PD-ABI-109

Agency for International Development

Project Paper (PP)
and
Program Assistance Approval Document (PAAD)

Ghana Family Planning and Health Program
(FPHP)

Unclassified

Office of A.I.D. Representative
Ghana

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/PD, Timothy J. Bork

SUBJECT: Ghana Family Planning and Health Program (641-0118/0121)

I. PROBLEM: Your approval is requested for: (1) a multi-year program grant of $30,000,000 from the Development Fund for Africa (DFA) appropriation to the Ghana Family Planning and Health Program (FPHP) and (2) authorization of the $17,000,000 project component of the FPHP. The planned FY 1991 obligation, including both program and project assistance, is $5,590,000.

II. DISCUSSION: The goal of the Ghana Family Planning and Health Program is to lower fertility of the Ghanaian population through maternal and child health interventions. The purpose of the FPHP is to increase the use of and demand for family planning through expanding the public and private sector capacity for providing family planning and maternal and child health services and supplies. While a foundation for rapid expansion of family planning goods and services exists, significant infrastructural and Government of Ghana (GOG) policy impediments remain which will be addressed by the FPHP.

Although USAID/Ghana does not have an approved Country Development Strategy Statement (CDSS) at this time, a country strategy has been elaborated in the FY 1990 Ghana Concept Paper. In addition, the Mission is operating under its FY 1989-90 Action Plan. The Ghana FPHP design is derived from the Mission's Concept Paper, its proposed Country Program Strategic Plan, the 1983 A.I.D. Sector Strategy for Population and strategies under the Development Fund for Africa (DFA).

The FPHP supports two key areas of the Ghana Concept Paper country program strategy:

--to provide fast-disbursing program assistance through the foreign exchange (FX) auction, and

--to improve Ghana's management of population pressures through assistance in family planning and child survival.

The Ghana Family Planning and Health Program will create a policy and institutional framework supportive of Ghana's efforts to

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limit population growth through the increased use of modern methods of family planning. The FPHP will utilize a two part approach:

--program assistance to encourage policy reform and to generate local currency to relieve financing impediments to increased public sector expenditures for family planning and maternal and child health (MCH) services, and

--project assistance primarily to improve private sector implementation of the national family planning program.

By the final year of the program, it is expected that 525,000 women and their families will have benefited from modern family planning methods; 150,000 children will have received oral rehydration salts (ORS); and 370,000 children will have received the benefits from the complete regimen of anti-malarial medication. Individual women are major beneficiaries of the FPHP. The benefits to women accrue in a variety of areas (e.g. health, empowerment, income and education).

The GOG implementing agencies are the Ministry of Finance and Economic Planning (MFEP), Ministry of Health (MOH) and the national population authority. A project technical committee (consisting of representatives of the cognizant technical divisions of the MOH, national population authority, MFEP and USAID) chaired by MFEP will have overall monitoring and management responsibilities for the FPHP.

Program Conditionality

A.I.D. will grant $13.0 million to the Government of Ghana for use in the Bank of Ghana's foreign exchange auction. A.I.D. will disburse the program grant in three tranches as policy conditions are fulfilled. The conditions fall into two broad categories:

-- Fundamental policy and institutional changes, designed to create a sense of national commitment and a supportive policy framework, which will allow the long-term expansion of population planning activities in a time frame that goes beyond the life of this project, and

-- Regulatory changes to immediately remove constraints on public and private sector health workers and commodity suppliers, in order to permit increased numbers of health workers and distributors to handle and sell family planning commodities, ORS and chloroquine.

A special covenant has been included in the FPHP project authorization. In substance, it relates to an effort to achieve partial price recovery of the value of donated contraceptives and creation of a Return to Project Fund which would be used for procurement of additional contraceptives.

Financial Summary

It is planned that a multi-year program with an A.I.D. contribution totaling $30,000,000 in life-of-program (LOP) funding will be approved which includes $13,000,000 in non-project assistance and $17,000,000 in project assistance. The first year (FY 1991) and LOP obligations are estimated as follows:

	First Year	LOP
Project Assistance:		
Technical Assistance/and Procurement of Contraceptives	$2,590,000	$17,000,000
Program Assistance	3,000,000	$13,000,000
Total:	$ 5,590,000	$30,000,000

Host Country Contribution

The host country contribution to the Ghana Family Planning and Health Program will be the local currency equivalent of U.S. $12,253,000 (consisting of GOG in-kind contribution and cash). This contribution satisfies the FAA requirement that the host country contribute at least 25 percent of the cost of the entire program. A written assurance to this effect will be received from the GOG prior to or as a part of the subject program and project grant agreements. The $12,253,000 will be allocated as general sector support for health and family planning budgets and will provide the counterpart resources necessary to support both aspects of the FPHP.

Initial Environmental Examination (IEE)

The IEE contained in PAAD/PP Annex S has determined that the Ghana Family Planning and Health Program meets the criteria for categorical exclusion under A.I.D. Regulation 16. The IEE has been approved by the Africa Bureau Environmental Officer.

Local Cost Financing

The Ghana FPHP will finance $3,580,000 worth of local goods and services. These items primarily are local logistical and administrative support for the contractor team, local long-term and short-term technical personnel, local social marketing and

information, education and communication (IE&C) activities and related training activities. Pursuant to HB 1B Chapter 18(A)(1)(c), as a precondition for local cost financing, the Acting A.I.D. Representative has made a determination, based upon an analysis of the supply and prices of indigenous and locally available imported goods and services, that such prices are reasonable taking into account comparable delivery terms and prices from eligible sources and the implementation schedule of the program. Based on USAID/Ghana's experience and that of other donors with similar programs, the proposed program costs are believed to be consistent with supplies and prices for similar goods and services procured locally. A copy of this determination is included as Annex R to the PAAD/PP.

Exception to A.I.D. Policy on Exchange Rates

A.I.D. Exchange Rate Policy requires dollars to be exchanged at the highest rate not unlawful in a country. In Ghana there are two lawful systems for converting foreign exchange: the Bank of Ghana (BOG) auction system and the Foreign Exchange (Forex) Bureaus. The subject PAAD proposes that non-project assistance dollars should be sold through the weekly foreign exchange auction. Because the rate of exchange obtained through the auction is less favorable than that available through the Forex Bureaus, an exception to the A.I.D. exchange rate policy is required.

The World Bank, the American Embassy Accra Economics Section, and USAID/Ghana monitor the openness and non-directiveness of the auction. The foreign exchange auction rate has increased substantially since its inception. The Mission believes Ghana's weekly foreign exchange auction system is managed efficiently and honestly.

Forex Bureau capacity is limited and is not designed to handle the volume of foreign exchange activity required by international donors and commercial importers. Also, donor use of the Forex Bureaus would be very difficult because no established arrangements exist for obtaining information about Forex transactions.

Considering the policy implications and the implementation problems associated with working through the Forex Bureaus, the Mission has recommended approval of an exception to the A.I.D. Exchange Rate Policy to permit exchange of non-project assistance program dollars through the Bank of Ghana's foreign exchange auction system.

Exemption to the Dollar Tracking Requirement

On October 17, 1990 the Acting Assistant Administrator for Africa approved the inclusion of an exemption from the requirements of Section 575 (b)(1) of the Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1991 (the Appropriations Act) (formerly Section 592(b)(1) of the FY 1990 Appropriations Act) in the Congressional Notification (CN) for the Ghana Family Planning and Health Program.

Justification to the Congress

The Ghana Family Planning and Health Program was not included in the FY 1991 Congressional Presentation. Therefore, a CN was sent to the Hill to inform the Congress of a planned FY 1991 obligation of $5,590,000. The CN was submitted to the Congress on December 7, 1990 and expired without objection on December 21, 1990.

Gray Amendment Considerations

USAID/Ghana has considered the participation of Gray Amendment entities in the implementation of the subject program. The American College of Nurse-Midwives (ACNM) is a women-owned association and qualifies as a Gray Amendment firm. ACNM will be invited to implement a key component of the FPHP technical assistance which involves substantial project resources.

Human Rights

No human rights clearance is required for the subject program.

Waivers

The subject PAAD/PP contains Annex Q, a waiver justification and request for waiver of the requirement for full and open competition to permit the award of a grant to the American College of Nurse-Midwives through a cooperative agreement for technical assistance. However, based upon discussions between GC/AFR and REDSO/WCA/RCO it was recommended that Annex Q be deleted from the PAAD/PP and that the matter of a grant to the ACNM be processed pursuant to the provisions of A.I.D. Handbook 13.

III. COMMITTEE ACTION AND FINDINGS: The Africa Bureau ECPR met on September 20, 1990 and recommended that the AA/AFR approve the Ghana Family Planning and Health Program. The following are primary concerns based on ECPR discussions:

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Program Feasibility

Various analyses conducted during the design of the FPHP concluded that the program approach was technically and institutionally feasible, appropriate and responsive to the socio-cultural context, and financially sustainable. A cost benefit analysis of the program, based on projected savings in primary education and health care associated with reduced population growth, resulted in an internal rate of return of 18.8 percent.

Program Conditionality

The ECPR generally felt that the non-project assistance program first tranche conditions precedent (CPs) were clear and well-reasoned. Also, the ECPR was impressed with the level of analysis in the PAAD discussion of program conditionality. Nonetheless, the ECPR cautioned the Mission to carefully review the CPs with their host country counterparts prior to signing the program agreement to assure that the CPs can be implemented as proposed.

Level of Funding for Non-project Assistance

The ECPR supported the Mission's request to increase the level of subject non-project assistance to a new total of $13,000,000 within the Mission's OYB amount. The PAAD/PP has been revised accordingly.

Implementation Arrangements

The ECPR indicated that A.I.D. has had significant problems in several countries with supra-ministerial population councils or authorities (such as the proposed national population authority) which can hinder activities rather than facilitate implementation or planning. Therefore, the ECPR cautioned the Mission to take special interest in questions of responsibilities and leadership of the subject program while continuing the policy dialogue with the Government of Ghana on this issue.

Local Currency Generations

The ECPR cautioned against Mission involvement in deciding where in the MOH budget the local currency (LC) generations should be directed primarily because of the proposed new A.I.D. guidance for monitoring and accountability over host country-owned local currency, and strongly encouraged the Mission to provide general sector support to the fullest extent possible and consistent with A.I.D. local currency policy guidance in effect at the time.

HIV/AIDS

The ECPR recommended that the Mission include authorization for expected HIV/AIDS activities under the subject program in view of the close relationship between HIV prevention activities and the planned social marketing of condoms. The ECPR guidance cable (90 State 346936) provided the Mission with the Africa delegation of authority to approve an amendment to the subject project authorization and project paper of up to $5,000,000 for HIV/AIDS activities over the current LOP of six years.

Program Sustainability

The subject PAAD/PP has been revised to clearly state that family planning in Ghana is a long-term effort, and to assure that the section on sustainability describes what the FPHP anticipates achieving by 1996 in terms of sustainability of impact and sustainability of activities.

IV. RECOMMENDATIONS:

A. That you sign the attached PAAD facesheet thereby approving a multi-year non-project assistance program grant of $13,000,000 for the Ghana Family Planning and Health Program and authorizing $3,000,000 to be obligated in FY 1991.

B. That you sign the attached Project Authorization and Project Data Sheet and thereby approve a project grant of $17,000,000 for the Ghana Family Planning and Health Project.

C. That you sign below and thereby approve an exception to the A.I.D. Exchange Rate Policy requiring exchange of dollars at the highest rate not unlawful in the recipient country.

Approved: S M Spangler

Disapproved: _____

Date: 2-21-91

Attachments
Program Assistance Approval Document (PAAD) Facesheet
Project Authorization
Project Data Sheet
PAAD/PP and Annexes

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Clearances:

DAA/AFR:ELSaiers		Date 2/10/91
GC/AFR:PJohnson		Date 24 Jan 91
AFR/PD/CCWAP:AGetson	(draft)	Date 11/21/90
AFR/PD/CCWA:WHammink	(draft)	Date 1/17/91
AFR/PD/CCWA:MGolden	(draft)	Date 11/21/90
AFR/TR/HPN:GMerritt	(draft)	Date 12/11/90
AFR/DP:JGovan		Date 2-5-91
PPC/PB/C:RMaushammer	(draft)	Date 12/14/90
PFM/FM/CONT:MUsnick		Date 2/7/91
AFR/CONT:MRogal	(draft)	Date 11/21/90

Drafter: AFR/PD/CCWAP:WDarkins:11/06/90 (rev.):79068:0568K

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CLASSIFICATION: UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROGRAM ASSISTANCE APPROVAL DOCUMENT (PAAD)

1. PAAD Number: 641-T-603 (641-0121)
2. Country: Ghana
3. Category: SSA
4. Date:
5. To: AA/AFR, Scott M. Spangler
6. OYB Change Number: N/A
7. From: USAID/Ghana, Joseph B. Goodwin
8. OYB Increase: N/A
To be taken from:
9. Approval Requested for Commitment of: $ 3,000,000
10. Appropriation Budget Plan Code: 72-111/21014
BPC GSS1-91-31641-KG39 (181-61-641-00-53-11)
11. Type Funding: ☐ Loan ☒ Grant
12. Local Currency Arrangement: ☒ Informal ☐ Formal ☐ None
13. Estimated Delivery Period: FY 1991
14. Transaction Eligibility Date: N/A
15. Commodities Financed

16. Permitted Source	17. Estimated Source
U.S. only	U.S.
Limited F.W.	Industrialized Countries
Free World	Local
Cash	Other

18. Summary Description

Program Summary

The goal of the Ghana Family Planning and Health Program (FPHP) is to lower fertility of the Ghanaian population through maternal and child health interventions. The purpose of the FPHP is to increase the use of and demand for family planning through expanding the public and private sector capacity for providing family planning, maternal child health services and supplies. While a foundation for rapid expansion of family planning goods and services exists, significant infrastructural and Government of Ghana (GOG) policy impediments remain which will be addressed by the FPHP. Part of the problem with increasing acceptance of family planning is the high infant and child mortality rate. The largest contributors to this problem are diarrhea/dehydration and malaria.

(continued on the following pages)

19. Clearances	Date
DAA/AFR:ELSaiers	2/16/91
GC/AFR:JJohnson	[illegible]
AFR/PD:TUBORK	[illegible]
AFR/PD/CONAP:AGetson (draft)	11/21/90
AFR/CONA:AGolden (draft)	11/21/90
AFR/TR:RGood (draft)	12/11/90
AFR/DP:JGovan (draft)	12-5-90

20. Action: ☒ APPROVED ☐ DISAPPROVED

Authorized Signature: S M Spangler — Date: 2/21/91

Title: Assistant Administrator, Bureau for Africa

AID 1120-1 (5-82)

CLASSIFICATION: UNCLASSIFIED

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Clearances (cont'd)

PFM/FM/CONT:MUsnich	for [illegible]	Date	2/6/91
AFR/CONT:MRogal	(draft)	Date	11/21/90
PPC/PB:RMaushammer	(draft)	Date	12/14/90

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The Ghana Family Planning and Health Program will create a policy and institutional framework supportive of Ghana's efforts to limit population growth through the increased use of modern methods of family planning. The FPHP will utilize a two part approach:

--program assistance to encourage policy reform and to generate local currency to relieve financing impediments to increased public sector expenditures for family planning and maternal and child health (MCH) services, and

--project assistance primarily to improve private sector implementation of the national family planning program.

USAID/Ghana will monitor and verify GOG compliance with the FPHP PAAD conditionality for disbursement of program grant funds. The Mission's monitoring and evaluation plan will follow the procedures outlined in the FPHP PAAD.

Conditions Precedent to Disbursement (Program Conditionality)

A.I.D. will provide $13,000,000 in non-project assistance grant funds to the Government of Ghana (GOG) over the life-of-program for use in the Bank of Ghana foreign exchange auction. The program dollar funds will be disbursed in three tranches based on the following substantive conditionality:

Tranche No. 1: Prior to the first disbursement of $3,000,000 in program funds, the Government of Ghana (GOG) will submit to A.I.D.:

1. An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified 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 and titles of the persons who will act as representatives of the Grantee together with a specimen signature of each person named in such statement;

3. A statement designating the U.S. bank and the number of the separate non-commingled dollar account into which the dollar disbursement is to be made;

4. A statement confirming that the special local currency account has been opened in the name of the Government of the Republic of Ghana and specifying the bank and the number of the account;

5. Written procedures describing the mechanism by which local currency will be released from the special account and the procedures which will ensure that funds from the special account are used for agreed upon purposes.

6. Evidence that the essential drugs list has been expanded to include all formulations of oral contraceptives now used in Ghana and that oral contraceptives have been changed from distribution Category D to Category A.

7. Evidence that vaginal foaming tablets, oral rehydration salts and chloroquine have been placed in the exempt category under the Pharmacy and Drugs Act.

8. Evidence that oral contraceptives have been redesignated as Category C (rather than Category A, dangerous drugs) under the restricted drugs section of the Pharmacy and Drugs Act.

9. Evidence that the GOG has revised its regulations to allow the distribution of oral contraceptives by health service providers who have received appropriate training offered or approved by the Ministry of Health.

Tranche No. 2: Prior to the second disbursement of $5,000,000 in program funds, the Government of Ghana will submit to A.I.D.:

1. Evidence that the GOG has formally established a national population authority ("authority") and has issued a statement which sets forth its organizational purpose, function, structure, authority, and membership. The authority should have a technical secretariat to support it. To satisfy this condition precedent, the Grantee shall establish the "authority" in such a way that it:

(a) has the authority to direct and coordinate the efforts of all ministries and governmental agencies in all aspects of activities affecting population and development;

(b) has the authority to represent the Government of Ghana in dealing with foreign donors in matters affecting population and development;

(c) has as one of its purposes to maximize the role of the private sector in achieving national population goals;

(d) has provision for adequate funds and staff to implement its assigned functions.

2. Evidence that the GOG through its national population authority has officially issued a time-phased scope of work for preparing a national population implementation plan. The plan shall, at a minimum, a) articulate an overall strategy to establish and reach demographic goals, b) define the role that each governmental and nongovernmental organization must play if the demographic goals are to be reached, c) estimate the human, commodity and financial resources required to implement the proposed strategy, d) establish mechanisms to coordinate the efforts of the various participants in the strategy, e) establish mechanisms to monitor progress toward meeting the implementation goals as well as overall demographic targets, f) establish standards to assure that population planning activities are evaluated for both cost effectiveness and impact and that the lessons learned are appropriately applied, and g) establish mechanisms to set standards for and to coordinate and oversee the implementation of a continuing campaign of national education and information.

3. Evidence that the GOG through its national population authority has officially issued a detailed, time-phased scope of work for studying the effects of completely deregulating the distribution of oral contraceptives in Ghana.

4. A time phased plan for the elimination of price controls on contraceptive commodities.

5. Evidence that the GOG has eliminated customs duties on the commercial importation of contraceptive commodities, oral rehydration salts and chloroquine.

Tranche No. 3: Prior to the third disbursement of $5,000,000 in program funds, the Government of Ghana (GOG) will submit to A.I.D.:

1. Evidence that the GOG has formally reviewed, adopted, promulgated, and initiated steps to carry out the national population implementation plan.

2. Evidence that the GOG has established procedures for the periodic review and revision of the national demographic goals and the population implementation plan.

3. Evidence that the GOG has reviewed the results of the study of deregulating the distribution of oral contraceptives and decided whether oral contraceptives will be classified as restricted or exempted drugs under the Pharmacy and Drugs Act.

4. Evidence that contraceptive commodity prices in Ghana have been decontrolled.

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D C 20523

PROJECT AUTHORIZATION

Name of Country: The Republic of Ghana

Name of Project: Family Planning and Health

Project Number: 641-0118

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning and Health Project for the Republic of Ghana (the "Cooperating Country"), involving planned obligations of not to exceed Seventeen Million United States Dollars (US $17,000,000) in grant funds (the "Grant") over a period of four years 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 and local currency costs for the Project. Except as A.I.D. may otherwise agree in writing, the planned life of the Project is six years from the date of initial obligation.

2. The Project will assist the Cooperating Country to increase the use of and demand for family planning services and supplies by expanding the capacity of the public and private sectors to provide family planning and maternal/child health services, supplies and information. The Project will finance technical assistance, training, contraceptives and other commodities, research, studies, evaluations and financial management reviews.

3. The Project Agreement(s) which may be negotiated and executed by the officers 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. <u>Source and Origin of Commodities, Nationality of Services</u>

Commodities 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 A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States, the Cooperating Country, or countries included in A.I.D. Geographic Code 935 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 A.I.D. may

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otherwise agree in writing, be financed only on flag vessels of the United States or countries included in A.I.D. Geographic Code 935.

b. Conditions Precedent

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, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., the following:

(1) A statement of the names and titles of the persons who will act as representatives of the Grantee under the agreement, together with a specimen signature of each person named in such statement.

(2) Evidence that the Grantee has constituted a Project Technical Committee comprised of a senior member of the Ministry of Finance and Economic Planning (MFEP), as chairperson, and representatives of the cooperating technical divisions of the Ministry of Health, including at a minimum a senior representative each from the Maternal and Child Health Department and the Health Education Department.

(3) Evidence that the Grantee has executed the Program Grant Agreement for the Ghana Family Planning and Health Project, No. 641-0121.

c. Covenants

The Cooperating Country shall covenant to:

(1) Fund completely the budgets for Maternal and Child Health/Family Planning (MCH/FP) and Health Education activities of the Ministry of Health throughout the life of the project.

(2) Appoint or hire a full-time accountant to manage the Return to Project Fund under the supervision of the Accountant General and the MFEP.

(3) Appoint an officer with commensurate experience in the Ministry of Health as liaison to the Ghana Supply Commission to ensure that A.I.D.-donated commodities are cleared quickly from the port.

(4) Deposit into the Return to Project Fund a proportional amount of the value of contraceptives actually distributed each calendar year.

(5) Allow all durable commodities, including vehicles and office equipment, that were provided under the Contraceptive

Supplies Project to continue to be used by the agencies carrying out the same activities under the Family Planning and Health Project.

(6) Carry out a complete audit of the existing Return to Project Fund, and not commingle other funds with that account until a full accounting has been made.

SCOTT M. SPANGLER
Assistant Administrator
Bureau for Africa

2/21/91
Date

Clearances as Shown on
Action Memorandum

GC/AFR,PGJohnson/tim:17Jan91:79218:GHANA.FPH

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APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number

DOCUMENT CODE: 3

COUNTRY/ENTITY: GHANA

3. PROJECT NUMBER: 641-0118

4. BUREAU/OFFICE: AFRICA 06

5. PROJECT TITLE (maximum 40 characters): FAMILY PLANNING AND HEALTH PROGRAM

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 01 DD 31 YY 97

7. ESTIMATED DATE OF OBLIGATION (Under B." below, enter 1, 2, 3, or 4)
A. Initial FY 91 B. Quarter 4 C. Final FY 93

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 91 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	2,590	0	2,590	17,000	0	17,000
(Grant)	(2,590)	(0)	(2,590)	(17,000)	(0)	(17,000)
(Loan)	(0)	(0)	(0)	(0)	(0)	(0)
Other U.S. 1.						
Other U.S. 2.						
Host Country	0	1,889	1,889	0	11,478	11,478
Other Donor(s)						
TOTALS	2,590	1,889	4,479	17,000	11,478	28,478

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DFA	440 B	440	–	0	0	6,000	0	17,000	0
(2)									
(3)									
(4)									
TOTALS						6,000	0	17,000	0

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 420 | 430 | 450

11. SECONDARY PURPOSE CODE

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

A. Code	BRW	TNG	PVOU			
B. Amount	8,500	840	836			

13. PROJECT PURPOSE (maximum 480 characters)

TO INCREASE THE USE OF AND DEMAND FOR FAMILY PLANNING, THROUGH EXPANDING THE PUBLIC AND PRIVATE SECTOR CAPACITY FOR PROVIDING FP/MCH SERVICES AND SUPPLIES.

14. SCHEDULED EVALUATIONS
Interim MM 01 YY 93 MM 07 YY 93 Final MM 07 YY 96

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.)

IN ADDITION TO THE $17.0 MILLION AUTHORIZED IN THIS PROJECT PAPER, $3.0 MILLION IS AUTHORIZED FOR A POLICY-BASED PROGRAM ASSISTANCE COMPONENT OF THE FAMILY PLANNING AND HEALTH PROGRAM IN PAAD 641-0121.

I CONCUR IN THE METHODS OF IMPLEMENTATION AND THE FINANCIAL ARRANGEMENTS UNDER THIS PROJECT

WILLARD GRIZZARD, CONTROLLER

17. APPROVED BY
Signature: [signature]
Title: ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA
Date Signed: MM 01 DD 21 YY 91

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AMENDMENTS, DATE OF DISTRIBUTION: MM DD YY

BEST AVAILABLE COPY

18

The Ghana Family Planning and Health Program

Executive Summary

A. The Program: The Ghana Family Planning and Health Program is a U.S. $30.0 million, six-year program which combines project and program assistance. The goal of the program is to lower fertility of the Ghanaian population through maternal and child health (MCH) interventions. The purpose of the program is to increase the use of and demand for family planning goods and services through expanding the public and private sector capacity for providing family planning and MCH services and supplies.

Through program assistance, the Government of Ghana will be given a cash grant of $13.0 million for the foreign exchange auction, upon the successful implementation of certain policy and regulatory reforms. These reforms fit into two broad categories--1) the creation of a national population authority to develop a national population and family planning implementation plan and to orchestrate the national effort; and 2) the reform of regulations to broaden the categories of family planning and MCH services and supplies which can be provided by government and private health care providers.

The project component, $17.0 million, will support activities to improve the capability and increase the capacity of health care providers to deliver family planning and MCH services. In addition, contraceptives will be supplied.

B. The Problem: Ghana has a population of 14.8 million with an annual growth rate estimated at 3.4%. Seventy percent of this population is rural, and is poorly reached by existing health and family planning services. Despite twenty years of a population policy, fertility and growth rates have not significantly slowed. This was due to the lack of continuous government commitment and general economic collapse. Rapid population growth is continuing to undermine economic recovery and causing a deterioration in health status. The Government of Ghana has recognized the negative impact of rapid population growth and has renewed its commitment and intensified its population and family planning efforts. While a foundation for rapid expansion of family planning goods and services exists, significant infrastructural and policy impediments remain which are to be addressed by this project. Part of the problem with increasing acceptance of family planning is the high infant and child mortality rate, the largest contributors to which are diarrhea/dehydration and malaria.

C. The Population/Health Sector: Services are provided to Ghanaians through a wide variety of public and private sector mechanisms. The previous USAID Contraceptive Supply Project assisted the public sector by providing contraceptives, strengthening the supply and monitoring system and by training. It assisted the private sector by financing contraceptives, information, education and communication activities through the Ghana Social Marketing Program, and it also established a wide network of retail outlets for these goods and services.

Nonetheless, significant constraints exist: (1) some policies restrict the distribution of family planning (FP) and maternal and child health (MCH) goods and services in both the public and private sectors; (2) coordination between the public and private sectors, particularly in terms of meeting FP goals, is lacking; and (3) consensus on what appropriate FP goals should be, what resources are needed, and how these should be mobilized in a single national population plan does not exist.

Infrastructural constraints include (1) interrupted supply of subsidized contraceptive commodities; (2) few service provision points beyond the urban population to rural areas; (3) insufficient amount of information, education, and communication activities to augment demand for FP/MCH interventions; and 4) low public sector recurrent expenditures for FP/MCH activities.

D. Program Assistance: The non-project assistance grant of $13.0 million will be released in three tranches over 36 months in response to specific policy conditionalities designed to effect:

- fundamental policy and institutional changes, to create a sense of national commitment and a supportive policy framework which will allow the long-term expansion of population planning in a timeframe that goes beyond the six years of this project; and

- regulatory changes to remove immediately constraints on public and private sector health workers and commodity suppliers in order to permit increased numbers of health workers and distributors to handle and sell family planning, oral rehydration salts and malaria products, and, in the case of the private sector, to sell them at a sufficient profit margin to drive nationwide commercial distribution.

Specifically, policy reforms will:

1. create a national population authority charged with defining areas of responsibility, recruiting ministries and nongovernmental organizations, and coordinating efforts of all agencies;

2. establish demographic goals to define the parameters of the population planning effort in terms of financing, human resources and supplies;

3. prepare and adopt a national population and implementation plan which coordinates all agencies and is promulgated at the highest levels of government; and

4. remove restrictions, including pricing and duty, on the sale and distribution of most contraceptive, oral rehydration and malaria therapies.

E. Project Assistance: Seventeen million dollars ($17.0) will be granted to finance inputs to build on the strengths of the existing USAID Contraceptive Supply Project, in both the public and private sectors. This project component will:

For Public Sector:

1. continue to supply needed contraceptives, building in mechanisms designed to lead ultimately to financial sustainability;

2. continue to provide assistance to training of traditional birth attendants as rural-based family planning and maternal and child health suppliers;

3. continue to provide assistance to the Ministry of Health's Health Education Division to implement effective information, education and communication campaigns; and

4. assist with the further development of provision of long-term methods such as voluntary surgical contraception, intra-uterine device and Norplant.

For Private Sector:

1. continue contraceptive supply, building in cost recovery mechanisms which will lead towards reasonable profits to sustain sales network;

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2. expand the private distribution network for contraceptives, oral rehydration salts, and chloroquine;

3. strengthen the social marketing component to effectively reach all areas of the country; and

4. continue assistance to nongovernmental organizations already active in the field of family planning, such as the Ghana Registered Midwives Association, and recruit and assist other nongovernmental organizations to become effective providers of information, goods and services.

F. End of Project Status: By the end of the project, it is expected that:

1. the modern contraceptive rate will have risen from 5% to 15% nationwide;

2. the use of oral rehydration salts per diarrheal episode will have increased from 33% to 50%; and

3. the use of proper anti-malarial treatment for febrile episodes will increase from 25% to 35%.

These will be achieved by:

1. making goods and services for family planning, oral rehydration, and malaria treatment regularly available at a minimum of 5,000 private sector delivery points and at all Ministry of Health health centers, hospitals and through traditional birth attendants;

2. continued monitoring and supervision of 3000 traditional birth attendants and training of an additional 3000-4000. (All 6000-7000 will be trained in oral contraceptive use);

3. carrying out three nationwide public sector information, education and communication campaigns, and five social marketing campaigns which will stress teaching providers and consumers about appropriate and timely use of each of these health interventions;

4. establishing both public and private sector monitoring systems to monitor the impact of above interventions;

5. establishing 15 new surgical contraception centers with 24 doctor-nurse teams and 140 counseling nurses providing referrals from all district hospitals to the surgical contraception centers; and

6. inserting 1000 Norplant sets.

G. Beneficiaries: The primary beneficiaries of the program are women and children who will have improved health through family planning and maternal and child health services and commodities.

H. Disbursements: The $13.0 million non-project assistance grant for policy reform will be disbursed in three tranches, from 1991-1993 upon A.I.D.'s receipt of evidence that the conditions precedent to disbursement have been met. Local currency generations from the auction will be used for budget support to the Ministry of Health's maternal and child health and primary health care programs. Project assistance funds will be expended over the six-year life of project.

I. Conclusion and A.I.D. Recommendation: The program design and emphasis is in conformance with A.I.D.'s and USAID/Ghana's policies and strategies for population and family planning assistance programs and for supporting Ghana's Economic Reform Program. The program addresses Government of Ghana's strategies and priorities. The feasibility analyses, including economic, financial, institutional, technical and social, indicate that the program is an appropriate mechanism for achieving the impact of increased modern contraceptive prevalence. Therefore, it is recommended that the Family Planning and Health Program be authorized in FY 1991.

GHANA FAMILY PLANNING AND HEALTH PROGRAM (641-0118/641-0121)

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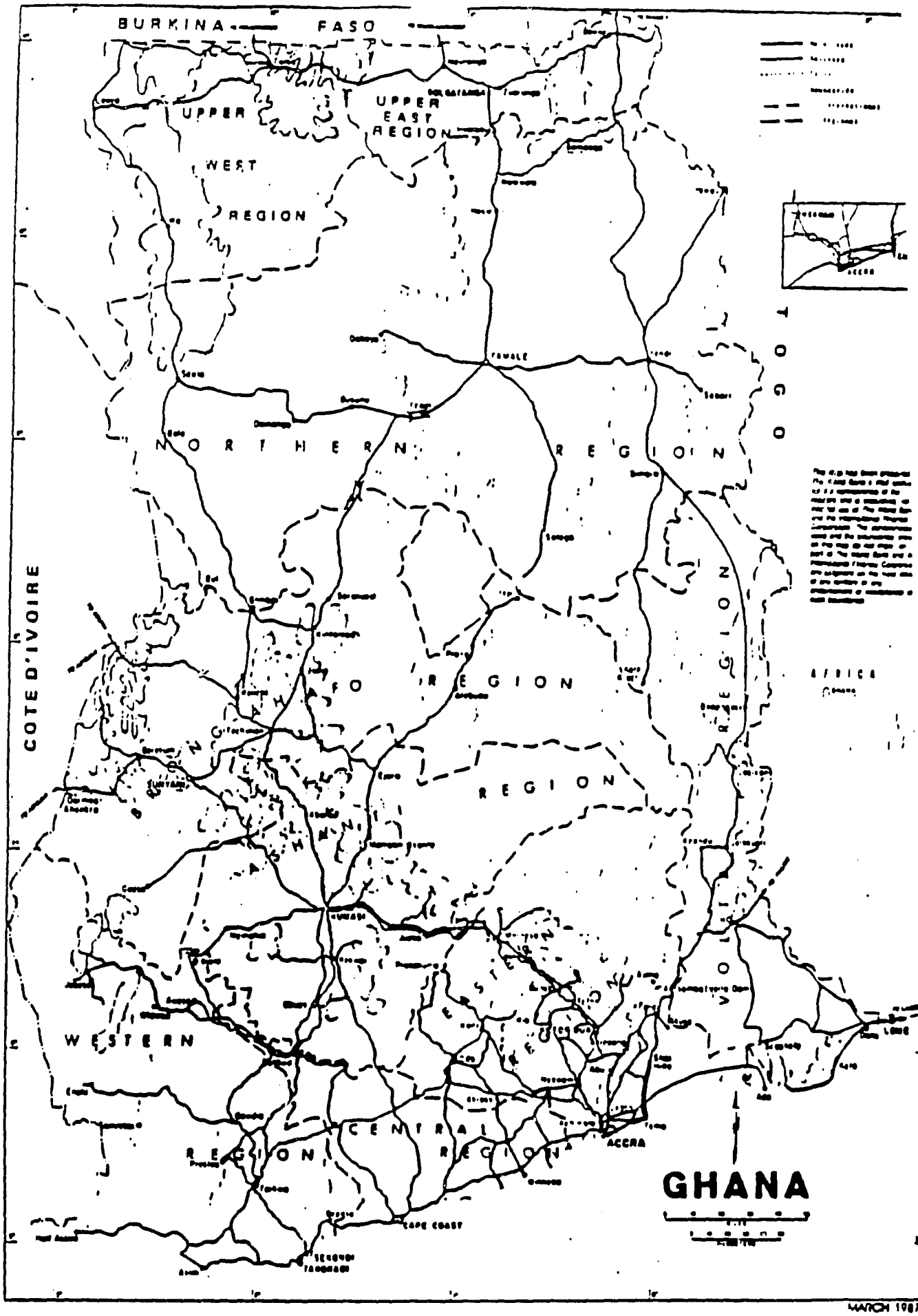
ACRONYMS

A.I.D.	Agency for International Development
AIDS	Acquired Immune-Deficiency Syndrome
ACNM	American College of Nurse Midwives
AVSC	Association for Voluntary Surgical Contraception
CDC	Center for Disease Control
CDD	Control of Diarrheal Diseases
CHAG	Christian Health Association of Ghana
CSP	Contraceptive Supplies Project
DFA	Development Fund for Africa
DHS	Demographic and Health Survey
EPI	Expanded Program of Immunization
ERP	Economic Recovery Program
FP	Family Planning
FPHP	Family Planning and Health Program
FY	Fiscal Year
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
GRN	Ghana Nurses Association
GSMP	Ghana Social Marketing Program
HED	Health Education Division (Unit of the MOH)
HIV	Human Immuno-deficiency Virus
HPNO	Health, Population, Nutrition Officer
IE&C	Information, Education, and Communication
IBRD	International Bank for Reconstruction and Development
IMF	International Monetary Fund
IUD	Intra-uterine Device
MCH	Maternal and Child Health
MFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NCWD	National Council for Women and Development
NGO	Nongovernmental Organization
OC	Oral Contraceptives
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Salts
PAAD	Program Assistance Approval Document
PDO	Project Development Officer
PHC	Primary Health Care
PID	Project Identification Document
PNDC	Provisional National Defence Council of Ghana
PPAG	Planned Parenthood Association of Ghana
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	A.I.D. Mission to Ghana
VFT	Vaginal Foaming Tablets
VSC	Voluntary Surgical Contraception
WB	World Bank



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I. BACKGROUND

A. Country Overview

Ghana, on West Africa's Gulf of Guinea, derives its name from one of the great West African trading empires which flourished from the 4th-11th centuries and included the famed university city of Timbuktu in what is now Mali. In 1470 Portuguese traders made contact with the coastal population, and later developed a gold mining and slave trade in the area. The British gained control over of what is presently Ghana in 1901 after 74 years of fighting the peoples of the Ghanaian interior.

The Convention People's Party, under the leadership of Kwame Nkrumah, won legislative elections in 1951 and in 1957 Ghana gained independence from Britain. Three years later, Ghana became a republic and Nkrumah was elected president. President Nkrumah was deposed by a military coup in 1966. Thereafter, Ghana has been ruled by a series of military and civilian governments. The current leadership, the Provisional National Defense Council (PNDC) assumed power in 1981.

Ghana, lying in the tropical climactic zone, has four major geographic characteristics: low-lying plains on the coast; tropical forest areas in the West and southern interior; savannah woodland and swamps in the central Volta River region and savannah in the North. About 19% of the land is used for agriculture. Lake Volta, created by damming the Volta River, is the largest man-made lake in the world.

Seventy percent of Ghana's 14.8 million people reside in rural areas which are defined as villages or towns with less than 5,000 persons. Population density is about 110 per square mile. About 99.8% of the population is African, the balance being of European and other non-African extraction. There are over 100 different ethnic groups, each with its own language and culture. Due to the great diversity of dialects, no single native national language exists. English, the official language, is used in schools, business and government. Most Ghanaians are multilingual.

Ghana is divided into ten administrative regions: Greater Accra, Central, Western, Ashanti, Eastern, Volta, Brong-Ahafo, Northern, Upper West, and Upper East. Most of the population resides in the southern and central portions of the country.

B. Macroeconomic Overview

Ghana has suffered significant economic problems since independence in spite of large natural resource endowments, including arable land, gold, diamonds, minerals, forest, ocean and rivers. In 1960, Ghana had one of the most highly developed economic and social infrastructures in Sub-Saharan Africa. It was ranked as a middle-income country, with a Gross Domestic Product per capita in the $600 range. By the 1970s, the relatively high standard of

living enjoyed by Ghanaians had been eroded by inappropriate development policies and strategies. Industrial development based on protected import substitution resulted in an industrial structure dominated by large-scale, capital-intensive and inefficient state-owned enterprises. Cocoa, the backbone of the economy, was so heavily taxed that Ghana's share of world production fell from 25% in 1974/5 to 9% ten years later, against a backdrop of falling world cocoa prices.

By the early 1980s, plunging terms of trade, a drought, bushfires and the forced repatriation from Nigeria of nearly one million Ghanaians brought the economy to virtual collapse. The internal infrastructure was eroded. Foreign reserves were nearly exhausted. Large payment arrears accumulated, and severe food shortages were eased only through foreign emergency food aid. These conditions set the stage for Ghana's Economic Recovery Program.

In 1983, in coordination with the International Monetary Fund (IMF), the Government of Ghana (GOG) launched one of Africa's most stringent economic recovery programs (ERP). Ghana's ERP has been supported by three IMF stand-bys, nearly US$ 1.1 billion in commitments from the World Bank, and further aid from many multilateral and bilateral donors. Reforms to date include liberalizing the foreign exchange and trade systems, increasing producer prices for cocoa and other cash crops, eliminating most price and distribution controls, and rationalizing the public investment program which has improved physical infrastructure. Appropriate fiscal and monetary policies eliminated the budget's fiscal deficit, reduced inflation and helped reduce the current account deficit. Donor inflows have created an overall surplus in the balance of payments and has virtually eliminated external payment arrears. These policy changes and aid funds have resulted in an annual GDP growth rate of about 6% per year.

To alleviate the hardships on the poor and other groups especially vulnerable to economic restructuring, the Government has instituted a Program of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD), which finances projects with high economic and social rates of return. PAMSCAD has proceeded slowly due to the delayed disbursement of donor contributions and institutional constraints on the part of GOG.

The future direction of the economy depends on the GOG's ability to sustain its present reform program as it moves from the medium-term economic stabilization, rehabilitation and liberalization into the ERP's long-term sustainable growth phase. Sustaining economic recovery will take years of continued reform. So far, in spite of growing domestic political and economic demands and sharply deteriorating external conditions, the GOG has resisted most pressure to rescind or significantly modify the ERP. Improved public information on the ERP and increased GOG interaction with

the private sector will be key factors to enhancing the sustainability of the reform program. Discussion and analysis of the Ghana's macro-economic performance can be found in Annex E.

C. Health and Family Planning Sector Framework

Health and family planning status of the Ghanaian population is poor, even when compared to other African countries. Facilities exist in many places but access to health and family planning services are limited, especially in the rural areas. The population relies heavily on the Ministry of Health which provides the majority of health care services. Private health facilities make up the remaining health and family planning service delivery network.

1. Overall Health Status

Life expectancy at birth in Ghana is 54 years, which is among the highest in West Africa. This is partially due to a successive drop in infant mortality, from 100 per 1000 births in 1973-7 to 77 per 1000 births in 1983-8. Child mortality rates remain very high at 155 per 1000, a reduction of only 17% since the mid to late 1970s. The major causes of child mortality are measles, malaria, pneumonia, anemia and diarrhea. These diseases are all part of a linked complex of causes of death; the diarrhea--dehydration--pneumonia complex is a well known phenomenon throughout the developing world. Malaria and its resulting anemia compounds the problem in Ghana. Maternal mortality also remains high at 10/1000 births. Among the many causes are lack of access to perinatal care and too closely spaced births. A new factor in this is the rapidly increasing number of AIDS cases. While the epidemiological situation in Ghana is not yet clear, neighboring countries are currently finding very high prevalence rates. A fuller discussion is included in the Technical Analysis (Annex A).

2. Population Growth

Ghana's population in mid-1990 is estimated to be 14.8 million. With a growth rate of 3.4%, the population is expected to double in less than 21 years. This is caused by a total fertility rate of 6.4, which, while among the highest in the world, still represents a drop from 7.03 estimated in 1969. The total fertility rate has not changed since 1979.

3. Population Policy

Ghana was a pioneer in Africa in recognizing the impact of unrestrained population growth on economic development and, inter alia, employment and the provision of public services, such as education and health care. In 1969, Ghana became the second

sub-Saharan country to adopt a national population policy (after Kenya). A major objective of the policy was to reduce the annual population growth to 2% by the year 2000.

The 1969 policy was relatively comprehensive in its appreciation of population problems and statement of goals. The document treats this problem as "an organic part of social and economic planning" and states that it is further critical to treat "the high rates of morbidity and mortality," "gainful employment of women," "migration and spatial distribution," and "statistical research and analytical facilities."

Family planning aspects of the policy received high attention, particularly in its intended implementation. The policy states that it is the explicit goal of the government to reduce population growth through voluntary family planning efforts that are designed to maximize the privacy, convenience, comfort, and dignity of the methods offered and to minimize the price paid by users. Both private and public sector resources are to be mobilized and practical training for as wide a range of of health care workers as possible is to be emphasized. This policy is fully in line with USAID's assessment of what is needed to increase family planning use in Ghana.

Programs under this policy began well. However, political leadership changed, thereby influencing commitment to family planning. While the stated policies in themselves were good, implementation was poor and the program could not be sustained in the presence of both a lack of governmental commitment as well as general economic collapse. During the two decades since initiating the national policy, the population has increased from 8.6 million to almost 15 million.

In 1987, a national conference was held to discuss a recommitment to the 1969 policy, and, as a result, the goals articulated eighteen years earlier were reaffirmed. In 1989, a second conference established the preliminary steps to draft a five-year strategy and plan. Both conferences felt that a lack of clear delineation of responsibilities to carry out the population policy has resulted in a lack of direction and occasional divisiveness among participating agencies. The outcome has been weak overall coordination and program effort. The conferences therefore recommended establishing a national population authority to focus and coordinate efforts to meet the population objectives. The conference established a committee to prepare a plan for the implementation of such an authority. This committee has met several times, and has recommended that such an authority be placed under the auspices of the National Planning Commission.

The benefits that will accrue from sustained economic growth will be influenced by a number of factors, including Ghana's population

growth rate. Likewise, the ability of the government and private sector to increase health care expenditures and improve the quantity and quality of health care depends on sustained increased levels of economic growth. Ghana's Gross Domestic Product is projected to grow five percent annually. At current population projections, this will be reduced to less than two percent growth per capita per year.

High level government officials recognize that population pressures are a serious national concern. The Government of Ghana currently supports family planning for two major reasons: (a) the economic benefits of a lower birth rate and (b) the improved health of mothers and children.

4. Health Service and Family Planning Providers

Health services, including those necessary for family planning and maternal/child health, are provided by a variety of public and private sources, but the government, through the Ministry of Health (MOH) is the largest provider of these services. In both sectors, health care services are primarily provided by nurses, midwives, traditional birth attendants, and to a lesser extent by doctors in a variety of clinics, hospitals and public health centers.

a. Public Sector

The following is a brief description of district level health care provision which is the primary vehicle for the delivery of family planning services. A further description of the structure and function of the MOH is fully described in the Institutional Analysis (Annex C).

