community-based distribution programs in other countries.

(d) The training component of CSM will be discussed in Section 1.6.2.6.

(e) Management and Financing Plan. The USAID project manager and MCH training director (Annex I-1) will manage the project's training functions and monitor performance. Their rules and responsibilities are summarized in Annex E-2. A local hire project training assistant will be recruited to help coordinate the logistics of the training components and short-term external consultants. The USAID project manager, MOH training director and project training assistant will participate in the training program reviews and evaluations.

The costs of in-country training including GIMPA and training materials will be financed from local currency generation from sector program assistance and/or Title I food aid imports. In addition, the local hire project training assistant will be financed from those sources. These costs are reflected in the Financial Analysis (Annex F).

Short-term training in the U.S. and in third country and outside consultants to assist in the design and implementation of training (1.6.2.3) will, to the maximum extent possible, be funded from existing centrally (S&T/POP) and regionally (AFR/RA) funded projects. These are reflected in the preliminary budget (Table 2.1). Project funding includes \$235,000 for U.S. and third country training to supplement centrally funded resources. Should either of these sources prove to be insufficient, additional funding can be provided from the annual contingency line item.

Funding for the final evaluation (March 1988) is also included in the project budget.

1.6.2.4 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 emphasis.

The IE&C strategy has four major goals:

- . To inform potential clients of the availability of family planning services;
- . To recruit and maintain new clients;
- . To provide accurate information to new and existing clients and combat rumours and misconceptions on FP methods;
- . 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:

- . Radio programs on child spacing and family health;

- . Radio and T.V. spots focusing on the availability and health benefits of family planning services;
- . Information materials directed towards males;
- . Newspaper advertisements;
- . Popularized "comic book", or magazine publication for sale to the public.
- . Workshops for clinic staff and fieldworkers to ensure proper distribution of materials and proper approaches to inter personal communication;
- . 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 1.6.2.6 and in the CSM technical analysis, E-3.

1.6.2.5 Contraceptive Social Marketing

The Commercial Retail Sales portion of the project will operate through the very straightforward 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 of a range of contraceptive products. Experienced marketing and advertising professionals will increase public awareness about the contraceptive products and their availability, and 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 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 Future Group and CDC, centrally funded projects, will assist with technical consultation on marketing, program Management, advertising evaluation, logistical support and commodity supply issues.

1.6.2.6. CSM Program - Training Component

The objective of the CSM training program (annex E-3) is to provide up-to-date and authoritative training and information to retailers in the CSM Program network in order to: (1) improve individual retailer performance and provide better service to the community; (2) better equip the retail sales network with the means to respond to consumer demand; (3) create/strengthen the capacity of retailers to present a credible case for the role of modern contraceptives in child spacing and family health; (4) assist retailers in such matters as marketing and promotion including the

proper means of storage and display of the contraceptive products. In addition, some specialized short-term training will be provided to participating pharmacists to permit counselling to customers and up-date knowledge on contraceptive methods.

2. COST ESTIMATES AND FINANCIAL PLAN

The total value of this project is estimated at \$8.666 million. \$7 million coming from this bilateral project, \$1,090,000 equivalent of cedis from the GOG, \$290,000 of in-kind contribution from the MOH budget for personnel and distribution/storage of contraceptives and \$.8 million of cedis from counterpart funds. Centrally AID funded projects will supply approximately \$576,000 worth of technical assistance and commodities.

The \$8,666,000 of project inputs will be used in the first three years of LOP except for the final evaluation and audit, which will be performed in late 1988. Approximately \$5.5 of D.A. funding will be used for purchase of U.S. manufactured contraceptives. The remaining \$1.5 million will be used for the purchase of vehicles, commodities not available in Ghana, training costs, technical assistance, evaluation and auditing costs and for the contingency/inflation fund.

Tables 2.1 through 2.4 give break down by item, year, and source of project funds. All U.S. funds, both D.A. funded and centrally funded, are foreign exchange costs. All GOG contributions are in local currency or in-kind, whether from the MOH budget or cedi contributions from MFEP. The MOH in-kind contribution is based on cost during the calendar year 1983.

The desired obligation sequence of D.A. funds are \$2 million in FY85, \$3 million in FY86, and \$2 million in FY87. As seen in Table 2.4, this will allow the project to provide sufficient contingency funds available to overcome funding problems early in the project life. If funds remain after the third shipment of contraceptives (arriving in March/April 1987), the remaining unprogrammed funds will be used to purchase project commodities, T.A. and other inputs to obtain or exceed project goals.

The centrally funded projects, from which this project draws on for T.A. and some commodities, are now active and have sufficient funds to provide required project assistance. In some cases, D.A. funding will supplement central project funds to cover T.A. costs. In informal discussions with personnel from the firms implementing the centrally funded projects, USAID/Ghana has been assured that requests, of the variety the mission will be making, can be supplied and funds will probably be available to perform project activities. In addition, the contingency fund is purposely large enough to support more T.A. costs if central funding does not reach expectations.

Receipts which are in excess of costs of distribution, etc., from the CSM component and the MOH component of the project will be returned to the project and will be used in expanding or maintaining the family planning program in Ghana. The MOH will contribute 100% of the contraceptive sales receipts while in the CSM component approximately 3.5% of sales receipts will be placed in the return to project fund (RTPF). The method of accounting for these funds and their distribution have not, as yet, been decided but an agreement will be reached between USAID and the GOG prior to distribution of project funds.

2.1 Financial Plan for CSM Component

To encourage DANAFCO to implement the CSM program, the GOG will fund some of the initial start up cost of the program. The funds will come from a GOG counterpart funds (generated from other U.S.A.I.D. programs). These funds, all in Cedis, will be used to cover the start up costs of the advertising campaign, some labor costs and costs of materials which can be purchased locally (e.g. paper, cardboard). In addition to the GOG support to the CSM program, an AID centrally funded project, being implemented by the Futures Group will support the CSM program. Through this centrally funded project, DANAFCO will receive Technical Assistance in advertising, training of retailers, and also foreign exchange support for the purchase of necessary commodities which cannot be purchased in country (such as inks, dyes, promotion items, etc.).

Because of the low expected retail price of contraceptives (both in the public and private sector), a private entrepreneur would not be able to pay for the contraceptives, have them shipped to Ghana, repackage and distribute retail economically. Therefore, the GOG is willing to subsidize DANAFCO in order to make contraceptives available to the public. The cedi, the local currency, is now being systematically devalued to bring it down to its stable exchange value. The risk involved, without GOG support, would undoubtedly keep a profit oriented entrepreneur from venturing into the marketing of contraceptives, given the downward flexibility of the Cedi and the semi-rigid retail price level.

Once the CSM operation is fully functioning the CSM program should be profitable (assuming contraceptives are donated), but one of the conditions of the contract between DANAFCO and the GOG is for DANAFCO to increase its distribution network as well as develop a demand for contraceptives by advertising and promotion. Appendix II of Annex E-3 gives a hypothetical cost structure for DANAFCO. This cost data shows a return to project of approximately 3.5% of the retail price of the contraceptives.

The actual amount of GOG support to DANAFCO, the retail price of the contraceptives, profit margin to DANAFCO, return to project funds, etc. will be negotiated between MFEP, MOH and DANAFCO prior to the start of the CSM program.

2.2 Financial Plan for MOH Component

The MOH is currently operating its family planning program through the support of USAID, the UN, and other donors. One of the biggest problems is obtaining a continuous supply of contraceptives. The AID funded Family Health Initiatives (FHI) project is now ending, after supplying contraceptives to MOH over the last three years. The supply of contraceptives remaining in the MOH channels is now extremely low (see Annex E-1) and, in order to keep the family planning program working, the supplies from UNFPA will have to be supplemented.

This project will supply contraceptives to MOH during a three year period, given current estimates, the supplies will provide a sufficient amount of contraceptives for the entire four years of project life. To provide a better informed group of users and suppliers of contraceptives, the project will fund training both in-country and in other countries. This project will also provide vehicles to be used initially in the in-country training program and later in the regional centers for distribution of contraceptives to rural outposts. The vehicles provided are anticipated to

be Japanese (see Annex K), if U.S. vehicles do become available with an associated repair and maintenance system they will be purchased and the waiver will not be used.

This bilateral project and several centrally funded projects will also supply technical assistance for in-country training and other types of support to MOH's family planning activities. Some training both in the U.S. and third countries will also be funded.

Following is a tentative schedule for expenditures of project (D.A.) funds over project life (see also Table 2.4 and Table E-6 of Annex E-1).

| | | |
|------|--------------------|---|
| FY85 | \$1,100,000 | Contraceptives (\$600,000 MOH, \$500,000 CSM) |
| | 90,000 | Vehicles |
| | 235,000 | Training (U.S. and Third country) |
| | 85,000 | Technical Assistance |
| | <u>\$1,510,000</u> | SUB-TOTAL |
| | 490,000 | Contingency (carry over) |
| | <u>\$2,000,000</u> | TOTAL |
| FY86 | \$2,000,000 | Contraceptives (\$600,000 MOH, \$1,400,000 CSM) |
| | 130,000 | Training Materials |
| | 100,000 | Technical Assistance |
| | 50,000 | Evaluation/Audits |
| | <u>\$2,280,000</u> | SUB-TOTAL |
| | 720,000 | Contingency/Inflation (carry over) |
| | <u>\$3,000,000</u> | TOTAL |
| FY87 | \$2,425,000 | Contraceptives (\$625,000 MOH, \$1,800,000 CSM) |
| | 27,000 | Technical Assistance |
| | <u>\$2,452,000</u> | TOTAL |
| FY88 | \$ 25,000 | Final Evaluation |
| | <u>\$ 25,000</u> | TOTAL |

Table 2.1
Preliminary Budget

| A. USAID | <u>Project Funded</u> | | <u>Centrally Funded</u> |
|--|-------------------------|-----------------------------------|-------------------------|
| | <u>USAID</u> \$(000) | <u>GOG Cedis</u> \$ value(000) | <u>USAID</u> \$(000) |
| Contraceptives and freight for Public Sector | 1,848 | | |
| Contraceptives and freight for CSM | 3,679 | | |
| Support to the CSM component for packaging, advertising, training and distribution costs | | 300 | 200 (Futures) |
| IE&C materials and supplies | 80 | 50 | 20 (JH/PCS) |
| Vehicles and spare parts | 90 | | |
| In-country training (GIMPA) | | 200 | |
| Training materials and supplies | 50 | | 10 (JHPIEGO) |
| U.S. and third country training | 235 | | |
| Support for future NGO outreach activities, women's group and military, church and quasi- governmental health systems | | 50 | |
| Evaluation, surveys and ops research, audit | 150 | 100 | |
| Technical Assistance (see section B of this table) | 212 | | 346 |
| Contingency/inflation | <u>656</u> | <u>100</u> | <u> </u> |
| TOTAL | 7,000 | 800 | 576 |

* See Section C for GOG in-kind contribution.

| B. USAID (Technical Assistance) | | | <u>Project Funded</u> | <u>Centrally Funded</u> |
|---------------------------------|--------------|---------------------|-----------------------|-------------------------|
| | | | \$(000) | \$(000) |
| | <u>Trips</u> | <u>Person Weeks</u> | | |
| CDC | 14 | 55 | | 138 |
| ISTI | 2 | 4 | | 12 |
| INTRAH/MSH | 18 | 49 | 84 | 50 |
| JHPIEGO | 7 | 11 | | 36 |
| PCS | 9 | 30 | 48 | 30 |
| FUTURES | 20 | 60 | <u>80</u> | <u>80</u> |
| TOTAL | | | 212 | 346 |

| C. Government of Ghana in kind contribution (based on 1983 expenditures) | <u>Cedis</u> | <u>Dollar Value @1:50</u> |
|--|------------------|---------------------------|
| | (000) | rounded (000) |
| Clinical personnel salaries | 13,342,500 | 266,000 |
| Storage and distribution of contraceptives | <u>1,216,791</u> | <u>24,000</u> |
| TOTAL | 14,559,291 | 290,000 |

| D. Government of Ghana (local cost contribution) | <u>\$(000) Equivalent</u> |
|---|---------------------------|
| Support to CSM | 300 |
| IE & C materials and supplies | 50 |
| In-country training | 200 |
| Support to NGO's | 50 |
| Evaluations and Audits | 100 |
| Contingency | <u>100</u> |
| TOTAL | <u>\$800</u> |

Table 2.2
Summary Costs Estimate and Financial Plan
(In \$000 or equivalent)

| Source Use | AID | | Host Country | | Central Projects | | Total | |
|---------------------------------|------------|----|------------------|----------------------------|------------------|----|------------|------------|
| | FX | LC | L/C from MFEP | In-kind budgeted by MOH | FX | LC | FX | LC |
| Contraceptives for MOH | 1848 | | | 24 | | | 1848 | 24 |
| Contraceptives for CSM | 3679 | | | | | | 3679 | |
| Training and support to: MOH | 235 | | 200 | 266 | | | 245 | 466 |
| CSM | | | 300 | | 200 | | 200 | 300 |
| NGO | | | 50 | | | | | 50 |
| Commodities | 220 | | 50 | | 30 | | 240 | 50 |
| Technical Asst. | 362 | | 100 | | 346 | | 633 | 100 |
| Cont./Inflation | <u>656</u> | | <u>100</u> | | | | <u>731</u> | <u>100</u> |
| TOTAL | 7,000 | | 800 | 290 | 576 | | 7,576 | 1,090 |

Table 2.3
Costing of Project Outputs/Inputs
(In \$000 or equivalent)

Project Number: 641-0109
Title: Contraceptive Supplies

| Project Inputs | Contra- ceptives | Training | Technical Assistance | Commo- dities | Support to MOH & CSM + NGO Program | Conti- gency | Total |
|-------------------------|---------------------|------------|-------------------------|------------------|--|-----------------|--------------|
| AID Appropriated | 5,527 | 235 | 362 | 220 | | 656 | 7,000 |
| AID Centrally funded | | | 346 | 30 | 200 | | 576 |
| Host Country in-kind | 24 | | | | 266 | | 290 |
| Host Country L/C | | 200 | 100 | 50 | 350 | 100 | 800 |
| TOTAL | <u>5,551</u> | <u>435</u> | <u>808</u> | <u>300</u> | <u>816</u> | <u>756</u> | <u>8,666</u> |

Table 2.4
Projection of Expenditures by Fiscal Year
(In \$000 or rounded equivalent)

| <u>Fiscal Year</u> | <u>AID</u> <u>L/C</u> | <u>Host Country</u> | | <u>Central</u> | <u>Total</u> |
|-----------------------|--------------------------|---------------------|----------------|----------------|--------------|
| | | | <u>In-kind</u> | | |
| FY 1985 (6 months) | 1,500 | 200 | 48 | 100 | 1,848 |
| FY 1986 (1 year) | 2,500 | 200 | 97 | 250 | 3,047 |
| FY 1987 (1 year) | 2,500 | 200 | 97 | 150 | 2,947 |
| FY 1988 (1 year) | | 100 | 48 | 76 | 224 |
| FY 1989 (6 months) | | | | | |
| Inflation/Contingency | <u>500</u> | <u>100</u> | <u>-</u> | <u>-</u> | <u>600</u> |
| TOTAL | 7,000 | 800 | 290 | 576 | 8,666 |

3. IMPLEMENTATION AND MONITORING PLAN

3.1 Pre-Implementation

During the period between the authorization of the project (o/a February/March 1985) and the signing of the Project Grant Agreement (April 1985), many critical activities must take place. Foremost will be the assigning of a Population Officer to USAID/Ghana, as he/she will be responsible for coordinating the pre-implementation activities. Among the activities that must be coordinated are preparatory work before the project agreement is signed to permit rapid meeting of the C.P. requirements. These include: 1) insuring that MFEP and DANAFCO (implementor of the CSM program) are reaching an agreement toward signing of a contract; 2) insuring that GOG funds will be available to fund project implementation; 3) insuring that the MOH central warehouse has been rehabilitated and contraceptives are properly stored; and 4) keeping AID documentation flowing in preparation for the Pro Ag signing and early implementation documents (PIO's) are prepared. Additionally, the Population Officer (Project Manager) will have to coordinate pre-implementation consultations between central project contractors and the MOH and GSM personnel, setting the stage for the project training activities.

3.2 Implementation

After authorization of the project (o/a April 1, 1985) several activities must start simultaneously. Some are limited to GOG and USAID bilateral documents, such as issuing the first Project Implementation Letter (PIL), meeting of CPs prior to the first disbursement, and reaching agreement on the MFEP/DANAFCO contract. Other activities will be directed toward MOH or CSM activities.

AID documents, such as purchase orders for contraceptives, vehicles and commodities, and requests for T.A. should be issued immediately to get the activities moving. MOH will require help in arranging coordination of USAID funded T.A. for their family planning training and selection of participants for U.S. and other training. The CSM program under DANAFCO will probably need some assistance in preparing sub-contracts, acceptable to USAID, for advertising and training services. Negotiations with MFEP will also be needed to insure an arrangement suitable for both MOH and DANAFCO to get CEDIS from the MFEP account to start up training and other activities.

Coordination of Technical Assistance inputs from both centrally funded projects and services obtained from bilateral funds will be a critical activity. To aid the project manager in the coordination of T.A. for in-country training, an assistant may be required. This assistant will be a local hire funded from CCG L/C. The function of the training assistant will be transferred to the MOH when they are fully staffed (currently the position of Chief Director for Training is unfilled).

Third country and U.S. training will proceed as rapidly as possible. Third country training will normally be performed in Africa and will probably precede any participants being sent for U.S. training. Third country training will generally be short courses and seminars.

During the project there will be three audits performed and two evaluations. The audits will review DANAFCO's records and also review MOH and MFEP records/accounts of the counterpart Cedis account and project funds. There will be annual audits starting in November 1986. Two of the audits will immediately precede evaluations, the first in November 1986 for the mid-term evaluation in January 1987. The mid-term evaluation will be primarily used to compare the planned implementation to what has happened and to suggest changes in the implementation schedule. The final audit (November 1988) and final evaluation (January 1989) will document progress of the project in reaching project objectives. Either or both evaluations could be used to justify or initiate further family planning activities in Ghana.

3.3 Monitoring Plan

The majority of the monitoring activities will probably be placed on the project manager in AID. Although, he/she should coordinate closely with MFEP and MOH to move the monitoring activities to their project manager counterparts. Close supervision of the MOH training activities will be necessary as the timing of T.A. from the U.S. will be critical during the entire period. USAID's input in the MOH training activity is to end in April 1988, until January 1989 (final evaluation) the population officer should closely monitor MOH's ability to continue family planning training and provide additional T.A., as is necessary.

Another area deserving close monitoring is the storage and distribution of contraceptives by the MOH. Quarterly utilization reports are required from all MOH distributors of contraceptives (hospitals, health clinics, etc.). These reports should be reviewed and spot checked to insure supplies are being replenished regularly and that reports are accurate, both with respect to contraceptives and return to project funds. With periodic consultations by contractors of the centrally funded projects, the monitoring activities should be facilitated.