1) District Health Organization

The primary level of health service management is at the district level. The delivery of family planning services at the district level is highly restricted, depending on whether a nurse-midwife is physically present. Each district is intended to provide three levels of service, designated A, B and C. The 'A' level includes the community health providers: traditional birth attendants (TBA) and community health workers. Level 'A' providers are taught to distribute oral rehydration salts (ORS), chloroquine, condoms and vaginal foaming tablets. These largely unpaid workers are supervised by MOH staff assigned to health posts or health centers at the 'B' level. 'B' level facilities usually have a nurse clinician or nurse midwife, but generally do not have physicians. Only the specially trained nurse-midwife at the level 'B' facility provides family planning services, including IUD insertions. However, if the family planning provider is away from post for any reason, including supervisory tasks, family planning counseling and

services are not available. ORS and chloroquine are available whenever clinicians are present.

The district hospital is the level 'C' facility and is intended to provide referral services and clinical oversight for the lower levels. About half of the districts do not have district hospitals.

2) Distribution of Family Planning and Maternal/Child Health Commodities

Family planning and maternal/child health commodities are distributed downward in a tiered system: level A providers get supplies from level B, who get them from level C, who are provided either from the Regional Medical Stores or directly from the Central Medical Stores at Accra's port, Tema. However, at every level, family planning commodities are managed by the Maternal/Child Health Division and not by the Supply Division, so duplication of effort occurs, and needed supplies are often not available. As a result, commodities are frequently unavailable at levels A and B, while excesses accumulate at the Central Medical Stores.

3) Pharmacy Board and Drug Classification

The distribution of contraceptives by health workers throughout the public and private health care system is regulated by the Pharmacy Board and related Ministry of Health (MOH) policies. Linked to the MOH, but still autonomous, the Pharmacy Board registers, controls and monitors all drugs used in the country. Currently drugs are considered to be either 'exempt' or 'restricted'. 'Restricted' drugs are further classified into three groups: 'A'--Dangerous Drugs, 'B'--Narcotics, and 'C'-- all other restricted drugs. Oral contraceptives are listed in class 'A', and by law their sale is restricted to pharmacies. Within the MOH System, the dispensing of oral contraceptives are restricted by the Ministry's distribution policy to institutions with specialist capacity.

Exceptions to this restriction are made for programs specifically authorized by the Ministry. Thus, the existing Contraceptive Supplies Project is allowed to distribute oral contraceptives through chemical sellers and midwives who have received special training in their use. This project has shown that contraceptives can be safely administered by trained health care providers. These regulations and policies restricting the sale and distribution of family planning and maternal/child health commodities, in effect, have limited the availability of comprehensive family planning services.

b) Private Sector Providers

There are a wide variety of institutions providing family planning and health care in Ghana. The more important ones include: 1) Planned Parenthood Association of Ghana (PPAG), 2) missions, 3) industries, and 4) a large number of other nongovernmental organizations (NGOs). The service areas, strengths and weaknesses, and relation to the project of each of these are described in the Institutional Analysis (Annex C).

Similarly, a wide range of private practitioners functioning in Ghana will be affiliated with the project in one way or another, including physicians, nurse-midwives, commercial pharmacies and chemical sellers, traditional birth attendants, and other practitioners of traditional medicine.

D. A.I.D. Experience in the Health and Family Planning Sector

A.I.D. has provided support to the Government of Ghana's health and population sector since the early 1960s. Early USAID assistance contributed to the development of Ghana's 1969 Population Policy and the Ghana National Family Planning Program that was established two years later. A keystone of USAID activities in Ghana since that time has been the support and implementation of that policy. USAID/Accra's bilateral and A.I.D./Washington's centrally funded projects have concentrated on institution building, training, demographic research and expendable commodities. Since 1968, A.I.D. has obligated almost $30 million in assistance.

A review of USAID activities in 1987 found that the basic constraint to establishing an effective family planning delivery system was still bureaucratic in nature. Previous assistance had primarily focused on Ministry of Health programs, and even the 1970's social marketing program was so hampered by central administration that the distribution system did not expand to sustainable levels.

A.I.D.'s most recent cooperation with the Government is through the Contraceptive Supplies Project, initiated in September 1985. Scheduled to end in 1991, the project's purpose is to "increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples". Total A.I.D. funding for the project is $7.0 million from the bilateral agreement, supplemented by $4 million from central and regional funds.

The Contraceptive Supplies Project focuses on both the public and private sectors. USAID has supplied $5.4 million in contraceptives. Major inputs to the Ministry of Health (MOH) have been to supplies management, service, training, and information, education and communication (IE&C) while lesser resources have been

spent on research, including the 1988 Ghana Demographic and Health Survey. The private sector component focused on marketing contraceptives through using a social marketing approach. Under this effort, assistance was provided to DANAFCO, a local pharmaceutical manufacturer and distributor under contract to the Ministry of Finance and Economic Planning, to operate the Ghana Social Marketing Program (GSMP). The GSMP managed the distribution, marketing and sales of all A.I.D.-financed contraceptives, which comprise the bulk of the country's contraceptive supplies.

Accomplishments in the public sector include:

- a successful implementation plan for contraceptive logistics and supplies management and reporting;
- improved supervision of family planning service delivery;
- training of personnel in data collection and analysis;
- development of a pre-service curriculum for midwives and nurses and completion of in-service training at all levels of the MOH; and
- substantial improvement in IE&C capability and production.

The impact of these accomplishments is best seen in the 50-200% increase in family planning commodities provided through public sector outlets that occurred between 1989 and 1990.

Achievements by the private sector include:

- establishment of a wholesale system in all 10 regions for oral contraceptives (OCs), condoms, vaginal foaming tablets (VFTs), and oral rehydration salts (ORS);
- training of over 3000 pharmacists and chemists in these interventions;
- product placement in virtually all pharmacies and chemist shops (about 3,500); and
- successful testing of the viability of mass media public advertising for brand name family planning products.

The social marketing program has become accepted by the Government as an important complement to its national family planning program. However, as an urban pharmacy based program it has little chance of becoming self-sustaining under the current system. Reaching the rural majority of Ghanaians requires new strategies that will utilize commercial channels that reach the most remote areas of the country.

One positive consequence of the social marketing program has been the increased involvement of the commercial sector in providing family planning services. Before the project began, this sector's contribution was negligible; now it provides about forty percent of all family planning goods and services.

While the Contraceptive Supplies Project is ground breaking, demonstrated that its many multiple activities needed to be reoriented and more focused if momentum was to continue. A mid-term evaluation in April 1988 recommended a follow-on project and suggested that family planning be presented as a child survival program for wider acceptability. The addition of oral rehydration salts (ORS) and malaria treatment was deemed appropriate.

It also concluded that public sector support could be more effective if selected inputs were provided for policy guidance, system standardization, coordination and equalizing services for rural and urban populations. More resources were recommended to expand contraceptives delivery through existing commercial and nongovernmental organization (NGO) networks in urban and in neglected rural communities. Sustainability should receive greater emphasis in both public and private sectors, and management weakness found in each sector adequately corrected.

E. Other Donor Activities

Since 1984, a multitude of bilateral and multilateral donors have committed over $85 million of assistance to Ghana's health care system, including family planning activities. Several of these activities have direct bearing on the implementation of the Ghana Family Planning and Health Program. The World Bank will assist the Ministry of Health (MOH) to rehabilitate the drug supply system, will provide the MOH with $1.4 million worth of contraceptives (as well as an additional $2.5 million assistance in population activities), will assist in developing a ministry-wide information management system, will provide support to district level primary care, and will give a substantial amount of assistance to the Planned Parenthood Association of Ghana. In particular display of support for the USAID program element, disbursement of the $3.9 million programmed for population activities is conditional on the establishment of a national population authority. United Nations Fund for Population Activities (UNFPA) will provide contraceptive commodities, will support training of traditional birth attendants (TBAs), and will strengthen district health management functions. UNICEF will assist with the strengthening of the central medical stores, training TBAs, and providing raw materials for ORS production. The British Overseas Development Assistance will assist with midwifery training. A full description of these activities is given in annex C.

These contributions are crucial to achieving the project's intended outcomes. Coordination meetings among health sector donors have resulted in a division of areas of activity and coordination of effort. The multilateral development institutions--World Bank, UNICEF and UNFPA--will provide assistance primarily for public sector improvements. The newly created Division of External Aid

Coordination in the MOH is expected to assume the responsibility to convene and chair the ongoing donor coordination meetings.

F. Health and Population Sectoral Constraints

USAID and other donors' experiences in health and population assistance to Ghana over the last two decades have produced an understanding of the significant constraints that must be addressed in future programs. This project is being implemented against the backdrop of twenty years of population activities and must overcome the inertia that may have developed from over exposure. Whatever activities are contemplated must take into account what has gone before and specifically address concerns that people may have.

The major constraints can be grouped into four major categories

1) Management Constraints:

a. Ministry of Health (MOH) Budgetary Constraints: The majority of public health care expenditures are financed through the Ministry of Health budget. Since 1978, the share of government expenditures for health has varied. Between 1978 and 1983, the MOH budget expenditures fell from 9% of the total Government of Ghana budget to 4%. Since 1984 MOH recurrent expenditures have averaged 10% of the national budget, while capital expenditures averaged five percent. The recurrent expenditures on health are about 1 percent of GDP and capital expenditures are 1/8 of 1 percent of GDP. Tables in the Institutional Analysis (Annex C) detail these figures.

Despite budget figures which are well within the range of expenditures for countries similar to Ghana, the MOH budget figures are not completely reliable indicators of expenditures because actual budgetary releases may be quite different from the budget provisions. Funds which may appear in the budget may not be released for expenditure. Even budgetary releases are often not spent, particularly for non-salary line items. For the Ministry of Health Headquarters, approximately 56 percent of the 1987 non-salary budget was actually expended. The percent of budget spent also varies widely from one division to another. The Health Education Division, for example, disbursed only 8 percent of its budgeted amount.

Like many other countries in Africa, most of the MOH budget is allocated for curative care and administration. Given that the Ministry's budget has declined in real terms since 1986, the public sector will be seriously strained to make the large resource allocations necessary to fund family planning.

The Family Planning and Health Program will specifically address the budgetary constraints by providing local currency for family

planning, maternal/child health (MCH) and other primary health care activities. This will be accomplished by generating local currency through a cash grant program.

b. MOH Absorptive Capacity: Major public sector institutional and infrastructure weakness in the MOH are scheduled for donor community assistance, as is briefly outlined above and is thoroughly discussed in the Institutional Analysis (Annex C). While A.I.D. will not be heavily involved in addressing these issues because of other donor involvement, there is concern about absorptive capacity and depth of management. The present expectations for management and resource utilization may exceed Ministry of Health (MOH) capacity during the present decade. A prime example of this is the management of the Contraceptive Supply Project Return to Project Fund (RTP). This was established to maintain a small percentage of proceeds from the sales of A.I.D. financed contraceptives. Due to difficulties in tracking distribution of contraceptive sales at the district and regional levels, the MOH has been unable to adequately manage the funds. This problem is attributed partially to the lack of a trained accountant to manage the fund, but is part of slowly recovering management difficulties of the mid eighties.

2) Sustainability Constraints:

a) Popular Support: Leadership for family planning from top government levels appears to be growing and, hopefully, will grow. The GOG family planning program now needs to solicit the strong support of doctors and other recognized medical leaders for public pronouncements in favor of family planning. Developing this credibility will be the main thrust of the information, education and communication activities (IE&C) and contraceptive product advertising. At present a serious problem exists in lay persons' misunderstandings and fears about modern methods. Community leaders need to be assured that family planning and modern contraception have positive benefits for women, children and the community at large. Grassroots support from such leaders is available and needs to be cultivated. The support of chiefs and other authority figures is important for gaining general community support for family planning. Influential local women leaders need accurate information to help them be educators in their villages about the positive attributes of contraception. The full force of opinion leaders needs to be brought to bear if rumors, misconception, and fear of modern methods are to be overcome.

b) Cost Recovery and Broad Distribution: The Family Planning and Health Program strives for some cost recovery of A.I.D. purchased contraceptives in order to establish a precedent for payment in both the public and private sectors. The rationale of trying to build a commercial contraceptive market which functions without further donor support is sound, but, as has

been demonstrated in other projects world wide, is difficult to achieve. The joint problems of encouraging new users of modern methods and capturing the interest of merchants revolve around issues of price. A price acceptable to users may offer little incentive to sellers and, conversely, a profitable price for business may discourage users.

In addition, there is an ethos that people ought not have to pay for these services. Much of this revolves around provision of services to those too poor to pay for them. This is a real and a difficult issue to resolve. Policy dialogues focused on the need for a profit motive to increase availability of commodities as well as continued availability of commodities through public outlets at a lower price will need to be an ongoing part of the USAID/Government of Ghana dialogue.

c) Critical mass constraints: experience in other countries has shown that it is necessary to reach about 30% total contraceptive prevalence before an impact on population growth rate is measurable. In addition, this level is needed to maintain a self-sustaining demand for contraceptives. Since the project is only intended to reach a 15% modern contraceptive prevalence rate, (about 20% total CPR) follow-on activities must be contemplated. Whether these will GOG supported, A.I.D. supported or other donor supported will depend on the economic and political environment that exists at the conclusion of the project.

3) Demand Constraints:

a) Translating Latent Demand into Use: Several studies over the past decade indicate that knowledge of family planning (both modern and traditional methods) is widespread. Knowledge is at a high level and desire to limit family size is fairly strong, yet Ghanaians continue to have large families. In addition, close to half of women (45%) and men (41%) wish to postpone another child for two or more years. The data on current users, however, indicates that this desire is not translated into action; only 12.3% of married women currently use and 34% have ever used <u>some</u> form of contraception. (5.2% currently use a <u>modern</u> method, and 22.5% have ever used such a method) The Ministry of Health (MOH) and Ghana Social Marketing Program statistics indicate modern contraceptive use doubles as commodities become more readily available. Nevertheless, in the Family Planning and Health Program (FPHP) substantial resources will need to be invested in well focused advertising campaigns to improve the image of specific methods and increase overall contraceptive prevalence in modern method use. Motivating rural providers such as traditional birth attendants and registered midwives will also help with recruiting new users and sustaining method use. Recruitment of a wide variety of private voluntary organizations to encourage family planning

among their clientele will represent the third prong of this approach.

b) Method Mix: The desired drop in fertility or reduction in growth rate cannot be achieved without an increase in use of oral contraceptives (OCs) and long term methods. The current USAID project relies heavily on provision of condoms and vaginal foaming tablets. Oral contraceptives are confined to medical facilities, pharmacies and chemist shops. No other methods are commercially available. To achieve the desired fertility rates, a major campaign to increase demand for OCs will need to be carried out in conjunction with markedly increasing supplies at all levels of the distribution system.

4) Supply Constraints:

a) Regulation: Currently, the regulatory situation controlling who is permitted to distribute what commodities is unclear. Oral contraceptives and IUDs are the most restricted, being classified as dangerous drugs limited to distribution through specialty service centers. Vaginal foaming tablets (VFTs), oral rehydration salts (ORS) and chloroquine are classified as "other restricted drugs", but are distributed by the MOH at the community health worker level. Achieving contraceptive goals will require reclassifying oral contraceptives from "dangerous" to "other" and broadening distribution from "specialty center" to "community health worker". VFTs, ORS and chloroquine need to be reclassified from "restricted - other" to "exempt" drugs. Condoms need no reclassification.

b) Public Sector Handling and Distribution of Contraceptives: A recent financial assessment of the Contraceptive Supplies Project revealed that the MOH System for the clearances, handling and distribution of contraceptives needs improvement. The Central Medical Stores is often unable to track the distribution and sales of contraceptives at the regional and district level. This is partially due to poor stock control procedures in the regions and districts, but is primarily due to the general dysfunction of the overall supply system. While this is being directly addressed by the World Bank and UNICEF, continued monitoring will be required, and some USAID inputs may be needed to overcome specific problems.

c) Accessibility: Accessibility of contraceptives, oral rehydration salts (ORS) and malarial treatment has been a significant barrier to increasing contraceptive prevalence and use of these two life saving treatments. Several studies have shown that providing a source of contraceptives doubles user rates. Contraceptive and child survival services should be close to potential users through a variety of networks in tune with user's daily lifestyle.

The greatest constraint here is the rural nature of Ghana. As mentioned earlier, only 30% of Ghanaians live in urban (greater than 5,000 population) areas, and even some of these are so isolated as to be cut off from supplies and services. The transportation infrastructure is poor, which further hinders supply and resupply. At the same time, regulatory policies are directed towards an urban population, who have access to high levels of specialty services. Private practitioners, particularly the few physicians with their own offices, are oriented towards the urban centers. A major goal of this project will be to mobilize the local resources that exist, including whatever market women and itinerant traders serve isolated communities, to ensure an adequate supply of commodities to all areas of Ghana.

G. Conclusions

Over the past two decades Ghana has gone through a number of changes that have culminated in today's situation. Policymakers now recognize that coordinated actions are needed to attain population growth goals, and are prepared to take the steps necessary to make this coordination work. An opportunity exists to alleviate some of the constraints on growth of the private sector. Major issues within the Ministry of Health (MOH) are being addressed both by the Government of Ghana as well as by assistance from other donors. The tripling of modern contraceptive prevalence over the tenure of the Contraceptive Supplies Project, and the widespread stated interest in family planning uncovered by several surveys indicates that the people of Ghana are ready to use available modern family planning and maternal and child health (FP/MCH) methods.

All of these lead to the conclusion that in 1990 the public and private sectors are ready to back a vigorous population, family planning and MCH program. The climate is right to achieve the long sought for increase in the use of modern family planning methods and the long-range goal of lowering fertility rates. Based on the above review, and taking the constraints into consideration, USAID believes that the Family Planning and Health Program, in conjunction with other donor efforts, will be able to help the Government of Ghana to overcome some of the past implementation defects and remove major policy impediments. Policy reforms, when implemented, will set the stage for the actions needed to assure significant advances in contraceptive prevalence.

II. RATIONALE FOR THE FAMILY PLANNING AND HEALTH PROGRAM

A. Rationale and Strategy

The Family Planning and Health Program (FPHP) is a watershed intervention that culminates two decades of experience in family planning and population activities in Ghana. Contraceptive prevalence has increased slowly in Ghana over the last twenty years. Sage observation of the family planning phenomenon has indicated the need for two critical elements: (1) a favorable national policy and implementation plan to bolster family planning gains and to prevent lethargy, inertia, or digression from the national target, and (2) the cooperation of private sector health providers, commercial wholesalers and retailers to stimulate demand, expand family planning and maternal and child health (FP/MCH) services, and increase the supply and availability of commodities. The synergism of these two forces, policy initiatives and private sector delivery of services and supplies, is key to accelerating contraceptive prevalence in Ghana and is the linchpin of the FPHP.

B. Goal and Purpose

The goal of the FPHP is to lower the fertility of the Ghanaian population through maternal and child health interventions. The purpose is to increase the use of and demand for family planning through expanding the public and private sector capacity for providing FP/MCH services and supplies. Specifically, by the completion of the program, the following conditions will exist:

-- modern contraceptive prevalence will have increased from 5% to 15%;

-- the use of oral rehydration salts (ORS) per diarrheal episode in under five year old children will increase from 33% to 50%; and

-- the use of proper anti-malarial treatment per febrile episode among children will increase from 25% to 35%.

C. Program Approach

The FPHP utilizes a two part approach: 1) program assistance which includes a cash grant to encourage policy reform and to generate local currency to relieve financing impediments to increased public sector expenditures for family planning and MCH services and 2) project assistance to primarily improve private sector implementation of the national family planning program. The FPHP will be implemented over six years and will require USAID inputs of $30.0 million.

Through the program assistance component, the Government of Ghana will be given a cash grant of $13.0 million for the foreign exchange auction, upon the successful implementation of certain policy and regulatory reforms. Since the population policy environment, as outlined in I.C.3 is favorable, the proposed reforms focus on policy implementation. These reforms fit into two broad categories: 1) the creation of a national population authority to set national population and family planning objectives and to orchestrate the national effort and 2) regulatory reforms to broaden the categories of family planning and maternal and child health (MCH) services and supplies which can be provided by government and private health care providers. These reforms, discussed in Section III, will create a "windfall" policy environment needed to drive the implementation of the national family planning program. Clearly enunciated population objectives and program implementation roles and removal of regulatory impediments will allow population and family planning activities to proceed with pronounced government support. The environment will become conducive to private sector expansion of family planning services, commodities and information. Policy reforms will reinforce the government's renewed commitment to the objectives of population and family planning and will create a framework for sustained public education and support of family planning services.

The project component, $17 million, will support activities to improve the capability and increase the capacity of health care providers to deliver family planning and MCH services and supplies. The project component will address the following implementation constraints:

-- dearth in skilled family planning service providers through training in various methods;

-- information, education and communication and social marketing through technical assistance, commodities, and support for appropriate market research;

-- accessibility to family planning, oral rehydration salts (ORS) and malarial supplies through provision of commodities;

-- lack of Ministry of Health (MOH) financial resources for family planning/MCH activities; and

-- weak nongovernmental organization (NGO) service delivery by providing assistance to local NGOs in service delivery, promotion and provision of contraceptives.

Other donors, specifically the World Bank, UNICEF, United Nations Fund for Population Activities, International Planned Parenthood Federation and the British Overseas Development Assistance are providing resources that will leverage USAID's inputs over the six

year life of the project. Current estimates are that other donor inputs will double the numbers of commodities that are supplied by the FPHP. If these and other inputs are used effectively, it may be possible for modern contraceptive prevalence to rise much more rapidly than is predicted in this project.

Without policy changes, family planning services and supplies will still be provided by public and private facilities in Ghana. However, private services will be limited (and may even decrease); contraceptive prevalence will increase too slowly to produce a reduction in overall fertility within a reasonable time period; government resources will be overburdened; and the government will not achieve its objective of reaching an appropriate level of population growth in order to sustain the benefits of an expanding economy. The confluence of the program assistance policy and the project assistance components will create a synergism of propelling forces to accelerate an increase in contraceptive prevalence.

D. Relationship of Program to A.I.D. Strategy and Policies

FPHP is USAID'S major health sector intervention for the next six years. The project design derives from USAID/Ghana's goals and objectives stated in its Mission Concept Paper, its proposed Country Program Strategic Plan, the 1983 A.I.D. Sector Strategy for Population and strategies under the U.S. Congress-legislated Development Fund for Africa.

1. Concept Paper and USAID Country Program Strategic Plan

The FPHP supports two key areas of USAID's program strategy, as enunciated in its Ghana Concept Paper, to support Ghana's Economic Reform Program: 1) to provide fast-disbursing program assistance through the foreign exchange auction and 2) to improve Ghana's management of population pressures through assistance in family planning and child survival, focusing on private sector entities, and through policy dialogue with the Government of Ghana (GOG). The FPHP also fits within the Mission's proposed Country Program Strategic Plan which encompasses the strategic objective of increased use of family planning through private sector delivery of family planning services and supplies, the provision of oral rehydration salts (ORS) and malaria treatments which support acceptance of family planning and policy reform.

2. A.I.D. Population Strategy

As described in the 1983 A.I.D. Sector Strategy for Population, the two basic policy objectives are (1) to enhance the freedom of individuals to choose voluntarily the number and spacing of their children and (2) to encourage a rate of population growth consistent with the growth of economic progress and productivity.

Service delivery is given the highest priority. These programs are more effective if they are guided and supported by strong government policies and a combination of public and private sector programs. Therefore, consistent with the A.I.D. Sector Strategy, the FPHP will: (1) encourage and assist the institutionalization of broad public commitment to voluntary family planning programs; (2) support the development of effective family planning information and service delivery infrastructure in the public and private sectors; and (3) improve existing services which are under utilized or where discontinuation rates are high.

3. Development Fund for Africa (DFA) Strategies

The project addresses two of the four DFA strategic objectives. The first is "improving management of African economies by redefining and reducing the role of the public sector and increasing its efficiency". One target under this objective is "improved equity and efficiency in providing key public services, particularly in family planning services, health, education and transportation infrastructure". Under this objective, USAID Missions are encouraged to find better ways to engage top leadership of host countries and other donors to bring about a more genuine commitment to voluntary family planning. These family planning programs are to be integrated into other development efforts such as education, agriculture and child survival. Field programs are expected to involve policy restructuring/development, information, education and communication (IE&C), service delivery, training and research.

A second strategic objective of the Development Fund for Africa (DFA) is "strengthening competitive markets to provide a healthy environment for private sector-led growth". The liberalized commodity markets that are envisioned under this objective are often viewed as being larger markets such as food or agriculture. Nonetheless, contraceptives and, to a larger extent, health care commodities also should be viewed in market terms if contraceptives and family planning services are to be provided at the lowest cost to the most number of people. Additionally, by providing foreign exchange to the Government's foreign exchange auction, the program assistance component will assist market-led allocation of foreign exchange and contribute to greater private provision of goods and services in the economy. The cash grant will support Ghana's macro-economic structural adjustment and stabilization program. The Family Planning and Health Program (FPHP) encompasses both DFA's concerns in the policy and project components of the project.

E. Relationship of Program to Government of Ghana (GOG) Strategy and Priorities

The FPHP relates to the GOG's program for population and family planning activities. This is a reaffirmation of the 1969

population policy and includes a new thrust to intensify family planning efforts through the sale of contraceptives at all health centers, hospitals, pharmacies and chemical sellers' shops. Counselling on family planning is to be available at all health centers, hospitals, polyclinics and maternal and child health (MCH) clinics in the country. The Government has emphasized the need for the family planning social marketing program to make family planning information, services and commodities available.

Most of the Ministry of Health's efforts have been to strengthen the management and delivery of services in the public sector, while allowing the private sector some increased freedom. The FPHP places priority on improving private sector capacity for service delivery and therefore complements the GOG's efforts in the public sector.

A recent Policy Framework for Technical Cooperation, issued by the Ministry of Finance and Economic Planning, established policies to direct technical assistance towards: (1) strengthening economic management, (2) strengthening human resources development, (3) reducing the level of state-owned enterprise activity, and (4) strengthening national consultancy capacity. The FPHP is in consonance with these priorities.

F. Program Beneficiaries

1. Program Assistance

The primary beneficiary of the cash grant program is the Government of Ghana; the Bank of Ghana will have additional resources for its foreign exchange auction to support the Economic Recovery Program. Private sector importers gain through access to greater quantities of foreign exchange for an array of economic activities, which will have a multiplier effect within Ghana's economy. The Ministry of Health will benefit from the increased financial resources created from the auction's local currency generations which will be used to augment public recurrent expenditures for family planning, maternal/child health and other public health programs.

2. Project Assistance

Women constitute more than half of the country's population. As the project's goal and purpose are geared towards improving both the health and well-being of women and children, women and children are the primary beneficiaries. Women stand to gain the most when they accept family planning and maternal and child health (FP/MCH) services. The health improvements gained through the program will lead to increased productivity in whatever economic activity women are engaged in. The improved health status of women and children correlates with an improved societal standard of living.

Project participants are also beneficiaries. In the public sector, the project seeks to enhance family planning training in information, education and communication among the different levels of service providers. Most of the service providers are public health nurses, midwives, and traditional birth attendants. Clinical training provided to physicians, nurses and midwives will enable them to offer quality service to their clientele.

Acquisition of relevant skills improves the image of service providers in the community they operate. For example, the private sector midwives will benefit greatly in participating in the project. Receiving both theoretical and clinical training in family planning delivery improves the social image, influence and overall income of the midwife.

The Ministry of Health (MOH) has come to accept the role nongovernmental organizations play in delivering health care and in supporting the public sector to reach the 70% of the population which live in the rural areas. Subsequently, the MOH has given its total support to the national traditional birth attendant (TBA) program and the Ghana Registered Midwives project. As the majority of the traditional birth attendants are women located in the rural areas, they are the first to come into contact with the pregnant woman and later with her child. Therefore given the proper training, TBAs and registered midwives can have positive affects on the newly delivered mother through counselling and providing quality family planning and MCH services.

Organizations such as the National Council on Women and Development (NCWD) which is mandated to help improve the lives of women and their children have sought to be involved in programs that assist women. For example, the Market Operations Research project makes it possible for market traders to sell non-prescriptive family planning methods, thus making family planning accessible and affordable to many people who use the markets, especially women. In this way, busy wives and mothers can manage their time better and at the same time are able to improve their and their children's health.

III. PROGRAM ASSISTANCE OBJECTIVES AND DESCRIPTION

A. Program Assistance Overview

The program assistance component will create a policy and institutional framework supportive of Ghana's efforts to limit population growth through the increased use of modern methods of family planning. This will be done by encouraging the Government of Ghana (GOG) to implement policy and institutional measures which will permit a rapid expansion in the capacity of both the public and private sector to deliver family planning services, information and commodities.

The expected impact of the policy-based cash grant program is the creation of a policy environment which enables: (1) a wider distribution of contraceptives, oral rehydration salts (ORS) and malaria treatment throughout the private and public health service chain; (2) increased contraceptive and related products marketing by private firms and greater public accessibility to family planning, ORS and malaria treatment commodities; (3) greater public awareness of population and family planning as a national priority with the support of national and community leadership; (4) concerted effort by public and private agencies, with defined roles and targets, to achieve national family planning and population objectives; (5) garnering of national and community, public and private, domestic and international resources to bolster implementation of the national program; and (6) budget support for the MOH's family planning and maternal and child health activities.

Ultimately, the impact of the policy program is a synergism of efforts for a long-term directed and concerted program for a rapid increase of contraceptive prevalence and eventually a decline in the population growth rate.

B. Discussion of Program Conditionality

A.I.D. will grant $13.0 million to the GOG for use in the Bank of Ghana's foreign exchange auction. USAID will disburse the grant in three tranches as policy conditions are fulfilled. The conditions fall into two broad categories:

- fundamental policy and institutional changes, designed to create a sense of national commitment and a supportive policy framework which will allow the long-term expansion of population planning activities in a time frame that goes beyond the six years of this project, and

- regulatory changes to immediately remove constraints on public and private sector health workers and commodity suppliers in order to permit increased numbers of health workers and

distributors to handle and sell family planning, ORS and chloroquine and, in the case of the private sector, more profitably within the life of the project.

1. Fundamental Policy and Institutional Changes

a. National Population Authority: As described in the background section (I.C.3), meetings held in 1987 and 1989 reviewing the accomplishments of twenty years of a Ghanaian population policy concluded that a functioning coordinating body is needed if Ghana is to achieve its population growth goals.

USAID program experience has also demonstrated a need for a "national population authority" to mobilize support for a national family planning effort and facilitate the expansion and implementation of population planning activities within both the government and the private sector. This "authority" will define areas of responsibilities, recruit ministries and organizations that are currently not active in population sectors, and coordinate efforts of all involved organizations. This body will also formulate and publicize policies and national goals, orchestrate demonstrations of support for family planning by high level government leaders, and foster the building of a national consensus in support of family planning.

The rationale for creating the national population authority is based on past experience. If Ghana's population program is to be successful it will be necessary to develop a national population implementation plan with agreed upon targets supported by a broad spectrum of public opinion among both the public and private sectors of the economy. Such a plan developed and supported by high level GOG officials would signal to all concerned that the government's renewed commitment to lowering the rate of population growth is serious. It would help mobilize the resources of the country in a way that is mutually reinforcing. In addition, this organized approach to national family planning would help identify resource and skill gaps and provide ample time for their resolution.

The GOG has created a National Development Planning Commission (NDPC) which reports directly to the Provisional National Defense Council (PNDC). It is expected that the national population authority will be a sub-committee of the NDPC, and, as such, will have the authority to coordinate the activities of the various Ministries. The national population authority will have its own broad based senior level advisory council with members appointed from the community from government, private sector, NGOs, and private voluntary groups as warranted. It will be supported by a "Population Secretariat" to provide technical support needed to carry out its mandate. One of the conditionalities under the program component of the project will be establishing of this

authority and staffing the secretariat, as well as providing the necessary budgetary line item to help assure its sustainability. To assist the government in the early years of the project, some of the local currency generated from the cash grant will be allocated to support this activity.

The national population authority will add to the government's institutional resources and will strengthen the planning and budgeting capacity, thus filling a organizational gap. The new national population authority will help translate the gov ment's announced commitment to family planning into concrete ac n.

To carry out its mandate, the "national population authority" should be able to: 1) direct and coordinate the efforts of implementing ministries and agencies, 2) serve as the government's spokesperson to the donors, 3) have under its purview all aspects of the impact of population on development as well as with family planning, 4) have a charter which specifically directs it to maximize the role of the private sector in achieving national population goals, and 5) have adequate funds and staff to implement its assigned functions.

Including the creation of the "authority" as a condition precedent for the release of funds under the program assistance component of the Family Planning and Health Program will be an impetus to GOG to finalize and implement plans that were inaugurated at the two earlier conferences. Since the national population authority is to be a coordinating, planning and mobilizing body, it is not expected to develop an extensive bureaucracy. Instead, a tightly built authority with essential support staff as its supporting secretariat will be sufficient to provide the needed effort. An illustrative minimal structure and budget for a "national population authority" and its secretariat are included in Annex H.

As an interim measure, the Ministry of Finance and Economic Planning has formed the Population Policy Implementation Action Committee (PPIAC) which brings together representatives of a core group of university and Government of Ghana (GOG) Ministries to guide the development of national population policies. Since it may take several years to establish the National Development Planning Commission, and thus the National Population Commission, the GOG has proposed that PPIAC -- acting under the authority of the National Planning and Development Transition Team -- act in a temporary capacity as the national population authority until the permanent National Population Commission is created. Once created, the National Population Commission will become the permanent "authority" for coordinating the National Population and Family Planning Program.

b. <u>Establishing Demographic Goals:</u> A first order of the national population authority should be to establish new

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demographic goals in a joint public-private exercise which assures a national consensus under the aegis of the national population authority.

One of the problems that has hampered all areas of population and family planning implementation has been the lack of realistic demographic goals. The demographic targets that were initially established in 1969 have not been revised despite the passage of twenty years. The only way to develop realistic demographic [illegible]s is to gather all implementing agencies, both public and [illegible]e, under the aegis of the population authority, evaluate the [illegible]t situation and the contribution each actor can make, and formulate realistic goals which will have the broadest possible support in both the public and private sectors.
Demographic goal-setting is the first step in defining the parameters of the population planning effort in terms of financing, human resources, and supplies, and for developing the national implementation plan. It will help to reveal the magnitude of the task and the existing gaps in funding, the supply of goods and services, and other resources required to meet demographic goals. This will enable the Government of Ghana (GOG) to more effectively mobilize donor support as well as to organize the efforts of the public and private sectors in delivering family planning services, information and supplies. It is anticipated that the demographic exercise will also demonstrate the critical role the private sector must play in achieving national demographic goals.

Target-setting is not a one time exercise; it must become an established process within the GOG under the national population authority which will monitor achievements and update short and long-term targets.

c. Preparation and Adoption of a National Population Policy Implementation Plan: The development of a national population implementation plan is essential to enable Ghana to achieve its demographic targets. This plan will not only focus on family planning contraceptive prevalence, but also will reflect the resources which must be mobilized in other sectors that are affected by population problems. At a minimum, this plan should:

-- articulate an overall strategy to reach the demographic goals;

-- define the role that each governmental (i.e., Ministries of Education, Agriculture, Mobilization, Culture etc.) and nongovernmental organizations must perform if the demographic goals are to be reached;

-- estimate the human, commodity and financial resources required to implement the proposed strategy;

-- establish mechanisms for coordinating the efforts for the various participants;

-- establish mechanisms to monitor progress toward meeting the implementation goals as well as overall demographic targets;

-- establish standards to assure that population planning activities are evaluated for both cost effectiveness and impact and that the lessons learned are appropriately applied; and

-- establish mechanisms to set standards for and to coordinate and oversee the implementation of a continuing national education and information campaign.

The national population authority will need to issue a time-phased scope of work for preparing an implementation plan to implement the national population policy. The scope of work should assign responsibilities for plan preparation, develop a mechanism for coordinating plan preparation with demographic target setting, design procedures for reviewing and approving the plan, and authorize funding for plan preparation. Once the plan is developed, the Government of Ghana will need to formally promulgate the national population implementation plan and adopt procedures for the periodic review and revision of the plan.

2. Regulatory Reforms

Progress toward increasing contraceptive prevalence has been constrained by duties, price controls and certain other key restrictions which limit the marketing, distribution and sale of contraceptives (oral contraceptives [OCs], vaginal foaming tablets [VFTs] and condoms), chloroquine and oral rehydration salts (ORS). These barriers to service delivery must be eliminated to allow a sustained expansion of family planning and maternal and child health services and products.

a. Essential Drugs List

The Government's essential drug list currently excludes some types of OCs. Since inclusion on the list confers financial benefits on importers, the list should be expanded to include all OC formulations used in Ghana whether donated or purchased. This should provide an incentive for private importers to supply contraceptives and should contribute to sustaining supplies. The essential drugs list also determines at which level in the public health system each item can be distributed. OCs are placed in a category which limits their distribution to facilities with specialist capacities. In amending the essential drugs list, all public health facilities should be allowed to distribute OCs.

b. Pharmacy and Drugs Act

VFTs, OCs, chloroquine and ORS are presently treated as regulated drugs under the Pharmacy and Drug Act which restricts the outlets through which they can be made available to the public. In order to achieve even a moderate impact on birth rates, contraceptives must be made much more widely available. Increases in contraceptive use and the resulting decrease in total fertility in the coming years hinges on lessening restrictions on dispensing of OCs by trained personnel and eventual deregulation to allow sale by commercial retail outlets. ORS and chloroquine must be equally available both to improve the health status of women and children and to support family planning efforts. Experience in many countries has demonstrated that all these products can be safely distributed without restrictions. With the exception of OCs, they should be immediately shifted to the "exempt" category under the Act. It should be emphasized that the "exempt" category merely permits a wider range of distributors to legally handle a particular product. It specifically does not affect the Pharmacy Board's authority to regulate the quality of what is imported, produced and distributed. This is particularly important given the amount of adulterated drugs supplied in other West African countries.

Recognizing that there may still be some doubt regarding the safety of completely unregulating oral contraceptives at this time, they should at least be moved from Category A, which is for dangerous drugs, to the less restrictive Category C. To ensure that all health service providers are able to offer the full range of modern contraceptive products, the Ministry of Health (MOH) and the Pharmacy Board should work out an arrangement which will allow such persons to distribute oral contraceptives (OCs). Under such an arrangement, anyone receiving appropriate training offered or approved by the MOH should be qualified to dispense OCs. Appropriate language could be incorporated in training certificates to indicate that the person is authorized to sell these products.

It should be emphasized that the MOH has had a long dialogue with the Pharmacy Board about the redesignation of OCs prior to any USAID input. The MOH welcomes the USAID support in their redesignation effort, as well as the phased reduction of constraints on distribution of OCs. A full discussion of the technical aspects of decontrol of OCs is contained in Annex B.

Because of the critical importance of distributing OCs as widely as possible, the Government of Ghana through the national population authority should conduct a review of medical literature relating to experience with deregulation of OCs in other countries and formally determine whether it will continue to maintain OCs on the regulated drug list or move it to the exempt list.

c. Price Controls

Price controls affect the potential profitability of commercial marketing of contraceptive products, oral rehydration salts and chloroquine even when the products are donated. If businesses cannot earn a reasonable rate of return they will not participate in population planning efforts. Nongovernmental organizations (NGOs) must be able to obtain sufficient returns on contraceptive sales to permit them to mount sustainable programs. Removing these controls and allowing those responsible for marketing and sales to determine prices through market mechanisms, in concert with removing the restrictions discussed above, will permit the widest possible distribution of contraceptive products and contribute to the sustainability of family planning programs. Using market mechanisms and distributing products through multiple sources (e.g. private firms, NGOs, and the MOH) will ensure that all sectors of society have access to family planning supplies.

d. Duties

Although duty is not levied on donated contraceptives, private importers have to pay up to 15 percent on commercially imported contraceptive products, ORS and chloroquine. Eliminating duties on these products will facilitate future commercial importation by enhancing profitability. This, coupled with removing other restrictions, will contribute to the long-term sustainability of private sector family planning efforts by creating a favorable market environment. Commercial firms will be encouraged to import and market contraceptive products which MOH/USAID-supported social marketing efforts have shown to be profitable. Since all contraceptives are donated at this stage, the duty is not generating any revenue for the GOG. Therefore, eliminating the duty will have no impact on GOG revenues.

Each of these reforms have been thoroughly discussed with the Ministry of Health and the Ministry of Finance and Economic Planning. Representatives of each feel that these are attainable within the time framework set. In particular, since Ghana governs by regulation instead of legislation, actions altering regulatory practices can be implemented quickly. Of the current reforms, the Essential Drug List and the Pharmacy and Drugs Act should be the easiest to implement. There is reluctance to immediately decontrol the price of contraceptives, but USAID and the MOH agree that a gradual decontrol with full impact monitoring is acceptable. The Ministry of Finance feels that the removal of duties can be achieved.

C. Policy Conditions by Grant Disbursement Tranches

1. First Tranche - $3,000,000 - up to six months after signing the Program Agreement.

a. The Grantee shall expand the Essential Drugs List to include all formulations of oral contraceptives now used in Ghana and shall change oral contraceptives from distribution Category D to Category A.

b. The Grantee shall classify vaginal foaming tablets, oral rehydration salts and chloroquine in the "exempt" category under the Pharmacy and Drugs Act.

c. The Grantee shall redesignate oral contraceptives as Category C, all other restricted drugs (rather than Category A, dangerous drugs) under the restricted drugs section of the Pharmacy and Drugs Act.

d. The Grantee shall revise its regulations to allow the distribution of oral contraceptives by health service providers who have received appropriate training as offered or approved by the Ministry of Health.

2. Second Tranche - $5,000,000 - up to 12 months after signing the Program Agreement.

a. The Grantee shall formally establish a national population authority ("authority") and issue a statement which sets forth its organizational purpose, function, structure, authority, and membership. The authority should have a technical secretariat to support it. To satisfy this condition precedent, the Grantee shall establish the authority in such a manner that it: 1) has the authority to direct and coordinate the efforts of all ministries and governmental agencies in all aspects of activities affecting population and development; 2) has the authority to represent the Government of Ghana in dealing with foreign donors in matters affecting population and development; 3) has as one of its purposes to maximize the role of the private sector in achieving national population goals; 4) has provision for adequate funds and staff to implement its assigned functions.

b. The Grantee shall officially issue through the national population authority a time-phased scope of work for preparing a national population implementation plan. The plan shall, at a minimum, 1) articulate an overall strategy to establish and reach the demographic goals, 2) define the role that each governmental and nongovernmental organization must play if the demographic goals are to be reached, 3) estimate the human, commodity and financial resources required to implement the proposed strategy, 4) establish mechanisms to coordinate the

efforts of the various participants in the strategy, 5) establish mechanisms to monitor progress toward meeting the implementation goals as well as overall demographic targets, 6) establish standards to assure that population planning activities are evaluated for both cost effectiveness and impact and that the lessons learned are appropriately applied, and 7) establish mechanisms to set standards for and to coordinate and oversee the implementation of a continuing campaign of national education and information.

c. The Grantee shall issue through the national population authority a detailed, time-phased scope of work for studying the effects of completely deregulating the distribution of oral contraceptives in Ghana.

d. The Grantee shall present a time phased plan for the elimination of price controls on contraceptive commodities.

e. The Grantee shall eliminate customs duties on the commercial importation of contraceptive products, oral rehydration salts and chloroquine.

3. Third Tranche - $5,000,000 - up to 36 months after signing the Program Agreement.

a. The Grantee shall provide evidence that the GOG has formally reviewed, adopted, promulgated, and initiated steps to carry out the national population implementation plan.

b. The Grantee shall establish procedures for the periodic review and revision of the national demographic goals and the population implementation plan.

c. The Grantee shall review the results of the study of deregulating the distribution of oral contraceptives and decide whether oral contraceptives will be classified as restricted or exempted drugs under the Pharmacy and Drugs Act.

d. The Grantee shall present evidence acceptable to USAID that contraceptive commodity prices have been decontrolled.

D. Rationale for Number, Timing and Magnitude of Tranches

Several factors must be considered in determining the number, timing and magnitude of the tranches of the program assistance funds. First, the cash grant is valuable to the Government of Ghana (GOG) because it provides badly needed hard currency to support its structural adjustment program. The incentive value of the program assistance component is directly in proportion to the speed with which it can be made available to the GOG. Fortunately,

the most important conditions are needed as quickly as possible and appear to require relatively little time to implement. The condition dealing with the regulatory environment for the importing, marketing and distributing of contraceptive products is most important to implementing project activities and creating an environment for sustainable delivery of contraceptives. Disbursing over 61% of funds reserved for program assistance within twelve months of signing the program agreement is both consistent with the importance of the conditions to be met and feasible within the relatively short timeframe. It also provides a strong incentive for the Government of Ghana (GOG) to act promptly.

Similarly, the timing and amounts of the second and third disbursements are consistent with the importance of the conditions, the estimated time required to meet the conditions and the GOG's need for hard currency. The conditions for the second tranche require the establishment of the national population authority and the issuance of a time-phased scope-of-work for preparing a national population implementation plan to implement the population policy. The third tranche then requires evidence that the plan is being substantially implemented.

E. Tranche Disbursement

The first and subsequent dollar tranches will be disbursed to the GOG immediately after USAID issues an approved program implementation letter to the Ministry of Finance and Economic Planning (MFEP) finding that conditions precedent to disbursement of the respective tranches have been satisfied. After issuance of each program implementation letter, USAID will instruct A.I.D./Washington (M/FM/PAD) by cable to transfer the funds to the GOG. The cable will include 1) certification that all conditions precedents have been met and the date met; 2) any other information which may be required under the terms of the agreement to make the disbursement; 3) the dollar amount to be disbursed; and 4) the Bank of Ghana's (BOG's) U.S. bank address, account name, and account number. A.I.D./Washington will then make the transfer from the U.S. Treasury to that account.

Dollar tranches will be disbursed into a single, separate and non-commingled BOG interest-bearing account in New York. All dollars will be withdrawn via letters of credit. The BOG will sell these letters of credit through weekly auctions. Interest earned by the account will be utilized the same as principal and sold through the auction. In order to accelerate disbursement, there will be no restrictions on the auctions and use of Family Planning and Health Program dollars, except for those few imposed by the GOG (see Annex C). Within 90 days of the transfer, the BOG will report to USAID and MFEP on the auction of the dollars, including dollar amounts of the letters of credit, exchange rates, and cedis generated. In the unlikely event that not all dollars are

auctioned within 90 days of transfer, the BOG will submit reports quarterly containing the above information until all dollars are sold and accounted for.

Within 30 days after auction of the dollars, the BOG will deposit the local currency equivalent determined by the exchange rate on the date the dollars are sold, into an interest bearing MFEP account in Ghana.

F. Tracking of Dollars

Section 575 (b)(1) of the 1991 Foreign Operations, Export Financing and Related Programs Appropriation Act (formerly Section 592 (b)(1) of the 1990 appropriations act), requires countries receiving cash through nonproject sector assistance, to set up separate accounts for the receipt of the funds and to avoid commingling them with other funds. Additionally, A.I.D. is required to notify Congress, at least 15 days prior to the obligation of the program assistance funds, of the planned use of the dollars provided under the program. The separate account and the dollar use plan constitute A.I.D.'s dollar tracking requirement.

Under the Agricultural Productivity Promotion Program (APPP), the Government of Ghana (GOG) has opened and maintained a separate account for U.S. dollars. However, due to the transparent and market-oriented allocation of Ghana's foreign exchange auction--documented in annex C--USAID requested and was granted an exemption of the planned uses requirement, as allowed in Section 592(b)(4). A similar arrangement will be initiated under the recently approved Primary Education Program (PREP). USAID's waiver request is based on the analysis of Ghana's foreign exchange allocation system which concluded that A.I.D.'s requirement would lead to an administrative allocation of foreign exchange which would be more restrictive than Ghana's present system.

The basis for the exemption request for APPP and PREP apply to the Family Planning and Health Program (FPHP). Therefore, USAID, as part of the Congressional Notification of the FPHP, is requesting an exemption from the dollar use plan.

G. Programming, Managing and Monitoring Local Currency Counterpart Funds

The program assistance component of FPHP requires that GOG deposit into a separate account the local currency equivalent of $13.0 million after funds are auctioned by the Bank of Ghana (BOG). A detailed description of the foreign exchange auction operated by the BOG is included in Annex C.

The BOG auction is expected to generate a minimum of 2.64 billion in cedis. This estimate is based on an estimated auction rate of

330 cedis to a dollar. Actual deposits into the special cedi account will vary based on the prevailing auction rate. The auction rate is not the highest legally available rate in Ghana at this time. The Forex Bureaus, described in Annex C, also exchange foreign currency. As A.I.D. is required to use the highest legally available rate for program transactions, an exception to this policy is required from A.I.D./Washington.

1. Uses of Cedi Counterpart Funds

One of the constraints noted for expanding family planning and maternal and child health (MCH) services in Ghana is the shortage of public sector resources. While efforts are being made to increase the private sector's share of family planning and MCH service delivery, the Ministry of Health in the short- and medium-term will continue to provide the major share of primary health care services. Therefore, the Government of Ghana (GOG) will allocate a portion of the cedi counterpart funds to the Ministry of Health budget general sector support in the following divisions:

- Maternal and Child Health Division:
- Health Education Division;
- Epidemiology Division;
- Manpower and Training Division.

In addition, funds will be made available to support the National Population Authority.

Each of these sectors has multiple lines which will not be individually tracked by USAID. Prior to disbursement of the first tranche, the mission will undertake studies required under the revised local currency guidelines which are to be issued by A.I.D.'s General Counsel. The mission has carried out these assessments before in other ministries, and has a medium to high level of confidence in the financial and budgeting systems of the host government to trace these funds.

At such time as the MOH is reorganized, budget sectors to be supported will be negotiated between the GOG and USAID.

Ten percent of the cedi counterpart funds will be deposited in the USAID Trust Fund to help finance the Mission's local operating expenses and to assist in program implementation and support.

2. Programming Cedi Counterpart Funds

Due to the inordinate management load that would be required for significant USAID involvement in the programming of local currencies (LC), the GOG will be given primary responsibility for allocating and managing LC funds. USAID will provide only

sufficient oversight to meet statutory monitoring and financial reporting requirements. USAID will use financial assessments and other necessary measures to monitor the overall expenditures of funds, but USAID will not become involved in day-to-day operations related to implementation of local currency supported activities.

The Ministry of Finance and Economic Planning (MFEP), in consultation with the Ministry of Health (MOH) and the national population authority, will prepare and submit to A.I.D. an annual plan for the using cedi counterpart funds. An informal meeting will be held with MOH, MFEP and USAID to agree on eligible and ineligible uses of LC, after which MFEP will forward by official transmittal letter an LC use plan for counterpart funds. USAID will approve the LC use plans by issuing a project implementation letter. The Program Agreement will prohibit use of LC generations for police training pursuant to FAA Section 660, as well as for military or paramilitary purposes. The LC will be programmed over six years.

The cedi counterpart funds will be allocated through the GOG's normal budget process using its standard budget line items. Funds should be available for use during GOG fiscal year 1991 which begins January 1, 1991, assuming conditions precedent for the first tranche are met on schedule. The amount made available for each MOH budget line item to be identified in the MFEP plan will be additional to the funds which would normally be available from Government of Ghana (GOG) revenues. The average of the actual annual financial encumberances available to the Ministry of Health (MOH) for the budget line item in 1988, 1989 and 1990 will be used to establish this base amount for MOH allowable expenditures. The Ministry of Finance and Economic Planning (MFEP) will need to make funds available to the MOH in a timely fashion to enable the MOH to make appropriate disbursements.

3. Management of Counterpart Funds

Following the auctioning of U.S. dollars, local currency (LC) funds generated will be placed into a single, separate and non-commingled MFEP Special Account at the Bank of Ghana to facilitate monitoring and accountability. MFEP will disburse funds from the special account into separate Ministry of Health (MOH) accounts. Funds in these accounts will not be commingled with funds from other sources. MOH will directly disburse from these special accounts without MFEP approval, but funds will not be commingled with funds from other sources that also support MOH programs.

The MOH will submit annual program budgets to MFEP for inclusion in the yearly Government of Ghana budget. MOH, MFEP and USAID will jointly agree on the specific programming of LC. The transfer of funds for general sector support will follow standard MFEP procedures.

MFEP will provide A.I.D. with a mid-year progress review of transfers and disbursements and a detailed end-of-year assessment in conjunction with the presentation of the annual plan for the use of cedi counterpart funds. USAID will provide a semi-annual report to the MFEP on the utilization of the Trust Fund and will follow A.I.D. regulations in monitoring and accounting for them.

IV. PROJECT DESCRIPTION

A. Project Overview

The project component of the Family Planning and Health Program represents a follow-on to the Contraceptive Supplies Project (CSP) described in Section I.D. It continues many of the activities begun under the CSP in a revised and consolidated form.

The core of the project assistance activities is the expansion of the existing Ghana Social Marketing Program responsible for the sale and distribution of a variety of family planning commodities through private sector channels. Under the CSP the modern contraceptive prevalence rate rose from 2% to 5%. This project is expected to effect a 15% modern contraceptive prevalence rate, primarily by strengthening the private sector's ability to distribute commodities in a supportive policy environment and by strengthening the Ministry of Health's (MOH) ability to support and supplement the private sector. Project activities include public and private sector components. This division facilitates project planning, budgeting, management and implementation. The basic elements of these two components are: a) delivery of family planning services and social marketing of contraceptives, oral rehydration salts (ORS) and chloroquine; b) information, education and communication on family planning; and c) training of family planning service providers.

The social marketing activity is oriented to the marketing of contraceptives, the distribution and sale of ORS for the treatment of diarrheal diseases and chloroquine for the treatment of malaria. The latter two health interventions have the potential for substantially improving the health and survival of children under age five and their mothers as well as enhancing the social marketing of family planning products. Including these two interventions complements the MOH's reorientation from curative to preventive health and its desire to pursue an integrated approach to primary health care. The addition of ORS and malaria treatment to the social marketing product line results in a potent combination which will require no diversion of resources or effort from the project's family planning objective while enhancing the project's ability to achieve those goals.

A crucial element of both public and private sector activities will be intensive educational efforts: In the public sector these will be directed through the Health Education Division and in the private sector through the social marketing program and through assistance to PVOs. For each commodity--whether it be used for family planning, oral rehydration or malaria treatment--emphasis will be on teaching end users how to use each intervention appropriately. For contraception, this will involve teaching about the physiology of reproduction, the use and side effects of each

method, and how to prevent use failure. For ORS, the importance of breastfeeding will be stressed, the importance of feeding through the episode of diarrhea, the importance of starting early in the episode, and when to stop treatment or seek professional assistance. For Malaria, the major emphasis will be on treatment of febrile episodes--rather than all illnesses--and on completion of the medical regimen.

In addition to teaching the general public about these health interventions, health care providers, including community health workers and traditional birth attendants, will also be taught about the methods available in their areas, and will be given similar, albeit more extensive instruction in the techniques and rationales for the particular strategies. This is important to avoid giving contradictory information through educational and curative channels.

These interventions, when combined with training of local health workers and involvement of Private Voluntary Organizations, are expected to increase demand for each of the commodities. As has been noted in the background section, however, the primary constraint on use of health commodities in Ghana appears to be the distribution network. Both the supply side and the demand side will be closely monitored to ensure that the appropriate balance is achieved.

Several major improvements in the design of this project include reducing the number of implementing organizations and assigning responsibilities for major project implementation and administrative functions to a single competitively selected contractor. These design characteristics reduce the management burden on the Mission, improve monitoring of activities, and enhance the effectiveness of project inputs.

Because of the increasing importance of HIV/AIDS in Ghana, and the importance of the private sector to meeting the needs of those affected by this disease, this project may be amended in the future to include activities addressing this problem.

B. Detailed Description of Activities in the Private Sector

1. Social Marketing Component (Ghana Social Marketing Program - GSMP)

Social marketing refers to the full range of activities relating to the importation, distribution and sale of health and family planning products in the private sector. Under the Family Planning and Health program, the social marketing component (which will continue to be referred to as GSMP) will be implemented by a competitively selected, A.I.D.-financed contractor (the contractor) which will have operational responsibility for implementing a

complete program of social marketing. While some of these duties will be sub-contracted, they will include: receiving, clearing and storing A.I.D.-supplied contraceptives; procuring locally produced commodities; conducting marketing studies, test marketing products, designing and testing product names and packaging; designing, testing and implementing advertising campaigns; and distributing products through multiple channels.

The contractor, through associations with local firms (subcontracts, joint ventures, partnerships), will create a social marketing unit under the direction of a resident expatriate specialist with the capacity to implement the social marketing component of the project. The unit will implement the above activities largely by subcontracting for services and entering into distribution and sales agreements with appropriate organizations such as accounting, advertising, marketing and distribution firms. As described in Annex C.3.D, USAID is convinced that there are a variety of firms available which, with the appropriate technical assistance, can develop significant social marketing capacities.

In the course of implementing social marketing activities, the contractor's social marketing unit will assist affiliated Ghanaian organizations to strengthen their social marketing capacity. This will be done by providing advisory services, imported goods and training. The contractor will also be responsible for developing a plan for training the local personnel of its local associates and gradually transferring responsibility for the management and implementation of the social marketing program to its Ghanaian affiliates. During the life of the project, the contractor will investigate methods of assuring that the social marketing management and implementation capability it creates will continue after the end of the project. The Ghana Social Marketing Program (GSMP) activities to be implemented by the contractor are described in greater detail below.

a. GSMP Products

(1) Handling of Imported Commodities

Under the on-going Contraceptive Supply Project, the local pharmaceutical manufacturing and distribution firm, DANAFCO, has been responsible for receiving, clearing and storing A.I.D.-financed commodities. This arrangement will be continued until the social marketing unit of the A.I.D.-financed contractor is established in Accra. The contractor will then review the situation and recommend whether this relationship should continue or whether a competitive bid should be tendered using host country contracting procedures.

(2) Types and Sources of Products to be Marketed

A.I.D. will continue to provide the contraceptive products required for social marketing. The contraceptive methods to be marketed by private sector providers participating in this component are oral contraceptives (OCs), condoms, vaginal foaming tablets (VFTs) and intra-uterine devices (IUDs). The health interventions are oral rehydration salts (ORS) and chloroquine. The family planning products will continue to carry the brand names, Norminest (OC), Panther (condom), and Kamal (VFT), which were developed under the existing project. Other family planning products may be added as the project progresses (e.g. a second condom brand, other OC formulations, and Norplant), or as marketing research indicates the need for a product name change.

ORS has become identified as a brand name through usage. Distributors will obtain ORS from DANAFCO which produces it from raw materials provided by UNICEF. DANAFCO currently recovers its costs and profit from ORS sales. Other distributors should be able to do the same.

Several local firms import chloroquine powder and process it into tablets and syrups. This demonstrates the potential profitability of a socially marketed malaria treatment. A product name and dosage packaging will be developed as part of the marketing activities of this component. The Ghana Social Marketing Program (GSMP) will offer local producers of tablets free advertising support plus the use of the improved and pretested name, packaging and treatment instruction sheet. Interested manufacturers will enter into a contract with the GSMP. The contract will govern brand name use and packaging and set the terms under which the manufacturer will sell the product to the commercial and non-commercial wholesale distributors selected by the GSMP. The contractor will be required to provide assistance with establishing production quality control and good manufacturing practices.

The Family Planning and Health project component will continue marketing all products under the GSMP logo identification now printed on all materials.

(3) Packaging, Repackaging and Other Manufacturing Requirements

Since 1986, DANAFCO has packaged and stored all GSMP products. The cost of packaging is built into the wholesale price and accounts for a sizable percentage of the 1990 individual pack wholesale price. While it is expected that DANAFCO will continue to perform these functions during the initial stages of the project, the contractor's social marketing unit will investigate other commercial organizations and arrangements to determine whether

multiple and/or more cost effective sources for this service can be identified and developed. Once identified, these services will be procured by a competitively tendered host country contract.

2. Distribution and Sales of Ghana Social Marketing Products

a. Pricing of GSMP Products

Anti-malarials are being sold profitably through retail channels at prices which cover all costs of raw materials, processing, packaging, and distribution so this product is financially self-sustaining. Retail prices cover the cost of packaging and distribution of oral rehydration salts (ORS), but not raw materials. The latter, however, constitute such a small percentage of the total price of a packet of ORS that it should be possible to make the product completely financially viable. Ongoing monitoring of ORS prices will be included in studies undertaken by the contractor.

Contraceptive products are currently marketed under the GSMP at prices which cover the cost of packaging, distribution and profit. Currently, a small portion of the product's value is being recovered. Extensive studies and testing are required to determine how much can be charged for contraceptive products without significantly affecting the primary goal of the widest possible distribution and use. These studies will be the responsibility of the social marketing component of the project.

b. Commercial Distribution of GSMP Products

DANAFCO has been the exclusive distributor for the GSMP since the project began. Under this arrangement DANAFCO has received the contraceptives products free of charge and recovers its costs and profits, and a small part of the advertising budget from the sale price. As a pharmaceutical distribution agent for offshore companies, DANAFCO primarily sells to pharmacies and chemical sellers. This passive system of wholesale distribution limits GSMP sales and monitoring of outlets in areas which are more rural and distant from Accra, Kumasi, Koforidua and other southern capitals. These limitations will become more problematic when regulatory changes required under the program assistance component remove or reduce restrictions on the distribution and sale of these commodities. The effect of DANAFCO's organizational structure on the distribution of product is fully described in the Institutional Analysis (Annex C).

In order to capitalize on the greater freedom permitted by the regulatory changes, the contractor will explore other commercial distribution arrangements and enter into agreements with one or two companies which distribute through broader retail networks. The

planned infusion of GSMP condoms and vaginal foaming tablets as well as ORS and chloroquine into retail outlets which carry common consumer items such as soap, cigarettes, biscuits, tea and sugar will greatly expand the number of outlets in urban areas and push products deeper into rural markets. A number of such networks exist and hold great promise.

Project activities to improve commercial distribution should result in an increased number of outlets or sources for family planning and maternal and child health products including 5,000 pharmacies and chemical sellers and wholesale distribution providing at least one outlet in each of Ghana's 110 districts.

c. Nongovernmental Organizations (NGOs) and Other Non-Commercial Distributors

In addition to developing commercial distribution channels, the contractor's social marketing unit will tap into the networks offered by various Ghanaian NGOs operating at national, regional and local levels as well as other organizations with the potential to reach large groups of people such as the health service systems of large employers. The activities described in this section are expected to target 15 national and local NGOs for technical assistance and to distribute family planning and maternal/child health (FP/MCH) products.

Two types of NGOs will require somewhat different approaches and different types of assistance. The first group consists of organizations and associations of health professionals. This group includes the Ghana Registered Midwives Association (GRMA), the Private Medical Practitioner's Association, the Ghana Nurses Association, and Christian Health Association of Ghana (CHAG). The second group consists of NGOs interested in development or betterment of a particular group (e.g. women), such as the National Council for Women and Development and the 31st December Women's Movement.

Recruitment of non-health NGOs and their members to the Ghana Social Marketing Program (GSMP) will require a personal approach through their leadership by the social marketing team.

For health-related NGOs, there will be the additional element of upgrading member skills, including long-term clinical methods of contraception, as family planning service providers. This will require a greater degree of support and specialized training. The general model to be followed is the on going project to strengthen the GRMA, implemented by the American College of Nurse Midwives (ACNM).

The capability to deliver the GSMP products differs among and within these groups and depends on the institutional framework and

background of members, staff or volunteers associated with each. Medically oriented groups generally are easy to contact, and members can deliver a wide range of contraceptive methods and drugs. Until policies on oral contraceptives (OCs), vaginal foaming tablets, (ORS) and chloroquine are revised by the relaxation of Pharmacy Board regulations, the non-medical NGOs will be limited in the products they can promote.

When the Government of Ghana has complied with program assistance policy conditions, the members of these groups will be able to freely distribute all products except OCs. Those who have received appropriate training approved by the Ministry of Health will be able to dispense OCs. The contractor will develop appropriate training programs, approved with Ministry of Health, for participating NGOs that will permit their members to handle OCs.

d. Distribution of Ghana Social Marketing Program Products to Nongovernmental Organizations (NGOs)

The contractor and each participating NGO will develop a plan for linking the NGO and/or its members with a commercial wholesale supplier in order to assure regular supply of GSMP products at wholesale prices. Initially, NGOs will be serviced by DANAFCO, either through direct sales to headquarter offices or directly to members/service providers which are easier to reach or where the precedent is already established (e.g. physicians' clinics, midwives maternity homes) or through indirect cash and carry at pharmaceutical sales wholesale facilities. As other channels are developed, it should be possible to devise supply schemes which suit the nature and organizational structure of each NGO.

Since each NGO will have its own particular organizational strengths and weaknesses, the institutional contractor (through the Ghanaian subcontractors) will assist developing the NGOs' capacity to serve as a provider of goods and services. This assistance will be tailored to each NGO's needs and will take the form of training staff and members, and providing technical assistance to establish logistics and accounting systems, and to strengthen organizational and managerial functions.

Assuring a regular supply of contraceptives, oral rehydration salts (ORS) and chloroquine to NGOs, as well as monitoring performance, will require considerable effort on the part of GSMP. GSMP cannot expect to always receive sales data or information either on individual outlets or participating individuals. It is important, however, to understand how well different participant groups and their members are performing. To do this, the contractor will arrange periodic assessments, conducted by local Ghanaian management and accounting firms.

e. Industrial and Other Employer-Based Health Systems

Another group of potentially significant distributors of GSMP products are private health systems operated by large employers. These systems include hospitals, clinics and in-plant health facilities. In addition, there are a small number of companies which warrant further exploration. Some of these are detailed in the Institutional Analysis (Annex C). By project completion, five employer-based health facilities are expected to provide family planning/maternal and child health goods and services to their employees.

f. Market Women

Market women and other traders represent a special target group for the GSMP. They are special because they represent a potentially significant group of distributors and are difficult to organize, train and keep supplied. Despite these difficulties, developing a market women's network may be the only viable means of providing Ghana Social Marketing Program (GSMP) commodities to rural areas. A pilot market women's project was initiated under the Contraceptive Supplies Project. The project will be evaluated and the results will be available for consideration under the Family Planning and Health project assistance component.

3. Marketing Activities

a. Advertising

The contractor will assist Ghanaian companies to advertise and promote GSMP products to the public through all channels. This will represent a major responsibility. The same marketing techniques used for commercial products will be brought to play in social marketing in order to translate Ghanaians' latent desire for birth spacing and limitation into contraceptive practice. Promotion of oral rehydration salts (ORS) and chloroquine will be based on the same principles of specifying benefits and creating product demand. A full discussion of the application of social marketing techniques to the Ghanaian situation is found in the Technical Analysis (Annex B).

Prior to any new advertising, the contractor will analyze and redefine the target populations for GSMP products. The contraceptive targets were vaguely defined in the previous project in terms of overall project objectives of increased knowledge, acceptance and prevalence. In the Family Planning and Health Program (FPHP), target populations for all the interventions will be redefined to include rural residents and broader age groups for both sexes. The plan for promoting and advertising individual products will be based on the targets established, results of prior

and new research, and marketing and sales objectives. The goal is to develop a more focused and coordinated brand campaign which fits the overall long-range marketing plan which the contractor will develop as a first project priority.

The contractor is expected to carry out at least five national advertising campaigns for each GSMP FP/MCH product and to analyze the impact of each campaign on consumer demand. Advertising agencies will be asked to bid for campaign development based on an advertising brief developed by the team. Selection criteria will be established on an understanding of the goals and needs of social marketing as reflected in an agency's creative approach to product image and market position, message development and media mix.

Once the agency is selected, the contract for services will specify parameters normal to advertising contracts including, among others, expectations for artwork and production, deadlines, quality control, pre-testing and job sequencing.

b. Social Marketing Advisory Group

Due to the sensitive nature of the products to be advertised, the Ghana Social Marketing Program (GSMP), with A.I.D. assistance, will develop a mechanism for reviewing proposed advertising materials and campaigns with concerned representatives of the Government of Ghana (GOG) and private sector organizations. This will probably take the form of a Social Marketing Advisory Group consisting of representatives from the Ministry of Health, Ministry of Information, Ministry of Education, the national population authority, as well as private sector media representatives such as the owners/senior editors of newspapers, owners of advertising organizations, associations of advertisers, or leading educators from universities.

c. Promotion to Retailers

Developing a plan to promote the GSMP products to sellers -- retailers and NGO members -- is a vital early step. It will be done in close coordination with the contractor's efforts to identify and develop multiple channels for the distribution of GSMP products. While the social and development purpose of GSMP will be communicated to potential commercial sellers, it is most important to convey the potential for growing sales and increasing total profits. This is especially important as the project expands to the small shopkeeper market. Prior to any sales promotion, materials for retailers will identify price structure, profit margins, quantity purchase discounts, bonus goods, etc, as well as descriptions of upcoming media campaigns. Many of the same materials produced for the retail trade will be used or revised for nongovernmental organization sellers, but pretesting materials with different type sellers will precede production of flyers and

brochures. These materials will be distributed before any consumer advertising commences. The project then will monitor both retailer and customer reaction through ongoing analysis and small consumer and shop surveys. These activities are expected to lead to the retail sale of contraceptives, oral rehydration salts and chloroquine in each of the 110 districts.

d. Pricing and Sustainability

Once the Government meets the policy condition of removing price controls on contraceptives, ORS and chloroquine, it will be possible to sell GSMP products at a price which eventually recovers the cost of the donated product and provides a profit margin to encourage continuing commercial sales by wholesalers and retailers. A major challenge to the GSMP is establishing a pricing balance between wholesaler and retailer profitability, consumer affordability and project sustainability. GSMP will conduct a variety of studies, including test marketing and willingness to pay studies, and will monitor sales volume in relation to pricing levels.

While it may not be achievable within the six year project framework, the ultimate goal of GSMP is financial sustainability. Under the Contraceptive Supply Project, both DANAFCO and the Ministry of Health maintained "Return to Project Funds" in which a modest percentage of the retail sales price of contraceptive donated by USAID were deposited. This system represented a preliminary step toward financial sustainability. As wholesalers and retailers are able to sell Ghana Social Marketing Program (GSMP) products at market-determined prices, greater cost recovery will be achieved. However, a timeframe for full cost recovery and sustainability will have to be developed in consonance with other factors, accessibility and affordability of these products. The institutional contractor will assist GSMP to develop a cost recovery plan.

e. Social Marketing Management Information System (MIS)

The contractor will develop a microcomputer based MIS for all social marketing activities. This system will be designed to track the receipt and distribution of contraceptive products. The system should be able to produce reports which provide information on exactly who is selling and how much of each type of product at every level in the distribution chain. The MIS should permit the GSMP to evaluate the efficiency and cost effectiveness of various modes of distribution. The MIS should be linked to related systems which the contractor will be required to develop to manage and monitor other activities. As far as practicable, the MIS will be compatible with the systems used by nongovernmental organizations to facilitate information transfers.

4. Training of Private Sector Family Planning Service providers

a. Assistance to Other Health-Related Nongovernmental Organizations (NGOs) and Employer/Industrial Health Organizations in Long-Term Clinical Family Planning Methods.

In conjunction with GSMP's efforts to utilize health related NGOs and the health services of major employers for the distribution of contraceptive products, the contractor will also develop programs to assist these organizations to strengthen the capacity of their health professional members to provide family planning services. This will include training in long term clinical methods such as sterilization, Norplant and IUDs.

In arranging training, the contractor will first seek to use existing Ministry of Health (MOH) training facilities. If MOH training is not available or is insufficient to meet demand, the contractor will arrange training in country using private facilities and Ghanaian trainers, providing technical assistance and commodities as required. Since facilities for IUD insertion training are limited in Ghana, as a third alternative, small groups of midwives may attend clinical sessions at the University of Ibadan, Nigeria. This practice was used successfully under the Contraceptive Supplies Project.

b. Assistance to the Ghana Registered Midwives Association (GRMA)

The American College of Nurse Midwives (ACNM) will continue to provide assistance to the GRMA which was begun under the Contraceptive Supplies Project. This is a follow-on to the activity described in Section I. ACNM will assist GRMA improve its management, administrative and planning capabilities to ensure organizational sustainability and expanded member services. The new activity will also focus on basic family planning provider training, continuing education for members, refresher training, service support, standardization of quality service delivery, IUD refresher training and basic family planning and maternal and child health (FP/MCH) skills and motivation training. More specifically, ACNM's assistance to GRMA will accomplish the following objectives:

-- improve the management and administrative capabilities of the GRMA to ensure organizational sustainability and expanded member services;

-- plan, conduct and evaluate training for up to 200 private sector midwives who have not previously received training in family planning;

-- provide professional, individual and service support for up to 400 maternity homes in FP/MCH practice;

-- develop, implement and evaluate a system for standardization of quality family planning service delivery;

-- develop institutional capability to continue providing in-service FP/MCH training to members;

-- plan, conduct and evaluate training for up to 45 private sector midwives in intra-uterine device insertion and management; and

-- provide international exposure and experience for the GRMA.

C. Detailed Description of Activities to be Undertaken in the Public Sector

1. Distribution of Commodities

a. Contraceptive Commodities

Under the proposed project A.I.D. will continue to supply the Ministry of Health (MOH) with contraceptive commodities, specifically generic condoms, Conceptrol vaginal foaming tablets, Lo-Feminal and Ovrette oral contraceptives and Copper T 380A intra-uterine devices. If and when Norplant implants are approved by the U.S. Food and Drug Administration for A.I.D. use, and approved by the Ghana Pharmacy Board, the project will provide these commodities as well.

Contraceptive commodities will be distributed to all public sector level B (health centers) and level C facilities (hospitals) and level A community health workers and traditional birth attendants (TBAs) who have received appropriate training. During the life of the project, the MOH is expected to distribute: 13.8 million condoms, 3.0 million cycles of oral contraceptives, 5.2 million vaginal foaming tablets, 50,000 intra-uterine devices, and 1,000 Norplant implants.

Over the past four years, the Ministry of Health (MOH) has been developing the capacity to deliver and track contraceptive use at all levels of the public sector. MOH will be responsible for logistics management, although the contractor is expected to: 1) review Ministry reports and assist with projections of need and reordering of commodities and 2) detect problems in the storage and distribution of commodities and provide MOH with technical assistance needed to correct them.

b. Non-Contraceptive Commodities

(1) Oral Rehydration Salts (ORS)

UNICEF currently provides raw materials to DANAFCO for the production of ORS; this arrangement will continue under the new project. DANAFCO provides the MOH with ORS sachets equal to the value of the raw materials based on the retail price of processed and packaged ORS. This leaves DANAFCO with a quantity of raw material which it can process, package and sell. DANAFCO recovers the cost of manufacturing and packaging from ORS sales at a retail price high enough to cover these costs. USAID inputs to the public sector distribution of ORS will not be needed.

(2) Chloroquine

The MOH will be encouraged to purchase the unit packaged chloroquine from the private sector supplier established under the GSMP. No USAID inputs are anticipated.

c. The Return to Project Fund

In line with the Bamako Initiative, the Government of Ghana (GOG) has adopted a cash and carry policy for drugs and contraceptive products dispensed at public health facilities. Under the Contraceptive Supplies Project, the MOH was to deposit a portion of the funds it recovered from the sales of A.I.D.-supplied contraceptives and to use the funds for procuring additional contraceptives. This arrangement for a return to project fund (RTP) was made as a means to move toward financial sustainability and to prepare the MOH to procure its own contraceptive supplies.

Because of past management difficulties, MOH has had difficulty tracking funds from the point of sale through the district and region to the central level and then into RTP. The Ministry has only recently begun to install the necessary record-keeping systems. A.I.D. and MOH will amend the financial tracking requirements of RTP to ensure a workable arrangement which will move public distribution of contraceptives towards sustainability.

Initially, the Ministry of Health (MOH) will be asked to deposit an amount in the RTP Fund based on the numbers of commodities distributed rather than the cedis obtained through sales. This will substantially simplify the procedures for managing these finances.

The contractor will assist MOH to study, review and set prices for the sale of A.I.D.-provided products and other products which are marketed by the Ghana Social Marketing Program in parallel with

sale through public health organizations. These efforts should be directed toward achieving 50% cost recovery by the fifth year of the project, according to the following schedule:

Project Year	Percent of Value of Contraceptive Supplies
1	10
2	20
3	30
4	40
5	50

The Mission views cost recovery as critical for the sustainability of the program. As such the attainment of the above cost recovery schedule for contraceptives will be included as a covenant in the project grant agreement.

The contractor also will review the MOH's system for financial management of contraceptive sales. This review will take into account MOH efforts at health cost recovery and other donor activities in this area. The contractor will then recommend modifications in or alternatives to the Return to Project (RTP) Fund which will enhance A.I.D./MOH's efforts to move public sector contraceptive sales toward sustainability.

MOH will use all RTP funds for procuring additional supplies of contraceptives. This will assist the MOH to build up an independent procurement capability. The contractor and USAID will assist the MOH with this procurement, if required.

The contractor will be responsible for monitoring deposits into and disbursement from the RTP fund. However, A.I.D. will employ independent contractors to review the fund on an annual basis.

2. Information, Education and Communication (IE&C)

This element focuses primarily on the MOH Health Education Division (HED). This division will plan and implement IE&C campaigns in support of family planning in general and MOH efforts in this area in particular. HED is expected to carry out at least three nation-wide campaigns during the project.

The HED will utilize techniques developed and material produced with A.I.D. assistance under the Contraceptive Supplies Project. Demographic models will be updated and artwork or booklets already produced will be used to greatest advantage. New materials will be developed and media programs to be aired on radio and TV or published in print media will be designed.

As with the private sector, all materials will be pretested to avoid unproductive and costly mistakes. The effect of various campaigns will be monitored through further special studies and refinements will be made as needed. Themes and materials will be "refreshed" during the life of the project as new or unresponsive targeted groups needing further attention become apparent.

Before any new information, education and communication (IE&C) campaigns are initiated under the project, the Health Education Division (HED) with the assistance of the contractor will analyze existing data on the impact of public campaigns. HED launched a major national family planning campaign in the spring of 1990. There will be more than a year of experience by the completion date of the Contraceptive Supplies Project (CSP), as well as two years of data collection from HED surveys. The Project will benefit from these data and should learn important lessons which can be applied to renewed efforts in 1991 or 1992. A major IE&C campaign is anticipated six to ten months after the contractor's technical assistance team arrives in country to coincide with a similar activity in the private sector.

A.I.D. assistance will take the form of technical assistance and limited participant training. In line with Government of Ghana policies, as much training as possible will be conducted in country. The Ministry of Health (MOH) will provide an adequate budget to finance the local costs of HED activities, such as but not exclusively, contracting for the services of local advertising firms and purchasing media time.

Technical advisors, arranged by the contractor, will provide on the job staff development for all HED personnel. These advisors will assist HED in the planning and managing of IE&C campaigns. When HED becomes overburdened, the contractor will commission outside assistance, as was done under the Contraceptive Supplies Project. This serves to both assist the HED and provide spin-off training for personnel who will gain experience with creative and production skills common to the business sector. Because the technical assistance provided to HED and the private sector-oriented social marketing project component will come from the same source, public sector and private sector IE&C activities will be coordinated so that IE&C and advertising campaigns will be mutually reinforcing.

3. Training of Public and Private Sector Service Providers under MOH Auspices

a. Training of Traditional Birth Attendants (TBAs)

Training of TBAs is a high priority for the MOH. This program constitutes a national effort to upgrade TBA skills in caring for pregnant women, critical for reaching the goal of bringing improved

care, including family planning, to the rural majority. The proposed project will continue to finance technical assistance begun under the Contraceptive Supplies Project (CSP).

With A.I.D. funding, TBA training began in 1989 with technical assistance from the American College of Nurse Midwives (ACNM). Prior to actual training, a TBA curriculum was developed by the Ministry of Health (MOH), ACNM and UNICEF based on A.I.D.'s pilot efforts carried out by Columbia University. Under the CSP, A.I.D. supports TBA activities in five out of the ten regions in the country with a program designed to train, in a pyramid fashion, 3000 TBAs by 1992. This project is expected to train and monitor an additional 3,000 to 4,000 TBAs.

The MOH National TBA program is to be managed by a yet-to-be established unit under the Maternal and Child Health division of the MOH which will be responsible for TBA activities in nine of the ten regions (UNICEF assists in three, USAID in five and UNFPA in one). By mid 1991 fifteen master and sixty TBA trainers selected from health centers (level B) will be responsible for identifying, training and supervising 600 TBAs per region. The TBAs (mostly women although men attend births in some regions) receive family planning training in modern methods (with an emphasis on short-term methods), contraceptive and oral rehydration salts supply, counselling, and referral of high risk cases. Once TBAs are trained, the cadre of trainers assures that trained and family planning certified TBAs receive regular contact from MOH midwives, return records they are taught to keep, and are resupplied with kits upon completion of training. For family planning, this means USAID supplied condoms and vaginal foaming tablets, which TBAs are allowed to sell at established rates.

With existing regional USAID funding, the current ACNM project will run until 1992. The Family Planning and Health Program will finance the continuation of ACNM's TBA training activity through 1996. USAID recognizes that the institutionalization and sustainability of the national TBA program is dependent on its becoming fully integrated into the MOH structure. As MOH restructuring progresses, policy dialogue will help ensure that appropriate placement is achieved. If necessary, the grant to ACNM may be delayed to ensure that proper positioning of the TBA project has occurred.

The ACNM activity will:

-- strengthen the capability of the National TBA Program Secretariat to coordinate, support, monitor and evaluate the National TBA Program;

-- strengthen and expand the MOH system for monitoring, supporting and evaluating the National TBA program;

-- plan, conduct and evaluate a continuing education program for master trainers, trainers and TBAs; and

-- plan, conduct and evaluate a program to enhance the communication skills of TBAs.

A major change in the activity will be the incorporation of oral contraceptives into training for new TBAs and refresher training for already trained TBAs. The supply system also will be modified to incorporate the availability of oral contraceptives. This change will result from regulatory changes brought about by the policy reforms proposed under the program assistance component of this project.

b. Training in Long-Term Methods of Birth Control -- Voluntary Surgical Contraception (VSC)

USAID/Accra will buy-in to a centrally-funded contract or cooperative agreement to provide training in long-term, including surgical, contraception as part of the overall family planning emphasis in Ghana. If Ghana follows the experience of other countries, including Kenya and Zimbabwe, VSC or sterilization will become one of the most important forms of birth limitation over the next fifteen years. With a supportive environment, a foundation for safe and reliable surgical services to meet the anticipated need can now be established.

The training program, implemented over a five-year period, will:

-- Increase the availability of VSC in Ghana by training 24 doctor/nurse teams in surgical contraception and by equipping up to 15 hospitals to perform the procedure. It is anticipated that the procedure will be available at all regional hospitals, plus those district hospitals which have surgical facilities. Selected private hospitals will also be assisted to develop this capacity. Minor renovations averaging $3,200 per hospital are expected to be needed;

-- Ensure the continued safety of the operation by stressing the minilaparotomy under local anesthesia technique and by establishing and maintaining rigid quality controls; and

-- Ensure the availability of counseling and referral for surgical contraception by training up to 140 nurses in these techniques so that information and referral services are available at all district hospitals.

Training for long-term methods of contraception will be funded by a buy-in to an existing A.I.D. centrally-funded contract or cooperative agreement.

Since Norplant has only recently been approved by the U.S. Food and Drug Administration, and has not yet been approved by the Ghana Pharmacy Board, the numbers of trainees as well as project costs cannot be specified exactly. Demand is expected to be present given the history of the pilot Norplant study in Kumasi. Given the start-up time, even if product approval were to be given immediately, it is anticipated that only 1000 sets will be implanted over the life of the project.

4. Research and Studies

In 1994, the Mission will buy-in to the Demographic and Health Surveys II, an A.I.D. centrally-funded project, to repeat the Ghana Demographic and Health Survey done in 1988. This will be one of

the primary methods for verifying that the purpose of the Family Planning and Health Program has been attained.

5. Assistance to the National Population Authority

The contractor will assist the new authority to establish its secretariat and will assist the secretariat once it is formed. Technical assistance will be provided to assist the authority meet conditions for release of the program assistance cash grant, such as implementing of the demographic target setting exercise and the preparing the national population implementation plan. A small pool of funds for short-term U.S. consulting services will be reserved for ad hoc requests for assistance from the authority.

Additional technical assistance and commodity support will be furnished to assist the national population authority to mount a policy-oriented IE&C campaign in order to develop a national consensus in support of population planning and Government of Ghana (GOG) population and family planning policies. This assistance will be provided by continuing A.I.D. support for the Population Impact Project (PIP) of the University of Ghana at Legon. However, USAID's contribution will be limited to foreign exchange costs. The GOG will be asked to provide support for the local costs of the PIP through its budget allocation for the national population authority.

V. PROGRAM MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

A. Program Assistance

1. USAID Responsibilities

In conformance with A.I.D. delegation of authority, the A.I.D. Representative will be responsible for determining whether the Government of Ghana (GOG) has satisfied the conditions precedent for disbursement of program assistance funds. The A.I.D. Representative will be assisted by the Mission's Health, Population, and Nutrition Officer in maintaining a continuous policy dialogue with appropriate GOG offices, while steps to fulfill conditions are being implemented.

2. GOG Implementing Agencies and Responsibilities

The following is a list of GOG implementing agencies and their responsibilities for executing the program assistance component.

-- The Ministry of Finance and Economic Planning will be responsible for meeting the first tranche condition relating to establishing of a national population authority.

-- The Ministry of Health (MOH), Pharmacy Board, Customs Service, and the Price and Wage Board, under the coordination of the Ministry of Finance and Economic Planning (MFEP), will be responsible for the other first tranche conditions relating to the removal of duties, price controls and other restrictions on contraceptive products, ORS and chloroquine.

-- The national population authority, after it has been formed, will assume responsibility for assuring implementation of all other conditions.

-- The Bank of Ghana will have responsibility for the sale of the grant funds through the foreign exchange auction and reporting on auction transactions to USAID.

-- The MFEP, in concert with the Bank of Ghana, will be responsible for assuring that dollar cash transfers are made available to the foreign exchange auction and that the cedi equivalent is deposited in a Ghana Family Planning and Health Program special cedi account. MFEP will work with the MOH to develop a plan acceptable to A.I.D. for the use of the cedis and to assure that the cedis have been used in accordance with the plan.

-- The MFEP will monitor the activities of the other GOG organizations responsible for compliance with the terms of the program assistance agreement in order to assure that the GOG

obtains the foreign exchange as quickly as possible. MFEP will constitute and chair a program technical committee to monitor program assistance implementation.

A description of the major implementing agencies is found in the Institutional Analysis (Annex C).

B. Project Component

1. USAID Responsibilities

The USAID Health, Population and Nutrition (HPN) Office will have responsibility for the implementation of the project component. The HPN Office will be assisted by the Office of Program Operations, the Controller's Office, the Executive Office and A.I.D.'s Regional Economic Development Support for West and Coastal Africa's (REDSO/WCA's) offices of Procurement and Regional Contracting.

USAID will be responsible for providing the following inputs: the procurement of contraceptives for both the Ministry of Health (MOH) and the private sector social marketing component; procurement of services for evaluations and financial reviews; and procurement of services from centrally-funded projects including the project for voluntary surgical contraception. REDSO/WCA's Regional Contracting Office will be responsible for the contracting for the procurement of the competitively selected contractor and the services of American College of Nurse Midwives (ACNM).

USAID's Health, Population and Nutrition Office will be responsible for monitoring the performance of the competitively selected contractor, ACNM, and all buy-ins to centrally-funded contracts and cooperative agreements.

2. Competitively Selected Contractor

The contractor will implement all aspects of the social marketing component of the project, except contraceptive procurement, assist the MOH's Health Education Division to design and implement IE&C activities, and will assist nongovernmental organizations to become effective providers of family planning and health information, goods and services.

a. Social Marketing

The contractor will create a social marketing unit to manage implementation of a full range of social marketing activities under the Ghana Social Marketing Program. The social marketing unit will be staffed by Ghanaians obtained through an agreement between the contractor and a Ghanaian firm in whose offices the unit will be housed. The expatriate social marketing adviser will direct the

unit's activities while developing management capability within the Ghanaian firm. The contractor is expected to develop a plan for turning over full project social marketing responsibilities to the Ghanaian firm while continuing to provide backstopping support after three years.

b. Management and Monitoring

The social marketing contractor will create, in addition to the Social Marketing Unit, a project management unit through a subcontractual relationship with a Ghanaian firm, utilizing Ghanaian staff headed by a senior Ghanaian administrator to manage all project inputs. The unit will operate under the overall direction of the resident expatriate chief of party who will additionally assist in developing management capability within the Ghanaian firm. The contractor also will develop a plan for turning over full management responsibilities to the Ghanaian firm after three years.

The contractor's project management unit will handle the following project management and monitoring responsibilities:

-- A.I.D.-Procured Commodities: The contractor will monitor the receipt and distribution of contraceptive commodities procured by A.I.D. for the Ministry of Health (MOH) and for the contractor's social marketing activities. The management unit will assure that the MOH logistics system is functioning particularly with regard to storage conditions and record-keeping and provide technical assistance if necessary. The unit will also assist the MOH in preparing an annual request for contraceptives to ensure that method mix and quantities are reasonable and take into account orders requested by the private sector. The management unit will develop and maintain a micro-computer based management information system, linked to the system developed to monitor social marketing activities.

-- Support to Nongovernmental Organizations (NGOs): The contractor will establish a unit within the social marketing organization to liaise with and support local NGOs to become effective providers of family planning/maternal and child health (FP/MCH) commodities, services and information. This can include (but is not limited to) commodity logistics, technical support, and training of NGO staff and members.

-- Collection of Project Data: The contractor will collect data which are required to track both project implementation progress and project impact. The data will include both baseline data at the outset of the project and new data at regular intervals. Primarily, the required data will be generated by existing MOH, NGO and commercial sector data

collection activities, contractor reports and the contractor's management information system. To the extent that significant data are not available from existing sources, the contractor will make arrangements to obtain data first hand when secondary sources are not available. The data will be used by the contractor to produce regular progress and special analytical reports for USAID and the Government of Ghana. The data will be made available to independent evaluators engaged by USAID during the life of the project.

-- Financial Management Services: The contractor will monitor the Return to Project Fund established by the MOH to capture the proceeds from the sale of A.I.D.-supplied contraceptives. The contractor will provide technical assistance to overcome problems which may be indicated in financial assessments and procurement reports.

-- Services to the Contractor: The contractor's management unit will maintain the contractor's financial records, prepare vouchers for payment under its contract with A.I.D., arrange for the financial assessment of firms and organizations providing services to the contractor or receiving and disbursing funds on behalf of the contractor.

3. Other Input Providers

The services of the American College of Nurse Midwives (ACNM) will be obtained through a non-competitive sole source procurement. The justification for sole source procurement is provided in Section VII. The ACNM will assist the Ghana Registered Midwives Association (GRMA) to strengthen its organization and enhance the professional capabilities of its members. It will also assist the Ministry of Health (MOH) to implement its traditional birth attendant training program.

Support for long-term methods of contraception will be procured through a USAID buy-in to a centrally-funded contract or cooperative agreement. The selected contractor will assist the MOH with long term contraceptive methods training for both public and private sector health professionals.

The contractor that is awarded the Options II Project, a centrally-funded population policy activity, will assist the Population Impact Project (PIP) with the development of a population policy IE&C program and will assist the national population authority develop its secretariat.

Both the ACNM and the contractor providing long-term method training will be responsible for providing short-term technical assistance and commodities for implementing their in-country

programs. They will identify technical assistance needs, suggest timing, and length of each technical assistance visit for USAID approval.