Monitoring of the CSM program will be easier in that there are fewer activities but spot checks and review of their records should supplement the annual audits, quarterly sales reports and inventory.

Perhaps one of the most important areas of the project to monitor will be return to project funds (both in MOH and the CSM) and use of the counterpart Cedis account. These will be the primary activities of the annual audit reports. To facilitate these accounts, a firm under an IQC, with REDSO/WCA, will help set up the accounts and train, if necessary, the staff responsible. As the IQC firms are located in West Africa, urgent requests for their services can be easily accommodated.

The project manager, who will receive all audit reports, TDY trip reports, as well as make periodic field trips with his/her counterpart, should always have up-to-date knowledge of project progress, and will, therefore, be able to respond to any implementation difficulties.

Table 3.1
CRITICAL ACTIVITIES IN IMPLEMENTATION

| <u>Activity</u> | <u>Date</u> |
|---|-------------------------|
| PP completed | February 1985 |
| PP submitted to AID/W | February 1985 |
| PP authorized | February 1985 |
| Project Grant Agreement submitted to GOG | March 1985 |
| CPs to execution of Pro Ag met by GOG | March 1985 |
| Pre-implementation consultations under centrally funded projects ¹ | March 15-April 30, 1985 |
| Population Officer assigned ² | April 1985 |
| * * * * * | * * * * * |
| Pro Ag signed | April 1, 1985 |
| PIL #1 submitted to GOG | April 10, 1985 |
| CPs to 1st disbursement met | April 20, 1985 |
| Contraceptives and vehicles ordered | April 30, 1985 |
| Contract between MFEP and DANAFCO signed | May 15, 1985 |
| Printing supplies for CSM component ordered | May 20, 1985 |
| Sub-contracts between DANAFCO and LINTAS and PHARMAHEALTH signed | June 1, 1985 |
| Selection of Third Country and U.S. trainees selected | June 15, 1985 |
| Printing supplies arrive | August 1, 1985 |
| Contraceptives arrive | September 1, 1985 |
| Project Amendment adding \$3 million to project | October 15, 1985 |
| 2nd shipment of contraceptives ordered | October 25, 1985 |
| CSM retail sales of contraceptives start | December 1, 1985 |
| 2nd shipment of contraceptives arrive | April 1986 |
| Final Pro Ag Amendment signed adding \$2 million to project | October 15, 1986 |
| Final shipment of contraceptives ordered | October 25, 1986 |
| 1st audit of DANAFCO and MOH accounts | November 15, 1986 |
| Mid-term evaluation | January 1987 |
| Final shipment of contraceptives arrive | April 1987 |
| 2nd audit of DANAFCO and MOH accounts | November 15, 1987 |
| Final (3rd) audit of DANAFCO and MOH accounts | November 15, 1988 |
| Final evaluation | December 1, 1988 |
| End of project | March 30, 1989 |

¹Expanded by MOH and CSM detailed schedules located in Annexes E-2 and E-3.

²If Population Officer is not assigned on a timely basis, all subsequent actions will be delayed.

4. SUMMARY OF PROJECT ANALYSES

Below are brief conclusions reached from project analyses found in the Annexes of this PP. Although some of the analyses were not done in great depth, the conclusions reached are quite obvious.

Annex E (Technical Analysis) covers technical parts of the project. From requirements of contraceptives to the training plans for both the CSM and MOH programs, as well as demographic statistics and family planning policy in Ghana.

The requirements for contraceptives (Annex E-1) are based on types of family planning methods used in Ghana, the types of contraceptives which the U.S. can supply, amount of contraceptives on hand, anticipated supplies of contraceptives from other sources, and projections of prevalence during the project.

Because of the depleted supplies on hand for MOH the initial shipment of contraceptives is quite large. Once the pipeline is filled public sales of contraceptives should return to the level previously obtain and with regular resupplying of contraceptives to rural health centers should increase their usage from the current 2% prevalence to 6.2% by the end of the project.

The CSM program or retail sales do not, at this time account for any distribution of contraceptives. With an aggressive advertising campaign, larger distribution network, and a continuous supply, the CSM program is expected to account for 7% of prevalence by project end. The distribution and use of contraceptives by other non-governmental organizations now accounts for about 2.4% of prevalence and this is not expected to change during the project. The total prevalence at project end should be approaching 16%. This is a tremendous increase from the current 4.4% prevalence and might appear unrealizable, but the demand exists in Ghana. The parallel distribution of contraceptives through the MOH and CSM program will insure a supply of contraceptives in most places and the aggressive expansion of the CSM program will provide contraceptives to areas where supplies were often interrupted or non-existent. The training programs in both components should also provide more information to users and encourage new users. So, although the project appears to be over optimistic, the technicians who have made these projections are sure that they can be obtained

The quantity of contraceptives supplied by AID should provide a three to six month supply available at the central, regional and district warehouses in the MOH program. This is to insure that some types of contraceptives will not be out of stock if shipments are delayed. In addition, at the end of project there should be about three to six months of supplies remaining, thus allowing some time for AID or another donor to implement a follow-on project.

Annex E-2 explains in detail how training of the MOH staff in family planning is to take place. The plan is very detailed because this project will use resources provided from centrally funded projects for the technical assistance. Few resources from this project will be used in the training but with project oversight the utilization of these centrally funded resources will greatly improve. For this project to obtain the results anticipated the training and upgrading of MOH staff used in the prescribing and providing of contraceptives is necessary to allow the users to be well informed. To increase prevalence of contraceptive use during the project MOH staff must be well versed in encouraging increased usage.

The CSM component is described fully in Annex E-3. This includes what type of training will be provided to retailers and when. How the advertising of contraceptive will be done and how DANAFCO will do the marketing of contraceptive. Training will be provided to pharmacies, chemical sellers, private clinics and maternity homes and other retailers. Depending on the level and education of the retailers, the training program will include:

- 1) information on the use and effectiveness of different contraceptive methods;
- 2) information on marketing and storage;
- 3) the objectives and goals of the project; and
- 4) upgrade and expand information base for those with professional qualifications.

The marketing plan includes the current distribution network of DANAFCO and how they will expand the distribution and storage network throughout the country. Also discussed is how DANAFCO will receive and repackage the contraceptives and inventory of stock. The annex also includes projected pricing structure and product sales.

The final section of the CSM annex describes the advertising plan and costs during the project. As mentioned earlier it is an aggressive plan and will require an infusion of money (from the GOG Counterpart Funds). It might be argued that the advertising budget is too large but in order to obtain project objectives and to increase the prevalence rate by 12% the aggressive plan seems necessary.

Annex E-4 covers the background material on demographic and statistical data of the population while E-5 relates the positive population policy and the place for family planning in Ghana's future. The desire of the GOG to reduce the population growth rate of 3.2 is fully described from excerpts from the leaders in the GOG. Since the late 60's, Ghana has pushed for family planning and look to limit population growth. It becomes obvious that Ghana is very serious about controlling the rate of population growth, even more so in these times of economic problems.

Annex F is a review of the financial effect of the project on the participants, the public sector and the private sector. The conclusion reached is that no one in the private sector will be injured by the project and that by the end of project the only cost to the GOG will be the cost of the contraceptives (if they were to buy them), less the return to project funds from sales. In the long run the GOG will benefit as the cost of other social programs will decrease (e.g. schools and medical costs).

The economic analysis (Annex G), although not an in depth analysis, show that for Ghana to continue economic growth a project of this type can only help not hinder. With the current large amounts of food donated (by USAID and other organizations) the Ghanaian people have sufficient food but should these contributions stop the economy of Ghana would surely return to the downward movement similar to the period before the IMF agreement. Only the reduction of the population growth rate with an increase in agricultural production will be able to eliminate the tremendous food deficit problem in Ghana.

Annex H, Social Soundness Analysis, relates the effect of family planning to the social environment of Ghana. The conclusion is that some social traditions will change with the move toward more family planning but the idea of family planning is now accepted in Ghana, after fifteen years of intervention. The effect of this project will not be detrimental to the social environment of Ghana.

Annex I gives a brief description of both the MOH and DANAFCO and their ability to implement this project. It becomes obvious that the MOH is the weaker of the two institutions, but nevertheless has the ability to implement this project with the aid of technical assistance provided under this and centrally funded projects. It can be concluded that both institutions are capable to implement the project but that the MOH component will need more supervisor and help, this will come from USAID resources.

5. CONDITIONS AND COVENANTS

Included in the Project Authorization and also in the Project Grant Agreement will be a series of Conditions and Covenants. They have been included to avoid situations which might jeopardize the success of the project.

Prior to the disbursement of any project funds there are five conditions which will have to be met. They are:

- 1) An executed agreement or contract between the GOG and DANAFCO, the implementor of the CSM component;
- 2) Assurances that the GOG will make available \$800,000 worth of cedis, from counterpart funds generated from PL 480 Title I commodity sales, to fund implementation of the CSM and MOH programs;
- 3) Evidence that the MOH central warehouse is in condition to receive project contraceptives and that the contraceptives will be properly stored;
- 4) Evidence that funds generated from contraceptive sales will be properly utilized during and after the project life; and
- 5) Evidence of and plans for GOG in kind contribution to the MOH portion of the project.

Generally these conditions are self explanatory, but expansion on a couple of points will aid in understanding their purposes. The contract between the GOG and DANAFCO and the GOG's financial support of the CSM program are extremely critical in implementing the retail sales of contraceptives (by the end of the project retail sales are expected to exceed MOH sales and currently there are no retail sales).

Two other conditions, those dealing with proper storage facilities and MOH support of the project with in kind contributions are necessary to insure the success of the MOH contraceptive sales and distribution in the public sectors.

The final condition is to resolve problems which have occurred in previous projects. That is a plan for use of funds generated from the sales of contraceptives and a method for disbursing these funds properly and in a timely manner.

There remains one other condition which relates to off shore training of medical personnel. Currently MOH has a problem of retaining trained medical personnel due to economic conditions in Ghana. Through this condition we hope to insure that medical knowledge passed on the MOH staff does not leave Ghana. Although difficult to enforce the retention of MOH staff is a necessary condition to project success.

The three covenants which are included are usually included in all projects, but are a bit more explicit in this project in order to make the GOG well aware of our intentions to make this project succeed and build a firm base upon which future projects can grow. These conditions are that:

- 1) project vehicles will be well maintained during and after the project;
- 2) all AID funded project commodities will enter the country duty and tax free; and
- 3) all accounts of funds generated from or used by the project can be audited by AID or its representatives as is felt necessary.

The first covenant needs no explanation. The second is to insure the GOG is well aware that AID, through a centrally funded project will be purchasing and importing commodities to DANAFCO in support of the CSM program. Condition three stems from problem which have occurred in previous projects and will tighten up the accounting of project goods and funds used in the project.

The project design team feels that all of the conditions and covenants listed above are critical to project success and in the end will strengthen the GOG ability to carry on in future projects involving family planning.

6. EVALUATION ARRANGEMENTS AND AUDITS

A mid project evaluation will be carried out in January 1987 by USAID and GOG with assistance from consultants provided by central projects either D.A. or centrally funded, USAID/Ghana and REDSO. This process evaluation will determine the need for project modification or expansion in 1987.

The mid-term evaluation will focus on such issues as the efficiency with which the several contracting actions are operating. Have consultants of the right type been provided on time? Was the GOG prepared to receive them and use their skills? Has the ordering and receipt of contraceptives been efficient? Are they moving through the system with proper reporting? Are the training courses operating as scheduled? Has the strategy for I.E. & C been developed and are planned actions in progress? Was the service delivery model completed, the training schedule developed and training programs initiated? Does the cooperation between MOH and GIMPA appear to be effective? Is GIMPA providing leadership and management inputs as expected? Has the packaging and distribution of commercial contraceptives been efficient? Have the expected numbers of distribution and retail outlets been included? Does it appear that in the public and private sector there has been good receptivity to the product? Was the overall implementation plan realistic? Answers to this type question will give guidance for mid-term correction and indicate the likely need for project expansion or extension.

Three financial audits will be carried out in the course of the project (Nov. 86, Nov. 87, Aug. 88). These will review the financial records of the CSM project and the program use of cedis from the GOG Local Currency Account. These audits, to be carried out by a commercial auditing firm, will provide additional information for the evaluation noted above.

CDC will assist with a contraceptive prevalence survey in 1987. The survey, service and sales statistics, contraceptive logistics report, audit reports and the internal evaluation of the training component will provide the primary data base for a final evaluation in October 1988. This final evaluation will focus on project success in achieving training, sales and contraceptive use objectives. It will be carried out by USAID and the MOH with consultants from pertinent centrally funded projects, USAID/Ghana and REDSO.

ANNEX A

VZCZCGNA *
PP RUEHC RUEHAB
DE RUTAGN #7740/01 297 **
ZNR UUUUU ZZH
T 231548Z OCT 84
FM AMEMBASSY ACCRA
TO RUEHC / SECSTATE WASHDC PRIORITY 3002
INFO RUEHAB / AMEMBASSY ABIDJAN 3238
BT
UNCLAS SECTION 01 OF * ACCRA 07740

CLASS: UNCLASSIFIED
CHRG: AID 10/23/84
APPRV: DIR:RWAGNER
DRFTD: GDO:TLUCHE:BY
CLEAR: GDO:WBAIR
DISTR: AID3 CHG DCM
CHRON

ADM AID

AID/W FOR AFR/PD; AFR/CWA; AFR/TR/POP AND S&T/POP

ABIDJAN FOR REDSO/WCA, ATTN. S. CLARK AND E. RAUCH

P.O. 12356: N/A

SUBJECT: CONTRACEPTIVE SUPPLIES (641-0109) PID

REF: ABIDJAN 16730

1. USAID AND PP DESIGN CONSULTANTS HAVE REVIEWED PID CLEARED BY THEN ACTING USAID DIRECTOR 12/31/82. NO COPIES OF AID-APPROVED PID AVAILABLE ACCRA BUT DESIGN TEAM MEMBER BILL BAIR RECALLS THAT PID WAS APPROVED BY AID O/A FEB. 1983.

2. THE PID PROVIDED FOR DOLS 1.5 MILLION DA POP GRANT FUNDS OVER THE PERIOD FY 83-86. EVOLUTIONARY CHANGES SINCE THEN HAVE BEEN DOCUMENTED THROUGH THE FY 85 AND FY 86 ABS AND CURRENT PP DESIGN PARAMETERS (AT THE BEGINNING OF THE EXERCISE) ARE FOR DOLS 4.0 MILLION TOP AID INPUT -- DOLS 1.0 MILLION IN FY 85 AND DOLS 3.0 MILLION IN FY 86-WITH A FOUR YEAR DURATION. THE COMPLETED PP DESIGN WILL ESTABLISH THE FINAL COST AND TOP NEEDS BUT THESE SHOULD NOT EXCEED DOLS 5.0 MILLION OR 4 YEARS.

3. THERE HAVE BEEN A NUMBER OF CHANGES IN PROGRAM ASSUMPTIONS SINCE THE ORIGINAL PID. THE CHETS (PRIMARY HEALTH CARE) PROJECT (641-0082) HAS BEEN TERMINATED AT AID'S INSTANCE (AND PRESUMABLY WITHOUT TAKING INTO ACCOUNT CONGRESSIONAL LEAVENING OF THE HEALTH AND POP ACCOUNTS) AND EARLIER PLANS FOR A COMPREHENSIVE PHC/FP PROJECT HAVE BEEN SHELVED FOR AID/W-IMPOSED PROGRAM CONCENTRATION AND USDH PERSONNEL LIMITATION REASONS. THESE CHANGES BEAR ON DURATION OF THE PROJECT AS WELL AS RAISE THE CONTRACEPTIVE COMMODITY LEVEL TO BE PROVIDED THROUGH THE MOH SYSTEM.

4. IN ADDITION, THE DESIGN NOW RESPONDS TO SEVERAL NEW OR EXPANDED ELEMENTS:

-A) MOH DESIRE TO HAVE A SUBSTANTIAL MANAGEMENT TRAINING INPUT. THE IMPORTANCE OF IMPROVING MANAGEMENT HAS BEEN DOCUMENTED BY CDC REPORTS OF THEIR TECHNICAL

ASSISTANCE IN FP LOGISTICS AND REPORTING. THIS IS APPARENT THROUGHOUT THE HEALTH SYSTEM ESPECIALLY AS OTHER-DONOR-SUPPORTED MOH EFFORTS ARE UNDERWAY TO EXPAND THE PFC PROGRAM WHICH WILL BE A MAJOR MEANS FOR EXTENDING FP DELIVERY BEYOND THE CLINICS INTO THE COMMUNITY. THIS MANAGEMENT TRAINING ELEMENT WILL BE TAILORED TO THE NEEDS OF FP BUT BE BROAD ENOUGH TO CONTRIBUTE IMPROVED MANAGEMENT PRINCIPLES AND PERFORMANCE TO THE TOTAL DELIVERY SYSTEM WITHIN WHICH FP MUST WORK.

(B) USAID DESIRE, FOR MANAGEMENT REASONS, TO INCLUDE CSM AS WELL AS MOH CONTRACEPTIVE DELIVERY SYSTEMS IN THIS ONE BILATERAL PROJECT. A CSM COMPONENT WAS NOTED (PG. 10) IN THE ORIGINAL PID AS DESIRABLE BUT AT THAT TIME IT WAS NOT CONSIDERED FEASIBLE. A CSM FEASIBILITY STUDY INDICATING POSITIVE POTENTIAL FOR THIS ACTIVITY WAS COMPLETED BY DESIGN TEAM MEMBER RALPH SUSMAN 8/84 AND IS AVAILABLE IN AFR/TR/POP.

(C) AN ASSESSMENT THAT SERVICE DELIVERY TRAINING AND IEC COMPONENTS WHICH WERE MINIMAL IN THE PID MERIT INCREASED ATTENTION DUE TO MOH STAFF TURNOVER AND TO SUSTAIN THE CURRENT (RELATIVELY HIGH FOR AFRICA) LEVEL OF POPULAR DEMAND FOR FP AIDS.

(D) THE PROPOSITION TO KEEP CCG, APPLE AND PPAG OR OTHER PVO FP DELIVERIES UNDER THE SEPARATE FPIA OR IPPF SYSTEMS, AT LEAST DURING FIRST TWO YEARS OF THE PROJECT, BASED ON AN ASSESSMENT OF MOH SYSTEMS AND USAID MANAGEMENT CAPABILITY AT THIS TIME.

(E) CONSIDERATION IS BEING GIVEN TO THE PROVISION OF MODEST AMOUNTS OF CLINICAL EQUIPMENT AND BICYCLES OR MOTORCYCLES FOR COMMUNITY WORKERS TO ASSURE ADEQUATE PROVISION OF SERVICE AND SUPERVISION.