4. Government of Ghana Implementing Agencies

The Government of Ghana (GOG) implementing agencies for the project component are the Ministry of Finance and Economic Planning (MFEP), Ministry of Health, and the national population authority. GOG responsibilities for overall monitoring and management will be conducted by a project technical committee, comprised of a senior member of the MFEP, and representatives of the cooperating technical divisions of the MOH. At a minimum the committee shall include a senior representative each from the Maternal and Child Health (MCH) Department and the Health Education Department (HED). Other members might include a representative each from the Epidemiology Department and the section of Supply Division handling A.I.D.-financed commodities. Additionally, the committee shall include a representative from the national population authority. This committee is expected to be chaired by either the MOH or the National Population Authority.

The Supply Division (MOH) will receive, store and distribute all USAID-donated contraceptives geared for MOH distribution. It will obtain and distribute oral rehydration salts (ORS) and malaria treatment drugs, purchased by the MOH directly from local suppliers or received from other donors. The Supply Division will distribute contraceptives, ORS and chloroquine to public health regional and district facilities.

The MCH Division will assume responsibility for the TBA training program.

The University of Science and Technology (UST) Teaching Hospital, an MOH facility, will be responsible for collaborating with AVSC to train doctor-nurse teams in sterilization procedures and quality control of training-related facilities and maintenance of equipment.

The Health Education Division will be responsible for planning and implementing information, education and communication (IE&C) campaigns and related activities to promote family planning and the use of contraceptives.

The national population authority will be responsible for developing and implementing broad population planning IE&C activities directed at policy makers and community leaders.

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5. Private Sector Organizations

DANAFCO clears and stores A.I.D.-financed contraceptives. It then repackages and distributes them through its network of pharmacists, chemical sellers and wholesale depots under the Contraceptive Supplies Project. Additionally, DANAFCO maintains a Return to Project Fund. Once the Family Planning and Health Program is established, the Ministry of Finance and Economic Planning will initiate competitive procurement for the services currently provided by DANAFCO. The contractor will assist in this process.

Other organizations, described in the project description, will be identified and involved in the project as it progresses. These organizations include various commercial firms who will receive contracts to provide services for the social marketing activity, nongovernmental organizations and the health units of large industrial and commercial enterprises.

VI. MONITORING AND EVALUATION

A. Monitoring Plan

Monitoring activities will track and assess progress of program implementation for both the policy-based cash grant and project activities and will provide the baseline data required to monitor and evaluate the achievement of project benchmarks and eventually people level impact. To meet Women in Development objectives, data will be collected to allow disaggregation by gender.

1. Implementation monitoring

USAID will monitor the Family Planning and Health Program to track progress for the following activities:

For the policy-based program assistance component

- -- fulfillment of the conditions precedent to each of the three cash disbursements;
- -- A.I.D. disbursement of the grant funds upon fulfillment of the policy conditions;
- -- auction of grant funds;
- -- deposit of the local currency generations from the auction;
- -- programming of local currency generations; and
- -- disbursements to the USAID Trust Fund.

For the project component

- -- fulfillment of the conditions precedent to project start-up;
- -- contracting for long-term technical assistance;
- -- contraceptive procurement by USAID;
- -- provision of A.I.D. inputs;
- -- provision of Government of Ghana financial and other inputs;
- -- performance of the contractor;
- -- performance of the various nongovernmental organizations; and
- -- performance of the Ministry of Health recipients of project inputs.

2. People Level Impact Monitoring

The people level impact monitoring system will include the tracking of benchmarks indicating the status of (1) policy implementation in creating a policy environment which promotes the execution of a national family planning effort, (2) project performance in increasing the number of family planning service providers and family planning supplies, and (3) availability of family planning

information. Both the policy-based program assistance component and project assistance component contribute to achievement in these three areas. The program assumes a correlation between the planned policy changes and the increased availability of family planning services, supplies and information. Therefore, it is expected that an appreciable change in project activity benchmarks will be noted as policy benchmarks are achieved. Some positive changes are expected to occur in the project benchmarks, although not as dramatically, even if the current policy environment remains unchanged and the Government does not meet the policy benchmarks. If this happens, the Government of Ghana is less likely to achieve reasonable national family planning goals.

The contractor and the Ministry of Health are expected to collect much of these data on a quarterly basis, and all benchmarks will be reviewed internally by USAID (and reported to A.I.D. in the Assessment of Project Impact) on an annual basis.

a. The project benchmarks are:

1) increased number of family planning providers as measured by:

-- number of medical/health personnel providing family planning services by type of profession and geographic region;
-- number of private sector health care providers trained in family planning service delivery and contraceptive methods; and
-- number of public sector health care providers trained in family planning service delivery and contraceptive methods.

2) increased availability of family planning supplies and child survival commodities as measured by:

-- number and type of sites where contraceptives are sold;
-- number of contraceptive distributors (wholesale and retail);
-- number of private sector health professionals distributing contraceptives;
-- number of private firms importing contraceptives;
-- demand for contraceptives by age group and by contraceptive type;
-- use of contraceptives by type and age group; and
-- use of oral rehydration salts and malaria treatments.

3) increased availability of information on family planning as measured by:

-- number of women of reproductive age aware of family planning and methods;
-- number of men aware of family planning and methods; and
-- number of points/locations for family planning information, e.g. radio, television, newspapers, pharmacies, chemical sellers, family planning service providers.

b. The policy benchmarks are:

-- increased official government policy pronouncements supporting family planning;
-- greater incorporation of population factors in national planning;
-- decreased restrictions on the distribution and sales of contraceptives; and
-- increased interministerial participation in population planning.

The collective monitoring of these benchmarks will indicate whether the project is achieving the objective of increasing the demand for and use of family planning services. Increases in the contraceptive prevalence rate and in the proportion of women favoring fewer children are the prime indicators for the achievement of the project objective.

It is far more difficult to measure the impact of interventions such as Oral Rehydration Therapy and Malaria interventions on morbidity and mortality. Early in the project, plans will be made to include questions about these in the sentinal surveillance studies. Small area surveys will be conducted early in the project to establish baselines, with follow-up late in the project to determine impact.

3. Monitoring Responsibilities

Monitoring is the responsibility of USAID and the GOG, including all the implementing agencies, the Ministry of Finance and Economic Planning (MFEP), the Ministry of Health (MOH), the national population authority, the institutional social marketing contractor, and the non-governmental organizations.

USAID through its Health, Population and Nutrition Office and the GOG, through MOH and MFEP, will have responsibility for overall monitoring to ensure the entire program is implemented according to the agreements between USAID and GOG. The USAID HPN office will be responsible for tracking project and program assistance benchmarks

through reports received from the contractor, Ministry of Finance and Economic Planning (MFEP) and the Ministry of Health (MOH) and special analysis and evaluation.

The GOG program technical committee (described in Section V), chaired by MFEP and comprised of the relevant implementing and technical agencies, will have responsibility for monitoring the progress for fulfilling the project and program assistance grant conditions precedent, auctioning the foreign exchange, depositing and programming of local currency generations, providing financial and in-kind inputs from the GOG, and program impact. The national population authority is expected to keep the committee abreast of progress on achieving policy benchmarks and to maintain and update statistics on population and family planning.

The institutional contractor will be responsible for establishing a management information system (MIS) to measure implementation progress and to aid in project management decision-making. This management information system will include baseline data to enable the tracking of project benchmarks, as listed in the previous section. The institutional contractor also is expected to work with the Ministry of Health Maternal/Child Health (MCH) division to ensure that basic family planning and maternal child health data are generated and routinely updated. The contractor should make every attempt to utilize existing MOH monitoring systems and statistics. The MIS will be a primary source for impact monitoring. The contractor will be required to submit regular reports to the Government of Ghana (GOG) and USAID on the status of project implementation and progress towards achieving the project benchmarks, for formal review by USAID and the GOG technical committee.

Nongovernmental organizations (NGOs) will maintain records on the implementation of their activities and will provide the social marketing contractor with statistics on the changes in the project benchmarks in their service areas.

B. Evaluation Plan

The evaluation component of the Family Planning and Health Program will be managed directly by USAID. Both the program assistance and project assistance aspects will be evaluated by the same team (external or in-house). All evaluation activities will be carried out with the full collaboration of the Government of Ghana, NGOs and private sector institutions which participate in the program. Annual in-house evaluations are proposed to assess the progress beginning one year after the signing of the project and program agreements. Two external evaluations are proposed during the life of the project.

Monitoring activities will provide the baseline data for both the mid-term and final evaluations.

Proposed Evaluation Schedule

12 Months	In-house joint evaluation (Start up review to identify any significant problems)
24 Months	In-house (first substantial joint evaluation)
30 Months	Mid-term external evaluation
Year 4	In-house joint evaluation and update of Ghana Demographic Health Survey
Year 5	Final evaluation including impact assessment

1. Mid-Term Evaluation

The Mid-term evaluation is planned about 30 months after the signing of the program and project agreements.

It is expected that the mid-term evaluation will review:

- -- management of inputs;
- -- status of outputs;
- -- progress in attaining purpose-level objectives;
- -- define any management changes required for timely fulfillment of the policy program and project objectives;
- -- status of policy and project benchmarks;
- -- adequacy of benchmarks and indicators for assessing overall impact at final evaluation and making recommendations for modifications in baseline monitoring, if required; and
- -- technical assistance requirements and progress by the institutional contractor in imparting management skills to the local Ghanaian subcontract firms to enable them to assume an increasingly greater role in project implementation.
- -- institutional questions and relationships
- -- impact of program assistance tranches on policy changes

2. Final Evaluation

The final evaluation will take place seven months before program completion. It will include:

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- -- review of the number of benchmarks achieved;
- -- review of progress made in attaining purpose-level objectives and progress of the policy and project components in realizing input and output targets;
- -- analysis of the macro-impact of the policy changes brought about by accomplishment of the program conditionalities, especially those which facilitate the role of the private sector in the distribution of contraceptives;
- -- assessment of impact on beneficiaries due to increasing numbers of service providers, availability and accessibility of supplies, and increased information;
- -- assessment of the project success in moving toward sustainability and in reducing subsidies;
- -- assessment of the impact of price increases, resulting from the removal of subsidies on demand for contraceptives; and
- -- assessment of both the attainment and potential for attainment of sub-goal and goal-level objectives.

3. <u>End of Project Report</u>

Following project completion, the prime contractor will prepare an end of project report which incorporates findings of the final report, but provides project data and accomplishments through the Project Assistance Completion Date.

VII. IMPLEMENTATION PLANS

Detailed implementation schedules have been developed for the program assistance and project activities. These plans outline the major implementation events over the life of the Family Planning and Health Program. For each activity a responsible party and approximate date of accomplishment are indicated. Detailed schedules for the program assistance and project activities are attached as Annex G.

A. Obligations

USAID will sign two separate agreements with the Government of Ghana (GOG) for the Family Planning and Health Program: (1) a program assistance grant agreement and (2) a project grant agreement for project assistance.

1. Program Assistance Grant

The Assistant Administrator for the Africa Bureau (AA/AFR), A.I.D./Washington, will sign the Program Assistance Approval Document, authorizing the overall program and approving the initial obligation and first tranche for the program assistance component. Subsequent authorizations and obligations will be executed by the A.I.D. Representative in Ghana following review and concurrence by the Director of A.I.D.'s Regional Economic Development Support Office of West and Coastal Africa (REDSO/WCA) in accordance with A.I.D. delegation of authority. An amendment to the program grant agreement will be executed for each annual authorization and obligation until the program assistance component is fully funded.

2. Project Assistance Grant

The AA/AFR will approve the authorization of the project assistance component. The A.I.D. Representative, with concurrence of the Director of REDSO/WCA, will sign the initial Grant Agreement and subsequent amendments. USAID will issue project implementation letters periodically to elaborate on terms and conditions of the agreement and implementation procedures.

B. Implementation Plan for the Program Assistance Component

The Government of Ghana (GOG) is responsible for accomplishing three sets of policy changes as conditions for receiving $13.0 million for use in its foreign exchange auction to support the GOG's Economic Recovery Program. These policy conditions are discussed in detail in Section III. USAID will make cash disbursements to the Government in three tranches over a 36-month period. Three months prior to the projected date for the Government's fulfillment of the conditions for each of the three tranches, USAID will convene a tranche review with the GOG to

identify and develop a strategy for resolving problems in meeting the conditions. Tranche reviews will be attended by the program technical committee and other personnel as required. The tranche reviews additionally will assess public expenditure for family planning and maternal and child health activities, tranche release documentation requirements, and policy performance targets.

To initiate the disbursement of funds USAID will issue program implementation letters to the GOG to certify that the conditions precedent have been met. A.I.D. will deposit disbursements into a separate dollar bank account in a U.S. bank, designated by the Government of Ghana (GOG). The Bank of Ghana will auction the grant funds, normally within 90 days of dollar disbursement and will submit regular reports to USAID and the Ministry of Finance and Economic Planning (MFEP), as discussed in Section III.E., on the auction of dollars, including dollar amounts, exchange rates and cedis generated. MFEP will submit regular reports to the Ministry of Health (MOH) and USAID indicating the status of funds, the amount of local currency generations and deposits into the MFEP special account and the USAID Trust Fund Account.

The USAID Controller will monitor the GOG implementing agencies' financial management of the cedi generations, maintain an accounting system for the dollar and cedi accounts and prepare quarterly reports for the A.I.D. Representative which describes the movement of dollars. USAID will contract with a local accounting firm for annual financial assessment of program funds.

The implementation status of the program will be assessed annually and during two external evaluations of the overall Family Planning and Health Program. A detailed 36-month implementation schedule, indicating the estimated timing for the fulfillment of the policy conditions, tranche reviews, disbursement of funds, use of local currency generation for MOH budget sector support, and other supporting activities, is included as Annex G.

C. Implementation Plan for Project Activities

The institutional contractor has primary responsibility for implementing project activities in the following areas: family planning service delivery, information, education and communication, training, research, social marketing plan for contraceptives, oral rehydration salts, and chloroquine treatment. The contractor will oversee all assistance to the public and private sectors. This includes providing technical assistance and training to the MOH, namely the Health Education Department, Maternal and Child Health Department, and other participating non-governmental organizations in the private sector. The contractor's specific implementation responsibilities for technical assistance, training, etc. are discussed in Section IV, "Project Description", for monitoring in Section VI, "Monitoring and

Evaluation," and for procurement in Section IX, "Project Assistance Procurement Plan."

The contractor will report regularly to the USAID Health, Population and Nutrition Office. Regular reporting includes quarterly progress reports indicating implementation status and achievement of benchmarks, quarterly financial reports, annual workplans, special studies, and final report. The contractor will develop and submit the first annual workplan for joint review and approval by USAID and the project technical committee three months after the initiation of in-country activities. The plan should include, inter alia, plans for scheduled major activities, attainment of benchmarks, training and technical assistance. First year contractor activities will also include developing a contraceptive marketing plan, assisting the Health Education Division in information, education and communication activities, developing a project management information system and procurement of all project commodities, excluding USAID-procured contraceptives.

The Health, Population and Nutrition Office of USAID will assume responsibility for pre-implementation activities and will arrange any special assistance required by the Government of Ghana in establishing the national population authority and to meet the preliminary requirements for project initiation. Additionally, USAID will procure contraceptives, execute contracts for the services of American College of Nurse Midwives (ACNM) and Association for Voluntary Surgical Contraception (AVSC), and arrange all financial management reviews. Both ACNM and AVSC will be required to submit for joint review and approve by USAID and the project implementation committee annual workplans, outlining plans for scheduled major activities, attainment of benchmarks, training and short-term technical assistance.

The project Implementation Plan (Annex G), presents the estimated timing for initiating and completing major project activities, including obligation schedules, project reporting and project evaluation. Specific policy benchmarks also are included where the contractor has responsibility for providing technical or other assistance.

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VIII. COST ESTIMATE AND FINANCIAL PLAN

A. Introduction

The Family Planning and Health Program will be implemented over a six year period with expenditures expected over five years. The cost estimates and financial plan are based on an initial obligation of funds in the first quarter of U.S. fiscal year 1991. Detailed budgets are included in Annex J and a summary financial analysis of the program is contained in Annex D.

B. Cost Summary

The total cost of the program is estimated at $42.253 million. A.I.D.'s contribution of $30 million, 71% of total program costs, is divided between the program assistance component ($13.0 million) and project component ($17.0 million). The remaining 29% of total cost is the Government of Ghana (GOG) contribution to the program. Contributions to the project by the GOG are expected to include in-kind and cash contributions. Cash contributions may come from local currency generations of the program and income generated from the Ministry of Health's sale of contraceptives. The income from the sale of contraceptives will be deposited in a Return to Project Fund for use in replenishing contraceptives stocks. However, it is impossible to establish a value for these returns until issues concerning subsidy, import duties, price control and distribution of contraceptives are settled. Therefore, revenues from the sale of contraceptives is not included in any of the tables which show the GOG's contribution to the program. Table VIII(a) summarizes the estimated total cost over the project's life span, separated into A.I.D's contribution of foreign exchange and foreign exchange converted to cedis, and the GOG's contribution of local currency and in-kind resources. Paragraphs C and D, below, briefly describe the line items which are listed in Table VIII(a). Table VIII(b) summarizes expenditures by fiscal year.

C. U.S.-Financed Inputs

1. Program Assistance

A.I.D. will grant $13.0 million for the GOG's foreign exchange auction in return for policy reforms specified in Section III.

2. Project Assistance

A.I.D.'s project assistance will be implemented via an institutional contractor, two private, voluntary organizations, buy-ins to existing central projects, and, in the area of contraceptive supply, direct procurement through A.I.D.'s Contraceptive Procurement Office. Thirty-eight percent of the budget for the institutional contractor is allocated for the

purchase of technical and professional services from Ghanaian firms. Additionally, the institutional contractor will make maximum use of Ghanaian professionals for short-term technical assistance needs when local expertise is available. US short-term technical assistance will be utilized to assist Ghanaians in project implementation and to transfer skills through on-the-job training. The following summarizes A.I.D.'s project assistance inputs, as presented in Table VIII(a).

a. Institutional Contractor

(1) U.S. Long-Term Personnel
   a) Chief of Party (36 person months)
   b) Social Marketing Adviser (36 person months)

(2) U.S. Short-Term Personnel (62 person months)

(3) Other Direct Costs (covers communication costs)

(4) Commodities and Equipment (covers office computers, vehicles, information, education and communication production materials)

(5) Participant Training (international/offshore)
   a) Workshops and Seminars (72 person months)
   b) Short Courses (42 person months)

(6) Local Costs
   a) Local Procurement (covers 45 person months of local short-term technical assistance, short-term contracts for advertising campaigns, commodity distribution and logistics, social marketing supplies and equipment, and short-term consulting contracts with accounting and research firms)

   b) Operating Costs (covers office and residential rents and utilities, office furnishings and equipment, expendable supplies, vehicle operation and maintenance, and cost of local travel)

   c) Local Personnel (covers long-term subcontracts with local firms for management and social marketing support)

b. American College of Nurse Midwives

(1) U.S. Personnel

a) Long-term (covers full-time home office project director and administrative staff totaling 36 person months)

b. Short-term (covers technical assistance trips to Ghana by home office staff totaling 68 person months)

(2) Commodities (covers medical supplies and related training materials for assistance to the Ghana Registered Midwives Association (GRMA) and training materials, computers and related maintenance costs for training traditional birth attendants)

(3) Participant Training (covers costs of attendance at international conferences and workshops for staff of Ghana Registered Midwives Association [GRMA])

(4) Local Costs (covers local costs of assistance to GRMA including equipment, teaching materials, local travel and per diem and local personnel)

c. Support for Voluntary Surgical Contraception and Long-term Methods of Contraception

(1) U.S. Personnel

a) Long-term (covers full time home office project director and administrative staff totaling 36 person months)

b) Short-term (covers visits by home office staff to plan and administer in-country training programs totaling 16 person months)

(2) Commodities and Equipment (covers medical supplies and equipment for laparoscopy training)

(3) Participant Training (covers international and local training, workshops, and seminars)

(4) Local Costs (cover teaching related equipment and materials and smallrenovations of laparoscopy facilities and local training workshops and seminars)

d. Other Buy-ins

(1) Demographic and Health Surveys II (A.I.D./Washington central project for update of Ghana Demographic and Health Survey)

(2) Options II Project (A.I.D./Washington central project for technical assistance to the Population Impact Project at the University of Ghana at Legon)

e. A.I.D.-Procured Commodities

(1) Contraceptives (covers cost of oral contraceptives, condoms, intra-uterine devices (IUDs) and vaginal foaming tablets)

(2) Contractor Support (covers the cost of household furnishings and equipment for institutional contractor long-term U.S. personnel)

(3) Financial Reviews (covers cost for local annual financial reviews of the local currency special account and Return to Project Funds)

(4) Evaluations (covers external mid-term and final evaluations)

D. Government of Ghana (GOG) Financed Inputs

1. Program Assistance

The GOG program assistance will consist of cash contributions ($685,000) and in-kind ($90,000) resources to cover salaries, office space, utilities, office equipment, supplies, and other related operational costs for the national population authority.

2. Project Assistance

The Government of Ghana (GOG) is making a significant contribution to the project through the provision of in-kind donations to cover that portion of the budgets of the Health Education (HED) and Maternal/Child Health (MCH) Divisions of the Ministry of Health (MOH), which relates to project implementation. The in-kind

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donation includes salaries, office facilities and equipment, and other costs associated with normal operations of the HED and MCH Divisions. Also covered are the normal costs of information, education and communications activities and field work costs for the MOH traditional birth attendance (TBA) program. Additionally, the GOG will provide facilities for project-sponsored TBA training by the American College of Nurse Midwives (ACNM) and training in long-term contraceptive methods. The GOG will also utilize in-kind resources to assist in equipping 15 new sterilization service centers.

The GOG will make local currency contributions to the project which equal $2.338 million dollars. A brief description of the local currency cash contributions, as shown in line items on Table VIII(a) follows.

a. American College of Nurse Midwives (ACNM) Participant Training (This covers the local cost for training TBAs under the program conducted by ACNM. Costs covered include trainee travel, per diem, supplies, etc.)

b. Long-Term Methods Participant Training (This covers trainee travel, per diem and costs of supplies for the training program in long-term methods of contraception.)

c. Demographic and Health Surveys II Project Buy-in. (Amounts in this line item are for local enumerators and related travel, per diem, and other costs.)

d. Options II Project Buy-In (This covers local personnel costs of the Population Impact Project at the University of Ghana at Legon.)

E. Methods of Implementation And Financing

Table VIII(c) presents a summary of the methods of financing for the planned project activities. The table describes the contracting method, type of procurement, and financing method. An estimated value for each method of implementation and financing is also provided.

The methods of financing which will be used are A.I.D direct payment and Federal Reserve Letter of Credit. Procurement will be by direct contract or, in the case of contraceptives, through A.I.D.'s Commodities and Program Support Division (CPSD).

F. Obligation Schedule

Table VIII(d) shows projected obligations by fiscal year, separated into project and program categories. USAID/Ghana plans to fully obligate the program by the end of fiscal year 1993.

TABLE VIII (a)
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(U.S. $000)

DESCRIPTION OF INPUT	AID FOREIGN EXCHANGE	AID LOCAL CURRENCY	GOVERNMENT OF GHANA LOCAL CURRENCY	GOVERNMENT OF GHANA IN-KIND
1. PROGRAM ASSISTANCE				
a. Cash Grant	13,000			
b. National Population Authority Operating Costs			685	90
SUBTOTAL	13,000		685	90
2. PROJECT ASSISTANCE				
a. Institutional Contractor				
1. U.S. Personnel				
a. Long-term (72 per months	1,187			
b. Short-term (62 per months)	1,472			
2. Other Direct Costs	23			
3. Commodities and Equipment	372			
4. Participant Training (International)	659			
5. Local Costs				
a. Local Procurement		1,037		
b. Operating Costs		449		2,448
c. Local Personnel		750		2,846
b. American College of Nurse Midwives (ACNM)				
1. U.S. Personnel				
a. Long-term (36 person months)	1,188			
b. Short-term (68 person months)	468			
2. Commodities and Equipment	127			
3. Participant Training	59		1,238	2,330
4. Local Costs		589		
c. Support for Long-Term Methods of Contraception				
1. U.S. Personnel				
a. Long-term (36 person months)	100			
b. Short-term (16 person months)	249			
2. Commodities and Equipment	147			
3. Participant Training (International and Local)	7		86	149
4. Local Costs		334		

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TABLE VIII (a)
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(U.S. $000)
(contd)

DESCRIPTION OF INPUT	AID FOREIGN EXCHANGE	AID LOCAL CURRENCY	GOVERNMENT OF GHANA LOCAL CURRENCY	GOVERNMENT OF GHANA IN-KIND
d. Other Buy-ins				
1. DHS II	48	252	115	10
2. Options	375	74	214	149
e. A.I.D. Direct Procurement				
1. Contraceptives and Commodities	6,500			1,893
2. Contractor Support Furnishing & Equipment	169	3		
f. Financial Reviews		92		
g. Evaluations	270			
SUBTOTAL PROJECT ASSISTANCE	13,420	3,580	1,653	9,825
TOTAL ASSISTANCE	26,420	3,580	2,338	9,915

TABLE VIII(b)
FAMILY PLANNING AND HEALTH PROGRAM
PROJECTION OF EXPENDITURES BY FISCAL YEAR
(U.S. $000)

A. PROGRAM ASSISTANCE

FISCAL YEAR	A.I.D.	GOVERNMENT OF GHANA	TOTAL
1991	3,000		3,000
1992	5,000		5,000
1993	5,000	685	5,685
SUBTOTAL	13,000	685	13,685

B. PROJECT ASSISTANCE

FISCAL YEAR	A.I.D.	GOVERNMENT OF GHANA	TOTAL
1991	2,505	294	2,799
1992	3,179	302	3,481
1993	4,272	317	4,589
1994	4,638	418	5,056
1995	1,661	322	1,938
1996	745	-	745
SUBTOTAL	17,000	1,683	18,653
TOTAL	30,000	2,338	27,338

The obligation projections for the Government of Ghana does not include the GOG in-kind contribution of $9,915,000.

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TABLE VIII(c)
FAMILY PLANNING AND HEALTH PROJECT
METHODS OF IMPLEMENTATION AND FINANCING

METHOD OF IMPLEMENTATION	METHOD OF FINANCING	(U.S. $000) APPROXIMATE AMOUNT
Institutional Contract (Technical Assistance, Training, Commodities, Non-Federal Financial Reviews)	Direct Payment	5,949
Buy-ins (Demographic Health Survey, Options II Project)	Direct Payment	1,586
ACNM Cooperative Agreement	Letter of Credit	2,431
A.I.D. Procurement (Contraceptives and Contractor Support)	Direct Payment	6,672
Direct Contract (Financial Assessments and Evaluations)	Direct Payment	362
Program Assistance	Direct Payment	13,000
TOTAL		30,000

TABLE VIII(d)
OBLIGATION SCHEDULE
(U.S. $ Millions)

ASSISTANCE CATEGORY	FISCAL YEAR 1991	FISCAL YEAR 1992	FISCAL YEAR 1993	TOTAL
Program Assistance	3.0	5.0	5.0	13.0
Project Assistance	6.0	5.1	5.9	17.0
TOTAL	9.0	10.1	10.9	30.0

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IX. PROJECT ASSISTANCE PROCUREMENT PLAN

A. Overview

The project is financed 100% from the Development Fund for Africa (DFA) Appropriations account. All procurement will be conducted following the procurement guidelines for activities financed under the Development Fund for Africa. Accordingly, the project will utilize to the extent practicable goods and services of U.S. origin and from U.S. sources. Most long-term technical assistance, except local Ghanaian consultants, will be of U.S. origin. All vehicles, due to the local availability of parts and maintenance shops, will be procured from Code 935 sources as allowed by the DFA legislation. Participant training will be conducted in the U.S., at local or regional training institutions, or in other developing countries. Services and commodities procured by nongovernmental organizations under their respective cooperative agreements will be of U.S. source and origin, with the possible exception of special training material which may need to be purchased from other free world country sources (Code 935). Computer equipment purchases may be from other free world country sources and will be of U.S. origin. USAID/Ghana with the assistance of A.I.D./Washington's Office of Transportation (SER/OP/Trans) will make every effort to ensure that commodities procured directly by A.I.D. or through A.I.D. contractors will be shipped on U.S. flag carriers in compliance with the U.S. Cargo Preference Act. The USAID project manager will maintain records of all project procurement by A.I.D. Geographic Code and will report this information annually to A.I.D./Washington's Africa Bureau Office of Project Development. With the development of the procurement plan in accordance with Africa Bureau guidelines, USAID/Ghana is maximizing to the extent possible U.S. procurement.

B. Responsibilities

USAID/Accra will procure the services of (1) the institutional contractor, (2) the American College of Nurse Midwives (ACNM), (3) technical services and personnel from A.I.D. centrally-funded projects, and (4) local technical personnel for financial assessments and evaluations. A.I.D./Washington through its Commodities and Program Support Division (CPSD) will purchase all forms of contraceptives. Additionally, USAID will procure household furnishings and equipment for the institutional contractor. The institutional contractor will procure all other project commodities except commodities required by ACNM and other centrally-funded projects. These responsibilities include procuring of all project equipment and supplies, vehicles, IE&C supplies, short-term local and expatriate technical assistance and services and participant training. Both ACNM and the long-term methods contractor are responsible for procuring supplies and services under their agreement with USAID. The Government of Ghana

(GOG) through the Ministry of Finance and Economic Planning (MFEP) will procure the services of a local firm to clear, store, package and distribute A.I.D.-donated contraceptives.

C. Procurement Plan Table

The procurement plan below shows the anticipated sources and origins of the project's technical services and commodities. The list of services and commodities is ordered according to project implementation responsibility areas. The Procurement Plan Table is included as Annex K.

D. Procurement of Technical Services

1. Competitively Selected Institutional Contractor

A.I.D. will procure the contractor through direct contract. The contracting officer at A.I.D.'s Regional Economic Development Support Office of West And Coastal Africa (REDSO/WCA) will solicit proposals by advertising in the U.S. Commerce Business Daily. The source for this procurement will be U.S. (Code 000). The REDSO/WCA contracting officer will chair a joint USAID-Government of Ghana (GOG) contractor selection committee and will execute a contract with the selected firm. The joint USAID-GOG contractor selection committee will evaluate the technical merit of all proposals and recommend a short list of firms to the regional contracting officer for contractor negotiation and contract execution.

The prime institutional contractor will provide two long-term advisors, chief of party and social marketing advisor, and will sub-contract a Ghanaian firm for management support and for the operating the Ghana Social Marketing Program.

Two important criteria for the selection of the institutional contractor are its ability to subcontract with local Ghanaian firms and its plan for achieving complete implementation of the FPH project by Ghanaians with US contractor backstopping.

2. A.I.D. Grants to the American College of Nurse Midwives (ACNM) and the Centrally-funded Contractor for Long-term Methods Training

USAID/Ghana anticipates entering into a five-year cooperative agreement with ACNM to provide assistance to the Ghana Registered Midwives Association (GRMA) and a three year cooperative agreement to train traditional birth attendants (TBAs) in family planning methods. ACNM has predominant technical capability in midwifery training. As the only professional association of this type in the U.S.A., ACNM has access to a cadre of professional midwives and can provide the essential institutional support to ensure continuity in the delivery of services at the highest professional level.

Technical assistance for training in long-term methods will be obtained through a buy-in/add-on to a centrally-funded contract or cooperative agreement in A.I.D./Washington's Office of Population (S&T/POP). This will enable the contractor to provide services for a five year period, beginning in 1991.

3. Contracting with DANAFCO

DANAFCO currently has a contract with the Ministry of Finance and Economic Planning (MFEP), under the Contraceptive Supplies Project, to clear, store, package and distribute A.I.D.-financed contraceptives. DANAFCO received this contract through a sole-source procurement, using A.I.D. guidelines for Host Contracting (A.I.D. Handbook 11), since it was deemed as the only available source for these services. MFEP will need to execute a contract for the handling of contraceptives under the Family Planning and Health Program. The institutional contractor will assist MFEP and USAID to identify and assess the capabilities of other local firms to competitively bid for this contract.

E. Participant Training Plan

The project will finance a small amount of participant training. Most training will be in the form of workshops and seminars, which will be conducted in the U.S., the cooperating country or other third world countries. A small number of nurses may be trained in midwifery at the University of Ibadan. However, the exact locations of workshops, seminars, and other training will be identified by the institutional contractor who will develop a training plan as part of the annual work plan which will be reviewed and approved by USAID and the Government of Ghana.

F. Participation of Gray Amendment Entities

USAID/Ghana has considered the participation of Gray Amendment entities in the design of the Ghana Family Planning and Health Program. ACNM, a women-owned association, qualifies as a Gray Amendment entity and will be implementing a vital component of the project with substantial resources.

The Mission will consider Gray Amendment entities during the procurement process. Further, the Mission anticipates publicizing locally a notice of the expected prime contractor procurement and requesting expressions of interest from qualified Ghanaian firms. These expressions of interest would be made available to all prospective U.S. offerors.

X. FINANCIAL MANAGEMENT

A.I.D. will directly finance annual financial reviews of the Return to Project Fund and the use of the cedi counterpart funds relating to the program assistance component. A.I.D. also will finance annual program reviews of the procurement, storage and distribution of contraceptives by the Ministry of Health. Funds have been budgeted for these reviews in the Family Planning and Health Program which will be performed by local qualified accounting firms.

Because the majority (97%) of project assistance funds will be committed through A.I.D.-direct contracts and buy-ins with U.S. firms which are required by A.I.D./Washington to be audited annually and for commodities procured through A.I.D./Washington, financial audits of these project components are not anticipated. The institutional contractor, however, will be responsible for contracting locally with independent auditors for non-federal reviews of the project activities in Ghana. Funds for such reviews are included in the contractor's budget. Reviews are expected at least every 18 months.

XI. CONDITIONS AND COVENANTS

The grant agreement with the Government of Ghana will contain the standard A.I.D. conditions precedent to the disbursement of project funds, policy conditions requisite for disbursing the $13.0 million non-project assistance grant for the foreign exchange auction, and a number of other conditions precedent and covenants to ensure the provision of adequate project resources, appropriate project management, monitoring and implementation.

A. Policy Program Conditions for Cash Grant

The policy conditions which must prevail for the disbursement of $13.0 million to the Government of Ghana are elaborated in Section III.B. "Discussion of Program Conditionality".

B. Other Project Conditions and Covenants

1. Other Project Conditions

The following project condition will help to ensure appropriate project monitoring and guidance.

a. The Government of Ghana, prior to A.I.D. initial disbursement of funds, will constitute a Project Technical Committee comprised of a senior member of the Ministry of Finance and Economic Planning (MFEP) as chairperson and representatives of the cooperating technical divisions of the Ministry of Health, including at a minimum a senior representative each from the Maternal and Child Health Department and the Health Education Department.

2. Project Covenants

The project assistance grant agreement will include the following covenants to ensure adequate financial resources for relevant MOH departments, expeditious and proper handling of A.I.D.-financed commodities donated to MOH, good financial management and accountability of the "Return to Project Fund" and progress toward full cost recovery of the MOH contraceptive distribution program.

a. The Government of Ghana shall covenant to fund completely the budgets for maternal and child health/family planning (MCH/FP) and health education activities of the MOH throughout the life of the project.

b. The Government shall covenant to appoint or hire a full-time accountant to manage the Return to Project Fund under the supervision of the Accountant General and the MFEP.

c. The Government shall covenant to appoint an officer with commensurate experience in the Ministry of Health as liaison to the Ghana Supply Commission to ensure that A.I.D.-donated commodities are cleared quickly from the port.

d. The Ministry of Health shall deposit in the Return to Project Fund a proportional amount of the value of contraceptives actually distributed each calendar year.

e. The Government of Ghana shall covenant to allow all durable commodities, including vehicles and office equipment that were provided under the Contraceptive Supplies Project to continue to be used by the agencies carrying out the same activities under the Family Planning and Health Project.

f. The Government of Ghana shall carry out a complete audit of the existing return to project fund, and will not commingle other funds with that account until a full accounting has been made.

XII. SUMMARY OF PROJECT ANALYSES

A. Technical Analysis

The project relies primarily upon a private sector social marketing approach for improving delivery of family planning services, information and commodities. An extensive analysis of the existing social marketing system is given in Institutional Analysis (Annex C). It concluded that significant barriers to its success appear to be minimal. Consumer demand is high, cultural barriers are small, price barriers have not yet been approached, and many men and women want to delay the birth of their next child.

An important constraint is the distribution system, which primarily extends to cities and towns. In the private sector, while considerable attention has been given to issues of commodity importation, processing and distribution, significant problems remain. Importation procedures still need to be improved to ensure efficient processing and distribution of commodities. While these are not atypical problems, they require even more attention in Ghana. Management systems are better than they were but still require development to make them run more smoothly. Intensive distribution systems based on multiple sales outlets need to be found and utilized to carry needed goods and information. With the increased complexity of the distribution system, this will be a paramount concern for the primary contractor.

The key constraint in developing these networks is the price recovered at each level of the distribution chain. Currently, the primary profitability is to the retailer, since wholesale prices are fixed. The wholesaler has little incentive to increase his distribution. While few data are available on the price elasticity of demand for contraceptive commodities, a recent doubling of the wholesale price of commodities had no effect on retail sales. This indicates that restructuring the price may provide better incentives to all levels of distribution.

In the public sector, one of the main technical issues is still the contraceptive supply logistic system. There are many inputs to this from a variety of donors, including the World Bank and UNFPA. USAID will monitor the supply flow and will provide assistance if needed in addition to other donor contributions.

Similarly, adequate financial management systems have not been developed. The prime contractor will make arrangements with appropriate Ghanaian accounting firms to assist the Ministry of Health (MOH) to develop and implement an adequate financial management system for project-related activities.

A related problem is the release of money from the Ministry of Finance and Economic Planning to the MOH for project activities.

Delays in funding have caused significant problems in the past. It is expected that the cedis generated under the program assistance part of the overall project will alleviate this problem.

A contraceptive supply plan is presented, which will provide sufficient commodities to reach a 12.8% contraceptive prevalence rate. This plan includes the phased acquisition of 52.6 million condoms, 6.9 million cycles of oral contraceptives, 12.8 million vaginal foaming tablets and 96,000 intra-uterine devices. Contributions from other donors, specifically the World Bank, International Planned Parenthood Federation and the United Nations Fund for Population Activities, as well as inputs from the return to project fund, will be more than sufficient to reach the projected 15% contraceptive prevalence rate.

B. Social Soundness and Beneficiary Analysis: Women in Development

Social Soundness: The primary question addressed by this analysis is that why, after twenty years of population policies and a historically pronatalist culture, should one expect this project to triple contraceptive prevalence rates? The nature of traditional Ghanaian culture is explored, with particular attention to the roots of pronatalism. While there are still strong tendencies towards high fertility, Ghana must be viewed as a culture in transition, where even rural areas are coming under nontraditional influences. Changing patterns of education and authority, and a shift away from subsistence agriculture are being seen throughout the country. At the same time, trends towards increasing use of contraceptives, decreasing fertility, and decreasing optimal family size are being seen. Both traditional and modern leaders are recognizing the impact of an increasing population on the welfare of their people and are becoming advocates of increased child spacing and earlier childbearing termination. A variety of analyses of potential demand for family planning--including desire to become pregnant soon, desired family size, and desired child spacing--all demonstrate an enormous potential demand for family planning that can be tapped through this project.

The other health interventions, oral rehydration salts (ORS) and malaria treatment are found to be socially acceptable in their current form.

The design of this project, which builds on existing patterns of authority, communication and commodity distribution rather than attempting to build an entirely new system, is likely to be successful. An emphasis on individual profits is more likely to motivate than any amount of exhortation.

Beneficiaries: Many different groups and individuals are beneficiaries of this project. If project goals are reached, in

the final year alone, 525,000 women and their families will be the beneficiaries of family planning methods; 1,500,000 children will receive ORS; and 370,000 children will receive anti-malarial treatment. Many others will benefit directly from receiving improved health services from registered midwives and traditional birth attendants, but the actual numbers cannot be easily calculated.

In addition to the health benefits, some 10,000 private sector outlets will be provided with an additional commodity to sell, thus improving the proprietor's economic status. About 250 midwives will receive technical and business management training, and some 6000 traditional birth attendants will receive a new source of income as they practice their profession. Thus small businesses will receive a large amount of support.

Nongovernmental organizations will also benefit, as their organizational structures improve to provide family planning services through their members. This is a crucial addition to developing an effective private voluntary sector.

Women In Development: This project is directly involved in this Agency priority area. In addition to the direct beneficiaries of the project listed above, most of whom are women, a number of other WID issues are directly addressed:

Health Benefits: The technical appendix details the health benefits to women and their children. Reducing a woman's fertility from seven children to four will decrease her risk of dying during pregnancy by 43%. Controlling the frequency and timing of births also has much broader health benefits.

Empowerment: By receiving assistance to control their reproduction, women are better able to control their lives. This is particularly true for adolescents, who will be targeted by parts of the project, who will thereby be enabled to complete their education.

Status: Women are the primary people receiving training. Midwives, Traditional Birth Attendants and Market Women are already recipients of this work, and others will be added. Already these women have experienced an elevation in their status among their peers: This is particularly true for the traditional birth attendants who receive training and recognition for a professional achievement.

Employment: Support for private sector enterprise, particularly through social marketing mechanisms, strongly creates and supports employment and income opportunities for

women. In Ghana, like many West African Countries, almost all retail and most wholesale trade is in the hands of women. Improving these channels will improve their incomes and lives.

C. Institutional Analysis

Much of the institutional analysis has been summarized in the first chapter where the public and private sector institutions to be involved in project implementation are described. The major public sector issues that affect the project are the lack of resources, whether they are financial, institutional, supply or manpower. The Ministry of Health (MOH) alone needs to double the number of district hospitals and increase the number of health posts by 60% to reach its own targets, to say nothing of rehabilitating or staffing the buildings that already exist. Even at the headquarters level, trained personnel able to manage and promote the project are few in number, whether they are accountants in the Maternal and Child Health Division or artists in the Health Education Division. The project responds to these institutional needs by: (1) recognizing the need for continued supplies; (2) avoiding duplication of managerial inputs provided by other donors; and (3) providing local currency through the program assistance cash grant to allow the MOH to augment its budget and improve its own managerial system, rather than continuing the off-budget donor driven programs that have been the norm in the past.

An important part of the project is the establishment of a national population authority, which will coordinate both public and private efforts through a national population and family planning program, and will mobilize all sectors in a target-setting and program implementation exercise. This authority will enable other governmental and nongovernmental entities to become involved in the national effort. In the private sector alone, the analysis shows that manufacturing and distribution capacity is able to reach the project distribution goals. Some private sector firms have not yet become involved in distributing health products, but have expressed an interest in doing so.

Several issues must be addressed if private sector involvement is to contribute to the success of this project. The first is correcting the misconception that a manufacturing and distribution firm can easily become a social marketing firm. DANAFCO, the primary firm implementing the social marketing component of the existing project, was never able to truly develop a social marketing capacity. This project addresses this issue by removing the social marketing functions from DANAFCO and placing them under an autonomous social marketing organization, initially headed by the institutional contractor.

Because of the nature of its product, DANAFCO has served cities and towns better than rural areas. Reaching rural areas will require an entirely different marketing approach; one that is piggy-backed onto the distribution network of other types of firms that do successfully reach the most remote areas. However, reaching Ghana's rural areas requires the use of non-health professionals in the delivery of goods and services, and therefore it is contingent on the deregulatory aspects of the program assistance component of Family Planning and Health Program.

Large commercial firms that have their own health facilities are another target of this project. The family planning and health initiatives of this project can easily be introduced into the health benefits of private companies. This can produce a significant cost savings to companies in terms of reduced time lost among employees due to pregnancies and family or personal illness.

Private voluntary organizations are also another target of the project. The ones already involved in clinical care, such as the Ghana Registered Midwives Association, the Christian Health Association of Ghana and the Private Medical Practitioners Association of Ghana, will be assisted in becoming organizationally more functional and more effective as a channel of all types of family planning goods and services. In particular, these will be able to provide clinical methods such as intra-uterine devices, Norplant and surgical contraception. Planned Parenthood Association of Ghana, the most significant nongovernmental provider of family planning services, will receive relatively little assistance from USAID because it is receiving substantial assistance from the World Bank.

Non-clinical organizations, such as the Home Economics Association, the December 31st Women's Movement, the National Council on Women and Development, and a host of other national and local organizations will receive assistance in training their members as effective community-based distribution agents.

Relevant assistance by other donors is reviewed in Annex C, and has been covered in earlier sections of this paper.

D. Economic and Financial Analysis

Performing a complete economic analysis of the impact of this type of program is difficult because many of the benefits are hard to quantify. Over the six years of the project, a total of U.S. $42.253 million are to be expended. This includes program assistance, project assistance and host country contributions.

Non-quantifiable benefits identified include improved nutrition, increased educational opportunities, reduced poverty and social inequity, improved opportunities for women, decreased environmental

pressures and increased rate of development. While these are very real benefits and, indeed, some of the main reasons for carrying out the program, they are not easily quantifiable in terms of their present economic value. To calculate an internal rate of return, the quantitative analysis evaluated two factors: the impact of the decrease in population on demand for primary education and on health care through the years 2010. If the program is successful in meeting its fertility targets, these two savings alone will result in an internal rate of return of 18.8%, indicating that the project is highly desirable.

The financial sustainability of Ghana's population and family planning program is a critical factor in maintaining the momentum in increasing modern contraceptive prevalence and reaching Ghana's population and family planning goals. The Family Planning and Health Program's interventions rely primarily on mobilizing private sector resources to improve the delivery of family planning and maternal/child health services, information, and commodities. The Government of Ghana (GOG), through the program assistance component, is expected to create a policy environment which will enable the private sector to expand its role, as part of a concerted national effort to attain Ghana's population and family planning goals However, until the private sector is able to finance a large share of family planning and maternal/child health services and commodities, the Ministry of Health will require substantial resources to support family planning and maternal/child health interventions. Therefore, the project component requires a substantial contribution from the Ministry of Health, much of which will need to continue beyond the completion of the Family Planning and Health Program.

The Family Planning and Health Program is financed by contributions of $30.0 million from A.I.D. and $12.253 million equivalent cedis in cash ($2.338 million) and in-kind ($9.915 million) from the Government of Ghana (GOG). Much of the in-kind contribution represent existing Government resources which are normally available to support Ministry of Health (MOH) activities. However, the Government is expected to fully fund the budgets of the Maternal/Child Health (MCH) Division and Health Education Division, which will increase the GOG's cash outlays for the Ministry of Health (MOH). The Government will also incur major costs for support of the national population authority and procurement of contraceptives.

Although the GOG has made a specific commitment to family planning and maternal/child health, in the past resources have not been available within the MOH budget to fuel the Government's program. While the MOH is allocated 9% of the national budget, relatively high for Africa, most of the funds are used for curative care and ministry administration. This has important ramifications for improving family planning and MCH service delivery as it falls

under the rubric of primary health care, which received approximately 24% of the Ministry of Health (MOH) budget in 1988 and 1989, respectively. Barring a substantial increase in the overall MOH budget, an improvement in allocations to primary health care, including family planning and maternal/child health (MCH), can be achieved through a reallocation of MOH resources from curative to primary care.

Although primary health care represents 24% of the Ministry's budget, actual expenditures represent a much lower percentage. This is partially due to the differences between budget allocations and actual budgetary releases and low expenditures caused by, inter alia, inappropriate financial encumbrances which provide funds for activities which are not part of an MOH department's responsibilities and late releases of funds to a department, occurring too late in the financial year for the funds to be spent. Once releases become more timely and complete, actual expenditures will increase and will be synchronized with the actual budget allocation.

The budget for primary health care, including family planning and maternal child health, has increased dramatically since 1988, and if this trend continues it is expected that MOH will be able to maintain recurrent expenditures for family planning and MCH. However, it is difficult to predict the actual expenditures required to maintain a national effort until the national population authority establishes demographic and family planning goals. Nonetheless, it is expected that the national population authority will develop a plan which is financially feasible and sustainable. The institutional contractor will provide assistance in this effort, if required.

Additional resources will be available to the Government of Ghana (GOG) from the auction of the $13.0 million non-project assistance grant. These funds will be programmed to augment the regular GOG allocation to MOH for family planning, MCH and other primary health care activities. Throughout the life of the program these funds average 35% of the MOH's current primary health care expenditures based on the estimated 1989 budget. A portion of these funds will finance the budget for the national population authority and the secretariat.

A large portion of recurrent expenditures will be spent for the repurchasing of contraceptives. Contraceptives represent 22% of total A.I.D. program financing and 38% of the project assistance component. Ghana is totally dependent on donor-provided contraceptives which are sold at subsidized prices. The availability of donated supplies is expected to decrease considerably in the future. In order to maintain a high level of contraceptive prevalence and ensure financial sustainability of the national population and family planning program, the full cost of

the value of contraceptives must eventually be recovered through sales, which will ultimately lead to decreasing subsidies. Previous experience with the Contraceptive Supplies Project indicated that further price increases for contraceptives can be sustained without deflating consumer demand. As the Government removes price and importation disincentives, the private sector is expected to pick up a larger share of the importation and distribution of contraceptives at market-determined prices. Under the Family Planning and Health Program, Ministry of Health (MOH) will institute a cost recovery program with the objective of 50% recovery of the value of the A.I.D.-financed contraceptives by the end of the program and full recovery shortly thereafter. Fund management will be improved through the MOH appointment of a full-time accountant. The institutional contractor will provide technical assistance to MOH to improve fund management and to improve the Ministry's contraceptive procurement capability.

It appears that the Government of Ghana should be able to mobilize resources to maintain the implementation of a national population and family planning program beyond the completion of the Family Health and Population Program. The budget allocation to primary health care, including family planning and maternal/child care, has increased dramatically since 1988. As primary health care, including family planning and maternal/child health, is a priority of the Government of Ghana, it is not unreasonable to project that expenditures in this area will increase (as long as the Economic Recovery Program produces positive growth in GDP and revenues) and to conclude that the expenditures proposed under the Family Planning and Health Program are feasible.

XIII. INITIAL ENVIRONMENTAL EXAMINATION

Project Country: Ghana

Project Title: Ghana Family Planning and Health Project
Project Number 641-0118

Funding: $30,000,000 FY(s): 1991-1996

IEE Prepared By: William Darkins
AFR/PD/CCWA Project Development Officer

Environmental Action Recommended: Categorical Exclusion

Positive Determination_____
Negative Determination_____
Categorical Exclusion ___X___
Deferral _____

Categorical Exclusion:

This activity meets the criteria for Categorical Exclusion in accordance with 22 CFR 216.2 (c) (2) (viii) and is excluded from further review because:

The project will promote the proper use of quality family planning and selected health interventions for the control of diarrheal diseases and treatment of malaria. This will be achieved by: 1) provision of technical assistance for management, policy development and service standards; 2) training of all levels of health care providers; 3) procurement and distribution of commodities such as contraceptives, oral rehydration salts, and anti-malarial treatments; 4) procurement of vehicles and clinic equipment and supplies. The project has no component which would directly affect the environment (such as construction of roads, water supply systems, waste water treatment, spraying with insecticides).

Pharmaceuticals for malaria treatment and prophalyxis will follow WHO and AID guidelines. Contraceptives use in child spacing will follow AID and manufacturer guidelines. Oral rehydration salts mixtures will follow AID, UNICEF and WHO guidelines.

Concurrence: _____ APPROVED: _____
Bureau Environmental Officer DISAPPROVED: _____
AID/AFR DATE: _____

Clearance: _____ Date: 16 Oct 90
GC/AFR

ANNEX A

FAMILY PLANNING AND HEALTH PROGRAM LOGICAL FRAMEWORK

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ANNEX A

LOG FRAME MATRIX

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program Goal	**Measure of Goal Achievement**	**For Project Goal**	**For Achieving Goal**
The project goal is to lower fertility of the Ghanaian population through maternal and child health interventions.	1. Lowered total fertility rate from 6.4 to 6.1 by year 1995 2. Slowed annual population growth rate from 3.4% to 3.0% by 2000.	1. National and international socio-economic reports 2. Donor reports 3. GOG statistics, reports 4. Census and survey reports	1. Economic recovery and political 2. Political and financial support will continue for FP/ORT/MAL in both the private and public sectors; 3. Use of FP/ORT/MAL interventions will improve maternal and child health and will lower fertility.
Program Purpose	**End of Program Status**	**For Program Purpose**	**For Achieving Purpose**
To increase the use of and demand for family planning, through expanding the public and private sector capacity for providing FP/MCH services and supplies.	1. Modern contraceptive prevalence increased from 5.1% to 15%. 2. Use of ORS per diarrheal episode in under fives up from 33% to 50%. 3. Use of proper anti-malarial treatment per febrile episode in target groups up from 25% to 35%.	1. GOG statistics, reports 2. Demographic and health surveys and updates 3. Commodity (contraceptive, ORS and anti malarial) supply and sales reports 4. KAP, spot surveys, focus groups, special reports 5. Donor agency reports	1. GOG will further encourage the delivery of FP/ORT/MAL info and services through private sector. 2. GOG gives FP/ORT/MAL high priority in primary health care services. 3. Increased availability of family planning services and commodities will result in increased use of contraceptives. 4. Donors will be able to continue to supply on a timely basis the contraceptives needed for the agreed upon program.
Outputs	**Magnitude of Outputs**	**For Project Outputs**	
A. Program Assistance Component	A. Program Assistance Component	A. Program Assistance Outputs	A. For Achieving Outputs
1. Policy environment created for the promotion and implementation of a national population and family planning program.	1.a. National population authority established and funded by GOG. b. National demographic goals are established. c. National implementation plan developed, adopted and promulgated.	1. USAID/MOH dialogue 2. Government documents 3. Public speeches 4. Government publications 5. Published regulations 6. Published plans	1. GOG willing and capable of developing and implementing policies and action plans. 2. Significant opposition to exemptions does not appear. 3. Significant opposition to removal of price control does not develop.

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs (contd)	Magnitude of Outputs (contd)		For Achieving Outputs (contd)
	d. MOH essential drugs list expanded to include all OCS.		
	e. VFTs, ORS and chloroquine exempted from regulation under the Pharmacy and Drugs Act.		
	f. OCs redesignated as class C (all other restricted drugs) under Pharmacy and Drugs Act.		
	g. Price controls removed on contraceptives and related drugs.		
	h. Duties eliminated on commercial importation of contraceptive products, ORS and chloroquine		
	i. OCs distributed by health service providers with MOH approved training.		
B. Project Assistance Component	B. Project Assistance Component	B. Project Assistance Component	Applicable to Both Sectors
1. Increased/improved FP/MCH public and private sector service delivery	1.a Private Sector -- for GRMA 200 public/private midwives trained in FP/MCH. -- service support in FP/MCH practice provided to up to 400 maternity homes. -- system for standardization of quality FP/MCH service delivery developed/implemented/evaluated.	1.a Private Sector -- Contractor progress and trip reports, USAID site visits -- Ministry systems reports in house reviews, audits mid-term and final evaluation reports.	1. Sufficient cost recovery will be achieved for sustained private and public service delivery.

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NARRATIVE SUMMARY Outputs (contd)	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs (contd)	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS For Achieving Outputs (contd)
	-- GRMA providing in-service FP/MCH training to its members -- 45 private sector midwives trained in IUD insertion and management. -- health professionals at 5 employer-based health facilities trained in FP/MCH service provision. 1b. Public Sector -- 3,000-4,000 TBAs trained in FP/MCH service delivery and patient communication techniques -- TBA continuing education program established. -- National TBA Secretariat providing on-going support, monitoring and evaluation of National TBA Program. -- 24 doctor/nurse teams trained in surgical contraception stressing mini laparatomy and rigid quality controls. -- 15 hospitals equipped to perform surgical contraception procedures. -- 1,000 Norplant sets implanted. -- 140 nurses trained in counseling and referral techniques for surgical contraception.	1b. Public Sector -- all above plus -- MOH quarterly service and commodity distribution reports. -- Special service site quarterly reports (for VSC & implants).	2. levels of demand for contraceptive will continue to rise. Applicable to Private Sector 1. Private Sector will respond positively to the more enabling policy environment. 2. Adequate revenues from commodity-sales will be allocated to help maintain commodity supply. 3. Community based distributors will be effective F.P. promoters. 4. Expansive distribution network can be identified to carry FP/MCH products. 5. Existing national and local PVOs can be motivated to become involved in provision of FP/MCH goods, services and information.
2. Improved marketing delivery systems of contraceptives, ORS & chloroquine	2a. Private Sector -- 5,000 pharmacies and chemical sellers retailing FP/MCH	2a. Private Sector -- all above under 1.a. plus -- distributions reports -- retail audits -- NGO reports -- Employee health facility reports.	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs (contd)	Magnitude Outputs (contd		
	-- Wholesale distribution in each of 110 districts. -- 15 national and local NGOs distributing FP/MCH products. -- 5 employer based health facilities distributing FP/MCH products. -- Private Sector distribution of 39 million condoms, 39 million cycles of oral contraceptives 76 million vaginal foaming tablets, 5,000 IUDs. -- Marketing plans developed and implemented for wholesalers, NGOs, and commercial retailers. -- at least five national advertising campaigns executed. -- Retail sale price of contraceptives reflects at least 50-75% of values of product. -- Wholesalers purchasing contraceptives at least 50-75% of value of product.	-- Private Sector all above under 1.a.	
	2.b Public Sector -- Distribution of FP/MCH products by all MOH health centers: 13.8 million condoms, 3.0 million cycles of oral contraceptives, 5.2 million vaginal foaming tablets, 50,000 IUDs, and 1,000 Norplants. -- MOH recovering 50% of the value of contraceptives sold in MOH system and partially restocking supplies.	b. Public Sector -- all above under 1.a. c. all above under 1.b. plus central and regional licensed stores reports. d. Public Sector -- all above under 1.a. plus -- prototype and final copy delivered to USAID -- marketing surveys -- consumer studies e. Public Sector -- all above under 1.b. plus -- special price/demand studies -- Financial reports from RTP funds showing contraceptive purchases. e. Public Sector -- all above under 1.b. plus -- financial reports and audits of return to project funds -- purchase orders for contraceptives	Applicable to Public Sector 1. GOG will provide adequate personnel and budget 2. Complementary IPIC resources needed will be provided by other donors in order to carry out the other aspects of the government's family planning program -- especially in the public sector 3. MOH will coordinate donors 4. Demand levels for contraceptive services and commodities will continue to rise. 5. Demand for long term contraception will increase.
3. Increased availability of family planning/MCH information.	3.a. Private Sector -- Information materials developed for distribution through 15 national and local NGOs. -- Five employer-based health facilities disseminating FP/MCH information.	3.a. All above under 2.a. & 2.d.	

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs (contd)	**Magnitude Outputs (contd)**		
	3.b Public Sector -- IED planned and managed at least three (3) nationwide family planning IEC campaigns and analyzes impact on public knowledge of FP/MCH issues. -- 3 IED staff trained in IEC planning and management. -- Policy-oriented IEC campaigns implemented by PIP.	3.a. All above under 1.b and 2.d	
Inputs			
A. Program Assistance Component	A. Program Assistance Component	A. Program Assistance Component	A. Program Assistance Component
1. AID Contribution Cash Grant	1. AID Contribution ($000) Cash Grant - $13,000	B. Signed Program Grant Agreement	
2. GOG Contribution National Population Authority	2. GOG Contribution ($000) National Population - $685		
B. Project Assistance Component	B. Project Assistance Component	B. Project Assistance Component	B. Project Assistance Component
AID Contribution	AID Contribution ($000)	AID Contribution	AID Contribution
1. Institutional Contract a. Technical assistance long term and short term b. Commodities c. Training d. Local support	1. Institutional contract a. Technical Assistance - $2,659 b. Commodities - $372 c. Training - $659 d. Local support - $2,236 e. Other Direct Costs - $23	1. Signed Project Grant Agreement	1. U.S. funds are available
2. Cooperative Agreement (ACNM for TBA training and GRMA assistance)	2. ACNM - $2,431	2. Signed Cooperative Agreements	
3. Cooperative Agreement Buy-in (AVSC for long-term FP methods training)	3. AVSC - $837	3. Signed Cooperative Agreements	
4. Other AID/W buyers (DHS and Options Projects)	4. Other buy-ins - $749	4. Signed Agreements	
5. AID Contraceptives	5. AID Contraceptives - $6,500	5. Invoices, Shipping Documents	
6. AID Contractor Support	6. AID Contractor Support $172		
7. AID Financial Reviews	7. AID Financial Reviews $92	7. Executed contracts and final reports	
8. AID Evaluations	8. Evaluations $270 TOTAL $17,000	8. Final Reports	

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NARRATIVE SUMMARY Outputs (contd)	OBJECTIVELY VERIFIABLE INDICATORS Magnitude Outputs (contd)	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOG CONTRIBUTION	GOG CONTRIBUTION	GOG CONTRIBUTION	GOG CONTRIBUTION
1. In-kind (personnel, facilities equipment, supplies, field support	1. In-kind - $9,915	1. GOG Budget Reports	1. GOG funds are available
2. Cash a. TBA Program (local training costs) b. Long-term methods (local training costs) c. Demographic Health Survey (costs of enumerators and per diem) d. Options Project (Local PIP)	2. Cash a. TBA Program - $1,238 b. Long-term methods-$86 c. DHS - $115 d. Options Project - $214 $11,568	2. Project Monitoring	2. GOG provides adequate personnel, facilities and other required support.

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ANNEX B

TECHNICAL ANALYSIS

TECHNICAL ANALYSIS

BACKGROUND

The Agency for International Development, A.I.D., has provided assistance to the Government of Ghana (GOG) for family planning for almost two decades. In spite of this and other donor support to the Ministry of Health (MOH) for public sector programs and to the Ministry of Finance and Economic Planning (MFEP) for social marketing, there has been limited impact on traditional and modern contraceptive prevalence (1979, 9.5%; 1988, 12.3%) or population growth rate (1970- 84, 2.5%; 1988, 3.4%) or total fertility (1979, 6.3; 1988, 6.1). Progress was impeded by the economic climate, political commitment of the GOG and health community, including the MOH, and the management of projects.

One example of the importance of the coordination of medical, political and management support comes from the three starts in social marketing. Ghana's first venture began in 1970 following a policy declaration. The design and management for condom marketing outside the MOH was sound, but political support was weak and medical opposition strong. The impetus floundered and the project failed in 1973. USAID supported the second social marketing project for condoms, vaginal tablets and oral contraceptives in the late 1970s. Despite more support from the medical community, management problems and weak political will, compounded by a series of coups and widespread economic collapse, caused a relatively successful project to die in 1981. The third and current initiative, the Ghana Contraceptive Supply Project (CSP), shows signs that it may have the success that eluded its predecessors in that it is primarily responsible for an increase in modern contraceptive prevalence from less than 2% in 1985 to 5.1% in 1988. Now medical and political support appear intact and the economic situation is improving. Rapidly rising sales of all contraceptives during the latter part of 1989 indicate that all the factors may have come together for a rapid increase in family planning acceptors.

The GOG embarked in the 1980s on the path to health care for all Ghanaians by the year 2000. Objectives and targets are very ambitious. The donor community, which has supported the Primary Health Care (PHC) program of the MOH for several years, plans substantial increase in support to improve both preventive and curative health care coverage. As its bilateral contribution, USAID continues support for family planning, one of the elements of Primary Health Care (PHC) and a growing MOH priority. This is consistent with USAID support to the GOG

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since the early days of support for family planning. It is generally conceded, however, that family planning and PHC have bumped along a circuitous route with few notable milestones. Therefore, USAID has opted to focus its efforts on further development of a sustainable private sector program as follow-on to the Contraceptive Supplies Project. Interventions to reduce the impact of two health problems of significance to childhood morbidity and mortality, diarrhea and malaria, are incorporated into the new project to 1) link the relationship of child survival with lowered fertility and 2) better match the MOH's PHC priorities. More than 20% of children die before the age of five, and malaria and diarrhea are significant factors in mortality of those age 1-4 years. A focus on the private sector and perinatal care was selected to overcome some past road blocks to family planning accessibility and acceptability. These are sound decisions which are technically quite feasible.

This analysis is divided into several sections, all of which build on the analyses in the social soundness and institutional analyses (Annexes C and F). Following a discussion Ghana's current health and population status, a series of technical sections analyze factors affecting activities in the private and public sectors. These are followed by the contraceptive procurement plan, and then a discussion of generic technical issues that are important to the whole family planning and health sector.

Despite the division into private and public sectors, this is a unified project; it has been designed so the implementing contractor has links to both the private and public sectors, and so activities in one are coordinated with similar activities in the other.

Health and Population Status Analysis

A. Overall Health Status

The life expectancy at birth in Ghana has steadily increased since independence. In 1960 it was estimated to be 46 years, and had risen to 54 years by 1985. The increase is partially due to a successive drop in infant mortality, from 100 per 1000 births in 1973-7 to 77 per 1000 births in 1983-8. However, child mortality rates remain very high at 155 per 1000, a reduction of only 17% since the mid to late 1970s. Ghana's infant and child mortality rates are poor compared to other African countries: Nigeria in 1986 had infant and child mortality rates of 56 and 108, respectively and Botswana, 40 and 56 respectively. The major causes of child mortality are measles, malaria, pneumonia, anemia and diarrhea. These

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diseases are all part of a linked complex of causes of death: the diarrhea--dehydration--pneumonia complex is a well known phenomenon throughout the developing world. Malaria and its resulting anemia compounds the problem in Ghana. Maternal mortality also remains high at 10/1000 births. Among the many causes are lack of access to perinatal care and too closely spaced births.

A new factor that affects the health of Ghanaians is the rapidly increasing prevalence of HIV/AIDS. While the true prevalence of this virus in Ghana is not known, in 1989 alone the number of confirmed clinical cases rose from about 250 to 1250. In the neighboring country of Cote d'Ivoire, HIV prevalence as high as 30-40% has been reported in selected populations. There is some evidence that the prevalence in Ghana lies between 3.5 and 10 percent, but a full understanding of this awaits the results of epidemiological surveys that are just beginning. Since the major intervention in combatting HIV/AIDS is Information, Education and Communication, particularly by teaching safe sexual practices, extending the social marketing and IE&C parts of this project may represent a logical extension of the proposed activities. This would also be in line with with Africa Bureau policy to bilateralize all HPN activities. This project may therefore be amended following handbook 3 guidelines to include HIV/AIDS control activities.

B. Population Growth and Key Determinants of Growth

The three forces affecting population growth are mortality, fertility and migration. The first of these in terms of life expectancy and infant/child mortality has been discussed above.

Ghana's population in mid-1990 is estimated to be 14.8 million. With a growth rate of 3.4%, the population is expected to double in less than 21 years. This is caused by a total fertility rate of 6.4, which, while among the highest in the world, still represents a drop from 7.03 estimated in 1969. There has been essentially no change in the total fertility rate since 1979. Decreases in the total fertility rate are not likely until infant and child mortality rates decline and the population has access to effective family planning methods. Family planning acceptance and maternal/child health are inexorably linked.

In the 1980's Ghana's population was subjected to two opposing migration pressures: (a) in 1983 Nigeria expelled one million Ghanaians who returned home that year and (b) the economic hardships forced many people to migrate first from urban to rural areas where food was available, and then abroad where incomes could be found. This latter pressure probably affected the more educated classes of people, but no reliable statistics

are available on how this affected the total population of Ghana. Current estimates are that there are a relatively small number of Ghanaians working in other West African Countries, so the shock of a mass migration as was experienced in 1983 is unlikely to recur. Most authorities feel that in and out migration are likely to stay in balance for the coming years. However, what has not been considered, and what is not predictable is what the effect of a recovering Ghanaian economy in the midst of other West African economic collapse is likely to be in terms of its effect on migration and population pressure.

C. Current Contraceptive Use Patterns

The Demographic and Health Survey explored the current use and market segmentation of Contraceptives. Data on this are presented in the following table:

Current and Intended Contraceptive Use
Currently Married Women

Method	Current Use	Intends to Use
Pill	1.8%	24.2%
IUD	0.5%	2.5%
Injection	0.3%	20.1%
Diaphragm/Jelly	0.3%	1.6%
Foaming Tablets	1.0%	2.2%
Condoms	0.3%	0.8%
Sterilization*	1.0%	10.5%
Periodic Abstinence	6.2%	8.5%

*Intended Use includes both Female (10.4%) and Male (0.1%) Sterilizations
Source: DHS: Tables 4.6 and 4.15

While there is evidence that the true use, particularly of condoms, is underrepresented in this survey, it is very encouraging to find that several of the most effective methods--Sterilization, Injections and the Pill--are the methods that most women indicate that they wish to use in the future. The Social Marketing and Public Sector IE&C campaigns will capitalize on this. One of the most important factors is the continued availability of supplies, and in the case of IUDs and sterilization procedures, of continued clinical services. In addition, successful continuing use of the long term methods requires availability of information and counseling for women and their partners. Both the private and public sectors will need to pay close attention to training suppliers in providing this information.

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Private Sector

A. Importing and Processing of Commodities

Bulk-packed contraceptives are procured by USAID and shipped to Tema, where the distributor, currently DANAFCO, clears them from port and transfers them to their facility. They are repackaged into appropriate size containers for retail sales and enter the distribution network. While there have been some difficulties in the past, for the most part Danafco has been able to expedite importation formalities. The most important difficulty has been receipt of shipping documents from AID/Washington. For example, DANAFCO was recently notified of a shipment that had arrived at port two years ago. Because the original bill of lading was lost, it was difficult to arrange for release of this shipment from customs. A recent A.I.D. Inspector General investigation of the Commodity Procurement and Supply Division identified many of these problems and has suggested some remedies. The contractor and Mission will need to be aware of potential difficulties and be prepared to intervene more rapidly than has been possible in the past.

Raw materials for the production of oral rehydration salts are procured by UNICEF and delivered to DANAFCO. These are mixed and packaged using equipment supplied by USAID. Manufacturing quality control is maintained by a laboratory also provided with USAID support. Part of the finished product, equal in value to the value of the raw materials supplied by UNICEF, is then given to the Ministry of Health, and the remainder is available for retail sales.

Chloroquine powder will be obtained imported by the manufacturer through standard commercial channels. It will then be processed into the forms recommended by social marketing research and enter the distribution system. DANAFCO is currently capable of doing this. A major issue will be strengthening the quality control part of the manufacturing process to ensure appropriate dosing.

Issues: One of the legacies of the past project is that DANAFCO has established a near monopoly on family planning products. This was an appropriate strategy when the Contraceptive Supply Project was designed because there was no other firm with the capacity to implement the project. However, in the long run it is counter-productive. The contractor will need to monitor production and distribution capacities industry-wide, and, at appropriate time tender contracts for competitive bidding. Nonetheless, a substantial investment has been made in

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increasing DANAFCO's manufacturing and managerial capacity to produce ORS, and this investment cannot be abandoned.

B. Distribution Systems

Using vehicles provided by USAID, DANAFCO distributes social marketing products to its ten regional depots and seventeen subdepots. These vehicles are primarily intended for distribution of social marketing products, but to avoid being under-utilized, DANAFCO has been permitted to transport their own products on a space available basis. A recent audit found that vehicles were generally being used appropriately, but in some instances requests for more stock were not completely filled because the vehicles were carrying too many non-GSMP products. This has been discussed with DANAFCO and new controls are being implemented. However, it will remain an issue throughout the project.

A second issue that spans both distribution and management concerns the nature of the regional representatives. As noted in the institutional analysis, six of the ten regional depots (Accra, Ashanti, Western, Volta, Eastern and Northern) are run by DANAFCO regional managers, who are direct DANAFCO employees. These depots are functioning relatively well, and reports are being received regularly. The remaining four depots (Central, Brong Ahafo, Upper West and Upper East) as well as the seventeen sub-depots are run by DANAFCO agents who are paid on a commission basis. Reporting and stock management are much poorer in these regions. With the increasing importance of distribution to rural areas, regional and sub-regional distribution centers take on an added importance. The project will need to monitor these activities closely and ensure that sufficient supplies are being distributed to each region, and that the regional managers are actively expanding their distribution.

C. Management Systems

The management structure described in the institutional analysis should be reviewed. Within DANAFCO three issues are significant . The first concerns the relative lack of importance of the GSMP to DANAFCO's overall corporate goals. This has led to the project being relegated to a less important position, and some initiatives have not been accomplished, or have been implemented more slowly than would otherwise be the case. Part of this will be alleviated by increasing the profitability of the GSMP products. Given that the current return on all of GSMP is only 1.5% of DANAFCO's gross income, it is hard for the company to justify more managerial attention on a cost-effectiveness basis.

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The second issue is that, despite several years of technical assistance, DANAFCO has not developed the capacity to manage the social marketing campaign. Several reasons explain this, many of which--like the year long advertising ban on contraceptives--are completely beyond DANAFCO's control. However, this problem, which was originally identified two years ago in the mid-term evaluation, has not improved in the interim. Therefore this analysis concludes that it was a mistake to base a social marketing campaign within a manufacturing and distribution company. In this project design, removing the social marketing component from the manufacturer and establishing it as a separate unit under the prime contractor are proposed. Doing this will avoid many of the difficulties that the GSMP has encountered, and will not harm DANAFCO, since that company will be able to concentrate on distribution.

The final issue is that insufficient staff have been assigned to carry out GSMP activities. This may be linked to each of the two previous issues. A recent audit pointed out that DANAFCO has only one full-time GSMP employee, with the remaining support coming from part-time assistance from other divisions. This has resulted in delays in reporting, in decreased levels of oversight both within DANAFCO and of the advertising firm, and in inadequate accounting procedures. The auditors recommended that additional staff be provided to perform these functions. However, the removal of the social marketing component may well reduce the burden on DANAFCO's GSMP manager to the point that he can manage the manufacturing and distribution network effectively. Even with this change, lines of responsibility will need to be established to ensure that he is able to get the accounting and secretarial staff support to accomplish his tasks.

While DANAFCO is unique in this project, this analysis concludes that any other pharmaceutical firms will encounter similar problems, and that simply changing firms will not eliminate any of the issues.

Beyond focussing on DANAFCO, a separate management issue will arise when more than one distribution channel is functioning to provide commodities to market. For example, the Unilever network is a possibility. The project team will need to be alert to the complications that can arise and be prepared to negotiate agreements that will satisfy each party.

Another generic management issue that will require significant attention is the coordination of all groups that are participating in the GSMP effort. Certainly improving

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advertising agencies' understanding of social marketing as being something more than marketing is one of these issues. Market research has also not been carefully tied into these campaigns. Certainly, there has been little coordination between DANAFCO's activities and those of the MOH. One of the main reasons for this is that each piece of the previous project was carried out by a separate cooperating agency, who sent their people to Ghana for short periods for specific purposes, and who were rarely coordinated with each other. The major step taken by this project is to have a single firm with resident advisors who will manage needed consultants, provide program and technical assistance needed, and will keep the project moving in a coordinated fashion.

D. Social Marketing

The major issue to be resolved in a follow-on social marketing program is whether there is any possibility that it will succeed better than any of its three predecessors. The history has been briefly reviewed above, and socio-cultural changes that indicate possibilities for success are included in the social soundness analysis.

Consumer Interest

An analysis of potential consumers couched in a marketing perspective provided insights helpful for deciding about options to choose in Project design.

The Ghana Demographic and Health Survey (DHS) found that three fourths of female respondents approved of family planning products, and over half thought their husbands also approved.

Ghanaians need much more information about modern contraceptives than is currently available. When questioned about specific methods in the DHS, many women said that they were unaware of the method (26%), were not familiar with its use (24%), or perceived it as irrelevant to their needs (26%). Advertising specific family planning methods will be a necessary supplement to the generic information, education and communication (IE&C) campaign that the Ministry of Health is planning.

Several indicators show that the monetary price appears to be no barrier to use. It is worth noting that the social and personal cost of sub-fecundity for Ghanaian women and men can be great. In addition, for women, the most significant cost is the time needed to seek out and acquire regular supplies.

The accessibility of the places where contraceptives can be acquired probably has significant influence over contraceptive

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use. The Project mandate is to extend availability to rural areas where 70% of Ghanaians live.

These indicators point out the serious limitation of confining contraceptives to a pharmacy/chemical shop network, which largely serves urban areas. Nonetheless, for those who use modern methods, almost 75% currently obtain their supplies from the private sector (32.5% from pharmacy/chemical sellers, 20% from Planned Parenthood Association of Ghana, and 20% from friends/relatives/school); private doctors were mentioned by only 1.3%. Even when IUDs and sterilization are included, the private sector is the largest supplier of these goods and services. The project is entirely on target when it emphasizes strengthening private sector distribution.

In Ghana as in other countries, social marketing programs have depended on retail sales. To solve accessibility problems, then, the first option is to enlist small retailers of consumer goods. Less attention will be given to private practice providers and hospitals, and to community based voluntary groups and professional associations. The consumer goods retail system is also technically more feasible because the distribution network already exists and shops are regularly supplied.

Information, Education and Communication:

The key to increasing use of family planning and other health commodities appears to be promotion. Even the best strategy for supply cannot be viable if products are not in enough demand to translate into sales. Even if demand is high, the products must be used correctly to obtain satisfactory and satisfying results. The DHS findings demonstrate that Ghanaians do not know enough about the use of Contraceptives, ORS or Malaria treatment. If these interventions are to become relevant to lifestyle and "habit-forming," they must be better understood and perceived by potential and current users as both meaningful and beneficial.

The Project will, as described in the text, heavily stress a variety of information, education and communication (IE&C) techniques which would provide the basis for an individual's selection of a suitable method. The option for mass media advertising of brand specific GSMP products was chosen as a first priority, with more generic family planning IE&C campaigns as a second emphasis for reinforcing widespread advertising. Communication through both techniques was deemed critical to Project success in order to create the initial demand and to stimulate continued use.

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E. Provider Interest

Providers represent the supply side for the Project. The different provider groups selected represent diverse skills, motivations, and background. The rewards requisite for initial and sustained interest in acting as contraceptive suppliers may differ, but individual providers all need to believe that adequate incentives are available.

Private sector providers fall under three classifications: private medical, non-professional or non-medical NGOs, and the commercial sector. Each group is analyzed for: 1) potential interest, 2) technical options for contraceptive methods, and 3) supply on a sustained, cost-effective basis.

1. Private Practitioners

Private practice medical providers to be assisted will largely limited to physicians, although some ties to traditional healers will be sought. Private services are available from doctors and midwives. Nurses, because of legal restrictions against private service, can only work for independent doctors.

A private doctor's income depends on fees for services rendered and sale of drugs, although the latter is technically illegal. Most physicians and, indeed, most Ghanaians who use their services are not accustomed to the idea of paying for advice or preventive services, including family planning. However, this changes if technical skills are employed, as is the case with IUDs and surgical contraception. Teaching private practitioners these skills will significantly expand the number of sites where these services are available.

The DHS confirms that private physicians are not currently being used as a source of supply. The major reason for this is that approximately 300 physicians are in private practice, and they are concentrated in the urban areas around Accra and Kumasi--those areas where other channels of family planning goods and services are already plentiful. Their support for other family planning providers, however, is important. The Project will include assistance to professional associations of physicians, especially the Ghana Medical Association, which registers all doctors as members. Arrangement for conferences and workshops as well as long-term method training for a select group is included in the program design. This is a relatively low-cost, simple intervention intended as much for advocacy as development of another service delivery mode.

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Midwives offer the best potential for expanding private family planning practice. Many already operate maternity homes. As described in the institutional analysis, the Ghana Registered Midwives Association (GRMA) has been working with the American College of Nurses Midwives since 1987 to upgrade member's family planning and management skills and to organizationally strengthen the association. The GRMA has over 600 members, most of whom are in private practice. Membership has been growing rapidly, and GRMA's growth and activities are a real stimulus to the 8000 Ghanaian registered midwives to consider becoming more entrepreneurial. In the past, almost all private midwives were retired MOH employees; today more younger women are moving to the private sector.

The major issues which constrain private practitioners are the absolute numbers of professionals available--primarily true of physicians--and financial constraints on entering and maintaining a practice. Until the economic recovery reaches a point when credit to small businesses is a reality, little can be done other than to train in business practices to improve cash flow. Priority will be given to those private practitioners most interested in delivering long term methods (injectables, Norplant, IUDs and sterilization) and those most accessible to rural populations.

2. Non-Governmental Organizations (NGOs)

As described in the institutional analysis, a wide variety of NGOs operate in Ghana. These will not be repeated here, except to address some major technical issues. For the most part, established NGOs will be supported over new NGOs, although, if sufficient potential exists, a new NGO may receive assistance.

Experience with many NGOs, including GRMA, has demonstrated that most of them need assistance with training their members, with access to commodities for resale, and with management and business skills. These can be readily provided and can make a significant impact on the effectiveness of the NGO with relatively little commitment of funds. The project will establish an NGO coordinator, who will assess each NGO's needs, and then make recommendations and help mobilize the assistance that each needs to become most effective. In addition to assisting NGOs that actively seek out help, this individual will attempt to mobilize other NGOs which have potential that they themselves have not yet realized.

The primary assistance that most NGOs <u>want</u> is vehicles, which they believe will solve all of their problems. Since provision of vehicles in the past has hindered some in addressing

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management problems and has ultimately slowed sustainability (since they do not have the resources to replace a vehicle once it is worn out) this project will rarely consider vehicles to be appropriate assistance to NGOs.

3. Commercial Sector

The goal with the retail arm of the private sector initiative will be to expand the range of existing outlets in both urban and rural areas. Present coverage of pharmacy and chemical sellers appears to be satisfactory. DANAFCO, the pharmaceutical distributor for the GSMP, however, has little capacity to expand beyond this network. Its business is drug products, and GSMP, which account for a reported 1.5% of profits, is a minor addition to DANAFCO's line of pharmaceuticals.

DANAFCO, the implementor of the GSMP under the existing project, has established 10 depots and 17 sub-depots for commodities throughout the ten regions. Four regions have DANAFCO warehouse (depots) and six have contract wholesalers (depots) which DANAFCO supplies. These depots service the 400 pharmacies and over 3000 chemical sellers, most of whom are located in regional or district capitals. In 1988, 57% of pharmacies were in Accra, while only three pharmacies and 10% of chemical sellers covered the entire northern three regions.

The Project now must move into a phase of distribution through intensive consumer goods networks. This will enable broader coverage of urban markets and deeper penetration of rural markets. One analysis conducted as background for this project investigated the capabilities of the GOG distributor, Ghana National Trading Corporation, and four private distributors. It found that two companies exist which have national networks and have an interest in distributing Ghana Social Marketing Program products. These are Pioneer Tobacco and G.B. Ollivant, a Lever Brothers subsidiary. Ollivant handles a wide range of goods from fast moving consumer items such as soaps to consumer durables, including building materials. The company operates out of its main warehouse in Accra and uses its own trucks to deliver to 10 regional depots. Attached to each regional depot is a delivery vehicle and motorized salesmen. The depots deliver to some 240 franchised wholesale/retailers. Its organization is well run and it has a very good reputation in its field. This is an excellent organization for distributing products such as condoms, vaginal foaming tablets (VFT), oral rehydration salts (ORS) and malaria tablets. If constraints on sales of oral contraceptives can be lifted, this would be an excellent means of distribution of these commodities as well. Initial contacts with representatives of Ollivant have indicated that they may be willing to handle these products.

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Pioneer is a subsidiary of British American Tobacco Industries. It also has Ghanaian shareholders (55%) including the government, local institutions and individuals. It is one of the largest industrial companies in Ghana. The company has 20 distributors who receive products weekly. Distributors have their own delivery vans and bicycles and employ their own sales staff. With the exception of one route in the north of the country which operates on a fortnightly cycle, the distributors' sales force reaches more than 20,000 retailers every week. These retailers range from hotels, supermarkets, bars, nightclubs,
restaurants to kiosks and hawkers. Contraceptive social marketing and health products proposed under the FPHP project would include condoms, VFTs, ORS and malaria tablets. Pioneer provides a tremendous potential for reaching beyond the urban areas, and has an excellent potential for non-prescription products. Preliminary indications are that they have the capacity and would be willing to consider adding non-prescription products to their line, but only if they can "piggy-back" on their existing products. They would not want to add new outlets to the sales routes.

Both present excellent opportunities for gaining the coverage required to meet Project objectives. A serious dialogue between the MFEP, the Ministry responsible for the GSMP, the MOH, USAID and chief executive officers of these or other large companies should begin as soon as possible so there is a clear understanding of the imperative for extending products within reach of far more of Ghana's population. This will assure that Government Ministries lend full support to sale of condoms, VFTs and, perhaps, ORS by consumer good stores.

Matching the commercial retail sector with the GSMP products is a compromise between of Project objectives and merchant objectives. It is also more cost effective than spending energy on enticing and supplying private practice doctors or non-medical NGOs. The limitation, of course, is in the methods these retailers will be allowed to sell. While condoms and VFT have proved acceptable to Ghanaian consumers, as mentioned earlier, these two methods alone cannot achieve the Project objectives or goal. They can be viewed as starter products, which will lead to later use of more effective methods.

F. Pricing

Promotion may help convince retailers to buy and stock products, but price is the key factor in this equation. The Program grant to the GOG calls for lifting price controls at the wholesale level. The issues surrounding price control,

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free market adjustment, and return of an accelerating percentage on USAID donated commodities by DANAFCO is dealt with in the body of the Project Paper. The impact, however, is a concern for the technical analysis. Initially, DANAFCO will be charged 20% of commodity value. This will rise to 50% by the end of the project. This cost will naturally be passed along to wholesalers, retailers and finally customers. The entire success of this plan rests on the elasticity of demand for these contraceptives. There is very little experience, either in Ghana or elsewhere in the developing world, that allows quantification of this. However, a 'natural experiment' was performed in Ghana in 1989 when the wholesale price of commodities was doubled. There was no decrease in wholesale sales as a result, indicating either that price elasticity was low or that the price increase was absorbed by the retailers who were already charging what the market would bear. Fortunately the starting price of the current products is unnaturally low, indeed, the lowest in Africa; three condoms cost about the same as a box of matches and oral contraceptives are cheaper than a bar of soap.

Freedom from price control is a stimulus to all levels of the distribution chain. It will mean, however, that retailers may be less inclined to buy products with higher wholesale price tags until steady consumer demand is clearly demonstrated. Project management will need to pay special attention on an ongoing basis to the dynamics of market response when this restriction is removed. The project is in a good position to monitor and adjust prices when necessary. It is likely that DANAFCO will continue to be the primary wholesaler to both its own pharmacy network and to consumer goods distributors.

During the existing project, prices of commodities provided by the MOH, Planned Parenthood of Ghana (PPAG) and the GSMP were set in the same range to reduce competition and leakage from one sector to another. This served a useful purpose in establishing the precedent for payment for commodities from the MOH and PPAG. In the current project, where retail prices will be allowed to rise, price competition may occur, but this is expected to have a salutary effect in not allowing over-pricing of needed commodities. In effect, those who can pay will have commodities available to them; those with low incomes will still be able to receive services from the MOH.

Users fees for USAID donated contraceptives are ¢15 for OCs, ¢25 for 12 VFTs, and ¢10 for 4 condoms; these same products in 1988 retailed at ¢50, ¢60 and ¢20 respectively. It is unclear how the PPAG's community-based distribution (CBD) project may be changed or shifted away from retailers by the proposed World Bank $5 million grant, but PPAG does expect to expand CBD activities.

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In short, competition for GSMP products is likely to continue and, perhaps, even increase. The impact of this will be close monitored, and prices will not be allowed to fluctuate without control. The Project staff, USAID and the MOH will need to monitor the situation closely and maintain a dialogue about ho to address this competitive price issue.

The establishment of brands will discourage leakage from the public to private sector. The MOH believes the diversion out the public sector will be curtailed as institutions and their employees are made accountable for drugs they now sell to patients (full cost recovery of drugs is a recent MOH policy).

Retail sellers of consumer goods products may need to be convinced to buy GSMP products. Even though profits may seem adequate, these products are unfamiliar to them, and they may view them as untried for their market. Before investing in a purchase, retailers may choose to see first how their competition fares. The Project has several options. One is tc hire a temporary promotional sales force to blanket a marketing area. This personal approach can be very persuasive; it is mor costly, however, and requires organization, hiring and scheduling. Typically these sales representatives work on a commission and/or bonus basis in a territory, so incentives are built in. Another option is to distribute pre-sales information to retailers on new products. Well-designed trade promotion materials can be very effective. A third option is to offer a special first purchase price, substantial discounts for quantity purchases, or special two for one offers. Prizes or sales awards can be another inducement. An option not recommended is to simply load products on a distributor's truck and see what happens. The Project team should have the option of trying one or several promotional techniques suitable to the Ghana retail sector for launching contraceptives into the consumer goods market. Resources for stimulating retailer interest are included in the Project budget as an IE&C input.

One final issue on the problem of pricing is that the cost of contraceptives in Ghana is much lower than in the surrounding countries, sometimes by a factor of tenfold. This leads to leakage of contraceptives out of the country to other African countries. GSMP products have been seen in Cote d'Ivoire, Togo and Nigeria. It is not known how large this problem is. Certainly, considered in a regional sense, there is little to be concerned about since the commodities will still be used for their intended purpose. However, exportation of subsidized contraceptives intended for Ghana does cause some difficulties in sales attribution and internal impact. Some guesses as to

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the extent of the problem have been made, but until an extensive retail audit of much of Western Africa is undertaken, precise knowledge will be lacking. Increasing prices of contraceptives in Ghana, as is proposed in this project, combined with increasing internal contraceptive supply projects in the surrounding countries should help counter this trend.

G. Feasibility of Using Non-clinical Providers

Over the past decade, extensive experience with the use of auxiliary health workers has been gained. While difficulties have been experienced, if health care trainees are educated according to their educational level and cultural background, and are adequately supervised and managed, they have been found to be effective in delivering appropriate health care in their communities. Literacy is not even an absolute requirement if appropriate record keeping materials for non-literate providers is created.

To some extent, the issues of distribution by non-professionals is moot, since in practice all pharmaceuticals are available without prescription. However, since the network of pharmacies and chemical sellers only reaches the major population centers and, thus, is inaccessible to 70% of Ghanaians, most people rely on itinerant traders for what few drugs and nostrums they can get. From this point of view, any efforts that USAID can make to raise the quality of product and distributors will be an improvement of the existing situation.

The specific project interventions given here lend themselves to implementation by low level community health workers in that each commodity is dose packed and educational messages will be carefully developed and tested to ensure that they communicate the message that is intended. Appropriate supervisory structures are important, and the project is building them in as well, particularly in the TBA project.

Contraceptive training is not a vital need for retailers of non-clinical methods. Also, such training is costly, logistically difficult, and often ineffective. Experience has shown that retailers and customers rarely talk about contraceptives.

If informing consumers is the objective of pharmacy or chemical seller training, consumer inserts or flyers with product displays usually convey the necessary information in a more private way. If the MOH still believes training is necessary and the special sales force is an option selected by the GSMP, these salespersons can double as an education team using as primary tools their trade promotion materials.

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Training for pharmacy and chemical sellers about OCs probably should continue. New approaches are needed, perhaps stressing more use of counter manuals, algorithms and permanent wall charts. Such self-instruction materials have an added bonus; the regular in-store salesperson may not be (and is not usually) the same as the store owner who underwent more formal training. If good, understandable counter materials are developed for pharmacies and chemist shops, they might later be used or adapted for other retail stores if and when OCs are more freely available.

Public Sector

In the current project, there are four main inputs to the Ministry of Health: (1) contraceptives, (2) money from the program assistance, (3) technical assistance for the implementation of effective, safe long term and permanent methods of contraception, and (4) information, education and communication technical assistance for the Health Education Division.