5. THE PROJECT GOAL REMAINS THE SAME, TO REDUCE THE LONG TERM FOOD SUPPLY DEFICIT IN GHANA. THE PROJECT PURPOSE REMAINS ESSENTIALLY THE SAME -- TO INCREASE THE VOLUNTARY USE OF SAFE, EFFECTIVE AND APPROPRIATE CONTRACEPTIVE METHODS BY GHANAIAN COUPLES -- EXCEPT THAT THE SUPPLY OF FP SERVICES TO BE MADE AVAILABLE ON A CONTINUING BASIS WILL MOVE THROUGH BOTH PUBLIC (MOH) BT

2.1.2. Major Findings, Conclusions and Recommendations

The home improvement program has been functioning effectively since March, 1981, principally in three of the upgrading communities with the very recent addition of two more. A substantial number of loans have been made, nearly reaching original expectations already.

The loans have been quickly translated into tangible housing extension, improvements, as well as housing additions for rental. Borrowers have added significant amounts of their own money to the loans in making improvements. Additionally benefits of the loans have gone systematically to people of lower incomes as intended. The one substantial setback was a temporary freeze on loans, followed by a limitation in the types of loans could be made, beginning in mid 1983. The collapse of a building triggered enforcement of a requirement for a building license for any construction -- a requirement which was impossible to meet without land title. The freeze was relaxed and a final resolution of the problem appears imminent.

Major findings concerning the replicability and viability of the HILP, and conclusions regarding alternative ways for restructuring the program are as follows:

ACTION: AID INFO AMB DCA ECON CERON 10/ECW

VZCZCTAB1561SC226
RR RUTAGN
DE RUEHC 48936 4911214
ZNR UUUUU ZH
R 012759Z APR 83
FM SECSTATE WASHDC
TO RUTAGN/AMEMBASSY ACCRA 2178
INFO RUEHAB/AMEMBASSY ABIDJAN 4058
BT
UNCLAS STATE 088936

RECEIVED
- 5 APR 1983
USAID/GHANA

17 APR 1983
JAGC: AID

AIDAC, ABIDJAN FOR HEDSO/DCA

E.O. 12356:W/A

TAGS:

SUBJECT: GHANA - CONTRACEPTIVE SUPPLIES 541-0143 - PID
ISSUES MEETING

ACT: H PM
INF: AIDIR
PRM
CHN
R?

1. PID WAS REVIEWED AT ISSUES MEETING ATTENDED BY REPRESENTATIVES OF AFR/PD, AFR/TR/POP, AFR/CA, AFR/DP, AFR/ED PR

AND GC/AFR. CONSENSUS OF MEETING WAS THAT PID CONTAINS NO ISSUES THAT WOULD PRECLUDE ITS GOING TO ECPR. PID WILL BE PRESENTED TO BUREAU ECPR WITH THE FOLLOWING COMMENTS.

2. THE REVIEWERS, WHILE AWARE OF PREVAILING PRACTICES IN GHANA, FEEL THAT THE MISSION SHOULD MORE ACTIVELY PURSUE A POLICY DIALOGUE WITH THE GOVERNMENT TO PROMOTE COMMERCIAL RETAIL SALES OF CONTRACEPTIVES. THE PID STATES THAT RETAIL SALES WILL BE VIABLE ONLY IF THE GOVERNMENT REMOVES BUREAUCRATIC CONTROLS FROM THE SYSTEM, BUT FAILS TO SHOW HOW THIS PROJECT WILL FACILITATE ON-GOING DISCUSSIONS TOWARD THAT END. REVIEWERS WERE SUPPORTIVE OF MISSION EFFORTS TO REMOVE OBSTACLES TO REINSTATING COMMERCIAL RETAIL SALES PROGRAM, AND ENCOURAGE THE MISSION TO INCLUDE ITS RESUMPTION IN THE PP DESIGN, IF POSSIBLE. THE PP SHOULD INCLUDE A FULL DESCRIPTION OF PLANNED ACTIONS AND PRE-CONDITIONS FOR RESUMPTION OF THAT ACTIVITY.

3. MANAGEMENT CAPABILITY - IMPLEMENTATION REQUIRES THAT A HEALTH/POPULATION OFFICER BE ON YOUR STAFF THROUGH 1983. UNDERSTAND FROM DISCUSSIONS WITH WAGNER THAT PP DESIGN SHOULD NOT PROCEED UNTIL RICHER REPLACEMENT ON BOARD. PLEASE CONFIRM.

4. THE PP SHOULD EXPLAIN HOW DATA COLLECTION AND PROCESSING WILL BE UNIFORM AMONG THE AGENCIES PARTICIPATING IN THE PROJECT.

5. AFR/TR/POP, AFR/PD AND S/T/POP, BASED ON ANNEX A ANALYSIS, AND AFTER CONSULTATION WITH CDC'S MONITORING WILL CABLE PROPOSED FY 83 CONTRACEPTIVES PROCUREMENT. NO ACTION HAS BEEN TAKEN AT THIS TIME TO INCREASE THIS PROJECT BY DOLS 500,000 AND REDUCE DAPIT BY THE SAME AMOUNT. WILL PRESENT A DOLS 2.5 MILLION TO ECPR. WILL ADVISE SEPTEL ON REQUEST TO INCREASE POP OYB LEVEL.

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6. WILL ADVISE DATE ECPR IS SCHEDULED. SHULTZ

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- At least in the long-term, restructuring could include capturing somewhat more of the resources of the program's highest income beneficiaries. But more centrally, it could include arranging for financial institutions to provide the home improvement loans from their own funds, rather than only servicing loans made with GOE and AID resources. The GOE and AID role could then focus on providing adequate operating budgets and skilled staff, sufficiently low interest payment levels (subsidized if necessary), and loan-security arrangements to keep the program functioning and to ensure that it continues to serve lower income people. The up-front costs of such an approach would be significantly lower, allowing more extensive early progress.
- Two additional program structuring issues are relevant in considering extension and structuring of the HILP. First, consideration should be given to utilizing graduated payment mortgages as a means of increasing borrower's ability to pay. Second, in communities where there are fewer salaried workers than Helwan, new provisions may be required to guarantee repayment by borrowers.

The seven parts of this chapter present in detail the findings summarized above and provide supporting evidence and analysis.

These seven parts discuss in turn:

1. Costs of the HILP, cost recovery from beneficiaries, and the subsidies required;
2. Financial viability of the current program, and alternative ways to structure and support it;
3. The incomes of HILP beneficiaries.
4. The demand for HILP loans;
5. The types of improvements made with them;
6. The contributions of HILP beneficiaries to rental supply and to home improvements from non-HILP resources; and
7. The process of implementing the HILP;

Each part begins with a summary of its key findings and conclusions, for the convenience of the reader.

2.2. HILP Costs, Cost Recovery, and Subsidies

2.2.1. General Summary

The substantial experience in actually operating the HILP provides a good basis for estimating its costs, the share of cost that is recovered from borrowers, and the subsidies that USAID and the GOE provide. Based on this evidence, the overall picture is one of very reasonable expense levels for a program of this type.

Cost recovery on the HILP meets Project Paper capital cost recovery standards with repayments of principal at 7% interest. Full cost recovery would require repayments at higher interest rates, reflecting the true value of capital. By such standards, the HILP recovers an estimated 70 to 85 percent of capital costs. There are, however, net expenses of program administration in addition to the capital cost of credit that reduce the repayments available for future use, a major portion of capital cost, though not all of the expense will be paid for over time by the HILP beneficiaries. This cost recovery level appears to compare favorably with past experience in housing programs in Egypt and elsewhere. The residual subsidy costs have been shared quite equally by AID and JHP, with JHP having a modestly larger share.

2.2.2. Capital Costs, Cost Recovery and Subsidies

Costs of the HILP fall into two major categories: capital costs and operating expenses. Capital costs are simply the costs of providing credit for the home improvements themselves. In any loan program, this cost involves making an initial capital outlay and then waiting for any repayments, both principal and interest, to be returned.

In the HILP, the average loan amount is now about \$1580. 2/
This direct capital cost of making the loans is shared equally
by GOE and USAID. The total cost to date has been \$2.17 million
for 1369 loans.

The capital costs can also reasonably be thought of as being
incurred over time, instead of all in one lump (conceptually, as
though the alternative use of the money were to invest it
elsewhere at some rate of interest). That allows them to be
compared to the stream of repayments. Such costs per year
depend on the rate of interest and the period over which the
money is lent.

According to interviews with CFE Helwan Branch Office Staff, the
average period for payment in the HILP is about 12 years. It is
appropriate to use this actual repayment period in assessing the
costs of providing these loans. There are at least 3 appropri-
ate interest rates at which to consider the cost of capital over
time: 3/

2/ LE 1298 as of March, 1984.

3/ A fourth is the cost of long-term capital in Egypt, not subsidized by
(Footnote continued on next page)

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- 7.0 percent, the recovery rate sought according to the Project Paper.
- 10.5 percent, the rate at which CFE can currently borrow money from the Egyptian Central Bank (increased by 1% for servicing costs), which represents the potential cost of using borrowed funds in Egypt to finance the program.
- 14%, an approximate cost of long-term capital invested in the U.S.

The first two columns of Table II.1 show the annual cost (per loan and in total) of the loan financing, for each of these rates of interest.

TABLE II. 1
ANNUAL COSTS AND RECOVERY
OF HILP LOAN CAPITAL

| | <u>Annual</u> <u>Per Loan</u> <u>Costs(a)</u> <u>(\$)</u> | <u>Total Annual</u> <u>Costs</u> <u>(\$)</u> | <u>% of Costs</u> <u>Recovered</u> <u>in HILP</u> | <u>Annual</u> <u>Implicit</u> <u>Subsidy(b)</u> <u>(\$)</u> |
|--------------------------|--|--|---|--|
| at 7% cost of capital | 195 | 267,000 | 100% | 0 |
| at 10.5% cost of capital | 232 | 318,000 | 84% | 51,000 |
| at 14% cost of capital | 272 | 373,000 | 72% | 106,000 |

a. Loans through June, 1984

b. Divided evenly by AID and GOE, on the basis that the two share the initial credit cost equally.

(Footnote continued from previous page)

the Central Bank, which given the high current rates of Egyptian inflation (about 16%) would be higher still if borrowed and paid in LE.

Much of the annual loan cost is being recovered through repayments by borrowers. Borrowers are repaying loans at 7% interest over a 12 year period. ^{4/} The effective interest rate ranges as high as 8% due to the accounting procedures in which monthly repayments to principal are only credited annually. How much borrowers actually repay of course depends on the level of defaults or arrears (late payments) occurring. The experience to date, as reported by CFE, shows no defaults at all. About 5 to 15 percent of loans have been in arrears in a given month. But all of these arrearages have been of short duration (2-3 months) and payments have been restored. Thus repayments are actually being received, combining principal and 7% interest.

As indicated in the third column of Table II.1, the share of capital cost being recovered is high by any standard. The Project Paper's goals are being fully met. The repayments cover a substantial part of capital cost measured at "market" rates. The last column of the table shows the annual subsidy, net of repayments, of capital valued at the various rates, which is effectively divided equally by AID and GOE. These costs will rise as the amount of credit lent out rises for the cases of

^{4/} The repayment period on a given loan ranges from 5 to 20 years.

10.5% and 14% interest. However the subsidy given the 7% Project Paper recovery rate will remain at zero, because on each loan the PP goal of recovery is met.

Continued good performance in recovering capital costs depends on maintaining a low level of defaults. CFE staff are concerned that defaults will rise over time as people retire or die before loans are paid off, or lose their jobs; but CHF observers disagree. We do know that if defaults occur only after many years of repayment, the losses will be low on each default.

It is important to recognize that borrowers' repayments of capital are not actually available solely for capital cost purposes. One percent of each payment is given to CFE as a servicing fee and two percent of the interest is set aside as a bad debt reserve.

2.2.3. Administrative Costs and the Subsidies Involved

In addition to capital costs, there are the full administrative costs of the HILP to be paid. These include the costs of CFE in servicing the loans (processing applications and collecting receipts) and the costs of JHP-PIU and CHF in helping people make loan applications, designing the home improvements and

estimating their costs, inspecting contractor work, and cooperating with CFE in its work, along with initial work in program design. Based on staffing and overhead cost levels obtained in interviews with CFE, JHP-PIU, and CHF staff, the administrative costs are those reported in Table II.2. ^{5/} The table shows both total costs to date and cost for a typical year during implementation. The yearly cost average excludes a CHF program design start-up cost that is not being repeated.

The total administrative cost of just over \$330,000 in Table II.2 reaches about \$400,000 if one-time expenditures in providing a computer capability to CFE are included. The less than \$90,000 average annual cost seems very reasonable for operation of a new and quite complex program, given the need to work out procedures and especially the disruption caused by the freeze on new loans for a major part of 1983-1984. The yearly administrative cost is roughly between 6 and 14 percent of annual loan volume, a good performance under any circumstances.

Borrowers are paying for part of the administrative costs, as well as repaying capital costs. Each borrower pays 2 percent of

^{5/} It would be useful to increase CFE expenditures by an amount that is sufficient enough to provide the branch office with telephone and auto capabilities.

the amount lent as a loan origination fee. As noted above, 1 percent of the interest paid goes to CFE for loan servicing costs. Total fees to date paid to CFE are \$47,780, or 14 percent of total administrative costs of all agencies (without computer).

TABLE II. 2
HILP ADMINISTRATIVE COSTS
(\$)

| <u>Institution</u> | <u>Total Costs</u> <u>Jan 1981-June 1984</u> | <u>Average Annual</u> <u>Cost During Implementation</u> |
|--------------------|---|--|
| CHF | 50,559 | 6,585 |
| JHP | 172,557 | 51,086 |
| CFE | 108,360 | 30,960 |
| TOTAL | 331,476 | 88,631 |

That leaves total administrative costs to AID and JHP of about \$284,000 (see Table II.3). ^{6/} With AID paying half CHF and all computer costs and JHP paying for its own and CFE administrative costs, JHP has paid well over two-thirds of the HILP administrative expense subsidy (see Table II.3).

^{6/} Note that the as yet very small 1% loan servicing fees have been doublecounted in analyzing capital and administrative cost recovery separately.

Since the much larger capital costs for the program are split equally, the overall subsidy is split nearly equally between AID and JHP.

Note that JHP has not yet formally agreed to pay CFE anything beyond the origination and service fees CFE is collecting from borrowers, as in their original agreement. The cost figures are based on a tentative agreement to pay enough beyond fees to cover CFE's direct expenses and 80% overhead rate. In the long run, it would probably be best to choose a new service fee level that covers CFE costs even if borrowers pay only part of it, but CFE is willing to participate under the current arrangement, taking a small loss, or under the tentative agreement.

TABLE II. 3
ADMINISTRATIVE COSTS, REVENUES, AND SUBSIDY
(\$)

| | |
|----------------------------|---|
| Total Admin. Costs to Date | 331,476 |
| Total Fees Recovered | 47,780 |
| Net Admin. Costs (Subsidy) | 283,695 |
| AID subsidy share | 25,280 (plus computer costs of \$67,000 to date) ^a |
| JHP subsidy share | 258,417 |

a. Computer costs are based on 50:50 allocation of total computer costs between new communities and upgrading.

TABLE E-6
ESTIMATES COSTS OF CONTRACEPTIVES
PROVIDED AS PART OF GHANA BILATERAL
PROGRAM: 1985-1987

| PROGRAM | PRODUCT | UNIT | QUANTITY | | | COST (US \$) | | | |
|-----------|------------|----------|-----------|------------|------------|--------------|-----------|-----------|-----------|
| | | COST | 1985 | 1986 | 1987 | 1985 | 1986 | 1987 | TOTAL |
| MOH | Noriday | \$0.1599 | 0 | 0 | 170,000 | 0 | 0 | 27,183 | 27,183 |
| | Lo-Femenal | \$0.12 | 857,000 | 478,000 | 485,000 | 102,840 | 57,360 | 58,200 | 218,400 |
| | Condom | | | | | | | | |
| | (Plain) | \$0.043 | 115,000 | 890,000 | 705,000 | 4,945 | 38,270 | 30,315 | 73,530 |
| | Condom | | | | | | | | |
| | (Tahiti) | \$0.043 | 0 | 33,000 | 288,000 | 0 | 1,419 | 12,384 | 13,803 |
| | Copper T | \$0.70 | 7,620 | 9,300 | 8,300 | 5,334 | 6,510 | 5,810 | 17,654 |
| | Conceptrol | \$0.072 | 6,234,000 | 6,263,000 | 5,957,000 | 448,848 | 450,936 | 428,904 | 1,328,688 |
| Sub-Total | | | | | | 561,967 | 554,495 | 562,796 | 1,679,258 |
| | | | | | | | | | + 10% |
| | | | | | | | | | 1,847,184 |
| CSM | Lo-Femenal | \$0.12 | 555,300 | 1,810,700 | 2,281,800 | 66,636 | 217,284 | 273,816 | 557,736 |
| | Condom | | | | | | | | |
| | (Plain) | \$0.043 | 1,275,900 | 3,627,200 | 4,392,000 | 54,864 | 155,970 | 188,856 | 399,690 |
| | Condom | | | | | | | | |
| | (Tahiti) | \$0.043 | 415,500 | 1,725,400 | 2,718,700 | 17,845 | 74,175 | 116,904 | 208,963 |
| | Conceptrol | \$0.072 | 4,180,000 | 11,833,000 | 14,232,200 | 300,960 | 851,976 | 1,024,718 | 2,177,654 |
| Sub-Total | | | | | | 440,327 | 1,299,405 | 1,604,294 | 3,344,043 |
| | | | | | | | | | + 10% |
| | | | | | | | | | 3,678,447 |

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TABLE 5
CSM PROJECTED REVENUES: CONSOLIDATED PROJECT YEARS 1985, 1986, 1987 (CEDIS)

| | FLORAL | PANTHER | SSS | CORAL |
|------------------------------|------------|-----------|-----------|------------|
| GROSS SALES RECEIPTS | 26,982,000 | 5,350,496 | 3,836,283 | 20,880,154 |
| WHOLESALE/DISTRIBUTER MARGIN | 4,613,922 | 917,075 | 656,962 | 3,584,426 |
| RETAILERS MARGIN | 4,505,994 | 891,928 | 637,781 | 3,480,025 |
| RETURN TO PROJECT FUND | 944,370 | 184,592 | 134,270 | 730,805 |

TABLE 6
 CSM PROJECTED REVENUES - CONSOLIDATED TOTALS
 1985 - 1986 - 1987 (CEDIS)

| | |
|------------------------------|-------------|
| GROSS SALES RECEIPTS | 157,048,933 |
| WHOLESALE/DISTRIBUTER MARGIN | 9,772,385 |
| RETAILERS MARGIN | 9,515,728 |
| RETURN TO PROJECT FUND | 1,994,037 |