One of the major focuses of the existing Contraceptive Supplies Project was on support of the Ministry of Health family planning programs. The mid-term evaluation of that project provides a good analysis of the technical factors that apply to the current project design. The evaluation found that enormous progress had been made specifically in that:

-- a plan of action had been developed to improve contraceptive supply management and a reporting system developed and implemented.

-- MOH supervisors have visited all regions, districts and health centers in an effort to improve the reporting system and ensure availability of contraceptive supplies;

-- MOH has cleared all expired contraceptives, redistributed overstocks and distributed new contraceptive supplies;

-- a training plan for improving data collection and analysis skills at all levels was developed, and 100 regional and district supervisors were trained; and

-- a streamlined reporting form for contraceptive supplies and usage has been developed to reduce workload, allow unified reporting to all donors, and provide greater accountability of revenue raised from the sales of contraceptives.

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Despite this progress, significant issues remain to be resolved. The mid-term evaluation found that:

-- despite improvements in contraceptive logistic management, the MOH logistic system has not improved and remains fragile, in need of additional technical assistance and monitoring;

-- distribution of commodities from the central warehouse to regional stores is relatively smooth, but distribution from the regional level to the district and lower levels remains problematic due to the lack of transport;

-- MOH procedures for reporting and remitting return to project (RTP) funds are grossly inadequate, and represent a continuing loss to the MOH and to the project;

-- MOH has not submitted regular reports to the Ministry of Finance and Economic Planning (MFEP);

-- MOH has experienced significant implementation delays because of the difficulty in obtaining money from the MFEP for such activities as port clearance of commodities.

Most of the difficulties center around inefficient management within the Ministry of Health. For example, while inadequate transport is cited as a root cause of little or no supplies at the periphery, fully two-thirds of donor supplied vehicles are inoperable due to a non-existent vehicle maintenance and management system. To address this specific problem, the major donors are supporting an evaluation of the current vehicle situation, to recommend specific action. Movement on this front is a pre-requisite if donors are to supply additional vehicles to the MOH.

Flow of money into the MOH both for special expenditures such as port clearance of commodities as well as for ongoing expenses is irregular at best. This has been described under the MFEP section of the institutional analysis. A major goal of the local currency generation part of the non-program assistance in this project is to overcome these difficulties. These cedis should be sufficient to ensure that the various units of the MOH receive the funds that they need to function effectively in a timely fashion. If this does not occur, the project will need to consider the impact and will need to consider whether to shift funds away from the MOH until the management difficulties can be resolved. Given the nature of the problem and the number of donors currently involved, it is unlikely that USAID resources can be successfully used in directly providing technical support to the management unit.

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In 1990, USAID attempted to conduct an audit of this fund. Despite four months of assistance, the MOH was unable to provide sufficient documentation of the fund for an adequate audit to be performed. This was not a new finding, since each previous audit had found the same thing. However, with the implementation of the new project, the issue of financial management within the MOH is at a crisis situation, and will soon adversely affect donor contributions to the MOH. Recognizing the great difficulties involved in building an adequate accounting system, and not wanting to interfere with the current management assistance that is being offered by the World Bank, UNICEF and UNFPA, USAID recommends changing the nature of the return to project (RTP) fund. Funds will be deposited in the RTP fund based on the number of commodities sent to the regions, and will not be based on strict accounting of funds from district to region to headquarters. This fund will be used solely to purchase more contraceptive commodities, unlike the current project where the fund serves no specific purpose. This will simplify procedures and will establish mechanisms within the MOH to procure commodities.

As in most countries, including some developed ones, the Ministry of Health devotes most of its resources to the provision of curative care. This emphasis cuts all the way to the health center level in Ghana, where separate staffs deal with preventive and curative care, and even report to different supervisors at the divisional and regional level. MOH staff, as in most countries, primarily see their job as curative service providers. A salutary effort currently underway is a changing emphasis from national to district control. However, this process must be watched carefully. With resources extremely scarce, it is unlikely that districts will have the political will to put a primary emphasis on preventive rather than curative health care.

Unfortunately, even staff trained for PHC allocates family planning to a lesser priority and often restricts it to specialized personnel. Clinic staff often operate in ill-equipped and difficult work environments. Pay is low, the workload is heavy, and mid-level workers usually have little autonomy under the supervision of senior staff. There is no extra incentive for adding family planning to their daily routine. In addition, the price of promoting family planning in an atmosphere not conducive to relaxed or private client-provider dialogue is probably higher than most MOH employees can afford. Thus it is a common sight to observe well-child clinics where no family planning education is provided. In the long run, family planning will not reach the target levels unless staff at all levels, in all types of

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positions, are recruited as family planning advisors. The extent to which this can be taken is demonstrated by one clinic where the gatekeeper was found to be the most effective counselor. This person was out in the yard with people waiting to be seen, and was available for conversations without the cultural barriers that normally surround health workers in their white coats.

The Contraceptive Supplies Project provided technical assistance and other inputs to the MOH for training all categories of medical staff at B and C level facilities; 3,400 doctors, midwives and nurses were targeted for training by tutors whose skills had been upgraded, also through project training. In addition 3,000 TBAs are being trained for pregnancy management and family planning. MOH statistics show 213 persons trained (35 tutors and 178 service personnel) from mid-1987 to mid-1989. Assistance by the American College of Nurse-Midwives (ACNM) for TBA training in the 5 regions for which USAID has assumed responsibility, namely Volta, Northern, Upper West, Brong Ahafo and Central, is expected to produce these numbers of TBAs with the required trainers and supervisors. Except for TBA training and monitoring, which are high priority for the MCH/FP division, the MOH has developed the capacity to continue training of its staff without further technical inputs. With the assistance of cedis generated by the non-project assistance, this training should be able to proceed unhindered.

In order to reduce fertility and growth rates, however, as well as to sustain medical support for family planning long-term method training is important. The previous project established the MOH's ability to train both nurses and physicians in IUD insertion techniques. In this project, technical assistance inputs for expanding the number of MOH personnel and institutions capable of performing minilaparotomy surgical contraception procedures (as well as implanting Norplant in the future) is necessary. The Association for Voluntary Surgical Contraception (AVSC) has taken the lead in developing methods for teaching safe surgical contraception procedures and for ensuring long-term quality of care. As part of their commitment to quality long-term care, they are rapidly moving into the field of adding Norplant to their training skills. This experience will be a useful addition to the project armamentarium.

In addition, the project will supply technical support to the Health Education Division (HED) in their nationwide educational campaigns to promote the use of family planning, oral rehydration therapy, and malarial treatments. Over the past two years, with assistance from the contraceptive supply project, the HED has grown rapidly, and has added skilled staff that can

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form the core of an effective communications unit. The primary issues that will hinder this are the financial ones listed above. Even with the program assistance funds it is uncertain whether the MFEP will increase the budget of the HED to the point that it can carry out these activities. It is also uncertain whether the MFEP will make this money available early enough in the year for it to be used effectively. These developments will have to be monitored closely. If it is not done, then USAID will need to engage the MFEP in a dialogue to endeavor to overcome roadblocks, and, if that fails, reprogram technical support money to the private sector IE&C campaigns.

Contraceptive Procurement Plan

At the beginning of the project, both the private sector and the public sector will have a full, i.e. at least two year, supply of all contraceptive commodities. To accomplish this, approximately $1.5 million worth of contraceptives will be brought into the country from existing funds before the beginning of the project. The project intends to leave both sectors with a two year supply of these commodities.

One of the main accomplishments of the previous project was improvement of the contraceptive supply system, particularly insofar as port clearance and entry into the Central Medical Stores were concerned. Still, managing the Central Medical Stores and distributing commodities throughout the country are difficult tasks. Substantial work has been done with the assistance of the World Bank and UNICEF, and this will continue over the next five years. In addition, UNFPA will also be providing managerial inputs to the supply distribution and management system in the MOH. While USAID and the prime contractor will need to monitor the system, additional inputs would appear to be superfluous.

An estimate of the numbers of commodities distributed by year and a projection of the increase for each year of the project are in Table 1, along with the price adjusted for 5% inflation. The figures for 1988 and 1989 are actual distribution figures, and the projected growth rates are a combination of straight line projection, or, when that yielded results that appeared too optimistic, projections based on actual experience in other countries. As can be seen from the third table, CPR (Contraceptive Prevalence Rate) by method, this procurement schedule will provide sufficient contraceptives to reach a 12.8% prevalence rate, and will cost about $6.5 million. In addition to this, the return to project fund is expected to inject another million dollars worth of contraceptives into the system, which should provide sufficient contraceptives to reach about 14.5% CPR. Given the World Bank, International Planned

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Parenthood Federation and UNFPA contraceptives that are programmed over the next five years, sufficient contraceptives should be in country to reach the targets. This leaves an adequate margin; contraceptive supply will not be interrupted at the end of the project. Additional contraceptives can be acquired should the targets prove to be too modest.

A major issue in contraceptive procurement is whether AID/W will be able to provide sufficient commodities on time. Delays in shipment have caused problems in the past, as has problems in transmitting the paperwork, specifically the bills of landing. As the numbers of contraceptives being shipped by AID/Washington has burgeoned, manufacturing, management and shipping capacity have been strained. A recent Inspector General report has addressed some of these AID/Washington issues, and it is hoped that they will be resolved. However, should AID/Washington prove to be an unreliable source, USAID/Accra and the prime contractor will need to examine the possibility of direct procurement.

Generic Technical Issues

Health Impact of Reproductive Behavior

There are four reasons to believe that women who limit their fertility will have better health.

(1) Each time a woman becomes pregnant, she is at risk of pregnancy complications that she does not face if she is not pregnant. Thus, over the course of a lifetime, women who have many children are more likely than women who have fewer children to experience reproductive morbidity or mortality. The risks associated with pregnancy include pregnancy induced hypertension, ectopic pregnancy, hemorrhage, obstructed labor, infection and, for some, hazards of unsafe abortion.

In Ghana, maternal mortality is estimated to be 1000/100,000 live births, which is ten times the mortality experienced in industrialized countries. A woman who has the national norm of seven pregnancies will have about an 7% chance of dying of pregnancy related causes during her lifetime. Were she to reduce this to 4 pregnancies she would reduce her risk to 4%, or, to put it another way, she would experience a 43% reduction in risk of dying simply from pregnancy. Other significant risks in Ghana include a very high incidence of ectopic pregnancy, although exact figures are not available, and a high incidence of abortion. Indeed, the MOH officials state that abortion is the most common form of birth control in Ghana, although

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again, exact figures are not available. (In accordance with the Mexico City Policy, no funds from this project will be used to support abortion activities.)

(2) Women who control their fertility can avoid pregnancies that pose higher-than-normal risks to their health. First pregnancies, particularly those that occur in women less than 17 years old carry between 4 and 10 times the risk of a subsequent pregnancy. Women with more than five pregnancies have between 1.5 and 3 times the risk of women with fewer pregnancies. Older women also experience higher risk, although this is more difficult to quantify.

The 1988 Ghana Demographic and Health Survey showed that 4.2% of women had their first birth before age 15, and 23.3 between ages of 15 and 17. Therefore, more than a quarter of Ghanaian women unnecessarily experience a higher risk of dying than they would if they had methods available which would allow them to postpone childbearing. The same survey showed that 76% of Ghanaian women who have completed childbearing (ages 45-49) had more than five births, again placing them at higher risks for morbidity and mortality. Interestingly, of this age group, 36% also had their first child before age 17, which places them at risk at both ends of the age continuum. However, trends indicate that teenage deliveries are decreasing in that only 23% of women aged 20-24 had their first child before age 17.

(3) The use of contraceptives may have a direct effect on a woman's health. Studies have shown that oral contraceptives decrease the risk of iron deficiency anemia, which is a severe problem in Ghana. This method also reduces the risk of pelvic inflammatory disease by as much as 40%, which is also widespread in Ghana. The risk of endometrial and ovarial cancer is also reduced by a similar amount. Adverse effects are discussed under each method below.

(4) A general improvement of health may be caused by decreasing demand on limited family resources. Families with fewer young children to care for are likely to have more resources, including time, food and money, to devote to the health and nutrition of each member.

Data also indicate that family planning has a salutary effect on the health of children as well as that of the mother.

(1) Child survival is strongly associated with longer intervals between birth. Several studies indicate that if the inter-partum period is less than 24 months, mortality is

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1.8 times higher in the first year of life. Interestingly, the older child is also at risk if the next birth occurs too soon. Having another child within twelve months more than doubles the older child's risk of dying.

(2) There is some evidence that children born to either very young or very old mothers are at higher risk, but this effect is small and the studies have been inconsistent.

The old adage that birth control helps prevent "too soon, too many, too late" births has been demonstrated to be true. These data indicate the extreme importance of delaying first birth, of postponing subsequent births, and terminating childbearing early. All of these are included in the educational programs of this project.

Technical Commodity Issues

Background

This project will deal with the provision of a variety of medical products that, in many countries, have restricted distribution. Specifically, the project will be involved with distribution of condoms, vaginal foaming tablets (VFT's), oral contraceptive pills (OCPs), intrauterine devices (IUDs), Norplant, oral rehydration salts (ORS), and chloroquine. In addition, selected professionals will be trained in minilaparotomy under local anaesthesia female sterilization procedures, and some may be trained to perform vasectomies. Each of these raises issues of safety and efficacy, particularly when distribution by non- professionals is being contemplated.

Safety and efficacy

Several general safety and efficacy issues arise that apply to all methods. While efficacy rates cited from laboratory experiments is quite high for most methods, use-efficacy, or the effectiveness of a particular method when used in everyday life, is quite a different matter. Most of these methods have a theoretical efficacy of near 100%, and a laboratory efficacy in the range of 90%, but a use-efficacy that can be as low as 50%. One issue that must be addressed in counseling--but is often ignored--is the question of how to deal with method failure. A person who has experienced a failure with one method may be unwilling to try another.

Drug Classification

In Ghana, drugs are classified according to two systems: 1) how dangerous they are, and 2) what level of health care should use

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them. The Pharmacy Board classifies drugs by safety into three groups: A-Dangerous drugs; B-Narcotics; and C-Others. The second classification system in the essential drug list ranks drugs according to their appropriateness to a level of care. In this system, "A" drugs are to be available to community health workers, "B" drugs to health posts and centers, "C" drugs to hospitals and "D" drugs for specialty care. Commodities being supplied under this project fall under many of the possible combinations of these two systems--with the obvious exception that no narcotics will be provided.

Safety and efficacy of FP products

1. Condoms

Side Effects: The only major side effect is allergy to latex. This occurs rarely and has no major health impact.

Failure Rates: Since condoms require use for each coition, failure rates due to incorrect or irregular use are relatively high. While theoretical failure rates are in the range of 2% per couple year, use failure rates in developed countries are about 12% per year. More recent and unconfirmed studies suggest that failure rates may be much higher, in the range of 50% per year. This emphasizes the need for good information, education and communication (IE&C) activities to teach appropriate techniques, as well as better training for method providers.

This issue will be met by better IE&C programming and training of suppliers with particular attention to storage and display. Condoms will also no longer be sold in strips but will be repackaged into a light-proof container.

Storage and Transport: Storage is a particular problem with condoms. The latex used deteriorates quite rapidly when exposed to high temperatures and ultra-violet light. Since all condoms provided by USAID are supplied in transparent/translucent films, the distributor should repackage them into user packs, and retailers should be taught that they should never be exposed to direct sunlight. Six hours of ultra-violet exposure will reduce burst strength by 83%. This has particular implications for market women/street vendor programs, where commodities are commonly displayed on a tray carried on the vendor's head. The project will teach appropriate storage and display techniques to distributors.

In Indonesia, use breakage rates for stored condoms is 49% after 42 months in a tropical warehouse, compared to 7% for unaged condoms. This 7% rate compares very unfavorably with studies from UK which found a 0.6% breakage rate. Sequential studies of

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stored condoms reveal a sharp decline in air burst volume tests after 12 months of tropical storage. This has important implications for logistic management. Because of difficulties with transport and supply, the MOH has requested a 31 month supply of condoms on hand at all times. While both the medical stores at Tema and DANAFCO central stores are air-conditioned, regional medical stores and some DANAFCO depots and sub-depots are not. Currently the MOH requests a six-month supply of condoms at the regional level, and four-month at district/local. This may result in severe deterioration that can only be addressed by more timely logistical support, coupled with lower regional stock levels.

In an attempt to quantify this problem in Ghana with the assistance of the World Health Organization, the MOH is establishing a condom quality control center under the auspices of the Pharmacy Board. When the extent of the problem is known, specific actions can be identified to resolve the issue. In particular, the number of month's supply held at each level of the system will be evaluated and optimized in terms both of necessary supply to avoid stock-outages as well as maintain optimum product quality.

Classification: Condoms are not classified by the Pharmacy Board, and are freely allowed to be sold.

Other Comments: Condoms are important in health programs, particularly in the USAID-supported AIDS/HIV and other sexually transmitted disease programs. Condom use is the only method--except for abstinence--that is effective for preventing transmission of these diseases. This affects the family planning program in that sales statistics will not reveal the intended use of the condoms. Much condom use is with casual partners as a prophylactic measure rather than with regular partners to prevent pregnancy. IE&C campaigns will be designed to reduce the stigma attached to condoms and promote them as a regular method with one's usual partner.

2. Vaginal Foaming Tablets (VFTs)

Side Effects: Conceptrol, the VFT provided by USAID in Ghana has Nonoxynol-9 as its spermicidal ingredient. Neo-Sampoon, the VFT provided by Planned Parenthood Association of Ghana and UNFPA, on the other hand, uses menfegol. No serious side effects have been reported for either of these products. The most common minor side effect is skin irritation, although allergic reactions can develop as well. At one time, the question of whether birth defects were linked to spermicides was debated in the scientific literature, but several large, well-designed studies have failed to reveal any adverse fetal

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effect. The lack of side effects and overall safety have led most experts to advise that spermicidal methods should be available to users without medical evaluation.

Failure Rates: Like condoms, since VFTs require use with each act of coition, failure to use them is the major reason for method failure. In addition, unlike condoms and many of the other forms of spermicides like foams or jellies, the tablets require ten minutes between insertion and intercourse to be effective. Making people aware of this requires major attention during the project's IE&C campaigns. While perfect users could achieve a 3% failure rate, more typical first year users experience 21% failures. That is, one in five women using VFTs as the sole method of contraception will become pregnant each year. VFTs are probably the least reliable 'modern' method that is being promoted in Ghana. Nonetheless, because they can be readily provided without using a pharmaceutical distribution system, they may still be an important method to continue.

Storage: Less is known about the problems involved in storage of VFT's. These are packaged in foil, so the ultra violet light exposure is less than for condoms. Nonetheless, the same need for protection from extreme heat exists. There are no easily available methods to check continued reliability of aged samples. Distributors will be taught "first in first out" stocking, and samples will be submitted to AID/W for testing periodically.

Classification: VFTs are not included in the essential drug list and therefore cannot be purchased by the MOH. Their addition to this list is important to widespread use in MOH units. Since the Pharmacy Board considers them a drug, they would be listed in the safety class 'C' (most safe) and their distribution would be extended to health centers/posts, but not to village health workers including TBAs. The special programs that use TBAs and market women to distribute VFTs cannot expand unless these restrictions are lifted. This is part of the policy reforms that the project will implement.

Other Comments: While spermicides have often been cited as having an anti-bacterial and anti- viral effect, they do not actually reduce the transmission of sexually transmitted diseases, including AIDS--unless this method is combined with a barrier method such as diaphragms. Because of the failure of existing diaphragm programs in Ghana, USAID does not intend to provide them under the new project.

There is continuing debate in Washington as to whether A.I.D. will continue to supply VFTs in their worldwide population programs. While part of the reason is the high failure rates,

another reason is that demand for this method is relatively low, and it is the most expensive method, particularly if the cost per birth averted is calculated. If A.I.D./Washington discontinues providing these commodities, the resources dedicated to implementing this part of the project will be directed elsewhere.

3. Oral Contraceptives (OCs)

Side Effects: OCs are much safer than their reputation would indicate. The most serious complications are circulatory disorders, specifically stroke, myocardial infarction and thromboembolic phenomenon. These complications are extremely rare. Death rates of pill users is one third that of women who use no contraception. The single exception is among women who are older and smoke. Since smoking among women is unusual among Ghanaian women, this is not an issue.

A host of minor side effects of OCs can cause some concern, even though they are not significant health risks. An example of this is a change in menstrual flow pattern. These concerns will be addressed in the project through the IE&C campaigns, and through better training of distributors and family planning advisors.

The safety of OCs is such that at least eighteen countries allow sales without prescriptions: Antigua, Bangladesh, Brazil, China, Dominican Republic, Egypt, Grenada, Hong Kong, India, Indonesia, Mexico, Nepal, Nigeria, Pakistan, Philippines, South Korea, Sri Lanka and Turkey. During the Project's life it will be useful to study Nigeria's experience due to that country's proximity to Ghana. The Ghana project advocates making OCs far more available to women by downgrading the Pharmacy Board classification from dangerous to controlled, and by making them available through all levels of distribution, including level A.

A recent study of risk factors among women who had obtained their OCs with and without prescriptions concluded that "The acceptance of oral contraceptives through non-medical channels ... did not put any substantial group of women at greater risk of ill health or death than if the program had never existed. CBD [Community Based Distribution] acceptors are as healthy as acceptors from other sources. Moreover, increased contraceptive prevalence resulting from the CBD program has introduced an important public benefit to the individual by reducing unwanted pregnancy with its attendant dangers."

Failure Rates: Failure rates are very low with this method, reaching about 3% in practical use, even though the perfect user could theoretically achieve a 0.1% failure rate.

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Storage and Transport: OCs need the same attention to storage as VFTs. While they are not as susceptible as condoms to environmental degradation, protection from extremes of light and heat is prudent.

Classification: As mentioned, OCs are currently classified by the Pharmacy Board as Dangerous Drugs (Class A) and their distribution is restricted by the MOH to facilities with specialty services. In fact, the specialty services simply implies the presence of a family planning trained nurse, and most MOH level B and C facilities have such a person. However, FP commodities are stored separately from other pharmaceuticals, and are not available when the FP trained nurse/midwife is not at the clinic. The policy reform portion of the project will reduce the Pharmacy Board classification from A to C, and broaden the distribution in the MOH sector from D to A. It will also initiate a series of studies, including a possible study tour to Nigeria, which will lead to a formal decision whether to completely decontrol the sales of OCs or not.

Other issues: Oral contraceptive horror stories are commonplace in the Ghanaian media, despite official recognition of their safety by the MOH. It is difficult to determine whether this represents dissension within the government about family planning or whether it is a convenient journalistic target. An important part of the project is to use the technical support unit for the national population authority to help editors and journalists come to a better understanding of health and safety statistics. Already some seminars for journalists have been held with positive reviews. The press situation should be closely monitored during the life of the project.

4. Intra-Uterine Devices (IUDs)

Side Effects: IUDs are clinical methods, i.e. require clinical facilities for insertion and removal. They have a undeserved poor reputation in the United States. The major side effects from IUDs are uterine perforation on insertion, and a greater tendency for pelvic infections. While both of these side effects can have serious complications, including infertility and even death, death rates for women using IUDs are lower than for those using any other form of contraceptive and much lower than death rates for women using no contraceptives. Remarkably, the same World Health Organization study finds that death rates from IUD's are smaller than the death rates of women using barrier methods, which usually are considered to be harmless. The reason is that barrier methods are not as effective and expose the woman to a greater risk of pregnancy related complications.

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Less serious side effects are changes in menstrual bleeding and increased menstrual cramping. This can lead to early removal, and the need to change to another method. As with other methods, this requires that the project managers pay attention to counseling and motivation training.

Failure Rates: Failure rates for IUD's are very low, less than 1% per year. The most significant cause of failure is inapparent expulsion of the IUD, often during the menses, or discontinuation of the method because of the discomfort of some of the side effects.

Additional Facilities: Since these devices are small, storage and transport are relatively insignificant issues. The only problem that can develop is that the packaging can be damaged, sometimes invisibly, rendering it unsterile. A second issue is that the demand for IUDs is frequently overestimated, leading to large in-country stocks that reach their expiry date and must be destroyed.

However, IUD insertion does require that additional instruments be procured, and that instrument sterilization facilities be available. This effectively limits their use to facilities where other clinical procedures are done that will warrant the acquisition and maintenance of this capacity. Since all project inputs are going into existing facilities, this is not expected to be an issue.

Classification: The Pharmacy Board does not classify these devices, but they are considered a medical device for use only by qualified medical practitioners. Currently this only includes specially trained physicians and nurse-midwives.

Other issues: On the public side, the main constraint appears to have been the existence of trained personnel and necessary supplies. As trained personnel and supplies have been put in place, over the past year, demand for IUDs at public facilities has soared fivefold over previous years. MOH is currently providing training and is able to maintain it with little external support.

The private side has been less successful. Initial projections have proven to be exceptionally optimistic. (GRMA requested 5000 IUDs three years ago, and recently returned 4600 of them) It is not clear why the private sector has not experienced the expansion of demand that the public sector has. ACNM will be asked to investigate this and report training changes that can be incorporated into the GRMA and private medical practitioners support portions of the Project to improve private sector performance.

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5. Voluntary Surgical Contraception (VSC):

Side Effects: Most of the side effects are those of anaesthesia and surgery. When general anaesthesia is used, particularly in developing countries where there may not be full anesthesiology support services, the mortality rate can be high. For this reason, A.I.D. only supports the minilaparotomy under local anaesthesia procedure, a procedure that has been demonstrated to be both safe and effective. Mortality rates from all causes for the procedure are less than 1/1000. Major complications, including infection and bleeding occurs in less than 1% of procedures. Obviously, the complication rate decreases in proportion to the skill of the physician and the quality of the facility.

Maintaining quality control over procedures is a key element of any program. While a variety of organizations are beginning to address the technical and organizational issues involved with insuring quality surgical care, the Association for Voluntary Surgical Contraception (AVSC) has become the lead agency in this area. It has learned that quality control is one of the most difficult tasks that faces the propagation of surgical contraception. This is the primary reason why surgical contraception training and quality control has been allocated specifically to the AVSC buy-in, rather than including it in the institutional contractor's responsibilities.

A second side effect is that surgical contraception must be considered to be permanent. While microsurgical techniques exist in developed countries which permit reversal of sterilization in a small number of cases, this technology does not exist in Ghana. Counsellors must be carefully trained to provide appropriate information which will allow individuals to make the choices that are right for their own lives without a hint of coercion. AVSC has also been a leader in the developing counseling programs.

Failure Rates: Modern method surgical contraception is the most effective form of birth control with a failure rate of about 1/1000.

Additional Facilities: Storage and transport are, of course, not issues here, except insofar as people must go to a relatively small number of fixed facilities to receive the procedure. (Mobile clinics have not proven to be very successful for this procedure.) This poses problems if complications arise after leaving the facility, and there is limited transportation to return for follow-up care. It is only in countries where there are high population densities and high demand for sterilization services that mobile teams can be effective, and these conditions do not exist in Ghana.

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Classification: While some countries are experimenting with training paramedical personnel to carry out these technically simple procedures (especially Indonesia), in Ghana this method will be limited to physicians with surgical experience and special training.
Other issues: There are no laws restricting sterilization procedures in Ghana.

The major constraint to delivery of VSC services in Ghana is the lack of facilities and staff to do the procedures. Currently there is only one active center, the teaching hospital of the University of Science and Technology in Kumasi. (While the teaching hospital at Korle Bu also performs VSC, the rates are very low. There are also a few private providers of the service, but they are usually using an outdated technique.) Despite having a dedicated operating room for VSC, the emergency operation rate is so high that most scheduled procedures are postponed because the team is called to more urgent activities. Thus it is extremely important to establish more centers where the procedures can be performed, preferably in sites away from the main gynecological surgical facilities where staff and equipment are needed for other services.

6. Norplant

Norplant is a new contraceptive method which uses six capsules implanted under the skin (usually of the arm) to provide up to five years of contraceptive protection. As a progestin only type of hormonal contraceptive, it does not interfere with breastfeeding and has none of the thromboembolic effects of the estrogenic OCs. (This is also true of Ovrette, one of the OCs supplied by A.I.D.) A woman can have the implants removed and will become immediately fertile if she so desires.

Side Effects: The most common side effect is menstrual cycle irregularity. This is the main reason why women discontinue the method. Since this often results in increased frequency of bleeding, especially in the first year, this method is less acceptable to Muslims for ritual purity reasons. One would expect that this method will be more acceptable in the mostly non-Muslim south rather than in the north. If the implant is not performed with good surgical technique, there is a chance of infection which will require removal.

Failure Rates: Initial large multi-country studies have shown a failure rate of about 0.2% per year. The cumulative pregnancy rate for five years of use is 3.9 per 100 users. One important factor affecting effectiveness is the weight of the woman. Women weighing more that 70 kg have a pregnancy rate twice that

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given above. Since this method is not user-dependant and the implant cannot be inapparently expelled like the IUD, the failure rate for the first five years is lower than any other method other than surgical contraception. The failure rate increases markedly at the end of five years, so the need for replacing or changing to a new method at the end of five years needs to be stressed during counseling, and patient selection must exclude the obese. Discontinuation rates--which are much easier to calculate with Norplant than other methods since the capsules must be removed surgically--are in the range of 5-13% for the first year. In Ghana, only two women of the 96 who received Norplant requested removal. Good pre-insertion counseling, as with all methods, is the key element in client satisfaction and continuation.

Additional Facilities: This is a clinical method, and requires training both for surgical insertion and removal of the implants. While the procedure is simple to perform with local anaesthetic, a source of sterile instruments is mandatory. Removal can be more difficult than insertion, and needs to be available up to five years after the initial insertion. With the existence of fixed facilities, this should not be an insuperable difficulty.

Classification: In Ghana Norplant is an experimental drug. One trial of 100 implant sets was carried out at the University of Science and Technology in Kumasi, and the MOH has received an additional 300 sets from UNFPA. When these studies have been completed and U.S. Food and Drug Administration (FDA) approval has been granted, the findings will be submitted to the Pharmacy Board to approval for general use. Since clinical training and special facilities are required for insertion, the level of classification will not affect distribution of the commodity. Norplant has been approved for use in twelve countries: Finland, Sweden, China, Ecuador, Dominican Republic, Indonesia, Thailand, Colombia, Peru, Venezuela, Sri Lanka and Chile. Application to the U.S. FDA has been made, and is expected prior to full project implementation.

Other issues: Two other major issues are FDA approval and cost. FDA approval is needed before any programmatic Norplant activities can begin under USAID funding. Since all applications have been filed, this is expected to happen early in the project period. However, the need for training and for the clinical equipment will still significantly delay the introduction of Norplant on a wide scale until fairly late in the project period. The main goal of this project is to lay a foundation that can be built on during subsequent periods. An estimate of 1000 Norplant sets is established as a project output.

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Each Norplant set costs around $15.00, making it one of the more expensive methods. In addition to product costs, there are also equipment costs, training costs, and removal costs. Clearly, it should not be used by women who only want a year or two of protection, since it will not be cost effective. However, it is expected that costs will be reduced as the worldwide demand increases the supply.

The final additional difficulty is the question of who will implement the project element. While the picture is not yet clear, AVSC is developing the capacity to do so. Given its ongoing activities in the Ghanaian clinical sector, AVSC is the logical choice to take over this activity.

7. Natural Family Planning (NFP)

This is not a single method, like those listed above, but rather a variety of different methods of determining a woman's fertile period, and avoiding sexual relations during them. While the project will not have specific targets for NFP, given the large number of Catholics in Ghana, and the importance of the Catholic Church in delivery of health care, educational materials will be identified and either printed locally or obtained outside the country and made available to the groups that want them. In addition, as needed under the NGO support section, training in NFP methods can be provided.

Side Effects: The major side effect is an unplanned pregnancy. In addition, the careful attention to fertile and infertile times may induce considerable interpersonal conflict.

Failure Rates: This has not been determined with any degree of satisfaction. Proponents of each method claim a very high degree of reliability, but in practice, with well-motivated individuals, failure rates around 20% have been published. Recently a study of one method showed a phenomenal 84% annual failure rate. If this is true in Ghana, it is not an acceptable method. Clearly, the failure rate will differ from individual to individual, and between methods.

Storage and Transport: A major advantage of this method is that no commodities are required. Indeed, some of the mission health centers in Ghana are teaching these methods, not because of an ideological orientation, but because they feel that the supply system for the other contraceptive commodities is not reliable enough to be used as a dependable method.

Classification: Not classified by the Pharmacy Board. Recently, a division of Traditional Medicine was added to the

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Ministry of Health. Insofar as traditional methods are effective--in particular prolonged or periodic abstinence--promulgation of the techniques may fall under the purview of this new division.

Other issues: In a country with a high Catholic presence, where Catholic institutions provide some 20% of all health care available, inclusion of this method is needed to ensure reaching all available health providers. One of the most important aspects of this method is that it requires intensive training and reinforcement by the family planning advisors to help women understand and apply the methods in their daily lives. Unless the providers are willing to make this effort, NFP should not be provided.

Safety and Efficacy of Other Commodities

1. Chloroquine

Technically, chloroquine has been selected as one of the GSMP commodities because (a) the distribution system required complements the distribution of family planning commodities, and will result in a stronger system for both; (b) the intervention proposed is appropriately communicated and supplied through a social marketing system; and (c) because malaria is a major cause of morbidity and mortality in Ghana.

This is given special priority because of the spread of chloroquine resistance in Ghana. Currently, between 20 and 50% of Plasmodium falciparum infections are at least partially resistant to chloroquine. A major reason for this is the common practice of partial treatment of febrile episodes, which results in the less resistant organisms being eliminated and the more resistant ones left to propagate. In addition to attempting to reduce the morbidity and mortality due to malaria, one of the major goals of the project is to slow the spread of chloroquine resistant malaria by increasing the numbers of people using the correct dose. Prompt treatment of malaria prevents progression to severe illness or death and reduces the duration of the illness. Adequate dosing with chloroquine is essential to limit suboptimal usage which may promote development of resistance. This type of treatment can be initiated even at levels A and B.

While normally the recommendation is that malaria should be diagnosed by a blood smear prior to beginning therapy, this is not possible at the village level and is seldom possible at either health posts or centers (level B). In lieu of this, a simple protocol calling for malaria treatment for all children under age 5 who have a fever is recommended by consultants from the Centers for Disease Control.

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A major recommendation included in this report is that "An effective social marketing system may be useful to supplement the MOH health delivery system to ensure that chloroquine is available at the village level. A pre-packaging method that promotes compliance with recommended dosage for different age groups will help significantly in the dispensing and utilization of adequate amounts of therapy."

Side Effects: The doses recommended for malaria treatment have very few side effects. What difficulties have been experienced occur when the individual is taking high doses (greater than 250 mg daily) for treatment of other conditions such as arthritis.

The most significant danger is that chloroquine overdosage--even at relatively low levels (i.e. four times the recommended dose)--can be fatal. There are few facilities in Ghana capable of treating serious chloroquine overdose. Ironically, chloroquine, the most widely available drug on this list is also the most dangerous. The dangers here must be met by careful teaching of distributors: they must learn to teach their clients to take enough of the drug but not too much.

Failure rate: These are determined by (1) the adequacy of the dose taken and (2) the resistance of the parasite to the drug. They are therefore difficult to calculate. Currently, 20% of malarial infections in Ghana have been found to be resistant to treatment with chloroquine. (This is technically a different measure of resistance than that mentioned above.)

Classification: Chloroquine is classed as a level C--least dangerous--drug, and distributed through level A--the community health worker--MOH outlets. The availability of the drug is not restricted.

Other issues: Chloroquine powder is already widely imported into Ghana and made into tablets by a number of pharmaceutical firms. Since it has demonstrated its financial viability, USAID does not need to import more raw material. Instead, the project will emphasize developing of dose packaging, nation-wide advertising campaigns and training of distributors to encourage people to take the correct dosage.

In other countries in West Africa, specifically Nigeria, a high proportion of the chloroquine sold on the market contains less than the stated dose. A small survey in Ghana failed to reveal problems, but this needs to be verified prior to the beginning of the project. To avoid difficulties, the project may need to fund technical assistance for production quality control.

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Oral Rehydration Salts (ORS)

Method of Action: ORS work by replacing salts in the body that are lost through diarrhea. In so doing, they hold water in the body that otherwise would be lost. One of the great advances in diarrheal disease control was the discovery that the inclusion of glucose in the ORS mixture facilitates the uptake of salts in the intestine which made oral rehydration therapy possible. However, a crucial element of this is that each component--salts, sugar, and water--must be in the right proportions or the therapy will be less effective.

Side Effects: Serious side effects occur when ORS administration is delayed too long. This commodity must be promptly available, with few barriers such as transportation to a clinic. These reasons above all else indicate the need for a locally based supply, which can only be effectively delivered through a social marketing system.

Significant problems can develop if the ORS solution is either too dilute or too concentrated, either of which can make the child's condition worse. For this reason, two critical decisions [illegible] been made about the Control of Diarrheal Diseases pr[illegible] ana. (1) The project depends upon pre-mixed pa[illegible] er than teaching home mixtures of sugar and salt. Ex[illegible] other parts of the world has shown that people are una[illegible] accurately measure the necessary raw ingredients in the appropriate amounts. (2) The packet has been made to provide the correct concentration of each ingredient when mixed in the most common container in Ghana--a 600 ml. beer bottle. In addition, some ORS mixing cups are also being distributed. These two interventions reduce any the risks of over or under concentration.

Failure rate: If initiated early and in sufficient quantities, failure rates are low. However, some children with severe diarrhea will still need inpatient care. However, with time and experience, the number of severely dehydrated children requiring inpatient care should decrease, diminishing the demand on the health care system.

Classification: ORS is classified as a class C (least dangerous) drug, available at all levels of the MOH system. There are no limitations on its distribution.

Other issues: USAID, UNICEF and the MOH closely collaborate on ORS. This cooperation greatly strengthens the family planning program, both in terms of supporting MOH child survival initiatives, and in generating good will.

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Conclusions

The technical analysis demonstrates that the current project design has learned lessons from twenty years of USAID population experience in Ghana. Specifically, problems that occurred during the course of the existing project have been identified and addressed. The following are the major conclusions of this study.

-- Social marketing is a viable way to deliver family planning and health goods, services and information. From no market share in 1985, the social marketing program now accounts for 40% of the contraceptives distributed in country and a large proportion of the Oral Rehydration Salts. The major lesson is that commercial manufacturing and distribution firms are not necessarily the best managers of social marketing programs. This has been corrected in the current design.

-- USAID experience indicates that the greatest progress will be achieved when the private and public sectors are working in tandem. Having a single subcontractor providing assistance to both the public and private sectors will do much to ensure improved communications. In addition, the previous project emphasized institution building in the MOH and in the distribution system of the private sector. Having made progress in this area, the new project will address institution building in the Education Division of the MOH. It will also focus on recruiting additional private sector providers, especially those who are not yet clearly designated as health providers. Certainly TBAs have the potential to be effective community based distributors, but other groups of non-clinically trained individuals also have this potential. Using non-pharmaceutical distributors is also a way of reaching a vast network of retailers who service rural areas. This is the only feasible way to reach Ghana's 70% rural population.

-- Strengthening the Health Education Division will assist coordinating public information campaigns with the social marketing activities.

-- The MOH will need a continued supply of contraceptives, to be provided by a distribution system that was strengthened under the existing project, and that will be further developed by inputs from other donors.

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ANNEX C

INSTITUTIONAL ANALYSIS

INSTITUTIONAL ANALYSIS

1. Identification of Organizations:

The Family Planning and Health Project (FPHP) will work directly with public and private sector organizations, and with other bilateral and multilateral donors. The Ministry of Finance and Economic Planning (MFEP), the Bank of Ghana (BOG), the Ministry of Health (MOH), and the soon to be established national population authority will be the primary public institutions. The roles of the MFEP and BOG in implementation of FPHP will be limited. The former will monitor implementation by the MOH and exercise oversight of local currency generated by the program assistance component. The BOG will be responsible for continued operation of the foreign exchange system. An analysis of the MOH and the national population authority, the lead Government of Ghana (GOG) institutions for the public sector implementation of the FPHP is presented in Section 2.

In the private for-profit sector, the FPHP will work with commercial, pharmaceutical firms for importing, processing and distributing commodities. It will also work with non-pharmaceutical commodity distribution companies, and industries offering health benefits to their employees, as well as with private voluntary organizations (PVOs) to strengthen their capacity to provide family planning and health goods, services and information. Each of these are described in section 3, and the strengths and weaknesses outlined.

Other donor agencies' activities are extremely important to the success of this project. The World Bank, the United Nations Fund for Population Activities (UNFPA), UNICEF and the International Planned Parenthood Association (IPPF) can work synergistically with the FPHP to achieve Ghana's goals. These are described in section 4.

2. Public Sector

A. Ministry of Finance and Economic Planning (MFEP)

The Ministry of Finance and Economic Planning is responsible for the management, coordination and oversight of all macro-level financial and economic planning affairs of the Government of Ghana. The policies and programs may be initiated from within or outside the Ministry; but in all cases they are coordinated and in some instances implemented by MFEP. MFEP has been the lead ministry for the design and coordination of the Economic Recovery Program.

The Ministry has had a long history of involvement with family planning efforts. It has worked closely with the MOH in implementing the Contraceptive Supply Project (CSP). The now defunct Ghana National Family Planning coordinating body created in 1969 was lodged in the MFEP (see below). Further the MFEP signed a contract for DANAFCO services under the CSP. It is also the GOG body which will negotiate with USAID on the terms and conditionality of the cash grant under the nonproject assistance component of the project. One such conditionality involves removing price controls on contraceptive products sold by the private sector. The MFEP has been intimately involved in this subject in the past via its "Prices and Incomes Board" which is currently responsible for approving the sales price of contraceptive commodities sold by DANAFCO.

The MFEP will open a special counterpart account at the central bank for the local currency deposits as a result of the cash grant, and work with the MOH and USAID in preparing the requests for local currency releases to support the MOH budget.

The Ministry has six main divisions, under the management of two deputy PNDC secretaries. The major divisions are:

- -- International Economic Relations,
- -- Manpower,
- -- Investments Project Analysis,
- -- Planning and Research,
- -- Budget, and
- -- General Administration.

The Ministry also has an Economic Policy Unit, organizationally located between the divisions and the deputy secretaries, which integrates economic policy at the macro-level.

MFEP staff is grouped in the following broad categories: technical, administrative and support staff (secretaries, typists, clerical officers, etc.) The hierarchy is as follows:

Technical Divisions	Administrative and Budget Divisions
Chief Director	Chief Director
Chief Economic Planning Officer	Principal Secretary
Principal Economic Planning Officer	Principal Assistant Secretary
Senior Economic Planning Officer	Assistant Secretary III
Economic Planning Officer	Assistant Secretary IV
Assistant Economic Planning Officer	Assistant Secretary IV

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Among the six divisions, the Planning and Research Division, International Economic Relations Division (IERD), Manpower and Budget divisions will help to implement Family Planning and Health Project. The roles of these various divisions in the implementation of FPHP are expected to be as follows:

International Economic Relations Division

-- negotiating the Grant Agreement,
-- monitoring counterpart funds,
-- advising the budget division on the release of counterpart funds, and
-- program/project monitoring of FPHP project;

Manpower Division

-- developing and implementing of any population policies and
-- establishing a national population authority;

Planning and Research Division

-- programming of local currency,
-- monitoring of policy reforms, and
-- coordination with the National Population Authority on definition of policy studies; and

Budget

-- budgeting of counterpart funds and GOG cash contributions to project,
-- releasing funds to implementing agency,
-- monitoring expenditures by MOH, and
-- ensuring financial accountability.

The MFEP is also the ministry primarily responsible for negotiating and signing all agreements with bilateral and multilateral donors. In addition, it is the primary budget and development policy-making ministry. While MFEP delegates project implementation responsibilities to line ministries, such as the MOH, it monitors projects and wants to be kept informed by the line ministries about project implementation and impact. Unfortunately, line ministries such as the MOH have not developed adequate communication mechanisms to allow them to provide the information needed by the MFEP for budgetary decisions. One of the main issues raised in the mid-term evaluation of the CSP was that the MFEP was not adequately informed by the MOH on progress of the project's public sector component. At that time the MFEP had received no written reports from the MOH, nor any accounting for how counterpart funds had been spent. Budgeting for the various activities of the MOH has been an ongoing problem as well. In creating each new budget, a target is set for each line item, which is an increment (perhaps 10%) above what was actually spent in that line the previous year. While the various divisions of the MOH are allowed to make requests based on perceived needs, the budget itself is often created without reference to need statements. This budgeting process has resulted in particularly inadequate repair and maintenance line items.

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Once the budget has been finalized, the Accountant General decides on a quarterly basis what percent of each budget line can be funded. This is based on GOG revenues and is a laudable effort to maintain a balanced budget. Historically, the MOH has received about 75% of the original budget. However, this conceals vast differences between sublines. Salaries are completely covered, and, since they make up the bulk of the budget, other lines are often cut disproportionately. As a result, for example, primary health care has sometimes received only 15% of what was originally budgeted. In addition, encumbered funds can only be used for the specific lines that are designated, even if these designations are in error. Thus, in 1989, the Health Education Division received an allocation for feeding programs even though no such programs exist. This money then counted against their allocation even though it was not available for use.

MFEP is also responsible for providing funds to the MOH from GOG and counterpart funds. Delays in the provision of these funds have been a problem in the past, and, with the initiation of the program element of this project, will need careful monitoring. However, the MFEP now has two years of experience in managing funds provided under the Agricultural Productivity Promotion Program, and is able to perform this function adequately.

The International Economic Relations Division (IERD) deals with bilateral and multilateral donor projects. In the past, the IERD has been hampered by not having anyone responsible for overseeing MOH projects who was knowledgeable about health economics. Recently, individuals have been selected to have this responsibility. Previously interministerial communication was passed through USAID.

The Manpower Division of the MFEP is charged with overseeing specific family planning and population policy development and implementation. There are two major bodies charged with coordinating these activities. The first of these is the Ghana National Family Planning Programme Secretariat (GNFPP). This was established shortly after the promulgation of the 1969 population policy to coordinate all population activities. It was originally meant to coordinate activities in the Ministries of Health, Education, Labor and Social Welfare, and Information as well as activities of the Planned Parenthood Association, the Christian Council, the Catholic Secretariat and mission hospitals and clinics. Despite its elaborate organizational charts, the GNFPP has no clearly assigned role and no legal instrument defining its authority. Consequently, integration of population planning into national development planning did not occur, nor did an appropriate institutional mechanism develop to coordinate data collection, research, policy analysis, program implementation, and monitoring and evaluation.

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While it was intended to be a coordinating body only, in the 70's the GNFPP was given increasing implementation authority. However, management difficulties in the early 80's resulted in the GNFPP losing its original authority, and it is now described as being 'essentially defunct'. Currently its major activity is to conduct quarterly meetings of all family planning providers in the country and to collect reports of all family planning activities. In addition, it organizes an annual National Family Planning Week celebration.

Major lessons for implementing of the national population authority can be learned from this history. In the first place, as a secretariat within a division of a ministry, GNFPP did not have the authority to mobilize inter-ministerial cooperation towards a common goal, and did not even have enough influence within its own ministry to forward its own agenda. This will be avoided by putting the national population authority at the highest level of government, specifically at a supra-ministerial level.

Secondly, as part of the MFEP, it was administratively outside the ministry that had the primary implementing task, i.e. the Ministry of Health. While this weakness could have been made a strength if appropriate lines of inter-ministerial communication were established, this was not done. The national population authority will need to establish clear and open lines of communication with all ministries which will play roles in implementing national population objectives.

Thirdly, the GNFPP was given substantial implementation responsibilities, which overwhelmed its managerial capacity, and reduced its coordinating function. When managerial difficulties came, they also adversely affected its ability to coordinate other activities. This has persisted despite the passage of nearly eight years. The national population authority must have coordination and mobilization capacity but should not be charged with actual project implementation.

Finally, funding for GNFPP operations came almost entirely from donor sources. When these were withdrawn in the early eighties, it had no Ghanaian budget source to continue its activities. Because of this experience, this project requires the new national population authority to have ever increasing direct budget support from the GOG.

As a result of the failure of the GNFPP to fulfill its intended role, in 1988 the Secretary of the MFEP established the Population Policy Implementation Assessment Committee (PPIAC). This was to be comprised of representatives of the core group of institutions engaged in population, family planning, health and population-related policy fields. This was to be chaired by the director of the Manpower Division, and has representation from GNFPP, the Ministries of Mobilization and Productivity, Health, Education, Agriculture, Justice and Information. Representatives also come from the National Council on Women and Development, the 31st December Women's Movement, the Ghana Statistical Service, the University of Ghana, the Ghana Institute of Management and Public Administration, and the University of Science and Technology.

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The Population Policy Implementation Assessment Committee (PPIAC) is charged with:

-- conducting an up-to-date assessment of national population policies and drawing up a comprehensive programme to guide future implementation of population and human resources policies;

-- examining the inter-sectoral constraints of both governmental and non-governmental organizations on population and related issues and suggest suitable policy guidelines for the GNFPP and the Manpower Division of the MFEP;

-- collectively acting as a promotive communication link between policy formulating organs of government and the implementing agencies as far as technical matters on population are concerned;

-- providing other relevant technical advisory services on population and its related issues.

The PPIAC thus contains many of the elements that are being proposed as the function of the new national population authority. Assistance to the GOG to allow this to develop into the national population authority will expedite implementation of the already-begun process of coordinating population policies and activities. It will also allow the national population authority to rise to a level where it receives the visibility and political authority to effectively exercise its intended functions.

Appraisal of the MFEP: The Ministry is fully capable of establishing the necessary local currency account and monitoring it, as well as using the dollars received under the cash grant according to the requirements of the Agreement. Not only has the MFEP managed earlier USAID program assistance, it has also established and managed local currency accounts generated by the USAID PL 480 programs. It is assumed that the Ministry will continue its cooperative role in helping to implement family planning activities.

B. BANK OF GHANA

Institutional Responsibilities

For over 30 years, the Bank of Ghana (BOG) has been responsible for the issuance and management of currency, regulation and control of foreign exchange, monetary and credit policies, bank supervision, and development and promotion of a healthy banking system.

The BOG's roles and responsibilities in operating the foreign exchange regime will affect the Family Planning and Health Program, particularly the BOG's continuing efforts to 1) liberalize the exchange regime by ensuring smooth functioning of the auction market, 2) increase the role of commercial banks and other dealers in mobilizing foreign exchange, in part through the forex bureaus, and 3) reduce disparities between auction and forex bureau or parallel exchange rates.

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The Foreign Exchange Allocation System

During the first two years of the ERP, the BOG operated a system of import programming or licensing in which it allocated scarce foreign exchange (FX) among competing uses. This was accompanied by a system of exchange control for rationing use of FX for service transactions (e.g., workers, profit and dividend remittances), and supervision of special exemptions for exporters (e.g., those using supplier's credits, special retention accounts for debt servicing, or procuring vital production inputs). With the introduction of an auction system in 1986, the BOG's role in administering the foreign exchange regime was fundamentally changed.

The Bank of Ghana (BOG) Weekly Foreign Exchange Auction

The weekly auction was instituted in 1986 as an interim mechanism for developing a market-based system of allocating FX and liberalizing the trade regime. It is currently the longest-running FX auction market in Africa and has facilitated the re-orientation of foreign exchange allocation from administrative controls and licensing to a more market-based system.

The auction is used mainly for financing imports. Private importers submit a pro forma invoice and bid documentation indicating the types and amounts of foreign currency requested and the cedi rate offered in dollar terms. The importer also submits, usually through a commercial bank, a bank guarantee or authorization that permits the Bank of Ghana to debit the bank's account with 100% of the cedi equivalent of a successful bid. The bids are lodged with the BOG in time for the auction to be conducted on Friday afternoons.

Clearing the auction is supervised by a foreign exchange auction committee, composed of representatives from the BOG, GOG ministries and the private sector, which determines eligibility of applications. The auction market is cleared when the requests for FX for that week matches the allocation of FX to the market during the week. The official market exchange rate is the marginal exchange rate for the US dollar at which the supply of FX satisfies the demand. This rate applies to all official FX transactions for the following week.

The exchange rate of the cedi to other currencies than the US dollar is determined by the BOG based on the average weekly exchange rate of those currencies to the dollar in the international market.

The results of the auction are made available every Friday afternoon, and published in the press on Saturdays, indicating the numbers of bidders and successful bids, highest and lowest bids offered, the marginal rate and the total FX supplied by the BOG and level of demand during the week. With this information and the list of winners, the BOG matches the requests for various foreign currencies with the available sources of funds, taking into consideration donor restrictions on commodities and source/content. At present, several donors supply funds to the auction and source/origin/commodity restrictions have been minimized to facilitate expeditious disbursement of foreign funds through the auction.

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After matching funds, the BOG transfers the foreign exchange into a blocked account in the name of the bidder's bank which pays the BOG the full cedi value of the FX. The bidder's bank finances the import transaction upon the bidder paying the full cedi equivalent of the FX or fulfilling financing arrangements satisfactory to the bank.

The Forex Bureaus

The BOG began licensing institutions, including banks and individuals to operate forex bureaus in February 1988. At present, there are over 140 bureaus in operation countrywide. FX bureaus are permitted to deal in eight major currencies: the US dollar, pound sterling, German mark, Swiss franc, French franc, Canadian dollar, CFA franc and Japanese yen, as well as travellers cheques in US dollars and pounds sterling. The supply of and demand for FX at the bureaus are market-determined at daily prices freely quoted by each bureau. Bureaus obtain their supply of FX from private sources, including retained FX earnings of some exporters (excluding cocoa and mining), remittances, interest earnings, private foreign savings, and FX held by the public. The average monthly value of transactions has been close to U.S.$10 million, with the US dollar and CFA franc being the most dominant currencies traded.

The Auction

All firms and individuals meeting the eligibility criteria are free to participate in the auction market. Auction transactions are conducted openly and are open to observers. Access to the auction has been widened to include funding of all imports, except five categories on a negative list (beer and stout, cigarettes, cement pipes, roofing sheets, and asbestos and fibers) and imports prohibited for non-trade reasons. All bona-fide requests for FX for business travel and transfers of profits and dividends are also eligible. Thus, only a few restrictions, relating mostly to invisible transactions, remain in effect as of the end of 1989 on payments and transfers for current international transactions. Reflecting the low level of imported inputs in Ghanaian agriculture, industry (especially, textiles, metal, brewery and plastic & rubber) receives the largest share (about 50%) of FX from the auction followed by transport. Agriculture receives less than 10% of auction funds while use of the auction for importing consumer goods is limited. Auction funds can only be used to import drugs that appear on the Ministry of Health essential drug list. Since contraceptives are not on this list, commercial importers face an adverse currency exchange climate in addition to normal duties.

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The Forex Bureaus

All import transactions are permitted at the forex bureaus. Money is changed over the counter, transactions take place on a strictly confidential basis, and no records are kept on clients. No documentati other than simple encashment or sales receipts are demanded on transactions with the bureaus. Bureaus are only required to report to the BOG monthly on total purchases and sales of currencies and their respective rates; beyond this, their operations are entirely free of bureaucratic encumbrances.

Dependence of the Foreign Exchange on Market Forces

When the Economic Recovery Program (ERP) began in 1983, Ghana's foreign exchange regime was typical for an African country. It was characteriz by FX rationing through import licensing, currency controls, fixed and grossly overvalued exchange rates, a booming black market and lack of F for personal transactions. ERP's centerpiece has been the focus on achieving a flexible exchange rate and liberalized trade system to restore market incentives in the economy.

The auction has functioned well in reorienting the nature of the foreig exchange (FX) system. Total amounts of FX handled has increased from $ million in 1986, to $204 million in 1987 to $343 million in 1989. Total demand in 1989 was $354.5 million. The average weekly supply in 1989 wa $6.7 million versus an average weekly demand of $7.1 million (over 50 auctions). Econometric analysis of the auction market by International Bank for Reconstruction and Development (IBRD) shows the weekly marginal rate is significantly affected by the rate determined, as well as unmet demand at the previous auction, which signifies market behavior. The demand for foreign currencies is dominated by the US dollar (more than 50% of total demand) followed by the UK pound (about 20%). Transactions at the bureaus respond entirely to market forces. During 1989 and 1990, the spread between the auction and bureau exchange rates has narrowed considerably, reflecting the effects of GOG measures to integrate the tw markets. The spread as of August 1990 was only 11%. Since the beginnin of the auction, the auction rate has increased some 168% compared with a increase in bureau/parallel market rate of 77% (Table E-1).

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TABLE E-1

AUCTION AND PARALLEL FOREIGN EXCHANGE RATE CHANGES, 1986-1990

	Date			1986-1990
	9/86	7/88	8/90	%Change
Auction Rate	128	211	330	168
Parallel Rate	198	265	350	77
Percent Difference	55	26	6	

By abolishing the required import licenses needed to gain access to the auction a major source of bureaucratic intervention has been eliminated. The following reforms were undertaken to achieve a unified foreign exchange market and flexible exchange rate, as agreed with IBRD and the IMF.

1. Under the Structural Adjustment Program (SAP), the GOG is moving to achieve convergence of exchange rates from the two markets that will result in a realistic exchange rate in a unified market by the end of 1990, and complete liberalization of payments and transfers for current international transactions. The program for unification is two-phased. In the transitional phase the BOG will narrow the spread by implementing special auctions to allow access of forex bureaus to a larger share of auction funds relative to the regular auction. The special 'wholesale' auctions will be open only to authorized foreign exchange (FX) dealers (including the banks and bureaus) with a view to ensuring that end-users obtain FX from the regular auction or bureaus. At least 50% of the supply of FX from the Bank of Ghana (BOG) will go to the special auctions.

2. In April, 1990, the Bank of Ghana further liberalized the foreign exchange system. Now, commercial banks are able to purchase foreign exchange for their own account and trade it with other banks. As a result, the last major impediment to convergence of the forex bureau and auction rates has been eliminated.

BOG and Donor Experience with the Auction

Some bilateral donors using the auction have somewhat restrictive eligibility requirements on sources and commodities. The Dutch, for example, restrict the source to Holland or Third World Countries and commodities to agricultural inputs, raw materials for industry or agriculture, spare parts, or bitumen. A French agreement signed in December 1987 for French francs 26.5 million restricts the source to France and the franc zone, and commodities to raw materials, spare parts and vehicles. More onerous requirements imposed by other bilaterals,

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including the U.K. with program assistance requiring 100% U.K. content, and multilateral sectoral import programs (e.g., ADB fertilizer imports) encountered difficulties in using the auction and in disbursing funds efficiently. These and other funds are now disbursed in separate accounts at the auction rate. The World Bank and the International Monetary Fund have strongly urged donors to utilize the auction, and other bilaterals (Swaziland, Germany, Japan) are using or are considering participation in it.

Most observers expect these rates to further converge, with bureau rates increasing slower than auction rates. The BOG does not expect a unified rate, because these markets will continue to be segregated both by transaction costs and some continued capital flight which has been facilitated by the bureaus. Regarding recent draft guidance that the PAAD analyze potential problems of capital flight, it should be noted that the bureaus were established to generate proportionately larger inward remittances and service transactions relative to losses through capital flight, thus making this a desirable feature of the foreign exchange regime.

For donors, using the Forex Bureaus would also be very difficult because there are no established arrangements for obtaining information required by the parent agencies. Even information on the amount of the donor's grant actually sold and cedis generated would be impossible to obtain from the bureaus since they do not report on sources.

Recommendations

Since establishment of the auction in 1986, both the World Bank and the International Monetary Fund (IMF) have strongly urged bilateral donors to follow their lead in using the auction and to move increasingly toward quick-disbursing forms of program assistance that can be channeled through the auction. Most donors do so. Recent moves to expand the demand for funds via the auction should also be accompanied by an increased supply of funds, more than half of which has been coming from donor sources. The difference between auction and Forex Bureau rates has decreased from 54 cedis per dollar in July 1988 to 20 cedis by August 1990. USAID believes that there will be further convergence over the coming months and that adequate time should be accorded the GOG to bring this about.

Given these policy considerations, and the implementation problems associated with working through the bureaus, an exception to the exchange rate policy to permit exchange of Family Planning and Health dollars through the Bank of Ghana's auction system will be requested from A.I.D./Washington.

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C. Ministry of Health (MOH)

The overall institutional structure of the Ministry of Health (MOH) is described. An organogram is included as figure 1 at the end of this appendix. This section then looks at the structure of the Maternal and Child Health Division and the Health Education Division, and the Pharmacy Board. These three divisions have primary importance for the implementation of FPHP. Finally, the proposed reorganization of the MOH is discussed.

The current MOH health system reaches about 30 percent of the population, with the major share of health facilities and personnel located in the urban areas. Table 1 illustrates the number of MOH Staff by discipline or skill (Professional 32.8%; Technical 8.7%; Non-Technical (52.7%); Unclassified 5.8%). Only about 600 doctors work in the MOH. Many Ghanaian doctors left in the late 70s and early 80s and have not returned. Table 2 contains a list of MOH facilities by region comparing 1975 to 1985. Table 3 contains a list of MOH facilities by type comparing 1975 to 1988. While the number of hospitals and other major facilities remained stable over this period, the number of government clinics/maternity homes rose from 58 to 139.

During the 1970s to mid-1980s the infrastructure was allowed to deteriorate, and the government is currently involved in a program to refurbish its district level hospitals and primary health care facilities. The World Bank, African Development Bank, and other donors have been helping with this. About one-third of the health care is provided by non-governmental organizations. The Health Education Division (HED) is responsible for the Information, Education, and Communications (IE&C) activities of the Ministry received increased budget allocations in FY 89, and is doing an excellent job with only limited staff, albeit with substantial non-budgetary donor inputs. The Epidemiology Division is responsible for Childhood Diarrheal Diseases programs, including Oral Rehydration Therapy (ORT) as well as malaria control. Good data are available on obligations and expenditure for both the recurrent and capital investment budget -- in large part due to a World Bank Health Sector assessment in 1989 and MOH reporting. Tables 4 & 5 outline the major budget line items.

Headquarters Organization of the Ministry of Health

The Director of Medical Services (DMS) is responsible for public health operations in the country. The Deputy Director Medical Services (Medical Care) (DDMS-MC) oversees the curative sector and the Deputy Director Medical Services (Public Health) (DDMS-PH) the preventive sector. The Director for Manpower and Training reports directly to the Director of Medical Services as does a planning unit which does not have Deputy Director status. Divisions important to the project are under the DDMS-PH, and include Maternal and Child Health (MCH), Health Education (HED) and Epidemiology.

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Two Acting Chief Directors for Administration (permanent positions despite the acting title) at the DMS level are responsible for all specifically administrative actions in the Ministry, including partial responsibility for supply and management of the Central Medical Stores. DDMS (Hospitals) also has a supply division. This results in an extremely confusing system. USAID supplied contraceptives in the MOH system are stored in the UNICEF division of the Central Medical Stores.

The MOH headquarters operational authority lies in the Senior Medical Officer who is the director of each of the divisions under each DDMS.

The MCH division is responsible for implementing activities in family planning, safe motherhood and child survival.

The HED is responsible for all health education activities in the MOH regardless of which other division has primary responsibility for implementing service provision.

The Epidemiology Division is part of the DDMS-PH and includes units for Control of Diarrheal Diseases (CDD) and for parasitic diseases, including malaria. In addition, this division is responsible for the Extended Program of Immunization, AIDS, and health statistics.

Activities of functional divisions often overlap at central headquarters. For example, the oral rehydration salts program has its supplies managed by the supply division of the DDMS (Hospitals), its educational activities by the HED, its on-the ground implementation under MCH, and overall country implementation under Epidemiology.

Regional Organization of Public Sector Health Services

Each Region has a Regional Director of Health Services who is charged with overseeing the activities in his or her region. Each of these has a small staff with specific responsibilities. Unfortunately, there are organizational difficulties which split, for example, public health services in the region, even at the health center level, from the curative services. This leads to duplication of staff and an artificial fragmentation of service.

Service Delivery: Health services are provided by institutions at various levels. There are two teaching hospitals, Korle-Bu Teaching Hospital in Accra, affiliated with the University of Ghana at Legon, and Komfo Anokye Teaching Hospital affiliated with the University of Science and Technology (UST) in Kumasi. Korle-Bu is the national referral hospital, but Komfo Anokye Hospital is the regional hospital for Ashanti as well as being a major tertiary referral center.

Each of the remaining nine regions has a regional hospital (including Ridge Hospital in greater Accra) which is intended to provide full medical specialty services, and which is to be the final referral point from lower levels in the system. The regional hospitals are not as well-equipped or staffed as the teaching hospitals.

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District Health Organization:

The primary level of health service delivery is the District. About two years ago the sixty-five existing districts were divided into 110 new districts, a process that is still continuing as the new district human and physical infrastructure is assembled. Each district is intended to provide three levels of service, designated A, B and C. The 'A' level is the community health provider, including traditional birth attendants. These are to be supervised by MOH staff assigned to Health Posts or Health Centers (which have slightly differing staffing patterns) at the 'B' level. The district hospital is the level 'C' facility, and is intended to provide referral services and clinical oversight for the lower levels. It is difficult to tell what the distribution of facilities is since adequate records are not kept at the MOH. One estimate is that about half of the districts do not have district hospitals.

Responsibility for managing curative and public health services in each district lies in the District Health Management Team, a group that is headed by the District Medical Officer, and which involves the various political and administrative offices active in the District. Currently, approximately 27 of the 110 districts have Medical Officers in place.

Maternal and Child Health Division

The Maternal and Child Health Division of the MOH operates in six priority areas of action: malnutrition, maternity care, family planning, immunizable communicable diseases, diarrheal disease and malaria.

The Division is headed by a Senior Medical Officer, who reports directly to the Deputy Director of Medical Services (Public Health). She is assisted by one Deputy Director of Nursing Services (DDNS/PH), with support from one Principal Nursing Officer (PNO), one Senior Nursing Officer (SNO), one Nursing Officer and one Public Health Nurse (PHN). At the regional level, the Maternal and Child Health and Family Planning Division is headed by a principal nursing officer assisted by a senior nursing officer (SNO), nursing officer (NO), and public health nurse (PHN). The number of personnel at post varies from region to region and it depends principally on the availability of personnel.

Country-wide, the personnel at the MCH/FP division of Ministry of Health is as follows: 1 deputy director nursing services, 2 senior medical officers, 20 principal nursing officers, 107 senior nursing officers, 76 nursing officers and 84 public health nurses.

These professionals are supported at all levels by auxiliary nursing staff.

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A total of 1086 institutions offer MCH/FP services; 328 (30%) are being managed by the Ministry of Health. The distribution of institutions at the regional level is inadequate when compared with population demands. MOH requires an additional 246 health facilities to meet the national average ratio in each region. These may be governmental or non-governmental. However, based on the Primary Health Care Guidelines (1978) which recommend one health institution (Level B facility) per 8 km. radius, a total of 525 new Level B health institutions offering MCH/FP services is required for Ghana in the long term. It has not been possible to determine the number of localities with access to MCH/FP services. However, from available data, only about 50% of the population live within an 8 km. radius of a service delivery point.

A major change that will affect the project is the intended inclusion of the National Traditional Birth Attendant Secretariat under the Maternal and Child Health Division. Currently, the TBA Secretariat is not directly affiliated with any national division, but is housed in the Greater Accra Regional Ministry of Health facilities. Currently, all expenditures for this unit come from USAID project funds and are therefore not included in the Ministry of Health Budget. While there is commitment to bringing this project into a direct line relationship with an MOH division, and bringing its budget on line, the actual transition period is likely to be more complex, particularly since individuals involved with the project since its inception will be requested to relinquish control. Continuous monitoring and technical assistance from the implementing agency may be required as the situation develops.

Major constraints to service delivery are: insufficient manpower, insufficient supplies and equipment, inadequate number of service delivery, lack of staff accommodation and community attitudes.

Health Education Division

The Health Education Division (HED) is one of the MOH's key divisions for implementing Family Planning and Health Project.
A Principal Health Educator heads this division and reports directly to the Deputy Director of Medical Services (Public Health).

The division and is assisted by a Senior Health Educator and a Health Educator The Health Educator is currently the training coordinator for the Contraceptive Supply Project. Below these three Senior positions are 9 assistant health educators, two of whom are graphic artists. In addition there are 3 health education officers: one in-charge of drama who liaises with Ghana Broadcasting Corporation, one in charge of the AIDS program and the last is in charge of monitoring and evaluation of the family planning project education component.

At the Regional level, the Division is headed by a Health Education Officer who is in-charge of educational programs and campaigns in the region. Currently all the regions, except Volta and Upper East, have health education officers in-charge.

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At the regional level, each of the 10 regions has a Land Rover equipped with audio-visual equipment (16mm projector/screen), video deck and monitor for educational campaigns in the districts and villages. However, educational materials, including films and videotapes are rare.

The Pharmacy Board

The Pharmacy Board is a statutory body established by an Act of Parliament. The Board is composed of 9 members: 4 professional pharmacists, 3 medical officers, 1 legal advisor, and the Dean of Faculty of Pharmacy, U.S.T, Kumasi.

The Board is a policy-making authority whose responsibilities include registration of new drugs, control and regulation of drugs and pharmaceuticals, and the licensing of pharmacies and chemical shops. The Board meets once a month and its decisions are final and binding. The PNDC Secretary for Health is the only individual who can overrule the Board's decisions.

The Board has a Disciplinary Committee, chaired by the legal advisor of the Board. He is assisted by the Dean of Faculty of Pharmacy and one other pharmacist. The Disciplinary Committee has the mandate to apply strict sanctions for non-compliance with the Board's policies and regulations. Sanctions include; fines, suspension, closure of pharmacy shops/chemical shops or withdrawal of licenses.

The Board's policies or decisions are carried out by a Secretariat headed by a pharmacist/registrar. The registrar is assisted by 5 pharmacists, one acting as deputy, another as drug analyst and head of quality control. In addition, three inspecting pharmacists serve on the secretariat. They are assisted by the Deputy Directors of Pharmaceutical Services (MOH) in each region.

Even though the Pharmacy Board has board policy, regulatory and disciplinary responsibilities, its funding source jeopardizes its effectiveness. The MOH funds the board at will. If the MOH decides not to fund a particular disciplinary action, the Pharmacy Board is unable to act. Thus MOH programs are effectively free from Pharmacy Board control, even if they violate existing Pharmacy Board regulations. This is the case with the existing Contraceptive Supply Project distribution of Family Planning commodities through chemical sellers and midwives. Legally, both of these activities violate Pharmacy Board regulations. In fact, the Pharmacy Board is unable to take action.

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Consequently, participants in the existing programs fear that in the future policies may change, and regulations will be enforced retroactively. Since they would be in jeopardy of legal action, some hesitate before participating programs that violate existing Pharmacy Board regulations. The policy changes that this project will help implement are crucial to protect future participants from arbitrary changes in regulatory enforcement and therefore will broaden the numbers of providers who are able and willing to distribute these important commodities.

The Pharmacy Board is part of the MOH, but operates very much as an independent body, and the MOH has not always been able to get its cooperation. One of the conditionalities of the new project will require GOG agreement to switch Oral Contraceptives (OCs) from the Class A (dangerous drugs) list to the Class C. While discussions have already begun between the MOH and the Pharmacy Board as to how to accomplish this, further negotiations will be needed.

Reorganization of the Ministry of Health

MOH is undergoing a phased reorganization related to the general decentralization efforts of the GOG to give more authority to Ghana's 110 districts. The proposed structure is given as Figure 2 at the end of this appendix. Much of the MOH reorganization/decentralization effort is sponsored by the World Bank. The MOH has already formed a Donor Coordination and Implementation Division and staffed it. Reorganization of the MOH procurement system is underway, and the various MOH procurement groups are being consolidated into one major central division.

Following other ministerial structures in Ghana, a Chief Director will be appointed under the Deputy Secretary with a set of functional Directorates under him. Appropriately, the first Directorates will rationalize the supply functions and external aid coordination. To date, the other directorates to be created and their line responsibilities are subjects of intense debate within the MOH, and the final structure cannot be predicted.

Despite this political activity, the office of the External Aid Coordinator has been established and an incumbent named.

Under the reorganization the "vertical" programs (EPI, CDD, Malaria, MCH) will be decentralized to the 110 districts. It is not clear what the regional role will be but presumably it would include provision of specialists for the MCH/FP, IEC, and Epidemiology (CDD and Malaria) programs. Throughout the process of reorganization, USAID will maintain continuous policy dialogue in assisting the establishment of units that will be functional and enable the project to meet its goals.

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D. National Population Authority and Population Secretariat

The rationale for creating the national population authority is based on past experience. If Ghana's population program is to be successful it will be necessary to develop a national population implementation plan with agreed upon targets supported by a broad spectrum of public opinion among both the public and private sectors of the economy. Such a plan developed and supported by high level GOG officials would signal to all concerned that the government's renewed commitment to lowering the rate of population growth is serious. It would help mobilize the resources of the country in a way that is mutually reinforcing. In addition, this organized approach to national family planning would help identify resource and skill gaps and provide ample time for their resolution. In addition to the existing Ghana National Family Planning Program and the Population Policy Implementation Advisory Committee discussed above, the GOG has created a National Development Planning Commission (NDPC) which reports directly to the Provisional National Defense Council (PNDC). It is expected that the national population authority will be a sub-committee of the NDPC, and, as such, will have the authority to coordinate the activities of the various Ministries. The national population authority will have its own broad based senior level advisory council with members appointed from the community from government, private sector, NGOs, and private voluntary groups as warranted. It will be supported by a "Population Secretariat" to provide technical support needed to carry out its mandate. One of the conditionalities under the program component of the project will be establishing of this authority and staffing the secretariat, as well as providing the necessary budgetary line item to help assure its sustainability. To assist the government in the early years of the project, some of the local currency generated from the cash grant will be allocated to support this activity.

The national population authority will add to the government's institutional resources and will strengthen the planning and budgeting capacity, thus filling a organizational gap. The new national population authority will help translate the government's announced commitment to family planning into concrete action.

3. <u>Private Sector</u>

A. Commercial, For-Profit Pharmaceutical Firms:

Since this project is directed at strengthening the private sector, many of the activities will be carried out by commercial, for-profit firms. A primary goal will be broader distribution of pharmaceuticals, whether family planning commodities, oral rehydration salts or anti-malarials. A strong pharmaceutical manufacturer/distributor needs to be involved in managing the importation/manufacturing/distribution side of the project.

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Currently eight firms have the capacity to manufacture and distribute both tablet and liquid pharmaceuticals. None of these firms are capable of synthesizing or extracting raw pharmaceutical products, but all simply have the capacity to import pharmaceutical grade raw materials and combine them (as in mixing oral rehydration salts) (ORS) or simply make tablets or capsules from imported drug bases. For example, sugar and salt are produced commercially in Ghana, but no firm has the capacity to transform the commercial grade product into pharmaceutical grade that is needed for producing ORS. Similarly, all firms distributing chloroquine import the base powder and make it into capsules or elixirs rather than trying to synthesize chloroquine itself. Attempting to develop the pharmaceutical industry in this way is beyond the scope of the project.

At the time that the existing Contraceptive Supplies Project was being designed, the only firm capable of handling both the packaging and distributing contraceptives was DANAFCO. DANAFCO will be taken as a prototype of this industry. However, as stated in the project paper, once the project is established the contractor USAID may decide that the capacity in the pharmaceutical industry is sufficient to warrant competitive bidding.

'DANAFCO Ghana Limited' has three subsidiaries. DANAFCO Industries manufactures ointments and cosmetics, and is the parent organization for the Ghana Social Marketing Program (GSMP). DANAFCO/DUMEX manufactures and distributes pharmaceuticals, including GSMP oral rehydration salts. Pharmaplast manufactures plastic containers used by the other two subsidiaries. Of the three, DANAFCO/DUMEX is the only one with partial (35%) foreign ownership. Foreign investors hold two seats on the five member board of DANAFCO Ghana Limited.

While the three subsidiaries have different functions, they are managed by a single Managing Director, who has six general managers under him: (1) Personnel, (2) Administration, (3) Pharmaceutical production, (4) Accounting, (5), Internal Audit, and (6) GSMP. Each is responsible for carrying out his respective function for all three divisions, except for the GSMP general manager, who is responsible for a very small part of DANAFCO Industries operations. In fact, the GSMP's relatively weak position within DANAFCO is illustrated by the fact that it only accounted for about 1.5% of DANAFCO's gross revenue for the last year.
The strongest aspect of DANAFCO's operation is that its organized, country-wide distribution system. Five years ago, DANAFCO had depots in only two regions. Now it operates a network of ten regional depots and seventeen sub-depots which supply some 400 pharmacies and 2500 chemical sellers. Many of these pharmacies and chemical sellers act as middle-men providing supplies to small traders, who operate in the various markets. This, for example, is how the Market Women Project supplies its vendors.

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Under the existing GSMP, DANAFCO clears all commodities from port, repackages them into social marketing designed packages, and distributes them through its network. In addition, DANAFCO receives ORS raw materials from UNICEF, mixes and packages the powder using equipment and technology provided by USAID, and distributes the final product to both the private and public sectors.

With assistance from the USAID centrally-funded project Contraceptive Social Marketing II (SOMARC), DANAFCO manages the social marketing side of the GSMP. DANAFCO contracts for advertising production and oversees the marketing campaigns. Despite extensive SOMARC support, DANAFCO has not gained the ability to adequately manage the social marketing campaign. The reason for this is unclear. However, technical problems and/or insufficient profits may explain DANAFCO's managerial weakness.

This brief analysis raises an enormous number of questions, all of which relate to the design and outcome of this project. The crucial issue concerns the financial attractiveness of the social marketing project. Currently, all retailers retain all significant profit, thus leaving little incentive for wholesalers to become more active in marketing. This project will undertake a study to examine the impact of profits on distribution at all levels.

Because of these marketing issues, this project proposes to remove the social marketing component from DANAFCO's management. In fact, DANAFCO will lose very little from this move, since advertising for the products it distributes will still continue.

DANAFCO currently serves its networks relatively well depending on the depth of its organization. In the six southern regions, the DANAFCO regional depots are actually part of the DANAFCO organization, and these agents actively promote the products. In the Northern and Upper Regions the depots are run by sub-contractors, and the same enthusiasm does not exist. In places, such as Tamale, there are different sub-contractors for DANAFCO commercial products and for the GSMP products. This part of DANAFCO's system is not effective, and requires further study to determine the best distribution system that includes motivating wholesalers.

In addition, DANAFCO has only recently built up its distribution network, and currently only provides commodities to large towns and cities. To reach rural areas, new tactics need to be developed and implemented. In all likelihood, multiple distributors competing with each other will maximize rural market penetration.

As stated above, at the time of project development, no other pharmaceutical distributor appears to be a significant competitor with DANAFCO. However, the business scene in Ghana is changing rapidly, and by the time this project is implemented one may be available. Regardless of which firm implements the manufacturing and distribution side of the project, this analysis feels that the problems facing DANAFCO are typical for the industry as a whole.

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B. Commercial, For-Profit Industry

A number of large industrial operations have medical facilities which provide fee-for-service curative care to workers, their families, and the surrounding population. A 1988 report on the extent of individual company's medical capabilities and population catchment area indicates these companies should receive project attention.

The best example of this is the Ashanti Goldfields Corporation, which has a hospital and health service at its mining center of Obuasi. It provides free services for employees and their dependents, and subsidized services to other area residents. The total population served is about 300,000. In other parts of the world, industry has become interested in providing family planning services because it is cost-effective, reducing pregnancy rates decreases demands on inpatient maternity wings and reduces maternity leave among workers. Ashanti Goldfields is interested in pursuing these possibilities and will be able to do so with only minimal assistance in developing the technical capability in their already existing staff.

There are six other industrial hospitals in Ghana; all could be interested in providing services, particularly if Ashanti Goldfields' experience is successful. In addition, many large employers could offer family planning services as part of the package of health benefits they offer workers.

At a minimum, these industries will be offered supplies of non-clinical methods, including OCs, on a regular basis. They also will be invited to send doctors, midwives and nurses to training sessions and to project sponsored medical conferences or workshops. Access to long-term method technology will be offered as the technical capacity of a particular industry warrants. The sales and number of family planning acceptors recorded in clinic records will be monitored to determine the viability of the industrial sector as a potential recipient of additional project inputs.

C. Non-governmental Organizations (NGOs) and Private Voluntary Organizations (PVOs):

A number of NGOs work in Ghana. Some provide medical services, a few deliver family planning information and/or services, and others offer possibilities for adding family planning to their activities. In a separate analysis done for the PP, each of these were examined to determine their capacity to become effective, sustained providers of family planning and health goods, services and commodities. The major issues that will need to be addressed on an organization by organization basis are (1) the institutional capacity to manage the additional

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activities, and (2) other donor sources of support. The biggest distinction between these organizations is whether their membership can deliver clinical services. In this summary analysis, they are broken down into 'clinical' and 'non-clinical' organizations.

Clinical Non-governmental Organizations

The medical or family planning oriented NGOs with any significant viability include the Christian Health Association of Ghana (CHAG), the Planned Parenthood Association of Ghana (PPAG), the Ghana Registered Midwives Association (GRMA), the Society of General Medical Practitioners--Ghana, and the Ghana Psychic and Traditional Healers Association.

Christian Health Association of Ghana

CHAG has the institutional capability for expanding family planning services. Most of the 90 facilities which provide curative services have been in existence for many years. CHAG, which delivers a third of all medical services in Ghana, appears to be the supply source for less than 3% of family planning users. While there will be many difficulties in involving CHAG members in the family planning effort, they remain a substantial target of opportunity, not merely for family planning, but also for ORS and malaria treatment.

First among the many difficulties that is that 57% of CHAG member organizations are Catholic. This denomination has a natural family planning policy. Though CHAG's administrative staff believes the smaller number of Protestant units do not reflect accurately the higher proportion of services delivered, no supporting data are available at the association headquarters. Second, CHAG has begun to reorient toward PHC, but its mission remains one of ministration to the sick. Finally, it appears to be organizationally weak. CHAG is more of an affiliation of groups with some common needs and goals, and not a true association or organization with authority to implement decisions. Thus, as an organization it has a fairly small impact on the policy and services of its fourteen member denominations. In spite of shortcomings, CHAG will receive special Project attention as a recipient of contraceptive supplies. As opportunities for training of staff occur, CHAG will participate. Training is particularly important in the area of counseling. In addition, selected doctors and midwives will be trained in long-term methods as part of the project's planned clinical training. The Project team should monitor CHAG's performance as a family planning provider.

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Planned Parenthood Association of Ghana (PPAG)

The Ghanaian International Planned Parenthood Federation (IPPF) affiliate is the private voluntary organization that provides the most family planning information and services in Ghana. In 1989, PPAG provided services to about 100,000 acceptors in 46 clinical settings and provided non-clinical services to about 42,000 acceptors through 168 community agents. According to the 1988 Demographic and Health Survey, PPAG provides service to about 19% of modern method users in Ghana. In support of this project's policy initiatives, PPAG has taken a lead in demonstrating to the GOG that community-based health workers can responsibly provide oral and other contraceptives. In 1989, PPAG received a total of $855,000 in cash and commodities from IPPF. The World Bank is planning to support PPAG as part of its current loan package now being negotiated with the GOG.

Issues: Like many NGOs in Ghana and elsewhere, the primary difficulties facing PPAG are managerial. Despite assistance from IPPF/London, client records are poor. Supervision of community agents is also lacking, and a recent Price-Waterhouse management review recommends that more senior program officers be hired to supervise distribution agents and more evaluation officers to track program impact. Current planning also revolves around issues like user fees, cost recovery, business planning, fund-raising and sales margins. Basic business practices are often not incorporated into programs.

Because of the large World Bank grant, USAID probably will not become involved with assistance to PPAG. The most important reason for this is that PPAG lacks the absorptive capacity to receive more aid. If the managerial assistance package that is being developed in the project is effective, PPAG may request specific assistance in that area. Although it is not a specific target of USAID assistance, PPAG is one of Ghana's the most important family planning service providers. The USAID project will need to coordinate activities with it. The problems that PPAG faces appear to be typical of many NGOs in Ghana, and may serve as guidance as to the types of assistance that will be required to help NGOs become more functional in the future.

Ghana Registered Midwives Association (GRMA)

The GRMA was established in 1953 as the professional association of Ghanaian midwives. In 1954, GRMA became the first sub-Saharan African association to be admitted to the International Confederation of Midwives. As of August, 1989 there were 400 dues paying members. Between eighty and ninety percent of the membership are midwives in private practice. This usually takes the form of maternity homes offering antenatal, delivery and postpartum care. Many offer health care for well and sick children and family planning counseling. Because many of them are the only health advisors in the rural areas where they practice, they will be important service providers of ORS and malaria treatments.

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GRMA is an example of private and public sector cooperation. GRMA and the MOH are working together to integrate their training, referral systems and quality control standards to be applied to midwives' private practices. Additionally, ways are being sought to strengthen the links between registered midwives and traditional birth attendants. If this is successful, the quality of pre-natal care available in rural areas will substantially improve.

Despite its long history, GRMA was ineffective during the economic crisis. USAID awarded a grant to the American College of Nurse Midwives (ACNM) over the last three years which has enabled the GRMA to strengthen headquarters management, resource and budget planning, regional chapters, and training and supervision.
Issues: While GRMA clearly needed family planning training and commodity supply, what was not appreciated during initial project design was the extent to which administrative training would be required. One lesson repeated throughout the institutional analysis is that management is the most common weakness in every organization. As a result, the contractor is expected to develop management training and support services to assist many of the NGOs that will receive assistance under the project.

A second major issue is the need to expand GRMA, both in total membership and in additional private maternity homes. While there are currently 400 members, this represents only a small proportion of the 8000 midwives who are registered in Ghana. Many are in the public sector and many are not practicing, but establishing links to them will be a major organizational goal which will determine the long-range sustainability of GRMA as an organization.

The third major issue is that the individual responsible for GRMA's re-emergence is very close to retirement, and a successor has not yet been identified. GRMA and ACNM are aware of this pending transition, and are working to identify such a person and train her to be a leader.

Society of General Medical Practitioners--Ghana

This is a very small, loose, weak organization of physicians. Some assistance with technical training has been given in the previous project. Since only about 300 physicians are in private practice, and most of them are clustered in urban areas, they will not be significant providers of short-term methods. However, the private medical sector has the capacity to become very important in the delivery of long-term methods, principally surgical contraception and Norplant. While training will continue under the new project, it is uncertain whether organizational assistance will be appropriate.

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Ghana Psychic and Traditional Healers Association

Recently, the MOH has become interested in promoting traditional medicine and has even established a deputy director level division of traditional medicine. This organization is extremely loose, and probably cannot become a significant force in the health field. Nonetheless, involving traditional healers in some of the interventions proposed by the project--specifically ORS and some of the family planning methods--may increase their legitimacy and acceptance among the clientele of these practitioners.

Non-Clinical Non-Governmental Organizations

A plethora of other NGOs operate in Ghana. The ones listed here were selected from the list of social, civic, development organizations, and cooperatives, such as the YMCA, Rotary Club, National Council on Women and Development (NCWD) and local bodies of the Ghana Cocoa Board. In addition, many local NGOs provide organization and services. The Ghana Association of Private Voluntary Organizations in Development (GAPVOD) is an association of these NGOs, but is largely a very loose umbrella organization. The project contractor will need to do substantial ground work before plans can be made to develop this into a viable implementing agency.

For the purposes of this analysis, this list was narrowed to two women's groups and one association of teachers and extension agents.

The National Council on Women in Development (NCWD) was organized in 1975 to initiate the UN Decade for Women and has ministry status. Its mission is to bring women into more equal status with men. Activities focus on income generating projects, research on economic, education and health status, public education, and emergency services. In 1988, the NCWD was funded by USAID to undertake a pilot project with Accra market women. The project identified petty traders receptive to adding condoms and vaginal foaming tablets (VFTs) to items they hawked. These women were given basic training about non-clinical methods, including oral contraceptives, and information about referral points for methods they could not sell. They were supplied with condoms and VFTs. Results of an operations research project will be available to the Project team and will be analyzed to evaluate performance in relation to the viability indicators. Resources are included in the Project budget to allow for expansion of the market women's project, either through the NCWD or another mechanism.

The Council may be a more valuable resource to the Project in other ways as it reviews policy and moves more toward an advocacy mission and relinquishes project activities.

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The 31st December Women's Movement is a group which stresses grassroots membership and activities. As such, it touches the lives of women in small urban communities and in villages throughout Ghana. This popular movement, under the leadership of PNDC Chairman's wife, appears to offer good potential for bringing family planning to large groups of women. The 31st December Women's Movement is included for Project support because of its large network of members and high level political support. Again, the Project team will need to analyze the viability in relation to criteria for cost effective performance in delivery of non-clinical contraceptives.

Ghana Home Economics Association (GHEA) is the professional association of teachers trained to educate primary and secondary school pupils in homemaking skills and family life education. These teachers live in or near the communities in which they teach. They are good candidates for acting as home or school sales depots for non-clinical methods. This is a nice fit of product, price, place and promotion.

As an association, the GHEA is organized to be in contact with its members. This is an important factor for both training and supply. As with retail shop owners, the Project will need to consider the most reasonable (in logistics and cost) means for training this scattered provider group. Self-instruction materials should be given careful consideration and tested for effectiveness. Regular contraceptive supply will need to be provided, either through an arranged delivery system or through information about nearest sources where certified teachers can purchase at preferential prices. Operations research designed to gather data and information on performance is suggested for the GHEA project. Resources are included in the Project for this group of teachers.

D. Potential Social Marketing Firms:

Because of the difficulties described in the technical analysis that have been experienced with the previous social marketing firm, DANAFCO, this project proposes the establishment of a Ghanaian firm that will take the lead in this field. It is expected that, with technical assistance from the lead contractor, this firm will be able to be completely Ghanaian staffed by the third year. In the Technical Appendix, two other distribution firms were described: G.B. Ollivant and Pioneer Tobacco. While the design team hopes that these will be willing to be distributors of the project commodities, it is unlikely that they will become significant social marketing firms.

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However, there are an array of other possibilities: For several years, the social marketing program has used the Lintas advertising agency. It has the capacity to become the core of a social marketing firm. With the recovery of the Ghanaian economy, a wide variety of other advertising firms, some of which are concentrating on social marketing issues such as AIDS, have sprung up. Clearly, not all of these will have the resources to become self-sustaining firms, but there is an enormous array of talent to choose from.

A third possibility is to use the services of a business support or accounting firm that wishes to expand its technical capabilities. There are representatives of a variety of these in Ghana, including Price Waterhouse and Peat Marwick. While the international affiliates are less likely to be interested in performing these functions, there are a number of similar firms that Ghanaian entrepreneurs are establishing.

While it will be difficult for the prime contractor to select and develop the capacity of a Ghanaian firm, the mission and the Government of Ghana view it as one of the most important steps towards sustainability of the project.

4. Bilateral and Multilateral Donor Activities

The major donors are in the midst of preparing their programs for the 1990s. The following chart shows preliminary funding levels for donor assistance.

Indicative Planning Figures
Health and Family Planning
(1990 -- 1995)
$ (millions)

USAID FP and Health	5 years	30
World Bank Health and FP	3 years	25
UNFPA	5 years	10
UNICEF	5 years	10
WHO	5 years	7
ODA	5 years	10
Tentative Total		$92

**1. Source: Table 10 taken from The World Bank's "Ghana Population, Health and Nutrition Sector Review" document dated 3/31/89.*

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A. World Bank

Probably the most significant donor input, the World Bank's "Ghana--Health and Population II Project", is now being prepared --$25.0 million over three years (1990/91/92). The $25.0 million three-year project, developed by the MOH, was appraised in early 1990 by a World Bank team, and is presently under review at World Bank headquarters. According to the World Bank resident advisor, the initial proposal is too complex and needs revisions, which may delay the project approval process from late April to July.