1/2

REGIONAL CAPITALS AND IMPORTANT TOWNS

| <u>REGION</u> | <u>CAPITAL</u> | <u>OTHER IMPORTANT TOWNS</u> |
|-------------------|----------------|---|
| (1) Greater Accra | Accra | Tema, Nungua, Dɔdowa, Ada, Prampram, Ningo. |
| (2) Central | Cape Coast | Winneba, Elmina, Saltpond, Moree, Agona Swedru, Apam, Komenda, Mankessim, Assin Fosu, Dunkwa, Nyankumasi, Ajumako, Besease. |
| (3) Western | Takoradi | Sekondi, Prestea, Tarkwa/Aboso, Bibiani, Axim, Half Assini, Asankrangwa, Sefwi Wiawso, Enchi, Shama, Efiakuma, Kengen. |
| (4) Eastern | Koforidua | Nkawkaw, Kibi, Begoro, Akim Oda, Akropong, Kade, Odumasi Krobo, Nsawam, Akwatia, Akim Tafo, Akosombo, Akwamufie, Asamankese, Suhum, Aburi, Akwapim Mampong, Mpraeso, Adawso, Adeiso, Somanya, Begoro. |
| (5) Volta | Ho | Dzodze, Keta, Peki, Jasikan, Kete Krachi, Denu, Kpando, Hohoe, Worawora, Kadjebi, Anfoega, Sogakope, Aflao, Agbozume, Keta, Anyako/Abor. |
| (6) Ashanti | Kumasi | Manpong, Dunkwa, Bekwai, Juaso, Obuasi, Effiduase, Offinso, Fomena, Akrokerri, Atobiase, New Edubiase, Asokore, Konongo/Odumasi, Teppa, Ejura, Kumawu, Sekyedumasi, Nkenkansu. |
| (7) Brong Ahafo | Sunyani | Goaso, Atebubu, Nkoranza, Bechem, Wenchi, Kintampo, Hwidiem, Nsoatre, Duayaw Nkwanta, Abesim, Dormaa Ahenkro. |
| (8) Northern | Tamale | Yendi, Bole, Damango, Salaga, Kpandai, Gambaga, Waleware, Daboya, Naleriga, Nakpanduri, Nyakpala, Pong-Tamale, Yapei, Tolon, Sawla. |
| (9) Upper East | Bolgatanga | Pusiga, Zuarungu, Nangodi, Sandema, Navrongo, Paga, Zebila, Kologo, Chuchiliga, Chiana, Bawku. |
| (10) Upper West | Wa | Lawra, Hamile, Gwolu, Dorimon, Kaleo, Nadoli, Babile, Nandon, Busie, Han, Lambusie, Tumu. |

APPENDIX II

C O S T D A T A

| | SSS | Σ (a) | Σ (b) | Panther | Σ (a) | Σ (b) |
|-------------------------------------|-------------|-------------|-------------|--------------|-------------|-------------|
| Printing/Conversion Cost | .50 | 7.5 | 6.3 | | | |
| Direct Labor: Packing | .80 | 12.0 | 10.0 | 13.60 | 16.3 | 13.6 |
| Delivery & Transportation Expenses | .80 | 12.0 | 10.0 | 10.00 | 12.0 | 10.0 |
| Selling Expenses | .84 | 12.6 | 10.5 | 10.46 | 12.6 | 10.4 |
| Administrative and Other Overheads | <u>2.08</u> | <u>31.2</u> | <u>26.0</u> | <u>28.68</u> | <u>34.4</u> | <u>28.7</u> |
| TOTAL COST | 5.02 | 75.3 | 62.8 | 62.74 | 75.3 | 62.7 |
| Factory Margin | .67 | 10.0 | 8.4 | 8.33 | 10.00 | 8.3 |
| Wholesaler's Margin | .70 | 10.6 | 8.7 | 8.81 | 10.6 | 8.8 |
| Return to Project Fund | <u>.28</u> | <u>4.1</u> | <u>3.5</u> | <u>3.45</u> | <u>4.1</u> | <u>3.5</u> |
| Wholesale Price | 6.67 | 100.00 | 83.4 | 83.33 | 100.0 | 83.3 |
| Retailer's Margin | <u>1.33</u> | | <u>16.6</u> | <u>16.67</u> | | <u>16.7</u> |
| RETAIL PRICE | 8.00 | | 100.0 | 100.00 | | 100.0 |
| | ---- | | ----- | ----- | | ----- |
| | | Σ (a) | Σ (b) | | Σ (a) | Σ (b) |
| | Coral | | | Floril | | |
| Printing/Conversion Cost | .50 | 10.0 | 8.3 | .50 | 6.0 | 5.0 |
| Direct Labor: Packing | .80 | 16.0 | 13.3 | 1.00 | 12.0 | 10.0 |
| Delivery & Transportation Expenses | .60 | 12.0 | 10.0 | 1.00 | 12.0 | 10.0 |
| Selling Expenses | .63 | 12.6 | 10.5 | 1.04 | 12.5 | 10.4 |
| Administrative and Factory Overhead | <u>1.23</u> | <u>24.6</u> | <u>20.5</u> | <u>2.73</u> | <u>32.8</u> | <u>27.3</u> |
| TOTAL COST | 3.76 | 75.2 | 62.6 | 6.27 | 75.3 | 62.7 |
| Factory Margin | .50 | 10.0 | 8.3 | .83 | 10.0 | 8.3 |
| Wholesaler's Margin | .53 | 10.6 | 8.8 | .88 | 10.6 | 8.8 |
| Return to Project Fund | <u>.21</u> | <u>4.2</u> | <u>3.5</u> | <u>.35</u> | <u>4.1</u> | <u>3.5</u> |
| WHOLESALE PRICE | 5.00 | 100.00 | 83.3 | 8.33 | 100.0 | 83.3 |
| Retailer's Margin | <u>1.00</u> | | <u>16.7</u> | <u>1.67</u> | | <u>16.7</u> |
| RETAIL PRICE | 6.00 | | 100.0 | 10.00 | | 100.0 |
| | ---- | | ----- | ----- | | ----- |

KEY: (a) ... Expressed as a Σ age of Wholesale Price
 (b) ... " " of Retail Price

N.B. The value of the Cedi in November, 1984 is C 38.5 = \$1.00 (C1.00=2.597)

MARKETING PLAN COST DATA
EXPLANATION OF SELECTED LINE ITEMS

Printing/ Conversion Cost - Includes first steps in converting bulk packing materials into finished packages. This is primarily a labor cost.

Direct Labor: Packing - Conversion of bulk contraceptive stock into appropriate units for the retail trade.

Selling Expenses - This is a P.I.B. approved percentage cost and includes:

- Insurance on goods
- Warehousing in Regions
- Sales and Marketing staff salaries.

Administrative and Other Overheads - This items includes:

- Salaries for Management
- Fringe Benefits
- Factory overheads such as power, maintenance, repairs, cleaning, insurance
- Administrative Costs connected with reporting.

Retailers Margin - The P.I.B. allows a 16,6% profit margin or an amount equal to 20% on retailer costs on all pharmaceuticals and related items.

The difference indicated for retailer margin for "SSS" represents a mathematical rounding correction.

B. TRAINING PLAN

1. Objective

To provide up to date and authoritative training and information to retailers in the CSM Program network in order to (1) improve individual retailer performance and provide better service to the community; (2) better equip the retail sales network with the means to respond to consumer demand; (3) create/strengthen the capacity of retailers to present a credible case for the role of modern contraceptives in child spacing and family health; (4) assist retailers in such matters as marketing and promotion including the proper means of storage and display of the contraceptive products.

2. The Trainee Group

Those to be provided with training and information will include all those officially franchised as members of the CSM Program retail network. This will include:

- Pharmacies
- Licensed chemical seller shops
- Supermarkets
- Selected retail outlets in urban and rural areas including agricultural and fishing cooperatives
- private clinics and maternity homes

3. Training

Training for all participants will take place, to the extent possible, in cities/major towns convenient to the participants taking into account existing transport problems.

Training will consist of seminars and workshops to be conducted in all ten Regions. It is anticipated that this initial training will last one day for each group.

Training for Pharmacists:

- up-date knowledge to pharmacists concerning contraceptive methods;
- provide necessary information to pharmacists so as to permit counselling to consumers including the ability to respond to questions concerning proper use of various contraceptive methods, rumors, misinformation, etc;
- provide information on effective storage, display and sale of the contraceptive products; and
- provide all the information required in order to maximize sales in each locality with the objective of exposing the benefits of family planning to the people in general and to influential persons i.e. chiefs, local and district councillors and others in order to facilitate the orderly growth of sales along with product outreach.

Training for Chemical Sellers

Essentially the same as that for pharmacists except that it will be presented at a level appropriate to their existing knowledge keeping in mind that they do not have the scientific and professional training found among the pharmacists.

Subject to successful negotiations with the Ghana Pharmacy Board and the concurrence of the Ministry of Health selected licensed chemical sellers will be provided with additional training in order to permit them to sell oral contraceptives.

Training for Staff of Supermarkets, Cooperatives and Other Retail Outlets:

This will be essentially the same as that for the licensed chemical sellers except that it is not anticipated at present that this group of retailers will be authorized to sell oral contraceptives.

Training for Staff of Private Clinics and Maternity Homes:

The substance of training for this group will be essentially the same as that of the pharmacists but will include special emphasis on counselling.

4. Monitoring

Monitoring will be carried out through a variety of methods including:

- feedback from marketing/merchandising representative from DANAFCO; and
- periodic visits by the PHARMAHEALTH CENTRE training group. It is anticipated that regional training seminars/workshops will be held every twelve months in order to improve feedback, upgrade training and integrate new retailers into the expanding retail sales network.

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TRAINING PROGRAMS - CSM RETAILERS

Budget Estimate (Cedis)

YEAR 1

Fee for Training Program Director:

Estimated 80 days at ₵ 1,500 per day - ₵ 120,000

Estimated Trainee Per Diem:

2000 Trainees x ₵800 per day (1 day) - ₵ 1,600,000

Estimated travel costs at ₵ 3.00 per mile - 360,000

Estimated miscellaneous expenses including supplies of paper, pads, etc. - 20,000

Contingency - 25,000

Travel costs of trainer - 28,000

Administrative costs including production of materials, secretarial assistance, etc. - 75,000

Year One Total ₵ 2,228,000

YEAR 2

Fee for Services of Training Program Director:

Estimated 80 days at ₵ 1,500 per day - ₵ 120,000

Estimated Trainee Per Diem:

2400 Trainees x ₵800 per day (1 day) - ₵ 1,920,000

Estimated travel costs at ₵ 3.00 per mile - 432,000

Estimated miscellaneous expenses including supplies of paper, pads, etc. - 20,000

Contingency - 25,000

Travel costs of trainer - 28,000

Administrative costs including production of materials, secretarial assistance, etc. - 75,000

Year Two Total ₵ 2,620,000

YEAR 3

Fee for Services of Training Program Director:

Estimated 80 days at ₵ 1,500 per day = ₵ 120,000

Estimated Trainee Per Diem:

3000 Trainees x ₵800 per day (1 day) = ₵ 2,400,000

Estimated travel costs at ₵ 3.00 per mile = 540,000

Estimated miscellaneous expenses including supplies of paper, pads, etc. = 20,000

Contingency = 25,000

Travel costs of trainer = 28,000

Administrative costs including production of materials, secretarial assistance, etc. = 75,000

Year Three Total ₵ 3,208,000

consolidated Total Three Years = ₵ 8,056,000

C. ADVERTISING PLAN

Integrated Communication Plan Introductions

This plan builds upon the considerable experience developed in the previous commercial retail sales program in Ghana.

The brand names of contraceptive products used in the earlier program are still recognized and the advertisements are still remembered. There is little doubt that effective use of a multi-media advertising campaign is a powerful mechanism by which to communicate the goals and benefits of the CSM project.

There are no restrictions under existing laws or regulations that encumber a multi-media approach. This communication plan is predicated on an integrated approach using various media to promote general awareness, reenforce certain themes, provide reminder messages, support generic and product/brand specific marketing activities.

The Products:

SSS coloured condoms, 6 to a pack.

Panther plain condoms, single units packed 100 per dispenser box.

Floril - Oral Contraceptives, 1 to a pack.

Coral - Vaginal foam tablets, 5 to a pack.

SSS - This is the upmarket condom. They are coloured and packed six to a pack. Marketed in a point of sale dispenser.

Panther: Plain condoms, one hundred to a box. The shipping boxes can be used with a stitch on label.

Floril: Low Femenal oral contraceptive. Packed one cycle into a branded envelope. Marketed in a P.O.S. dispenser.

Coral: Conceptrol vaginal foam contraceptive. Packed six tablets to a pack. Marketed in a P.O.S. Dispenser.

The Market

The major source of supply is through M.O.H., PPAG and several USAID supplied PVO's. The private sector supplies have been very irregular with periods of total absence of any products. At the present time there are few contraceptives available in the private sector, and distribution is very limited with products being found mainly in a few cities and large towns in the Southern half of the country.

Marketing Intention

The current project is seen as a 3-year programme in its initial stage. It will be a national marketing effort. Distribution of products will again be handled by Danafco.

Distribution Intentions are:

- 1) To cover all Regional Capitals and selected major trading towns within 18 months of launch (10 capitals);
- 2) To cover all district capitals within 30 months of launch (140 District Capitals); and
- 3) Long term to have products available at outlets within the cash economy.

The Marketing Objective

Current estimates of contraceptive prevalence, indicate a level of some 4.4%.

It is the program's intention to produce and maintain product use so as to achieve the following prevalence levels from the commercial sector:

April 1986 - 1.0%
April 1987 - 4.5%
April 1988 - 7.0%

Communication Strategy

Advertising Requirement: The advertising for the products should create awareness of the brand so as to get consumer up-take and help to pull the products through the distribution pipeline.

Further, the advertising should create awareness of contraceptives and their benefits so as to expand the total market for products and to increase up-take from MOH clinics, PVO's as well as from commercial sources.

The Target Audience

Our target audience in the main will be: 1) Married couples, particularly the younger couples. 2) Unmarried adult men and women especially those from age 19 years. 3) The general public at large. 4) Opinion/community leaders.

The Plan

Within the initial 3-year program it is planned to produce three campaigns covering all four products: these will be the re-launch, the theme-campaign and the follow-up.

The Relaunch: This will be nationwide and include all four products. The advertiser will produce teaser ads for radio and press. The radio will feature the most memorable aspect of the previous campaign - the Panther roar - which will build up to "Panther is back, together with SSS, Floril and Coral".

- There will be newspaper support for the re-launch.
- The teaser ads will precede the start of distribution by some two weeks.
- During the initial distribution phase the announcement ads will continue.
- Products will also be supported by Point of Sale (POS) merchandising which will be designed to keep in step with distribution.

Theme Campaign: As soon as products have reached all regional depots and up-take begins in each Regional Capital the theme campaigns will be launched. These will involve radio, English as well as vernacular ads in Akan, Dagbani, Ewe and Ga. There will also be TV support for SSS Brand Condom and the female products. The ads will be simple, endorsement video ads.

Outdoor advertising, a prime medium, will be used on a cyclical basis. That is each product will have its poster plus there will be a poster incorporating all the products and showing the POS identity metal plate. Poster changes are every two months so within a year each site will show each product once and one product twice.

Point of sale and merchandising activities will be critical at this stage.

Press will be used as a support medium mainly to add authority to the advertising message.

The advertiser in coordination with DANAFCO will arrange for positive supportive editorial coverage of the CSM Program.

Follow-up

This will involve the same media but the advertising will be much more image creating. The advertising will be developed in response to feedback from the market place. It will have a lot more to do with expanding the total market rather than just offering products to those already motivated.

The advertising content of the Follow-Up Campaign will stress accepted and acceptable benefits of contraception using messages evolved from the cultural practices of the people.

Media Selection

1. Radio: Radio still enjoys the greatest popularity in launching a product, or service on the Ghanaian market. Without limitations to airspace, radio is the medium par excellence for advertising in this country. Lintas will produce a jingle and 30 commercials in English and local languages. With selected messages on Family Planning, child spacing, Family Health and the use of Contraceptives. Duration of commercials - 30 secs. and 15 secs. This will be used to get impact understanding and frequency. Estimated number of radios is 1.9 million. Peak listening audience 5 million.

2. Television: TV is urban based and with the advantages of speech and motion provides an advantage for endorsement ads. Estimated number of sets is over 1/2 million. Peak time viewing upwards of 3 million.

3. Press: The press in Ghana is plagued with an acute newsprint shortage. However, with good planning the press offers a good vehicle for communication. It reinforces in print what is said on radio. With half-page insertions in both the Mirror and Spectator (both weeklies) and 1/4 page insertions in the dailies (Graphic and Times) a wide readership will be reached.

| | | | | |
|-------------|---|------------------|---|---------|
| Circulation | - | Daily Graphic | - | 200,000 |
| | | Ghanaian Times | - | 150,000 |
| | | Weekly Spectator | - | 100,000 |
| | | The Mirror | - | 120,000 |

4. Outdoor: Outdoor is the major medium for product identification. With a 3-year life span it provides a constant reminder to the public about the existence and availability of the products in large visual format of the pack presentation.

The advertiser will erect and maintain 120 sites of 16 sheet posters, with 9 cycle changes in the first 18 months. These will be sited in the 10 regional capitals and district capitals all over the country.

5. P.O.S: Point of Sale materials such as metal plates, dispensers and double crown posters will be produced and displayed at retail outlets.

Point of Sale Identification Metal Plates: These will be metal plates, silkscreened, the design will feature the Project Logo plus brand names and "Products available here". These will play a major role in communicating the universal availability of contraceptives and expanding awareness and the market for contraceptive products.

EA

Give-aways such as car stickers, eye visors, will be produced and given out to the public to ensure that the theme of the campaign is given the widest possible coverage.

6. Supporting Activities: This will be in the form of lucky dips organized at dances and night clubs at which prizes (the products) would be won. Other activities such as card games, draught, and oware might be used to sustain publicity and support for the programme.

7. Product Usage Leaflets: These will be included in the packaging of each of the products. Those packed in their own packs will have a leaflet each. The Panther to be loose packed will have 20 leaflets per 100 box.

The Relaunch

1. Radio: In English and Local Languages.

- a) 15 secs. "Panther roar interspersed with silences" to run for one week.
- b) 15 secs. Panther roar interspersed with "They are back".
- c) 30 secs. roar and announcement of the re-availability of the four products.
- d) 30 secs. local announcement to the trade to contact DANAFCO for their supplies.

2. Press:

- a) 6" x 2 cls. teaser ads.
- b) 1/2 page announcement of all four products.
- c) 6" x 2 cls. trade announcement.

3. Point of Sale: The POS items will be produced in time for the re-launch and will be placed in a synchronised manner with the distribution.

Theme Campaign

1. S.S.S.: To differentiate between the two condoms, the one mass market and the other premium TV will be used for SSS and radio for Panther.

2. Sales Promotion Activities: It is envisaged that these will form an integral and on-going component of the campaigns. This offers an excellent opportunity to support outdoor and point of sale activities in each new distribution territory.