The essential project components are:

1) Population/Family Planning

Two areas of assistance are planned:

- Support for unfilled needs of MOH in MCH/FP, as well as for the build-up of a new program promoting Safe Motherhood (MCH/FP $1.4 million; Safe Motherhood $1.6 million).

- Assistance to the Planned Parenthood Association of Ghana (PPAG), for both clinics and an expanded community-based distribution program -- provided agreement is reached with the International Planned Parenthood Federation that PPAG's present institutional problems will be overcome by the assistance to be provided by IPPF itself and various donors. (PPAG - Clinics $2.3 million; PPAG-CBD $1.9).

The above amounts for population family planning should be treated with considerable caution since the proposals of the MOH are just beginning to be reviewed by the WB headquarters.

2) Drugs: This includes provision of drugs and rehabilitation of regional stores and other related facilities.

3) MOH Institution Building: The Ministry is still preparing detailed plans which will include, inter alia, a Management Information System for implementing better MOH investment programs, supervision at all levels of the health system, improvement of the logistics and manpower assistance.

4) Hospital Equipment and Maintenance: This component is intended to equip the regional and district hospitals, both MOH and Catholic in the Northern, Upper West and Upper East Regions.

5) District Level Primary Health Care (PHC): Support of PHC management through helping to meet needs of district health management teams.

6) Prizes Fund: An innovative component to encourage better performance among communities, individual health workers (and later teams) and health institutions which will be evaluated and compared annually.

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The World Bank intends to support USAID policy reform concerns by making the establishment of the National Population Authority a condition for disbursement for the $3.9 million Population and Family Planning component of their project.

B. United Nations Fund for Population Activities (UNFPA)

The UNFPA is currently beginning to implement a project designed in the fall of 1989. This is a US $10 million project whose elements include:

1) Assist the GOG to develop a renewal of the population policy and institute the establishment of a National Population Commission [This is the equivalent of USAID's proposed national population authority].

2) Support MOH information, education and communication activities by: a) Developing materials and staff to implement Family Life Education in the Ghanaian school system; b) assisting the Institute of Journalism to develop appropriate reporting capacity; c) targetting radio programming to the three Northern regions; d) assisting with the development of adult literacy programs; and e) assisting a variety of religious groups to expand their family life education and counseling activities.

3) Support of maternal and child health/family planning (MCH/FP) activities in the Ministry of Health by: a) creating planning units in each of the ten regions to expand the regional capacity to plan, coordinate, b) implementing and monitoring integrated MCH/FP programmes; c) training 2,500 TBAs in MCH/FP skills and other MOH staff needed to supervise these TBAs; Training of 80 mid-level health personnel at national, regional and district levels to be able to strengthen the district health management teams. UNFPA will assign two expatriate advisors to the MOH to be located in the MCH division and the Manpower and Training division.

4. Perform variety of other studies are proposed to help better understand constraints on women in development and policy analysis.

In addition to the above institution building components, UNFPA is contributing contraceptive commodities worth about US$ 500,000. The goals of this project are very closely aligned with USAID goals. World Bank and UNFPA inputs to strengthen the institutional capacity of the MOH are crucial to the success of the USAID project.

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C. UNICEF

The UNICEF Program will provide essential drugs and continue its support to PHC community-based activities. It will continue to supply raw materials for ORS production to DANAFCO for packaging and wholesale distribution and a limited amount of malaria tablets as it has over the last three years. Its only family planning activities will be in the context of its primary health care activities and participation in the "Safe Motherhood" program. Its program for 1990-1995 is currently under preparation and the budget was not available.

D. World Health Organization

The WHO program is oriented to health care at the district level and below. Only $10,000 of its $1.3 million dollar program for 1990/91 will be devoted to family planning activities. It is a strong supporter of the "Safe Motherhood" program.

E. International Planned Parenthood Federation (IPPF)

The IPPF contribution goes entirely to the Planned Parenthood Association of Ghana, and is described in section 3.C. above.

F. Donor Coordination

An operational foundation exists for coordination between multilateral, bilateral donors and the Government of Ghana. Donors in the health/family planning sector meet once a month to discuss program implementation, health sector issues, technical resource and other requirements and short-term, medium term planning. While ideally MOH should convene and organize the donor meetings, given its other urgent priorities, it would be premature to ask the MOH to take over the responsibility for donor coordination at this time. At present, the meetings are organized by the World Bank and USAID and all donors are welcomed to participate. Representatives from the Ministry of Health (MOH) and the Ministry of Finance and Economic Planning (MFEP) take part in all the meetings.

5. Conclusion

Based on the analysis above, better coordination will be required among the Ministry of Finance and Economic Planning, the Ministry of Health, and the Bank of Ghana if the project goals are to be achieved. Considerable assistance, primarily from other donors, is being directed at this problem. Similarly, the lack of coordination and insufficient institutional capacity limit the MOH's ability to implement the project. This project specifically addresses institution building in the Health Education Division, and provides funding for continued expansion within the Maternal and Child Health Division. With other donor support, this should be sufficient to ensure project success.

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Establishing the national population authority will require a considerable amount of dialogue, not merely between USAID and the GOG, but also involving other donor and implementing agencies as well.

The private sector, has sufficient capacity to implement the project. However, one of difficulties is that demand for assistance from the many NGOs/PVOs may exceed available aid. The project contractors will need to set priorities both on the types of organizations that are assisted, as well as the type of assistance given. The major private sector difficulties are establishing a social marketing organization and developing distribution channels for goods and services to rural areas.

Donor activities are relatively well-coordinated, and are mutually supportive. This process is expected to continue as the Ministry of Health further develops its ability to effectively coordinate external agencies.

In sum, the institutional structures needed for the implementation of this project exist, and allowances have been made to strengthen those that are not currently strong enough to bear the intended load.

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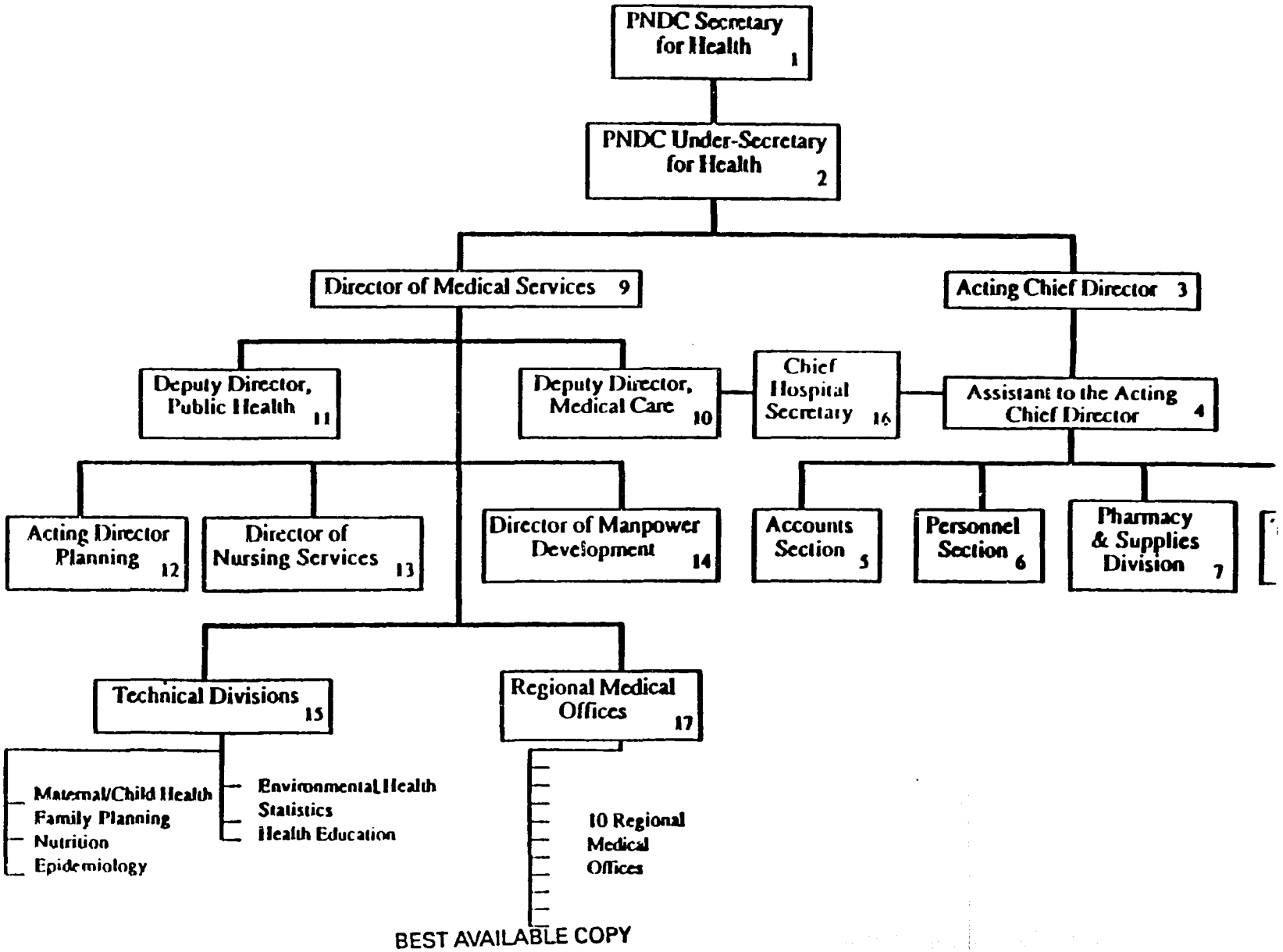
REPUBLIC OF GHANA

Current Organization Chart for the Ministry of Health



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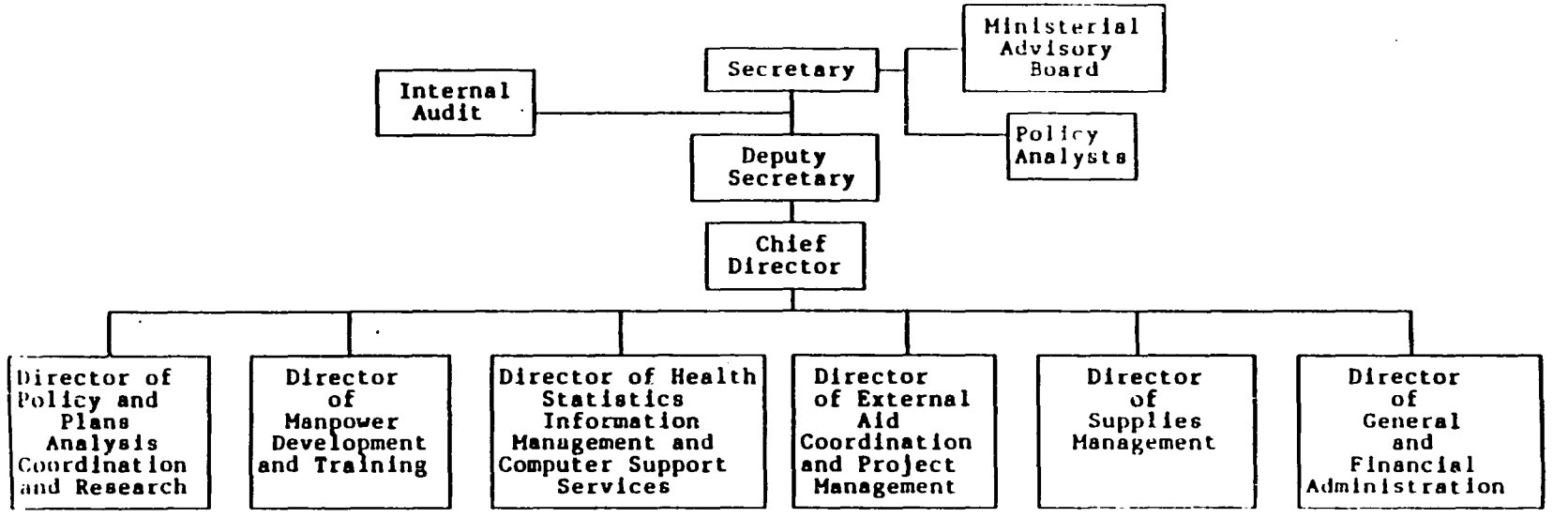
REPUBLIC OF GHANA

Proposed Organization Chart for the Ministry of Health



Director of Policy and Plans Analysis Coordination and Research	Director of Manpower Development and Training	Director of Health Statistics Information Management and Computer Support Services	Director of External Aid Coordination and Project Management	Director of Supplies Management	Director of General and Financial Administration
Policy and Plans Analysis Coordination for Public Health	Manpower Planning	Health Statistics	External Aid Coordination	Supplies Management	General Administration
Policy and Plans Analysis Coordination for Medical Care	Management Services	Information Management and Public Relations	Project Management	Coordination of Procurement	Finance
Program Budgeting	Training	Computer Support Services		Coordination of Storage	Legal Services
Monitoring and Evaluation				Coordination of Distribution	
Coordination of Research				General and Financial Administration for Supplies Management	

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TABLE 1

MOH STAFFING, 1987

	Number	% of Total
Professional:	12,513	32.8
Physicians	587	
Dentists	63	
Nursing:	11,863	
professional	3,512	
Auxiliary	8,351	
Technical:	3,318	8.7
Admin. Classes	32	
Accounting	70	
Executives	208	
Technical Officers	1,418	
Health Inspectors	1,260	
Supply/Materials/Stores	330	
Non-Technical:	20,104	52.7
Artisans, Skilled/Manual	6,780	
Catering	385	
Secretarial/Clerical	727	
Ungraded Posts	12,212	
o/w Students	1,652	
Cooks, Kitchen assistants	655	
Clinic attendants, clinic orderlies, disp. attendants	1,367	
Clinic, hospital, hostel, and health center orderlies	4,317	
Other	4,221	
Unclassified	2,203	5.8%
Total	38,138	100.0

Source: Office of the Head of the Civil Service.

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TABLE 2

HEALTH FACILITIES BY REGIONS AS AT JAN. 1990

REGION	HOSPITALS									CLINICS			TRAINING INSTITUTE
	TEACH -ING	REGION -AL	DIST -RICT	SPEC -IAL	QUASI -GOVT	MISSION	MINES	HEALTH CENTRS	HEALTH POST	GOVT	QUASI-GOVT	MISSION	
Greater Accra	1		4	3	4			9	10	11			7
Volta	-	1	5	1	1	6		12	30	64		5	4
Eastern	-	1	10		1	4	1	10	23	7		12	5
Central	-	1	3	2	1	4	1	6	30	9		6	3
Western	-	1	8	1	2	3	3	6	29	12	5	4	1
Ashanti	1	-	3	2	2	9	2	16	35	19	1	14	5
Brong Ahato	-	1	1	-	1	9	-	10	17	29	2	4	4
Northern	-	1	2	2	1	3	-	7	21	10	-	7	3
Upper East	-	1	1	-	-	1	-	2	10	-	1	10	1
Upper West	-	1	2	-	-	2	-	-	28	6	-	2	2
TOTAL	2	8	39	11	13	41	7	78	233	167	9	64	35

Source: Ministry of Health, National Health Planning Unit

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TABLE 3

RECURRENT BUDGETS FOR PRIMARY HEALTH CARE [illegible]
(Million)

Head	Sub-Head	Program	% of Budget Head	Recurrent Budget Estimates 1986	1987	1988	Increase % 1987	1988	1988	1987
150		MOH (GENERAL SERVICES)		331	455	571	[illegible]	[illegible]	[illegible]	[illegible]
	1	General Administration	15	285	400	536	40.3	[illegible]	[illegible]	[illegible]
	2	Budget & Planning Division	0							
	3	Common Services	0							
	4	Regional Health Administration	45	49	38	32	-22.1	[illegible]	[illegible]	[illegible]
	5	Stores	15	11	9	12	-16.2	[illegible]	[illegible]	[illegible]
	6	Health Education	30	6	8	11	25.0	[illegible]	[illegible]	[illegible]
	7	Center for Health Statistics	0							
	8	Training	0							
	9	Internal Audit	0							
	10	Research Center for Plant Medicine	0							
151		KORLE BU TEACHING		33	22	36	-33.1	32.3	[illegible]	[illegible]
	1	General Administration	0							
	2	Medical Dental Services	10	33	22	36	-33.1	32.3	[illegible]	[illegible]
	3	General Services	0							
152		KOMFO ANOKYE HOSPITAL		17	13	13	-22.5	[illegible]	[illegible]	[illegible]
	1	General Administration	0							
	2	Medical Dental Services	10	17	13	13	-22.5	[illegible]	[illegible]	[illegible]
	3	General Services	0							
163		MEDICAL, DENTAL SERVICES		1146	1037	1518	-9.5	[illegible]	[illegible]	[illegible]
	1	Dental Services	0							
	2	Environmental Health Services	100	323	298	438	[illegible]	[illegible]	[illegible]	[illegible]
	3	Epidemiological Division	100	281	251	350	-10.7	[illegible]	[illegible]	[illegible]
	4	Health Laboratories	10							
	5	Maternal & Child Health	100	206	192	326	-6.8	[illegible]	[illegible]	[illegible]
	6	Medical Care	15	297	264	357	-11.2	35.2	[illegible]	[illegible]
	7	Mental Health	0							
	8	Nutrition Services	100	39	32	47	-17.9	[illegible]	[illegible]	[illegible]
	9	National Blood Transfusion Services	0							
		TOTAL		[illegible]	1527	2237	-1.3	[illegible]	[illegible]	[illegible]
		PRIMARY HEALTH CARE AS % OF TOTAL		[illegible]	22.0	22.8				

Source: MOH, MFEP.

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TABLE 4
PUBLIC INVESTMENT PROGRAM IN HEALTH 1988-1990
(C MILLION)

A. TOTAL

Number	Project/Program	1986 FC	1986 LC	1986 Total	1987 FC	1987 LC	1987 Total	1988 FC	1988 LC	1988 Total	1989 FC	1989 LC	1989 Total	1990 FC	1990 LC	1990 Total
MED																
001	Primary Health Care Strengthening	195		195				214	20	234	503	20	523	575	20	595
002	Institutional Strengthening	30	21	51				72	21	93	144	52	196	162	83	245
003	MCH/Family Planning Rehabilitation	45		45				529	40	569	509	30	539	493	30	523
004	Nutrition Centers Rehabilitation	30	15	45				112	20	132	106	40	146	106	40	146
005	Health Stations Comp. and Rehabilitation Prog.		289	289					300	300		469	469		500	500
006	Equipment for Health Stations	60	28	88				143	103	246	222	120	342	201	120	321
007	New Health Status							100	50	150	200	200	400	300	300	600
008	District Hospitals Rehabilitation		100	100				160	408	568	680	750	1,430	880	950	1,830
009	Regional Hospitals Rehab.		50	50					200	200	360	200	560	360	250	610
010	Teaching Hospitals Rehab.		45	45					100	100	523	100	623	265	100	365
011	Psychiatric Hospitals Rehab.		34	34				30	70	100	72	100	172	83	100	183
012	Leprosaria Rehabilitation		3	3				15	15	30	11	15	26	10	13	23
013	Health Training Institution Rehabilitation		27	27					80	80	566	80	646	334	40	374
014	Health Support Services Rehab.		16	16				50	100	150	160	150	310	74	150	224
015	Research Centre into Plant Medicine		2	2				4	6	10	4	6	10	4	6	10
016	Radiotherapy Center - Korle Bu							15		15	479	200	679	424	175	599
017	Solar Power Proj. for Health Stations							15		15	712	80	792	727	100	827
018	Logistic Support - MOH								170	170	130	135	265	125	80	205
019	Neurosurgical Unit - Korle Bu							15	5	20	800	16	816	388		388
020	Cardio-Thoracic Unit							15	5	20	1,404	15	1,419			0
	TOTAL	360	630	990			2,218	1,489	1,713	3,202	7,595	2,773	10,363	5,511	3,057	8,569

Source: MOH, MEEP

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TABLE 5

PHARMACIES AND CHEMICAL SELLERS 1988

Region	Registered Pharmacies				Licensed Chemical Sellers	Total Drug Outlet
	Wholesale	Wholesale &Retail	Retail	Total		
Greater Accra	32	89	93	215	259	474
Ashanti	3	42	40	85	523	608
Brong Ahafo		4		4	446	450
Central		2	7	9	312	321
Eastern		6	9	15	558	573
Northern		3	2	5	188	193
Upper East						
Upper West		1		1	128	129
Volta		2	5	7	262	269
Western	1	15	2	18	401	419
Total	36	165	158	359	3,077	3,436

Source: MOH

Note: Total drug outlets excludes hospital pharmacies and manufacturers.

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TABLE 6

NON-GOVERNMENTAL ORGANIZATIONS OPERATING IN THE HEALTH SECTOR IN GHANA

Non-Governmental Organizations (Date of Information)	Regions	No. Communities	Program Expenditure ($000) MRC	(IP	Nutrition)	Water & Sanitation	Total Expenditure ($000)	Remarks
Adventist Development & Relief Agency-ADRA ('87)	All	633	171	*	*	500	2700	- 2.4 mil $ in donated foods - 36 nutrition centers
Catholic Relief Service - CRS ('88)	Northern Upper East Upper West Brong Ahafo Ashanti	420	*	*	6081		6091	- 4.8 mil $ in donated foods - all centers staffed by MOH
Christian Council of Ghana ('87)		10 clinics		30			30	
Meals for Millions ('88)	Brong Ahafo	15	100	*	*	10	110	
Planned Parenthood Association of Ghana ('87)	All but Volta Upper East &Upper West	46 clinics 168 CBD outlets	*	260			268	- excludes donated IP commodities, equipment, vehicles & volunteers
World Vision Relief Organization ('88)	All but Ashanti	90	636	*	*	250	2544	
Young Women Christian Association ('88)	All		*	*			130	

* Based on the value of government subventions to the mission facilities as approximately 50% of operating costs of these facilities.

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Table 6
(continued)

Mission Hospitals	Regions	No. Hospitals	No. Clinics	No. Beds	No. In-Patients	No. Out-Patients	Total Expenditure ($000)	Remarks
Christian Hospitals Association of Ghana ('87)		Total estimated expenditures of members					1918	-does not include value of MOH subventions nor foreign donations
1. National Catholic Secretariat ('87)	All	25	19					
2. Presbyterian ('88)		3	2	644			513	
3. Adventist ('87)	Ashanti	1		15	1389	16542	64	-30% OP & 111% IP increase from '88
4. Salvation Army	Ashanti, Eastern & Central		6					

Source: World Bank Estimates.

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ANNEX D

FINANCIAL ANALYSIS

I. FINANCIAL ANALYSIS

A. Project Costs and Recurrent Expenditures

A.I.D. is providing $30.0 million for the Family Planning and Health Program: $13.0 million for the program assistance component to support the Government of Ghana's Economic Recovery Program and to promote population and family planning policy reform, and $17 million for project activities (technical assistance, training, commodities, studies, research and evaluations). The project assistance funds will finance primarily foreign exchange costs. Every effort has been made to procure project assistance goods and services at the least cost to the program. The non-project assistance grant of $13.0 million will be auctioned by the Bank of Ghana. Since the Government of Ghana will use the program assistance grant for creating an environment favorable to achieving the program's goals, program assistance maximizes the use of the available funds.

The Government of Ghana's contributions to the project component are estimated at $9,915,000 (in-kind contribution) and $1,653,000, in equivalent cedis, for parallel A.I.D.-financed foreign exchange expenditures. Much of the in-kind contributions represent existing Government resources which are normally available to support Ministry of Health (MOH) activities. However, the Government is expected to fully fund the budgets of the Maternal/Child (MCH) Division and the Health Education Division of the Ministry of Health (MOH) throughout the life of the project in order to maintain MOH supervision and delivery of public family planning and MCH activities and to intensify the Government's family planning and MCH information, education and communication campaigns. This will effect an overall increase in the Government's cash outlays for MOH. It is difficult to predict the level of funding which will be actually required for these two divisions until the Government has established its demographic and family planning targets. The funds for parallel project expenditures are for the local cost of training various health care professionals. If quality delivery of family planning and MCH services is to be maintained, adequate funds for training will need to be programmed into the MOH's annual budget.

Another cost for the Government of Ghana (GOG) is the support for the national population authority which will plan and direct the national population and family planning effort. The Government is expected to finance the operations of the authority through its normal budget process.

A major cost and crux of any national family planning program is the provision of commodities. Through the Family Planning and Health Program A.I.D. is financing the procurement of $6.5 million of contraceptives. These contraceptives represent the majority of the total projected national need for contraceptives to achieve the target of 15% modern contraceptive prevalence. If the USAID-financed program is successful,

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modern contraceptive prevalence is expected to increase continually. The cost of contraceptives will need to be financed at increasing levels beyond the completion of the A.I.D. program. Under the A.I.D.-financed Contraceptive Supplies Project, the Ministry of Finance maintained a Return to Project Fund to recover a small percentage of proceeds from the sale of A.I.D.-donated contraceptives. This Return to Project Fund was a step towards cost recovery program for the purchase of contraceptives and will continue under the Family Planning and Health Program.

B. Financial Sustainability

The financial sustainability of Ghana's population and family planning program is a critical factor in maintaining the momentum in increasing modern contraceptive prevalence and reaching Ghana's population and family planning goals. The Family Planning and Health Program's interventions rely primarily on the mobilization of private sector resources to improve the delivery of family planning and maternal/child health services, information, and commodities. The Government of Ghana, through the program assistance component, is expected to create a policy environment which will enable the private sector to expand its role, as part of a concerted national effort to attain Ghana's population and family planning goals However, until the private sector is able to finance a large share of family planning and maternal/child health services and commodities, the Ministry of Health will require substantial resources to support family planning and maternal/child health interventions. Therefore, the project component requires a substantial contribution from the Ministry of Health, much of which will need to continue beyond the completion of the Family Planning and Health Program.

1. Government of Ghana Health Care Expenditures

Although the Government of Ghana has made a specific commitment to family planning and maternal/child health, in the past resources have not been available within the Ministry of Health's budget to fuel the Government's program. The Ministry of Health's budget (capital and recurrent) in 1988 was estimated at 11.5 billion cedis or 9% of the national budget, as seen in Table 1. While this share of the national budget is relatively high for Africa, most of it is used for curative care and ministry administration. This has important ramifications for improving family planning and MCH service delivery as it falls under the rublic of primary health care, which was estimated at 24% of the MOH budget in 1989, respectively. Barring a substantial increase in the overall MOH budget, an improvement in allocations to primary health care, including family planning and MCH, can be achieved through a reallocation of MOH resources from curative to primary care.

Although primary health care represents 24% of the ministry's budget, actual expenditures represent a much lower percentage. This is partially due to the differences between budget allocations and actual budgetary releases. Additionally, not all budgetary releases are actually spent,

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which further lowers the actual resources applied to primary health care. For example, as noted in Table 3, the Health Education Division spent only 8% of its budget. Several reasons may account for this, including inappropriate financial encumbrances which provide funds for activities which are not part of a department's responsibilities and late releases of funds to a department, occurring midway in the financial quarter or too late in the current financial year to be expended. Once releases become more timely, actual expenditures will be better synchronized with the budget allocations.

The picture for primary health care is improving. As shown in Table 2, the allocations for health education, environmental health services, epidemiology, and maternal/child health were estimated to have increased from 1988 to 1989 by 591%, 44%, 32% and 147%, respectively. The share of primary health increased from 22.8% to 24.1% of the MOH budget, while the MOH budget overall increased by 61% during the same period.

3. Projected Government of Ghana Health Expenditures

If the present trend continues, primary health care, including family planning and maternal/child health, is expected to attain an increasing allocation of the MOH budget. Therefore, it is expected that MOH will be able to maintain recurrent expenditures for family planning and MCH service delivery. However, it is difficult to predict the actual expenditures required to maintain the national population and family planning program until the national population authority establishes demographic and family planning goals. The institutional contractor is expected to provide technical assistance to the authority in the development of the national plan, including estimation of financial and other material resources, which is feasible and sustainable.

Additionally, an estimated 2.64 billion cedis are expected to be generated from the $13.0 million program assistance component of the Family Planning and Health Program. These funds will be programmed to augment the regular Government allocation for MOH primary health care recurrent expenditures, including family planning and maternal/child health, and to finance partially the budget for the national population authority and its secretariat. The total amount of local currency generations when programmed over the life of the Family Planning and Health Program would average 36% of MOH's current primary health care expenditures per year, based on the estimated 1989 budget.

4. Return to Project Fund

A large portion of recurrent expenditures will be for the purchase of contraceptive supplies. The availability of donor-supplied contraceptives is expected to decrease considerably in the future. In order to maintain a high level of contraceptive prevalence and ensure financial sustainability of the national family planning program, the full cost of the value of contraceptives will need to be recovered

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through sales. This means an eventual total reduction in contraceptive subsidy which prevails in Ghana currently. The experience of the Contraceptive Supplies Project, as discussed in Section II and in the Technical Analysis, indicates that further price increases for contraceptives can be sustained and will not deflate consumer demand. As the Government of Ghana removes price and importation disincentives, the private sector is expected to pick up a larger part of the importation, distribution and sale of contraceptives at market-determined, financially sustainable prices.

Both the private sector Ghana Social Marketing Program and the Ministry of Health are expected to maintain Return to Project Funds under the Family Planning and Health Program for the purchase of contraceptives. With the assistance of the institutional contractor, the Ghana Social Marketing Program will develop a full cost recovery plan for the sale of donated contraceptives.

The Ministry of Health has maintained a Return to Project Fund but has had difficulty in determining how much has been deposited and how much should be deposited based on the actual sales accounting records for MOH contraceptive sales from the MOH's regional offices. An independent financial assessment of the MOH's management of the fund has revealed weak financial accounting and management of the fund, in the absence of a full time qualified fund manager, in addition to incomplete and irregular reporting on contraceptives sales from the MOH field offices. To remedy this situation, the Ministry of Health should assign or recruit a full time accountant to manage the fund. MOH will be asked to make deposits to the fund based on the actual number of contraceptives distributed to the regions rather than on the amount of funds obtained through MOH sales, since contraceptives logistic records are more reliable than sales records. Additionally, MOH is expected to implement a cost recovery plan for A.I.D.-donated contraceptives with the target to achieve 50% recovery of the value of the contraceptives by the end of the project. These funds will be used to replenish the ministry's contraceptive supplies. The institutional contractor will provide technical assistance to MOH to improve the management of the fund and to improve MOH contraceptive procurement capability, if required. The ministry is expected to achieve full cost recovery shortly after the end of the Family Planning and Health Program in order to achieve full financial sustainability of the contraceptive commodities program.

5. Conclusion

It appears that the Government of Ghana should be able to mobilize resources to maintain the implementation of a national population and family planning program beyond the completion of the Family Health and Population Program. The budget allocation to primary health care, including family planning and maternal/child care, has increased dramatically since 1988. As primary health care, including family planning and maternal/child health, is a priority of the Government of Ghana, it is not unreasonable to project that expenditures in this area

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will increase, as long as the Economic Recovery Program produces positive growth in GDP and revenues, and to conclude that the expenditures proposed under the Family Planning and Health Program are feasible. Cost recovery programs for the sale of contraceptives also improves financial sustainability and feasibility, as the private sector will take on a greater share in the supply and sale of commodities at market prices, as prices are decontrolled, and as MOH improves its ability to procure its own contraceptives.

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TABLE 1

HEALTH EXPENDITURES AND NATIONAL BUDGET
(¢ million)

A. RECURRENT EXPENDITURES		1984	1985	1986	1987	1988
National Budget						
Wages % Salaries		5,282	14,524	26,194	35,901	46,671
Other Goods & Services		10,846	12,948	12,528	18,490	22,577
Total (incl. other)		23,326	38,462	60,833	80,444	100,842
MOH Budget						
Wages & Salaries					3,061	4,511
Other Goods & Services					3,366	4,583
Total (incl. other)		2,112	3,765	5,407	6,952	9,833
B. CAPITAL EXPENDITURES						
National Budget	(excl. project aid)	3,368	7,303	9,826	18,214	26,354
	(incl. project aid)	5,163	11,202	18,500	43,265	53,201
MOH Budget	(excl. project aid)	158	233	447	870	1,624
	(incl. project aid)				2,213	3,202
C. TOTAL EXPENDITURES						
National Budget	(excl. project aid)	26,694	45,765	70,659	98,858	127,196
	(incl. project aid)	28,489	49,664	79,333	123,709	154,043
MOH Budget	(excl. project aid)	2,270	3,998	5,854	7,822	11,457
	(incl. project aid)				9,165	13,035
D. MOH SHARE NATIONAL BUDGET						
Recurrent Expenditures						
Total (incl. other)		9.1%	9.8%	8.9%	8.6%	9.8%
Capital Expenditures						
Excl. project aid		4.7%	3.2%	4.5%	4.8%	6.2%
Incl. project aid					5.1%	6.0%
Total	Excl. project aid	8.5%	8.7%	8.3%	7.9%	9.0%
	Incl. project aid				7.4%	8.5%

Source: Statistical Services Board, Ministry of Finance and Economic Planning and Ministry of Health.

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TABLE 2

RECURRENT BUDGETS FOR PRIMARY HEALTH CARE 1986-1988
(¢ Million)

Head	Sub-Head	Program	% of Head	Recurrent Budget Estimates 1986	1987	1988	1989
160		MOH (GENERAL SERVICES)		351	455	671	1,158
	1	General Administration	15	285	400	596	961
	2	Budget & Planning Division	0				
	3	Common Services	0				
	4	Regional Health Administration	45	49	38	52	104
	5	Stores	15	11	9	12	17
	6	Health Education	80	6	8	11	76
	7	Center for Health Statistics	0				
	8	Training	0				
	9	Internal Audit	0				
	10	Research Center for Plant Medicine	0				
161		KORLE BU TEACHING HOSPITAL		33	22	36	57
	1	General Administration	0				
	2	Medical/Dental Services	10	33	22	36	57
	3	General Services	0				
162		KOMFO ANOKYE HOSPITAL		17	13	13	34
	1	General Administration	0				
	2	Medical/Dental Services	10	17	13	13	34
	3	General Services	0				
163		MEDICAL/DENTAL SERVICES		1,151	1,042	1,524	2,574
	1	Dental Services	0				
	2	Environmental Health Services	100	323	298	438	631
	3	Epidemiological Division	100	281	251	350	462
	4	Health Laboratories	10	5	5	6	13
	5	Maternal & Child Health	100	206	192	326	805
	6	Medical Care	15	297	264	357	568
	7	Mental Health	0				
	8	Nutrition Services	100	39	32	47	95
	9	National Blood Transfusion Service	0				
		TOTAL		1,552	1,532	2,243	3,823
		PRIMARY HEALTH CARE AS % OF TOTAL		23.8	22.0	22.8	24.1

Source: World Bank Estimates

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TABLE 3

BUDGETS, FINANCIAL ENCUMBRANCES AND ACTUAL PAYMENTS
(NON-SALARY PROCUREMENT EXPENDITURES) 1987

Head	Sub-Head	Item	Program	FEs as % of Budget	Payments as % of FEs	Payments as % of Budget
A.	MOH HQ (EXCL. TEACHING HOSPITALS) (Overall Percentages)			90	62	56
160	Total					
		1	General Administration (incl. drugs)	91	64	58
		2	Budget and planning			
		3	Common Services	58	21	12
		4	Regional Health Administration			
		5	Stores			
		6	Health Education	14	55	8
		7	Center for Health Statistics	37	44	16
		8	Training	98	34	34
		9	Internal Audit			
		10	Research Center for Plant Medicine	100	100	100
163	Total					
		1	Dental Services			
		2	Environmental Health	55	95	52
		3	Epidemiological	88	50	44
		4	Health Laboratories	76	48	36
		5	Maternal and Child Health	122	86	105
		6	Medical Care	21	96	20
		7	Mental Health	77	42	33
		8	Nutrition	83	35	29
		9	Nat. Blood Transfusion Center	81	36	29
PHC				87	62	55

Source: OIC/FIT Health Finance Study

Notes: Budget = Approved Estimates
FEs = Financial Encumbrances
Actual Payments by MOH Treasury Accra

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ANNEX E

ECONOMIC SUMMARY AND ANALYSIS

E 1--Economic Summary

E 15--Economic Analysis

ANNEX E

ECONOMIC SUMMARY

MACROECONOMIC BACKGROUND

I. Introduction

Ghana gained independence on March 6, 1957 very hopeful of a bright economic future. At that time its net external reserves stood at $269 million and its external payments position was satisfactory. It was a world leader in the production of cocoa, and its export earnings from timber and minerals were good. The income per capita was about the same level as that for Mexico or South Korea, and it was classified as a medium income country. The rate of inflation was only 1%. The economy, however, was not growing and in fact, per capita GDP declined at the rate of .5% per annum between 1960 and 1970. The rate of decline became more apparent in the 70's and 80's.

II. Structure Of The Economy

Ghana's economic structure has always been weighted heavily in favor of the primary sector. This sector has, however, been gradually yielding some of its share to the tertiary sector. From independence in 1957 until 1969, the primary sector's share of GDP dropped from 57% to 40%, and there was a similar though less severe decrease in its share of labor force from 65% to 59%. The tertiary sector expanded from 28% of GDP to 45%. The expansion in Government services was mainly due to the political ideology of the Nkrumah government. With socialism as its main political goal, Nkrumah increased State participation in almost every sphere of the economy. For example, between 1957 and 1969, the share of Government consumption in GDP increased from 10% to 18%, while private consumption declined from 80% to 70%.

Manufacturing also grew rapidly between 1957 and 1969, increasing its share from 2% to 9% of GDP. Apart from fishing and electricity (which expanded from a lower base), manufacturing maintained the highest growth rate of 10% per annum. The Nkrumah government placed a high premium on industrialization, and thus established a number of import-substituting industries. Manufacturing became an important contributor to exports with a 14% share plus another 11% from processing of cocoa and timber for a total of 25 percent. In spite of this expansion in the manufacturing sector, the secondary sector as a whole maintained the same share of GDP, due to a relative decline in mining and secondary industries.

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These sectoral shifts reflected the strong emphasis of the Nkrumah government on stimulating social and economic development through industrialization, and a lack of emphasis on agriculture. Cocoa dominated exports, but it was not growing. There was no clear policy to develop agriculture to feed the newly established industries. Most of the industries relied on imported raw materials; hence the attempt to make the country self-reliant through import substitution made it foreign exchange dependent. Agriculture and cocoa remained relatively low productivity sectors, in the sense that even though they were the largest employers of labor, they contribute proportionately less to GDP. Cocoa, for example, employed 17% of the labor force to produce only 8% of GDP. Because cocoa was the major foreign exchange earner and a major contributor to tax revenues, its neglect without an appropriate substitute contributed immensely to the drop in Ghana's economy.

Subsequent governments after Nkrumah (1957-1966) and the National Liberation Council (1966-1969), did not do much to change the structure of the economy. By 1982, agriculture's share of output had increased to 51% and yet the nation was not producing enough to feed itself. The increase in the share of agricultural sector was due mainly to a decline in the industrial sector. Industry's share of GDP fell from 15% to 8%, an annual average rate of decline of about 2%. The contribution of the service sector dropped from 49% in 1960 to 41% in 1982.

The decline in industry is a reflection of its dependence on imported intermediate inputs. Faced with a severe foreign exchange constraint, the country could not import the necessary spare parts and raw materials for her industries. Industrial capacity utilization dropped to below 25 percent.

Table 1

Basic Indicators of Economic Performance

	Average Annual Growth Rates		
	1960-70	1970-82	1986-88
GDP	2.2	-0.5	5.4
Gross Domestic Investment	-3.1	-5.1	16.9
Exports	0.1	-4.7	4.7
Imports	-1.5	-4.8	10.5
Terms of Trade	1.1	0.2	
Total Agriculture (Volume)	2.6	-0.2	1.9
Food Production	2.6	-0.2	
Population	2.3	3.0	
Labor Force	1.6	2.3	

Source: The World Bank, Toward Sustained Development in Sub-Saharan Africa (Statistical Annex), Washington, 1984 and Quarterly Digest of Statistics, GSS, March, 1989.

Table 1 summarizes the decline in the Ghanaian economy between 1960 and 1982. After about 1970, output declined while population increased at a faster rate. Exports dropped both in volume and in value. Cocoa exports in the 1970's and 80's were below the levels in the late 50's. As the foreign exchange constraint became more severe, imports contracted further. There was a shortage in both intermediate imports and consumables. By the early eighties the situation had worsened with inflation running at more than 100 percent, a very unfavorable balance of payments, cocoa and other exports at their lowest levels, and both unemployment and underemployment rife. By 1983, the economy was a classic example of stagflation. There were shortages of almost every conceivable item: food, raw materials and even water. The country's economic plight was, however, drawn to the attention of the international community in 1983, when in the midst of drought and bushfires, nearly a million Ghanaians were repatriated from Nigeria.

III. Causes of the Decline

The causes of the decline in Ghana's economy can be attributed to both internal and external factors. The external causes include unfavorable terms of trade and unfavorable weather conditions (especially the drought of the late 70's and early 80's). The economy was very fragile and dependent on a few primary exports - principally cocoa and timber. The instability of commodity prices on the international market thus exposed the economy to an unreliable and fragile source of earnings. For instance, throughout the early sixties as the Nkrumah government was "modernizing" the economy through the creation of industries and the provision of social and economic infrastructure, the international price of cocoa continually declined. Ghana, like other oil importing countries, also suffered from the oil crisis and the global economic slump of the 70's.

In the face of declining terms of trade, the country maintained a rigid fixed exchange rate regime and refused to devalue. As the foreign exchange constraint became more severe and goods became scarce on the market, the government resorted to regulated pricing. Almost every commodity item in Ghana had a controlled price. This introduced distortions into the economy which threw everything out of gear. It also brought in its wake corruption at unprecedented levels. 'Kalabule', a system in which the 'haves' took advantage of the scarcity on the market and exploited the 'have-nots', became the order of the day and reached its height during the Acheampong era. The chief causes of the economy's decline, however, were gross economic mismanagement, corruption, and political instability. Policies formulated were mere paper-work and were never properly implemented. In some cases, good policies drawn-up and commenced, could not be brought to fruition due to changes of government (mostly through coups d'etat). Since independence, Ghana has drawn up at least four development plans, none of which has ever been fully implemented. Monetary and fiscal policies were either out of tune with the realities of the situation or were not properly implemented. While the nation was engaged in opulent spending, not much was done to widen the tax base (See Appendices I and II).

In sum, both internal and external factors caused the decline in the Ghanaian economy. The internal factors included:

1. the maintenance of a fixed and highly overvalued exchange rate that discouraged exports of cocoa and other products and produced huge profits for traders of imported goods.
2. large deficits in government budgets which resulted in inflationary pressures that further distorted the effective exchange rates.
3. the imposition of price controls at the manufacturing stage which discouraged production while giving excessive profits to the unregulated small-scale trading sector.
4. misallocation and use of import licenses which created further inefficiencies and denied critical inputs and equipment to high priority areas.

The external factors included:

1. adverse weather in 1978-79 and 1982-83 which seriously reduced agricultural output.
2. sharp increases in petroleum prices in 1973, and again in 1979, followed by the world recession.
3. the deterioration in the terms of trade, and the continual decline in the world price of cocoa.
4. the expulsion of over one million Ghanaians from Nigeria in 1983.

IV. Consequence of the Crisis

The immediate consequence of the economic decline in Ghana was the general impoverishment of the nation as a whole. Most indicators point to a drop in the standard of living in the country. Per capita GDP, which had once been $800 per capita, dropped to about $250 in 1983.

Most people could not afford basic necessities of life such as food and shelter. The per capita index of food production with 1971 as 100 dropped to about 72 in 1982 creating a new famine situation.

Even though there was some indication of a general improvement in health standards over the 1960-1980 period, there was a severe deterioration in the early eighties. Life expectancy at birth increased from 46 years in 1970 to about 55 years in 1979 but then dropped to 53 years at the beginning of 1980's. The number of people per physician dropped from 21,600 in 1960 to about 7,630 in 1982, but has risen since then as physicians left the country. Daily calorie supply as a percentage of requirement dropped from 88% in 1979 to 68% in 1983. The drop in health indicators in the early 1980's was due mainly to the shortage of drugs, food and other supplies, and also to the brain drain that affected the medical profession.

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The indicators for education show a mixed improvement. The number of children of school age who went to school increased over the years, probably in response to the compulsory education law of 1961. The quality of education seems to have dropped, however, due to the shortage of textbooks and other educational equipment, and also to emigration of the better qualified teachers.

Another significant consequence of the economic crisis of the seventies and eighties was its effect on manpower development and labor. The high rates of inflation were not matched by increases in the nominal wage. Thus, workers saw their real incomes being eroded. This affected mainly those on salary incomes, and caused most of them to take second and third jobs. The most common second job was trading. At the height of the 'kalabule' period, those who benefited most were traders but the "trading" did not need to be in actual wares. Some people made huge gains just by knowing someone in a position to give them chits. One method of rationing scarce commodities was through the issuance of notes of rights to purchase, or chits. These chits were then sold to the actual traders for cash. Such dishonest acts did not encourage manpower development in the country. School drop-outs who turned themselves into 'businessmen' became better off than their counterparts who went on with their schooling. Skilled personnel like doctors, engineers and teachers who could not engage in these acts of 'kalabule' took flight. These specialized workers left mainly for other African countries and Asia. Nigeria was the main beneficiary of the Ghanaian brain drain, although most of the medical doctors ended up in Saudi Arabia. It is estimated that there are more Ghanaian doctors in Saudi Arabia than in Accra. Most teachers went to Nigeria since the oil boom had led to the establishment of new schools. By the beginning of the 1980's Ghanaians of every class and skill were leaving in droves to Nigeria. This is what led to the expulsion of almost a million Ghanaians from that country in 1983.

V. The Economic Recovery Programme: 1983-1988

In April 1983, the government of the Provisional National Defence Council (PNDC) accepted an IMF package for economic recovery. The Economic Recovery Programme brought with it a set of policies which sought to correct the ills in