- a) Public Dances: Its part of the "show" we will organize lucky dips during a break in the dancing. The contestant dips into the barrel and wins a T-Shirt or product or branded shopping bag. Many small prizes rather than one or two large ones.
- b) Card Clubs and Draught Clubs: These are all male activities. There are a number of highly organized clubs which have leagues and inter club competitions. Lintas will provide score boards and draught boards a trophy for the Panther league.

- c) P.R./Editorial Support: Lintas will organize an ongoing programme of radio, TV discussions and press articles to play a positive and supportive role.

BUDGET ESTIMATE:

Radio:

| | |
|---|-----------------|
| 30 secs. - ₱350.00 x 20 spots a week x 50 weeks | - 350,000 |
| 15 secs. - ₱320.00 x 80 spots spread over 2 weeks | - 25,600 |
| Announcement to the Trade to contact DANAFCO for supplies - ₱800 x 14 spots | - 11,200 |
| Production - Jingle and 30 commercials including translation into local languages | 200,000 |
| | <u>₱586,800</u> |

Television:

| | |
|--|-----------------|
| 30 secs. video film for each of 3 products @ ₱30,000 each including model fees | - 90,000 |
| Media: 2 spots a day x 52 weeks @ ₱340.00 a spot | - 247,520 |
| | <u>₱337,520</u> |

Press:

| | |
|---|-----------------|
| 8 x 6" x 2 cls. teaser and trade ads @ ₱1,600 an insertion | - 12,800 |
| 1/2 page (Mirror and Spectator) 50 insertions in each weekly per annum @ ₱2,829.00 = 100 x 1/2 page | - 282,900 |
| 1/4 page (Graphic and Times) 50 insertions in each daily (100) for a year @ ₱3,277.50 | - 327,750 |
| Production: 1/2 page press ad including photo-prints, photography, blocks and bromides | - 20,000 |
| 1/4 page press ad. as above | - 15,000 |
| 6" x 2 cls. press ad. as above | - 10,000 |
| | <u>₱668,450</u> |

Point of Sale:

| | |
|---|-------------|
| *Car Stickers -2-1/2 x 12" on PVC 100 for 4 products (25,000 each product) @ ₱55.00 | - 5,500,000 |
| <u>Eye-Visors</u> : 100,000 eye-visors for give-away for 4 products, and campaign theme @ ₱15.00 each | - 1,500,000 |
| <u>Metal Plates</u> : 04 gauge 16" x 12" with campaign theme 6,000 @ ₱450.00 each | - 2,700,000 |

These Point of Sale estimates represent costs including the purchase of materials locally.

Dispensers: Dispensers will be of cardboard.

Similar in size and design as used in previous project - 2,000,000

Canopies: Canopies will be produced for all 4 brands as well as campaign theme. Size will be about 8" x 8" each printed double sided, and

string 10 to a set. 6,000 @ ₱150.00 each - 900,000
₱12,600,000

Supporting Activities:

| | |
|---|-----------------|
| Lucky Dips at dances and draught, Cards, competitions, etc | - 230,000 |
| Radio, TV and Editorial Discussions | - 300,000 |
| | <u>€530,000</u> |

Outdoor:

Erection, rental and maintenance of 120 x 16 sheet sites

Year One:

| | |
|--|-------------------|
| Erection @ €8,000.00 | |
| Rental @ €1,000.00 | |
| Maintenance @ €5,000.00 | - 1,680,000 |
| Production of posters for 120 sites @ €3,500.00 a set | - 420,000 |
| | <u>€2,100,000</u> |

Only those outdoor ad activities actually carried out in year one will be charged in that period. Some of the above activities will be spread into year two.

Cost for 1st Year:

| | |
|-----------------------|--------------------|
| Radio | - 586,800 |
| Television | - 337,520 |
| Outdoor | - 2,100,000 |
| P.O.S. | - 12,600,000 |
| Press | - 668,450 |
| Supporting Activities | - 530,000 |
| | <u>€16,822,770</u> |

Costs for Point of Sale materials are shown as first year costs although production of various POS materials and their use will continue throughout the three year project period.

Cost for 2nd Year:

Year two will be a follow-up and will consist mainly of media with a little production work.

| | <u>Production</u> | | <u>Media</u> | |
|------------|-------------------|---|------------------|---------------------|
| Radio | 100,000 | | € 145,600 | |
| Television | - | | 88,000 | |
| Outdoor | 420,000 | | 720,000 | |
| Press | 30,000 | | 469,200 | |
| | <u>550,000</u> | + | <u>1,422,800</u> | = <u>€1,972,800</u> |

A new set of posters will be printed to cover the next 18 months which means there will not be any production work for year three.

Explanation to Costing for 2nd Year: Press will carry 1/4 page in both dailies (Graphic and Times) and now 1/4 page in the weeklies (Mirror and Spectator). Lintas will need to do new artwork production.

Cost for 3rd Year: Year three will maintain the same pitch for radio and television. Press advertising will be reduced by 50%. There may not be any need to do new artwork. However, the supporting activities especially the games competitions will continue in year three.

| <u>Costing</u> | <u>Production</u> | <u>Media</u> |
|-----------------------|-------------------|-------------------|
| Press | - | £ 234,600 |
| Radio | - | 145,600 |
| Television | - | 88,000 |
| Outdoor | - | 720,000 |
| Supporting Activities | - | 150,000 |
| | | <u>£1,338,200</u> |

Total Cost for 3 Year Programme:

| | | |
|------------|---|-------------------|
| Year One | - | 16,822,770 |
| Year Two | - | 1,972,800 |
| Year Three | - | <u>1,338,200</u> |
| Agency Fee | - | 20,133,770 |
| 10% | - | <u>2,013,377</u> |
| | | <u>22,147,147</u> |

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

A. Statistics 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

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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 GNFP 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 GNFP 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 | <u>600,000</u> |
| Subtotal | \$8,275,000 |
| Centrally or Regionally-Funded (estimated) | 9,300,000 |
| GRAND TOTAL | <u>\$17,575,000</u> |

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A
5. FAA Sec. 604(a). Will construction or engineering services be procured from firms of countries which are direct aid recipients and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? No
6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

Yes

N/A

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes

9. FY 1985 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes, it will.

B Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?

N/A

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N/A

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)? N/A

Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes
4. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f); FY 1985 Continuing Resolution Sec. 527. (i) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice Yes, this project will not be involved with either abortion or sterilization as a method of family planning.

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- abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?
- b. FAA Sec. 620(c). To compensate owners for expropriated nationalized property?
- c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?
- d. FAA Sec. 662. For CIA activities?
- e. FAA Sec. 535(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?
- f. FY 1985 Continuing Resolution, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?
- Yes, although sterilization is available through the MOH as a method of family planning, this project will not support or contribute to this procedure.
- Yes, abortion is not used as a method of family planning in the MOH nor will it be instituted. This project, of course, will not support abortion as one of its family planning methods.
- Yes
- Yes
- Yes
- Yes
- Yes. In this document a waiver has been requested for the purchase of six vehicles of Japanese manufacture because U.S. vehicles do not have maintenance/repair facilities nor spare parts.
- Yes

- g. FY 1985 Continuing Resolution, Sec. 505. Yes
To pay U.N. assessments, arrearages or dues?
- h. FY 1985 Continuing Resolution, Sec. 506. Yes
To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)?
- i. FY 1985 Continuing Resolution, Sec. 510. Yes
To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?
- j. FY 1985 Continuing Resolution, Sec. 511. No
Will assistance be provided for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?
- k. FY 1985 Continuing Resolution, Sec. 516. No
To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

*In case of reply the
number and date of this
letter should be quoted.*

DV 24 PR/17

My Ref No.....

Your Ref. No.....



REPUBLIC OF GHANA

MINISTRY OF FINANCE AND
ECONOMIC PLANNING
(CONTROL DIVISION)
P.O. BOX M.40 ACCRA

44 February 1985

REQUEST FOR USAID ASSISTANCE IN
CONTRACEPTIVE SUPPLIES AND TRAINING

The National Family Planning Programme remains a high priority of the Republic of Ghana. To ensure continuous supplies of contraceptives and efficient service delivery, this request is made through your good offices to obtain assistance in the form of contraceptives supply and support in training family planning personnel during the period 1985 through 1988.

The design and implementation of retail contraceptive sales (RCS) programme is requested as an integral part of the National Family Planning Programme. Due to their previous experience and capability, DANAFCC, a Ghanaian private company, has been selected as the Government's agent to conduct this RCS programme, with the understanding that no logistical support will be requested of Government.

Counting on your usual cooperation.

Kofi Sekyiamah

for: KOFI SEKYIAMAH
PNDC SECRETARY FOR FINANCE AND
ECONOMIC PLANNING

THE DIRECTOR,
USAID
ACCRA.

cc: PNDC Secretary for Health,
Ministry of Health,
Accra.

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.

HAS SLIPPED SOMEWHAT; THE CONTRACTING PROCESS REQUIRES THREE TO FOUR WEEKS TO CONCLUDE SO TEAMS MAY NOT BE IN THE FIELD UNTIL PROBABLY MID-MARCH.

2. QUOTE:

STATEMENT OF WORK

BUSINESS CLIMATE ASSESSMENT
AND INVESTMENT PROMOTION TEAMS

OBJECTIVE:

THE OBJECTIVE OF AN ASSESSMENT TEAM IS TO ASSIST A.I.D. MISSIONS AND AFR/PRE TO FORMULATE PROGRAMS WHICH WILL HELP AFRICAN COUNTRIES IMPROVE THE BUSINESS CLIMATE AND PROMOTE LOCAL AND FOREIGN PRIVATE INVESTMENT, THEREBY MORE EFFECTIVELY UTILIZING THE PRIVATE SECTOR IN ACHIEVING NATIONAL DEVELOPMENT GOALS -- GROWTH OF GNP, JOBS AND FOOD, ETC.

BACKGROUND:

GREATER A.I.D. INTEREST IN AND SUPPORT FOR THE PRIVATE SECTOR

EXTENSIVE EXPERIENCE IN AFRICA, LATIN AMERICA, ASIA AND THE MIDDLE EAST HAS CONVINCED A.I.D. AND OTHER DONORS THAT PRIVATE ENTERPRISE CAN CONTRIBUTE MUCH MORE EFFECTIVELY THAN IS NOW THE CASE TO ECONOMIC GROWTH IN

LESS DEVELOPED COUNTRIES. GOVERNMENTS IN SUB-SAHARA AFRICAN COUNTRIES NOW CONCEDE THAT THE PUBLIC SECTOR IS OVER-EXTENDED AND OVERPROTECTED, AND THAT COUNTRY POLICIES, INSTITUTIONS AND PROGRAMS MUST BE RE-ORIENTED TO GIVE MUCH GREATER SUPPORT TO THE PRIVATE SECTOR AND TO OPERATION OF FREE MARKET FORCES.

AFRICA BUREAU ACTION

IN EARLY 1984, THE AFRICA BUREAU ESTABLISHED A PRIVATE ENTERPRISE OFFICE TO ASSIST A.I.D. MISSIONS TO MORE FULLY UTILIZE INDIGENOUS AND FOREIGN PRIVATE SECTORS IN THE DESIGN AND IMPLEMENTATION OF DEVELOPMENT PROGRAMS, PROJECTS AND ACTIVITIES. IN DECEMBER 1984, THE BUREAU APPROVED THE AFRICA PRIVATE ENTERPRISE FUND. THE FUND, CAPITALIZED AT SIX MILLION DOLLARS, IS USED PRIMARILY TO FINANCE A WIDE RANGE OF CONSULTING AND TECHNICAL EXPERTISE REQUESTED BY MISSIONS TO INVESTIGATE AND IMPLEMENT ACTIONS AIMED AT IMPROVING BUSINESS AND INVESTMENT CLIMATES; STIMULATING BUSINESS EXPANSION AND INCREASING THE PARTICIPATION OF PRIVATE SECTOR FIRMS,

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.

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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

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.

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.)

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 ANALYSIS

Project Resources and Funding

The project appears to be adequately funded given the resources specified in the budget. AID funds for project activities should be available when needed, assuming the schedule for obligation can be met. GOC funds should be available from counterpart funds generated from PL 480 sales proceeds, and this paper contains a CP which covers the non-availability of funds in a timely manner from these sources. In sum, the financial planning for the project resources and the timing of funding for these resources appears sound.

Methods of Financing

All AID funds are to be used in direct AID procurements, and therefore all payments will be through direct disbursement by AID to the vendor. This method of financing is an approved method under Payment Verification Policy guidance.

Financial Management Procedures for Project Implementation

As stated above, all AID funding will be financed through direct AID procurement, using standard AID procedures. The Ghana Mission is serviced through the West Africa Accounting Center which is staffed with experienced AID Controller personnel. DANAFCO, the private sector organization involved in the packaging and distribution of contraceptives for this project receives financial reviews and guidance from Peat, Marwick Okoh & Co., a Public Accounting firm located in Accra. This project provides funding for an assessment of the financial management capability of involved GOC organizations, and in fact, stipulates this as a condition precedent (see CP1).

Summary

It appears that overall financial planning and proposed methods of financing for this project are sound, and that adequate consideration has been given to financial management capabilities of the project entities.

ECONOMIC ANALYSIS1. Macro-Economic Overview

Ghana and its citizens, at the time of its independence and in the years immediately thereafter, had a higher standard of living than most other West African countries. The economy was vibrant, with agriculture and mining the major factors contributing to growth. This state of affairs soon changed as a result of the economic development strategies pursued by successive Governments in the sixties and seventies. The development strategies of the Nkrumah era emphasized: (1) increasing import substitution oriented production investments; (2) reducing the percentage of cocoa exports to total exports; and, (3) decreasing the percentage of primary exports to total exports. Large-scale capital intensive investments were the priority and received the major share of the investments. Agriculture, the largest sector of the economy, contributing 60% of GDP and providing 70% of employment in the 1960's, grew at an uneven rate. In the latter part of the 1960's the emphasis shifted to one of economic stabilization and retrenchment. Unfortunately, there was little attempt to address the basic structural imbalances in the economy. External debt levels remained high. This led to persistent and increasing deficits and declining economic activity. The Government did, however, attempt to accelerate economic growth and reduce unemployment through a series of measures including the liberalization of imports and the expulsion of thousands of Nigerians and other immigrants from neighboring countries.

The beginning of the 1970's saw Ghana's development policies again change with agricultural production expansion re-emphasized. Strict import controls were re-introduced. The cedi was devalued by 26% in 1972. Unfortunately, the 28% decrease in cocoa prices in 1971 combined with the first oil shock of late 1973 to lead to a further deterioration of the economy. An IMF stabilization program initiated in 1978 included a 58% devaluation plus other measures to control fiscal expenditures and to better balance the country's budget and terms of trade. The effects of the stabilization program were highly unpopular and the modest improvements in the economy as a result of the program were short-lived.

The balance of payments position worsened. Foreign exchange became even more scarce, and Ghana's commercial credit worthiness vanished. The deficits of the late 1970's were financed by increased expansion of the money supply further worsening the spiralling inflation rate. In addition, the general slow-down of the economies of the industrialized nations accentuated the declining growth rate.

The economic recovery in several major industrial countries in the early 1980's has yet to make a significant impact on the Ghanaian economy. The economy continues to suffer from the continuation of its deep and prolonged recession. This recession is made all the worse by the poor economic performance of neighboring countries. The effects of the years of steady neglect of the agricultural sector were also evident. This neglect, the result of inappropriate policies, resulted in food and export crop production declines that necessitated increased food imports at a time of declining foreign exchange reserves. Other economic problems included the continuing budget deficits. These deficits, the result of falling export earnings, an oversized civil service, and inefficient parastatals, were a

drain on public resources. The poor economic prospects, with declining real wages and economic opportunities, also led to the migration of professional, skilled, and manual labor to neighboring countries, thereby increasing the domestic labor bill while shrinking the pool of experienced and trained labor for all sectors of the economy. The annual rate of inflation which averaged 7.5% in the 1960's rose to an average of 40% in the following decade. GDP declined by .5% per annum between 1970-1982. The economy also suffered from political instability that is the inevitable result of prolonged economic mismanagement. Inflation, shortages, and price and distribution controls were the result. Parallel market activities became increasingly common as the Government lost control of the economy.

In the early 1980's the Ghanaian economy suffered three "shocks" - "shocks" so severe that significant economic reforms were the GOG's only recourse to head-off the imminent collapse of the official economy. The first of these shocks, drought and subsequent brush fires, led to the most serious food crisis since independence. The drought that began in 1982 and continued through early 1983 and the accompanying brush fires destroyed both food and export commodities. The drought also affected the level of hydroelectric power available for domestic use and export. The decline in available hydroelectric power led to an increase in petroleum imports and a decrease in foreign exchange earnings from the loss of electricity power sales to neighboring countries. Petroleum price increases occurred simultaneously with falling prices for Ghana's principal exports, cocoa and gold, and the sharp rise in demand for petroleum imports. This shift in import requirements and export earnings led to a sharp deterioration in terms of trade. The third shock was the sudden return of hundreds of thousands of Ghanaians expelled from Nigeria. This return placed a severe strain on the domestic food, transport, and employment situation.

The Ghanaian Government instituted a series of new policy reforms and structural adjustments to correct the country's serious economic predicament in April 1983. Included in these reforms were an initial 900% devaluation of the cedi and the commitment to quarterly exchange rate adjustments; an increase in export producer prices (cocoa prices increased 75%); a reduction in subsidies on agricultural production inputs from 50 to 20%; a 104% increase in petroleum prices, and the commitment to the elimination of subsidies within fourteen months; and, the development of an investment code for the mining sector aimed at attracting foreign investors. Since the 1983 reforms, the Government has continued to adjust the exchange rate; the 30% devaluation in December 1984 was the fourth devaluation in fourteen months. Subsidies on petroleum products were eliminated by June 1984 and have been subsequently raised to reflect increased costs to the Government. Domestic interest rates have been adjusted twice to attract more domestic savings. The Government has adopted a flexible interest rate policy. The level of external credit arrearages has been reduced and economic rehabilitation programs in key sectors instituted.

The Ghanaian Government has made considerable progress in reforming the economy. The lack of significant economic performance is the direct result of the 1983 drought. Agricultural production, especially cocoa exports and hydroelectric power generation, were considerably lower than projected. Cocoa production fell to a record low of 158,000 MTs. Food shortages led to a dramatic increase in domestic prices further hurting the consumer. Inflation rose from 22% in 1982 to 123% in 1983 because of the drought-caused crop failures. The annualized inflation rate, through the

third quarter of 1984, has fallen to 23%. The drought led to power shortages and resulted in a fall in foreign exchange earnings from electricity sales to neighboring countries as well as lower domestic industrial production. These factors undermined the Government's efforts to increase essential imports to rehabilitate the transport and export sectors. This exacerbated the already tenuous economic picture and was only partially ameliorated by IMF and IBRD assistance.

The economic future of Ghana, as the Government begins to address the structural weaknesses of the economy, is promising even if the results to date are mixed. The country has tremendous agricultural, mineral, and hydroelectric resources that have yet to be exploited to their potentials. In addition, the human resources, with Ghana's higher standards and opportunities than in most West African countries, hold promise for the future, once the positive effects of the economic reforms are attained.

2. Project Economic Analysis

A. Policy Orientation

The macro-economic setting, as described above, is indeed bleak. At the sector level, however, there are some promising signs:

- a positive national population policy (especially in African terms);
- existing unmet demand for contraceptives; and
- some experience in private sector marketing of contraceptives.

At the project level, the goals and purposes are responsive to Section 104(d) of the Foreign Assistance Act, as amended, which states:

Assistance under this chapter shall be administered so as to give particular attention to the interrelationship between (a) population growth, and (b) development and overall improvement in living standards in developing countries, and to the impact of all programs, projects, and activities on population growth.

Besides addressing directly the long-run well-being of the Ghanaian society, this project focuses on three of the Agency programming objectives (Four Pillars) and sector objectives described in the AID Policy Paper on Population Assistance (September 1982). Specifically, these are:

- transfer of technology through the appropriate mix of contraceptives;
- increased private sector oriented development through the CSM; and
- institutional development through a broad-based training program for MOH personnel.

Each of these will, in turn, reinforce the goal of the project. Better trained health personnel will be able to provide advice and stimulation to their client groups and a more efficient and constant supply of contraceptives will allow client groups to achieve slower population growth.

B. Economic Impact

Since the targetted beneficiary group of the project is the Ghanaian society at large (via women of reproductive age) rather than a discrete pilot project group, quantitative projections of beneficiaries versus non-beneficiaries are not possible. Moreover, given the lack of an appropriate data base, sectorial impact simulations of reduced population growth (such as a RAPID analysis) are not possible. On the other hand, adequate conceptual modeling and actual LDC experience exist^{1/} to identify likely economic impacts. These can be identified at three levels:

1. Economy-wide, macro impacts.
2. Household or micro impacts.
3. Institutional impacts.

1. Economy-wide impacts

Many of the factors of determinants of fertility are economic in origin. As the World Bank notes (pp. 51-52):

- "First, where wages are low, the difference between children's and mother's earnings will be small, income lost by the mother during a child's infancy may be easily recouped by the child later on.
- "A second reason that having many children can make economic sense is the lack of schooling opportunities.
- "High infant and child mortality are a third reason for having many children.
- "Fourth, poor parents are worried about who will take care of them when they are old or ill."

In addition, families at the subsistence level need additional family members to increase total food production and income from off-farm employment. In this sense, however, poverty breeds poverty.

a. Recurrent Costs

Reducing population growth rates will relieve demand driven pressures on the recurrent costs of LDC governments' social services (health and education). According to the Quarterly Digest of Statistics data (June 1984), recurrent costs rose over sixfold between 1975 and 1980 and social service costs now account for almost one-half of total recurrent expenditures.

^{1/} Of the large body of literature, the World Development Report 1984 by the World Bank presents the most recent cross-country trends. The Committee on Population and Demography Report No. 16 (1982), Determinants of Fertility for Developing Countries, gives a good conceptual basis for impact assessments.

One way to measure the impact of population growth and structure upon recurrent costs is the dependency ratio of working age population (classically defined as ages 15-45) to the other age cohorts. In the case of Ghana, there are about one and one-half dependent persons to every working age person. Obviously, this is in large part due to the fact that 47.6 percent of the population is less than 15 years of age. A five percent shift toward a greater working age population would decrease the dependency ratio by 10 percent. This reveals the double-edged sword of population in that: (a) a lower rate of growth of population reduces recurrent cost demands and (b) a larger economic base to total population (lower dependency) should be able to generate revenues to pay for recurrent costs.

A similar argument can be made for capital expenditures in the longer run: less population pressure leads to less demand for social services (hospitals, schools) and infrastructure (transport) and generates higher levels of per capita income from existing resources.

b. Food Production

Rapid population growth exerts two distinctive pressures on food production. It has a positive impact on demand for food, especially staples, and a negative impact on food production capability. The former is self evident; across Africa populations are growing faster than the capacity to produce food. In Ghana, population pressures forced up food imports over 200 percent during the decade of the 1970's; per capita food imports rose from 9.20 cedis in 1970 to 22.57 in 1980. The impact on domestic retail prices was even more dramatic. While cocoa prices rose twentyfold, those of maize shot up over 85-fold.

The average size of farms in Ghana is less than 2.5 ha., with less than one out of five over 4 ha. in size. Even on such small holdings, farmers must pursue a mixed cropping system to survive and it is estimated that over 50 percent of food production goes to self consumption. Farmers are also faced with rudimentary technology, an inadequate and inefficient marketing infrastructure and adverse pricing policy. The pressure of rapid population growth immediately increases the density on existing agricultural land. From 1960 to 1980, the population density per square km. of agricultural land increased from 104 to 182. This negatively affects both the technical and economic efficiency of farming and average total yields decrease. Without incentives and investments to increase acreage under cultivation, production falls. The following are production data according to the Ministry of Agriculture.

Production of Important Crops

(thousand tons)

| | <u>1970</u> | <u>1975</u> | <u>1980</u> | <u>1983 Forecast</u> |
|----------------|-------------|-------------|-------------|----------------------|
| Total Cereals | 857.5 | 671.5 | 674.0 | 308.0 |
| (Maize) | 481.6 | 343.4 | 382.0 | 172.0 |
| Total Starches | 6,077.2 | 5,452.3 | 4,349.0 | 3,649.0 |
| (Cassava) | 2,387.8 | 2,398.0 | 2,322.0 | 1,721.0 |
| (Plantain) | 1,644.0 | 1,245.7 | 734.0 | 342.0 |

The net effect of population growth and declining food production is that of less and less food availability. The 1969-71 index of food production per capita rose slightly in 1970 to 101 and rapidly deteriorated to 82 in 1983.

Clearly the GOG must move forcefully to address both sides of the equation. Even though the effects of slower population growth will lag by some years, experience also indicates that a program to invigorate agricultural production, with improved technology, input distribution, marketing and proper prices, is a long-term commitment. Thus, reducing the rate of population growth is a powerful macro-economic tool. Indeed, slowing the rate of population growth must be seen as an integral step in addressing the structural imbalances in the macro-economy.

2. Household level impacts

Impacts of population growth to the macro-economy are relatively long-term and indirect. Those to the household are more immediate and direct. Each additional child is a mouth to feed, possibly a child to educate. But each child also equates with an additional laborer for the family farm or a source of cash income via remittances. Children are usually a source of prestige and social security in later years. What can be calculated as benefits to society may be perceived as costs to individuals. These calculations, however, cannot be made to any real precision without a sophisticated data base.

In the current context of Ghana, the weak economy, declining agricultural production, termination of Nigeria as a major source of migration and unmet demands for contraceptives all point to reduced population growth as a beneficial strategy at the household level. For resource poor rural families, smaller family size would decrease the proportion of agricultural production devoted to family consumption. A larger marketable surplus would increase total family income. Maternal and child mortality and morbidity would improve due to less wasted pregnancies. An important portion of farm labor productivity would therefore improve, thereby raising crop yields.

In essence, smaller families are an alternative survival strategy to those of increased land fragmentation, increase out-migration, and the resulting marginalization of the rural poor.

3. Institutional impacts

The GOG has acknowledged that poor institutional performance is an obstacle to the proposed economic recovery program:

"The dearth of experienced staff, inadequate remuneration, poor morale of the public service and unwieldy administrative systems are all proving to be a major handicap to realizing the ERP goals." (Republic of Ghana, Economic Recovery Programme, 1984-1986)

Both the Agency Policy Paper on Basic Education and Technical Training (December 1982) and Africa Bureau Development Training Assistance Strategy Paper (August 1984) give a high priority to relating training to institutional development and improving local training capacities. This priority is derived from the high economic return to improved skilled labor productivity and institutional efficiency.

Project technical assistance and training will have a positive impact on the medical service delivery institutions. These impacts will feed back to the economy via improved health (and health consciousness) and labor productivity of the population. The CSM program will have at least some positive impact on the level of private sector activities and demonstrate the viability of a more market-oriented approach to development.

1/
Social Analysis

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

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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) |
| 6,431,400 | - 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 Hospitals | 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 & | | | |
| Centers | 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 centers 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 GNFPP in the past. Generally, those GNFPP 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 primary health care concept and builds 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.

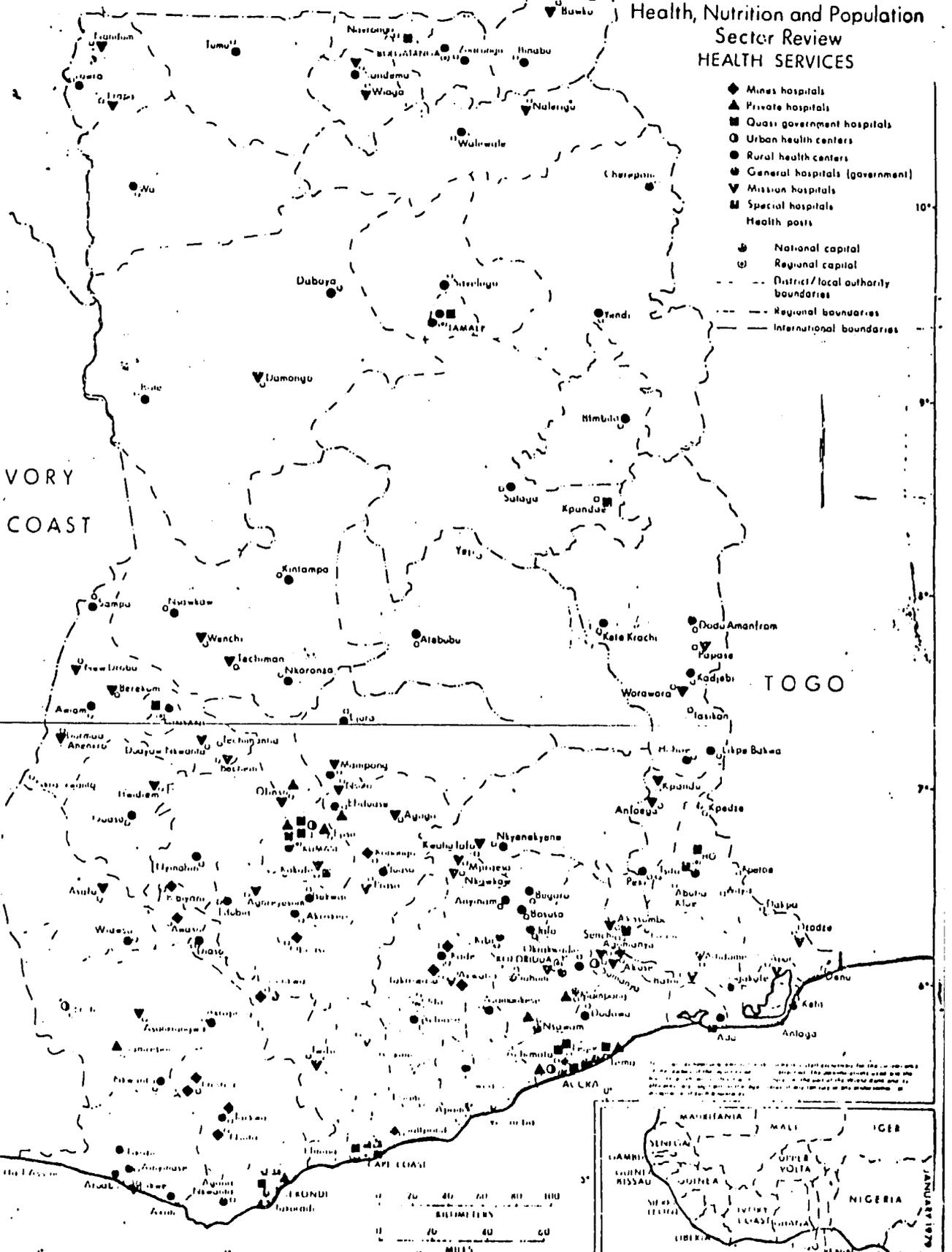
LOCATION OF HOSPITALS, CLINICS AND HEALTH POSTS AND THOSE PROVIDING F.P.

| 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 |

UPPER VOLTA

GHANA

Health, Nutrition and Population Sector Review HEALTH SERVICES

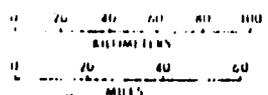
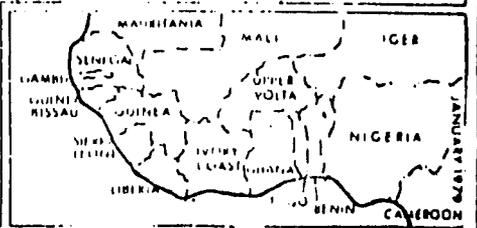


- ◆ Mines hospitals
- ▲ Private hospitals
- Quasi government hospitals
- Urban health centers
- Rural health centers
- General hospitals (government)
- ▼ Mission hospitals
- Special hospitals
- Health posts

- ★ National capital
- Regional capital
- - - District/local authority boundaries
- - - Regional boundaries
- - - International boundaries

IVORY COAST

TOGO



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 table):

(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

| Year | <u>Total MOH</u> <u>allocation</u> | <u>Total MCH/FP</u> <u>allocation</u> | <u>MCH/FP</u> <u>as percent</u> <u>of total</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

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 1980/1981, 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 cedis (000)</u> | <u>% of National Expenditure</u> | <u>Per Capita cedis (X)</u> | <u>Per Capita cedis (XX)</u> |
|-------------|--------------------------------------|--------------------------------------|---------------------------------|----------------------------------|
| 1970/71 | 34,505 | 7.1 | 4.03 | 4.03 |
| 1971 | 34,026 | 6.4 | 3.85 | 3.53 |
| 1972 | 41,965 | 7.4 | 4.60 | 3.82 |
| 1973 | 71,223 | 9.4 | 7.57 | 5.36 |
| 1974 | 103,279 | 8.9 | 10.64 | 6.36 |
| 1975 | 112,095 | 9.3 | 11.19 | 5.16 |
| 1976 | 125,414 | 10.3 | 12.42 | 3.66 |
| 1977 | 183,745 | 9.8 | 17.22 | 2.35 |
| 1978 | 239,630 | 9.1 | 21.71 | 1.71 |
| 1979 | 349,630 | 7.5 | 30.76 | 1.57 |
| 1980 | 407,130 | 7.6 | 34.71 | 1.18 |
| 1981/82 | 596,649 | 8.1 | 49.30 | 0.77 |
| 1982/83 | 678,216 | 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% | |
| | | <u>100%</u> | |

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 sidelines 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 resillance 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 Management

| <u>Headquarters (Accra)</u> | <u>(MCH/FP)</u> |
|--|-----------------|
| <u>Type</u> | <u>Number</u> |
| Physician | 1 |
| Deputy Director, Nursing Services | 1 |
| Principal Nursing Officer | 1 |
| Senior Nursing Officer | 1 |
| <u>All Regional Medical Offices (RMOH)</u> | |
| <u>Located in each of the 10 Regional Capitals</u> | |
| <u>Type</u> | <u>Number</u> |
| Principal Nursing Officer (Public Health) | 10 |
| Regional Medical Officer | 10 |
| Physician for MCH (Accra) | 1 |

A.I.D. PROJECT No. 641-0109

PROJECT GRANT AGREEMENT

Between the Government of Ghana, acting through the
Ministry of Finance and Economic Planning ("Grantee")

and the United States of America, acting through the Agency
for International Development ("A.I.D.").

Article 1: The Agreement

The purpose of this Agreement is to set out the understandings of the parties named above ("Parties") with respect to the undertaking by the Grantee of the Conceptive Supplies Project (the "Project") described below, and with respect to the financing of the Project by the Parties.

Article 2: The Project

SECTION 2.1. Definition of Project. The Project, which is further described in Annex 1, will increase the voluntary use of safe, effective and appropriate contraceptive methods by the Ghanaian population by making an adequate supply of contraceptives and other family planning services available to the Ghanaian public on a continuing basis. Contraceptives will be distributed through the existing service distribution networks of the Ministry of Health ("MOH") and through the development of a private sector contraceptive social marketing program on the wholesale and retail level. A.I.D. financing will be used to purchase contraceptives, commodities, training aids, evaluations and technical assistance. Annex 1, attached, amplifies the above definition of the Project. Within the limits of the above definition of the Project elements of the amplified description stated in Annex 1 may be changed by written agreement of the authorized representatives of the Parties named in 8.2, without formal amendment of this Agreement.

SECTION 2.2. Incremental Nature of Project. (a) A.I.D.'s contribution to the Project will be provided in increments, the initial one being made available in accordance with Section 3.1 of this Agreement. Subsequent increments will be subject to availability of funds to A.I.D. for this purpose, and to the mutual agreement of the Parties, at the time of a subsequent increment, to proceed. (b) Within the overall Project Assistance Completion Date stated in this Agreement, A.I.D., based upon consultation with the Grantee, may specify in Project Implementation Letters appropriate time periods for the utilization of funds granted by A.I.D. under an individual increment of assistance.

Article 3: Financing

SECTION 3.1. The Grant. To assist the Grantee to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended, agrees to grant the Grantee under the terms of this Agreement an amount not to exceed Two Million United States ("U.S.") dollars (\$2,000,000) ("Grant").

The Grant may be used to finance foreign exchange costs, as defined in Section 6.1, and local currency costs, as defined in Sections 6.2, of goods and services required for the Project.

SECTION 3.2. Grantee Resources for the Project

(A) The Grantee agrees to provide or cause to be provided for the Project all funds, in addition to the Grant, and all other resources required to carry out the Project effectively and in a timely manner.

(B) The resources provided by the Grantee for the Project over its three year life will be not less than the equivalent of U.S. \$1,090,000, including costs borne on an "in-kind" basis.

SECTION 3.3. Project Assistance Completion Date

(A) The Project Assistance Completion Date ("PACD") which is March 30, 1989, or such date as the Parties may agree to in writing, is the date by which the Parties estimate that all services financed under the Grant will have been performed and all goods financed under the Grant will have been furnished for the Project as contemplated in this Agreement.

(B) Except as A.I.D. may otherwise agree in writing, A.I.D. will not issue or approve documentation which would authorize disbursement of the Grant for services performed prior to the PACD or for goods furnished for the Project, as contemplated in this Agreement, subsequent to the PACD.

(C) Requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters, are to be received by A.I.D. or any bank described in Section 7.1 no later than nine (9) months following the PACD, or such other period as A.I.D. agrees to in writing. After such period, A.I.D., giving notice in writing to the Grantee, may at any time or times reduce the amount of the Grant by all or any part thereof for which requests for disbursement, accompanied by necessary supporting documentation prescribed in Project Implementation Letters, were not received before the expiration of said period.

Article 4. Conditions Precedent to Disbursement

SECTION 4.1. First Disbursement. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, except for the Assessment referred to below:

(A) A.I.D., using project funds, will conduct a detailed Assessment of the methods for implementing and financing the Project, including an assessment of the effectiveness of various methods of implementation and financing in Ghana overall and the level of efficiency of the implementing organization.

(B) The Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.

(1) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(2) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 8.2, and a specimen signature of each person specified in such statement.

(3) An executed written agreement(s) between the Grantee, represented by the Ministry of Finance and Economic Planning ("MFEP"), and the DANAFCO Ltd. which sets forth the terms and conditions governing cooperation between the Grantee and DANAFCO for the development and implementation of the private sector Contraceptive Social Marketing ("CSM") program. The agreements shall state the role and responsibilities of DANAFCO as the CSM distributor, the program's financial objectives, and how CSM program resources will be used and accounted for.

(4) Written assurances that not less than the cedis equivalent of \$800,000 in counterpart funds will be made available by the Grantee for Project purposes. Such written assurances shall also confirm the Grantee's agreement to make available funds from its own resources during the early stages of the Project, subject to later reimbursement from the PL 480 Title I generated counterpart funds.

(5) Evidence that the MOH central warehouse in Tema has been repaired and that contraceptives held in that warehouse are stored properly.

(6) Evidence that an appropriate system has been developed for the use and distribution of all return-to-project funds generated

under the public or private sector contraceptive sales programs, and that the appropriate A.I.D. representative has agreed to the means and methods of accounting for, and distribution, of these funds.

(7) Evidence that, and detailed plans under which, the MOH will provide sufficient funds to cover costs of personnel salaries, training, storage and distribution during the life of Project. These plans shall include a plan for the continued funding of the training program initiated under this Project, until all appropriate MOH, and Maternal Child Health/Planning personnel are trained in family planning procedures.

SECTION 4.2. Disbursement for Training. Prior to the disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, to finance training in the U.S. or a third country, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.

(A) Evidence that such participants will, upon return to Ghana, be employed by the MOH in family planning activities related to the Project or a similar project agreeable to A.I.D., and

(B) Evidence that participants for long-term academic training will agree before leaving Ghana to return to Ghana after their training and accept employment in the MOH for not less than three years, and that the GOG will endeavor to enforce this conditions.

SECTION 4.3. Notification. When A.I.D. has determined that the conditions precedent specified in Sections 4.1 and 4.2 have been met, it will promptly notify the Grantee.

SECTION 4.4. Terminal Dates for Conditions Precedent. If all the conditions specified in Section 4.1 have not been met within 180 days from the date of this Agreement, or such later date as A.I.D. may agree to in writing, A.I.D., at its option, may terminate this Agreement by written notice to the Grantee.

Article 5. Special Covenants

SECTION 5.1. Project Evaluation. The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

- (a) an evaluation of the progress towards the objectives of the Project;
- (b) identification and evaluation of problem areas or constraints that may inhibit such attainment;
- (c) assessment of how such information may be used to help overcome such problems; and
- (d) evaluation, to the degree feasible, of the overall development impact of the Project.

SECTION 5.2. Vehicles. The Grantee agrees that all vehicles purchased under the Project will be provided sufficient fuel and maintenance, as needed, during the life of the Project and thereafter as long as the vehicles are being used for Project purposes.

SECTION 5.3. Taxes. The Grantee agrees that any AID financed goods or commodities imported for use under the Project, including those for the private sector component of the Project, will be free of any duty, fee or tax under the laws of Ghana.

SECTION 5.4. Records. The Grantee agrees that appropriate representatives of A.I.D., or any individual or company employed by A.I.D. in connection with the Project, shall have free unencumbered access to the government's files, records and books relating to the following:

- (a) local currency owned by the Grantee which is generated by sales of PL 480 Title I commodities and which is used or will be used for Project purposes;
- (b) funds generated from MOH and private sector sales of contraceptives under the Project; and
- (c) funds generated under all previous A.I.D. financed projects in Ghana involving the distribution of contraceptives or family planning.

Article 6. Procurement Source

SECTION 6.1. Foreign Exchange Costs. Disbursements pursuant to Section 7.1 will be used exclusively to finance the costs of goods and services required for the Project having, with respect to goods, their source and origin, and with respect to services, their nationality in the United States and other countries included in A.I.D. Geographic Code 941 as in effect at the time orders are placed or contracts entered into for such goods or services ("Foreign Exchange Costs"), except as A.I.D. may otherwise agree in writing, and except as provided in the Project Grant Standard Provisions Annex, Section C.1 (b) with respect to marine insurance. Ocean transportation costs will be financed under the Grant only on vessels under flag registry of the United States, Ghana or countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

SECTION 6.2. Local Currency Costs. Disbursement pursuant to Section 7.2 will be used exclusively to finance the costs of goods and services required for the Project having their source and, except as A.I.D. may otherwise agree in writing, their origin in Ghana ("Local Currency Costs").

Article 7. Disbursement

SECTION 7.1. Disbursement for Foreign Exchange Costs

(A) After satisfaction of conditions precedent, the Grantee may obtain disbursement of funds under the Grant for the Foreign Exchange Costs of goods and services required for the Project in accordance with the terms of this Agreement by such of the following methods as may be mutually agreed upon:

(1) by submitting to A.I.D., with necessary supporting documentation as prescribed in Project Implementation Letters, (a) requests for reimbursement for such goods or services, or (b) requests for A.I.D. to procure commodities or services in the Grantee's behalf for the Project; or

(2) by requesting A.I.D. to issue Letters of Commitment for specified amounts (a) to one or more U.S. banks, satisfactory to A.I.D., committing A.I.D. to reimburse such bank or banks for payments made by them to contractors or suppliers, committing A.I.D. to pay such contractors or suppliers, under Letters of Credit or otherwise for such goods or services, or (b) directly to one or more contractors or suppliers, committing A.I.D. to pay such contractors or suppliers, through Letters of Credit or otherwise, for such goods or services.

(B) Banking charges incurred by the Grantee in connection with Letters of Commitment and Letters of Credit will be financed under the Grant unless the Grantee instructs A.I.D. to the contrary. Such other changes as the Parties may agree to may also be financed under the Grant.

SECTION 7.2. Disbursement for Local Currency Costs

(A) After satisfaction of conditions precedent, the Grantee may obtain disbursements of funds under the Grant for Local Currency Costs required for the Project in accordance with the terms of this Agreement, by submitting to A.I.D., with necessary supporting documentation as prescribed in Project Implementation Letters, requests to finance such costs.

(B) The local currency needed for such disbursement may be obtained: (1) by acquisition by A.I.D. with U.S. dollars by purchase, or (2) by A.I.D., (a) requesting the Grantee to make available local currency for such costs, and (b) thereafter making available if the Grantee through the opening or amendment by A.I.D. of Special Letters of Credit in favor of the Grantee or its designee, an amount of U.S. dollars equivalent to the amount of local currency made available by the Grantee, which dollars will be utilized for procurement from the United States under the appropriate procedures described in Project Implementation Letters.

(C) The U.S. dollar equivalent of the local currency made available hereunder will be, in the case of subsection (B) (1) above, the amount of U.S. dollars required by A.I.D. to obtain the local currency, and in the case of subsection (B) (2) above, an amount calculated at the rate exchange specified in the applicable special Letter of Credit Implementation memorandum hereunder as of the date of the opening or amendment of the applicable Special Letter of Credit.

SECTION 7.3. Other Forms of Disbursement. Disbursement of the Grant may also be made through such other means as the Parties may agree to in writing.

SECTION 7.4. Rate of Exchange. Except as may be more specifically provided under Section 7.2, if funds provided under the Grant are introduced into Ghana by A.I.D. or any public or private agency for purposes of carrying out obligations of A.I.D. hereunder, the Grantee will make such arrangements as may be necessary so that such funds may be converted into currency of Ghana at the highest rate of exchange which, at the time the conversion is made, is not unlawful in Ghana.

ARTICLE 8: Miscellaneous

SECTION 8.1. Communications. Any notice, request, document or other communications submitted by either Party to the other under this Agreement will be in writing or by telegram or cable, and will be deemed duly given or sent when delivered to such party at the following address:

To the Grantee:

MAIL ADDRESS: The Principal Secretary
International Economic Relations Division
Ministry of Finance and Economic Planning
Post Office Box M. 76
Accra, Ghana

Alternate Address for
Cables:

Principal Secretary
Prudence
Accra, Ghana

To A.I.D.:

MAIL ADDRESS: Director
USAID Mission to Ghana
Post Office Box 1630
Accra, Ghana

Alternate Address for
Cables:

USAID Accra

Other addresses may be substituted for the above upon the giving of written notice.

SECTION 8.2. Representatives. For all purposes relevant to this Agreement, the Grantee will be represented by the individual holding or acting in the Office of the Principal Secretary for the Ministry of Finance and Economic Planning, and A.I.D. will be represented by the individual holding or acting in the office of Director of USAID/Ghana, each of whom, by written notice, may designate additional representatives for all purposes other than exercising the power under Section 2.1 to revise elements of the amplified description in Annex 1. The names of the representatives of the Grantee, with specimen signatures, will be provided to A.I.D., which may accept as duly authorized any instrument signed by such representatives in implementation of this Agreement until receipt of written notice of revocation of their authority.

SECTION 8.3. Standard Provisions. A "Project Grant Standard Provisions Annex" (Annex 2) is attached to and forms part of this Agreement.

IN WITNESS WHEREOF, the Grantee and the United States of America, each acting through its duly authorized representative, have caused this Agreement to be signed in their names and delivered as of the day and year last below written.

UNITED STATES OF AMERICA

GOVERNMENT OF GHANA

BY: _____

BY: _____

TITLE: Acting A.I.D. Mission
Director

TITLE: Minister of Finance
and Economic Planning

DATE: _____

DATE: _____

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 ^{1/} | | 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 ^{3/} | 4,833 ^{2/} | 724 ^{3/} |

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 | 645 |
| Upper East | 95 | 251 | 8 | 71 | 629 |
| Upper West | 49 | 152 | 6 | 60 | 234 |

Source MOH Planning 1984

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.

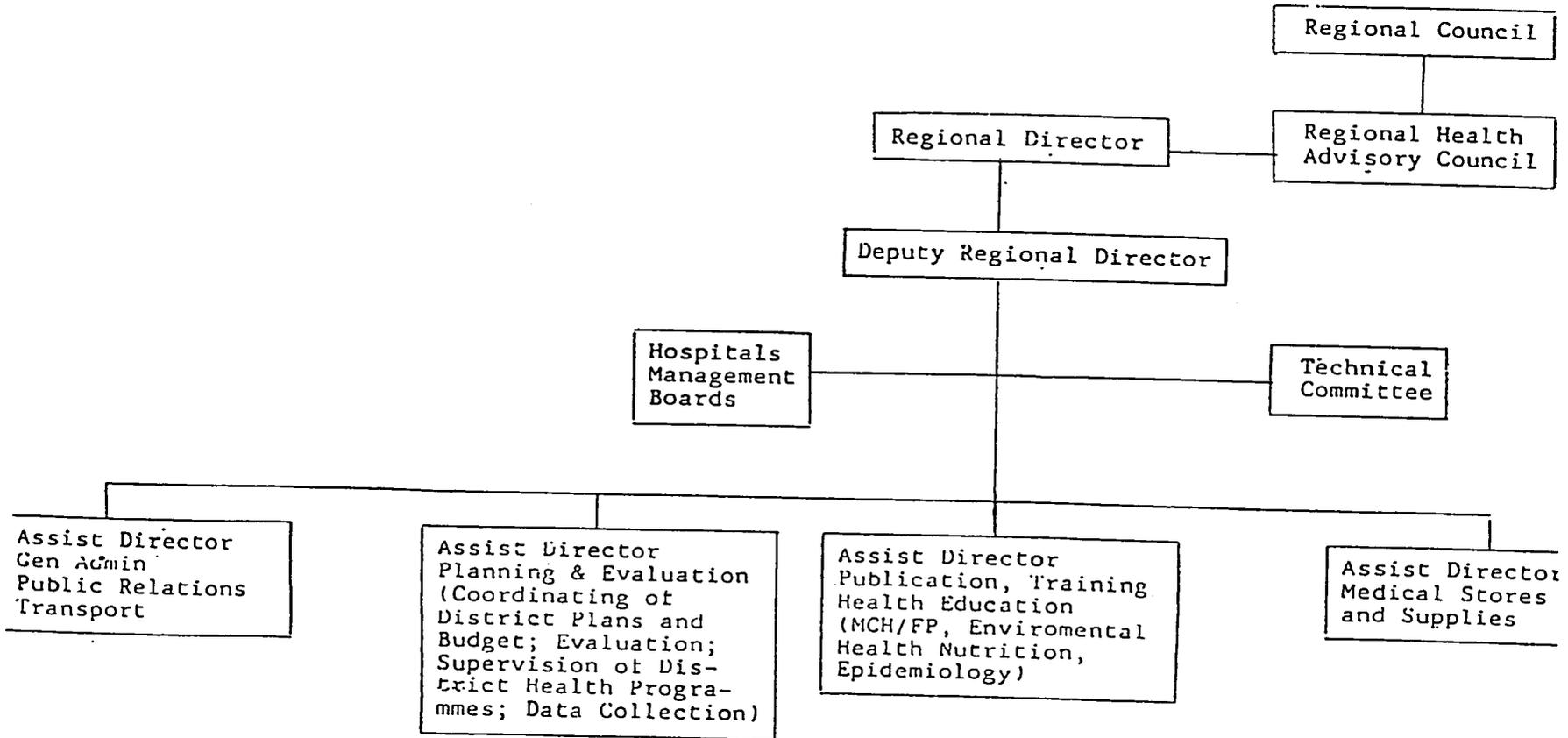
In summary, we see a general health system which has made considerable progress over the years in extending its services throughout the nation and toward the community level. Despite policy pronouncements favoring public health and preventive care it has not superceded the demands of hospital and curative 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 Ghanian 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.

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ORGANIZATIONAL STRUCTURE AT REGIONAL LEVEL

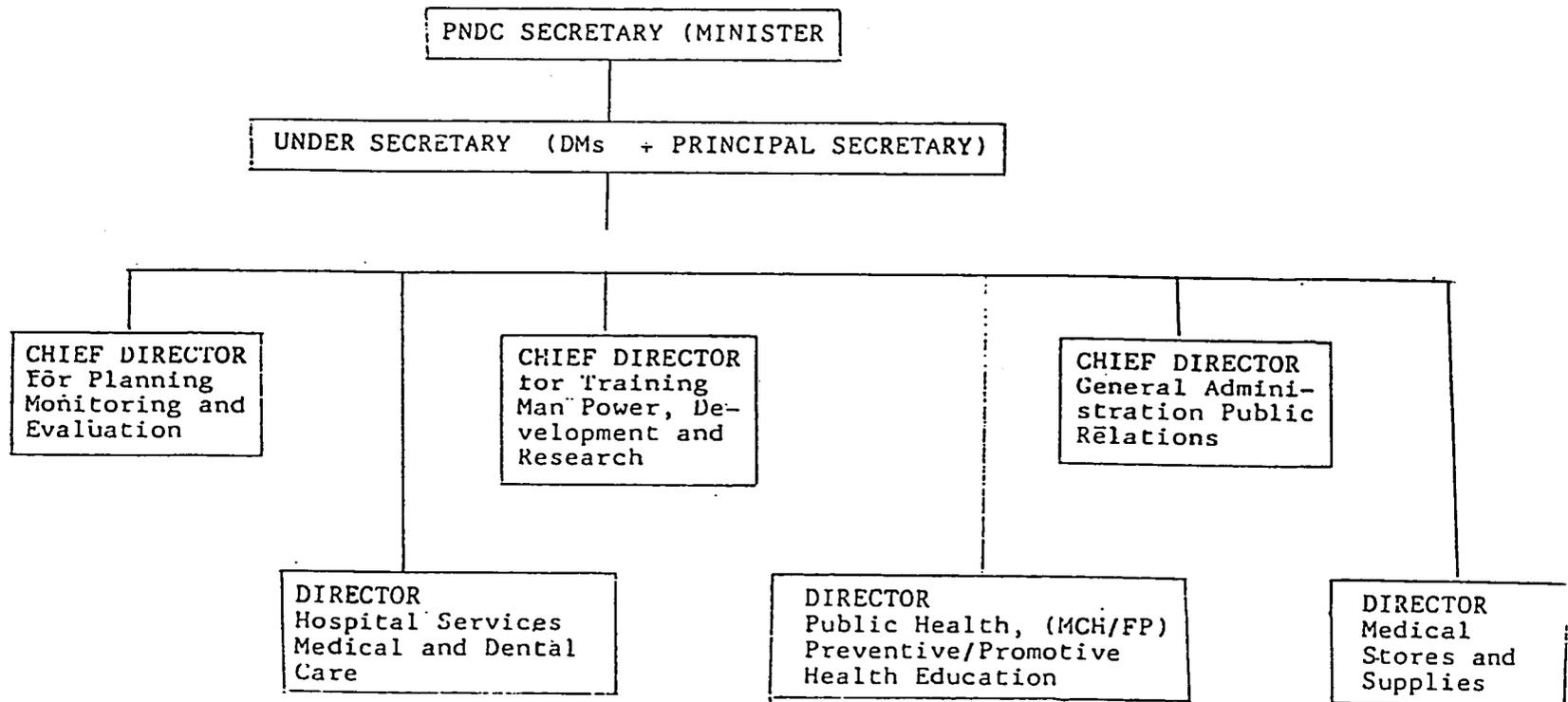
Annex I-1



SOURCE: UNFPA

PROPOSED ORGANIZATIONAL STRUCTURE - M.O.H.

Annex I-21



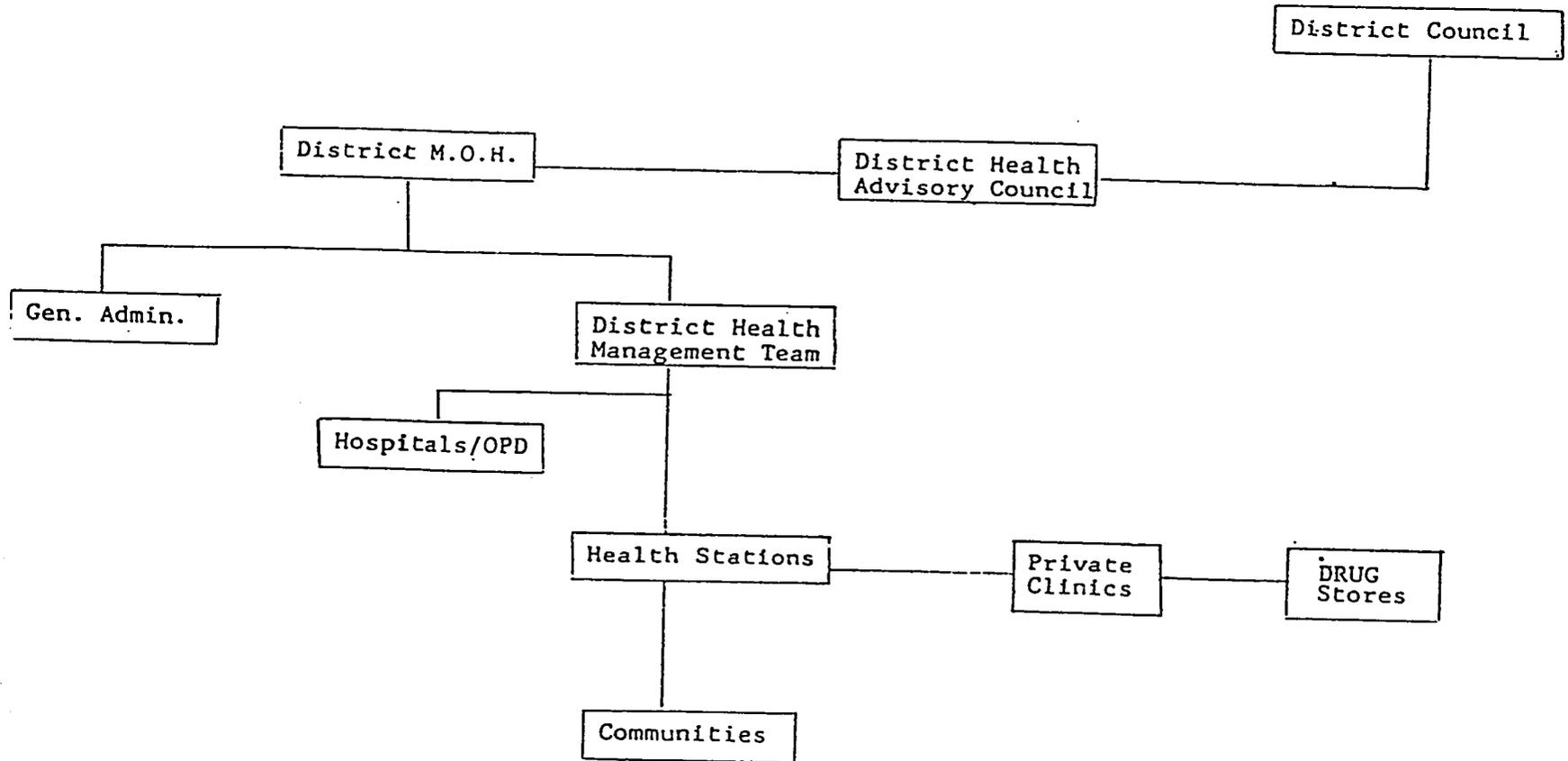
SOURCE: UNFPA

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ORGANIZATIONAL STRUCTURE AT DISTRICT LEVEL

Annex I-1

8/21



SOURCE: UNFPA

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

| NO. | REGION | DISTRICT | HEALTH INSTITUTION |
|-----|---------------|--|---|
| 1 | Greater Accra | <p>Accra City</p> <p>Tema</p> <p>Dangbe</p> | <p>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</p> <p>Tema Gen. Hospital Tema UHC Urban Health Center Ashiaman H/P Obom H/P Danfa H/P - Medical School Tema Newtown H/P</p> <p>Ada Health Centre Ningo H/P Sege H/P Kasseh H/P Dodowa H/P Prampram H/P</p> |
| 2 | | <p>Eastern</p> <p>Kaoga</p> <p>Kraboia Coaltar</p> | <p>Tetteh Quashie Hospital Nsawam Hospital Nsawam MCH Hospital Center Mampong MCH Akropong MCH Aburi MCH Adukrom H/P Okraokojo H/C</p> <p>Somanya MCH</p> <p>Suhum Hospital Suhum MCH Center Asuboi H/P</p> |

| NO. | 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 | Atibi Hospital Atibi MCH Center Pease H.P. Obo MCH Center Nkyenkyene H/C Donkorkrom H/C Nkwatia H/P Abetifi H/P Nkawkaw MCH Center |
| | | West Akim | Asamankese H/C Kade H/C Pramkese H/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 Asewewa 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 Ajedwa H/P Anyinam H/C Bososu H/C |

| 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 Akrokerri 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 |
|-----|----------|-----------------|---|
| | | Sissala | Walembele 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 |
| | Northern | Western Dagomba | Sakasaka MCH Center Regional Hospital Tamale Savelugu H/C Kumbungu H/P |
| | | Eastern Dagomba | Yendi Hospital Chereponi H/C Gushiegu H/P Sabuha 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 Bamboi H/P Bimbila H/C <u>301</u> |

STATEMENT OF CORPORATE CAPABILITY

The development of DANAFCO in Ghana has much in common with the country itself. From very modest beginnings in 1959 when Ghana was barely two years old as a politically independent nation, the Company has developed into the largest import, production and wholesale organisation in Ghana in pharmaceuticals and medical supplies. Danafco has its headquarters in Accra on Plot No.5, Dadeban Road, Ring Road North Industrial Area and has branches in Kumasi, Takoradi, Hohoe and Koforidua. Danafco enjoys the Ghana Government's support in providing the health needs of its people. In terms of supplies to the Government, Danafco always provides the largest share. Danafco products are widely seen in Government Medical Stores, Clinics, Hospitals and the Chemists and Chemical Sellers Shops in all Regions. The Company supplies about one third of the country's locally manufactured pharmaceuticals.

A significant factor in assessing the Danafco Group is its production and warehousing facilities. The Company has an integrated manufacturing and warehouse facility free from pest and insects with proper ventilation and air conditioning. The warehouse is dry, secure and maintains proper inventory control. Similar though smaller warehouse facilities exist in four other Regions.

Danafco engages the services of seven qualified pharmacists who are involved in the production and distribution of its numerous products ranging from Ethical Pharmaceuticals to Dressings and Oral Contraceptives. In this connection Danafco is an authorized agent for a number of overseas companies. A list of which is attached.

In the field of Sales and Distribution, Danafco has a well organised sales operation. Its sales and managerial are experienced and many have ten years or more service with the Company.

Presently employing about four hundred (400) people including two expatriates, the annual turnover of the Group is something near the ₵200m mark. With its effective plant, printing section, packaging lines and warehousing facilities throughout the country Danafco can effectively undertake the packaging and distribution of a wide variety of commercial products.

Danafco initiated three industries so far in Ghana. These are Dumex Limited which produces pharmaceuticals, Pharmaplast Limited which produces containers and packaging materials and Danafco Manufacturing Limited also a pharmaceutical production Company.

As its contribution to the present Green Revolution the Company has expanded its farms, the Golden Corn Farms, to produce not only cash crops but medicinal plants/herbs for which the Company maintains a laboratory facility to undertake appropriate research.

Danafco does not engage in retail trade but relies on Pharmacists and Druggists to ensure adequate distribution of its products.

Danafco celebrated its Silver Jubilee early this year.

Bankers to the Danafco Group of Companies are:

- (1) Ghana Commercial Bank,
Liberty Hourse, Accra.
- (2) Standard Bank (Ghana) Limited,
Adabraka Branch, Box 1707, Accra.
- (3) Merchant Bank (Ghana) Limited,
Liberty Avenue,
P.O. Box 401, Accra.
- (4) Barclays Bank of Ghana Limited,
High Street Branch, Accra.

INITIAL ENVIRONMENTAL EXAMINATION

OR

CATEGORICAL EXCLUSION

Project Country:Project Title:Funding: FY (s) 85, 86 & 87 \$ 7,000,000IEE Prepared By: Jeffrey W. Goodson, Regional Environmental Officer, REDSO/WCAEnvironmental Action Recommended: Categorical Exclusion

Positive Determination _____

Negative Determination _____

Categorical Exclusion:

This activity meets the criteria for Categorical Exclusion in accordance with Section 216.2 (C) and is excluded from further review because:

The project involves only family planning services and does not include activities directly affecting the environment (e.g., water supply, waste water treatment or other facility construction), pursuant to 22 CFR 216.2 (viii).

Concurrence:
Bureau Environmental Officer

APPROVED _____

DISAPPROVED _____

DATE _____

Clearance: GC/AFR _____ Date _____

JUSTIFICATION FOR VEHICLE SOURCE/ORIGIN WAIVER

Subject: Source/Origin Procurement Waiver from AID Geographic Code 000 (U.S. Only) to Code 935 (Special Free World) for 6 project trucks

Background:

- a. Cooperating Country : Ghana
- b. Authorizing Document : Project Authorization and Project Paper
- c. Project : Contraceptives Supplies Project(641-0109)
- d. Description of Goods : 6 light weight double-cabbed Nissan trucks and spare parts
- e. Nature of Funding : Grant
- f. Approximate value : \$100,000
- g. Probable Origin : Japan
- h. Probable Source : Ghana or Japan

Discussion: Section 636(1) of the Foreign Assistance Act (FAA) as amended, states that motor vehicles must be of U.S. manufacture unless special circumstances exist which would permit procurement of non-U.S. manufactured vehicles. AID Handbook 1, Supplement B, Chapter 4C2d states that one of the special circumstances justifying a waiver of this requirement is "present or projected lack of adequate service facilities and supply of spare parts for U.S. manufactured vehicles".

In addition, under AID Handbook 1, Supplement B, Chapter 4A1D(2)(a), AID Geographic Code 941 is the authorized source for grants to RLDCs, such as Ghana. Under AID Handbook 1, Supplement B, Chapter 5B4a, one of the criteria for waiving the AID procurement source/origin requirements for commodities is the unavailability of the commodities from countries in the authorized Code. Another relevant criteria is whenever there exists "such other circumstances as are determined to be critical to the success of the project objectives." These 6 vehicles are critical to the success of the project and they must be kept in running order. This, in turn, requires that there be adequate service facilities and supply of spare parts for whatever type vehicle is procured. If a waiver is authorized, the AID official making such authorization must certify that " exclusion of procurement from Free World countries other than the Cooperating Country and countries included in Code 941 would seriously impede the attainment of U.S. foreign policy objectives and objectives of the foreign assistance program."

The Ghana Contraceptive Supplies Project has as a part of its purpose to improve the training activities of the Ministry of Health (MOH) and improve the distribution of contraceptives. These 6 vehicles will be used initially to provide transportation for the training teams during training of Health Clinic personnel in the rural areas of Ghana. Following the completion of the training activities they will be used by personnel stationed at 6 of the regional centers for use in transporting regional nursing staff to district offices and rural health clinics while also carrying contraceptive supplies to these Family Planning outlets.

| NO. | REGION | DISTRICT | HEALTH INSTITUTION |
|-----|----------------|----------------------|--|
| 3 | Western Region | Sekondi/ Takoradi | Effia Nkwanta MCH MCH Hosp. Takoradi Hosp. + MCH Center Essikadu H/C Kwasimintim H/C Agona Nkwanta H/C Shama H/P Princess Town H/P Apremdu Military Hospital Axim Hosp. + MCH Center Half Assini Hosp. MCH Tikobo H/C Anyinamso H/C Kabeku H/P |
| | | Sefwi Bibiani | Bibiani Hosp. + MCH Sefwi Wiawso Hosp. + MCH Awaso Mines Hospital Jwabeso H/P Sefwi-Anhiaso H/P Tarkwa Mines Hosp Tarkwa MCH Center Tarkwa |
| | | Wasa-Fiase Mpohor | Mpohor H/P Nsuta Mines Hospital Prestea Ariston Gold Mines Hosp. |
| | | Aowin-Amenfi | Wasa Akropong H/C Enchi H/C Samreboi Hospital Enchi H/C Asankragwa MCH Center Endu Hospital |
| | Central | Cape Coast | Cape Coast Hospital Cape Coast MCH Clinic Elmina UHC Kissi H/P University Hospital Ewim OPD |

| NO. | REGION | DISTRICT | HEALTH INSTITUTION |
|-----|---------|----------------------|---|
| | Central | Twifu-Heman-Denkyira | Dunkwa Hospital Dunkwa MCH Center Diaso H/P Kyekyewere 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 Otuam H/P Otuam MCH |
| | | Agoa | Agoa 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 |

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| No. | REGION | DISTRICT | HEALTH INSTITUTION |
|-----|--------|-------------|---|
| | Volta | Hohoe | Hohoe Govt. Hospital Hohoe MCH Center |
| | | Ho | 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 Abutia Agove H/P Vane H/P Abutia Klöe Amedzofe H/P E.P. Social Center |
| | | Kete Krachi | Kete Krachi MCH Hosp. Banda H/P Katanga Hosp. Tutukpene H/P Adidome E.P. Hosp. Tokwano H/P Dormanbu H/P |
| | | Tongu | Adidome E.P. Hosp. Mafi-Kumase H/P Podoe H/P Sogakofe H/C |
| | | Kpandu | Kpandu H/C Have H/P Peki MCH Peki Dzake H/P Wusuta H/P |
| | | Jasikan | 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 |

| NO. | REGION | DISTRICT | HEALTH INSTITUTION |
|-----|-------------|---------------------|---|
| 6 | Brong Ahafo | Brekum-Jaman | Sampa H/C |
| | | Wenchi | Wenchi Meth. Hosp. Yeji H/C Nsawkaw H/P Sudinso H/P Atebubu H/C |
| | | Goaso-Ahafo | Goaso H/C Akrodie H/P Kukuom H/P Akyerensu H/P Gyedu H/P Hwidiem MCH |
| | | Techiman | Techiman MCH Tanoso H/P |
| | | Nkoranza/Kintampo | Kintampo H/C Nkoranza H/C Yefri H/P Nkoranza Hospital |
| | | Sunyani | Sunyani Hospital + MCH Center Nsuatre H/P Techimantia H/P Bechem MCH Center Chiraa H/C Yamfo H/P Duayaw-Nkwanta MCH |
| 7 | Ashanti | Dormaa-Ahenkro | Basel Mission Hospital Dormaa Ah H/C Wamfie H/P |
| | | 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 |

The above vehicles are essential to the improvement of the family planning training for rural staff and for transporting contraceptive supplies to the rural health clinics.

Justification: In order to get the training activities moving quickly at the start of the project (it is only 4 years in length), the Mission recommends purchase of the vehicles in country through a local distributor, such as Nissan which has a maintenance/repair facility in the Accra area, and spare parts too. There are currently no U.S. distributors in the Accra area and maintenance of U.S. manufactured vehicles has proven to be virtually impossible; moreover, there is no reliable source in Accra or up-country of commercially available spare parts for U.S. vehicles. In other words, U.S. manufactured vehicles which can be maintained adequately in Ghana are simply unavailable. Another reason for the purchase of these vehicles in-country from Nissan is the fact that the MOH has standardized on Nissan vehicles, and the U.N. is donating 8 such vehicles to support the MOH. The justification for this waiver request is based, therefore, on the lack of service facilities and supply of spare parts for U.S. manufactured vehicles, and the standardization of these vehicles by the Ghana Ministry of Health.

Recommendation: For the above reasons, it is recommended that the Assistant Administrator for Africa:

1. Approve a source/origin procurement waiver from AID Geographic Code 000 to Code 935 to permit the procurement of 6 vehicles of non-U.S. manufacture for the subject project;
2. Certify that exclusion of procurement from Free World Countries other than the Cooperating Country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program; and
3. Determine that special circumstances exist which justify the waiver of the requirements of Section 636(i) of the Foreign Assistance Act of 1961, as amended.

ACTION MEMORANDUM TO THE ASSISTANT ADMINISTRATOR FOR THE AFRICA BUREAU

Thru: Tom Luche, Acting Director, USAID/Ghana

From: Eugene H. Rauch, PDO, REDSO/WCA

Subject: Waiver of Competition for the procurement by the Government of Ghana of storage, packing, marketing and distribution, services under the Contraceptive Social Marketing (CSM) component of the Ghana Contraceptive Supplies Project

a) Cooperating Country : Ghana

b) Authorizing Document : Project Authorization

c) Project : Contraceptive Supplies Project (641-0109)

d) Description : Services for the project for:

(1) storing, packing, marketing, and distributing contraceptives;

(2) negotiating and entering into agreements for the wholesale/retail sales of contraceptives, and

(3) training of all authorized retailers in contraceptive handling, marketing, storage, and dissemination of basic information and counseling on use of contraceptives.

e) Nature of Funding : Project Grant Agreement

f) Approximate Value :

g) Probable Contractor : DANAFCO

Discussion: The Ghana Contraceptive Supplies Project (641-0109) has as a component a Contraceptive Social Marketing (CSM) program under which U.S. supplied contraceptives will be marketed through the private sector. The Government of Ghana (GOG) desires to procure on a non-competitive basis the services of DANAFCO, a Ghanaian owned firm, to provide for the storage, packing, marketing and distribution of such contraceptives.

In accordance with AID Handbook 1B, Chapter 12C4a(1), competition in the procurement of services by the cooperating country may be waived and a single source negotiated contract authorized by the appropriate Assistant Administrator if the value of the procurement does not exceed \$500,000. This waiver must be supported by a written record of the reasons for negotiation with only a single source. Pursuant to Handbook 1B, Chapter 12C4a(2)(a)4, such a waiver is justified if "One institution or firm can be demonstrated to have the unique capability by reason of special experience or facilities, or specialized personnel who are recognized as predominant experts in the particular field to perform the services required for the project."

With respect to the subject Project, DANAFCO has such "unique capability" to perform the services required by the GOG under the CSM component. First, the GOG had selected DANAFCO under informal competition to implement the prior AID financed contraceptive distribution project in Ghana and was completely satisfied with DANAFCO's performance. DANAFCO's special experience with distribution of contraceptives in Ghana is unique and will be critical to the overall success of the CSM project component. Second, it appears that DANAFCO, by reason of its special facilities, is the only distributor of pharmacy items capable of offering nationwide distribution of

contraceptives to retailers. In this regard, DANAFCO has four strategically located in-country warehouse/distribution facilities, in addition to the main manufacturing/warehouse facility in Accra. Furthermore, DANAFCO, unlike other potential distributors, has a complete in-house printing and packaging facility in Accra for the production of contraceptive packages, instruction documents and labels. In summary, DANAFCO has the unique capability to carry out the management and implementation of the CSM private sector component of the project, including the storage, packaging, marketing and distribution of contraceptives.

It is also important to note that the type of in-country services (storage, packing, and distribution of contraceptives) required by the GOG under the Project can only be performed by a distribution company already established in Ghana. Moreover, since the GOG restricts the sale of contraceptives outside of pharmacies, the field of potential distribution companies is in practical terms further limited to those few companies who distribute items to pharmacies.

Recommendation: Based upon the reasons set forth above and the waiver authority provided in section 12C4a(1) of Handbook 1B, it is recommended that you approve a waiver of competition with respect to the procurement by the Government of Ghana of the services of DANAFCO under the CSM component of the subject project.

Approved: _____

Disapproved: _____

Mark Edelman
Assistant Administrator for Africa

Date: _____

Clearances:

REDSO/WCA: RLA D. Keene *WJM*

REDSO/WCA: PDO, E. Rauch *E. H. Rauch*

REDSO/WCA: RSMO, A. Bilecky *AB*

M/SER/CM:

GC/AFR: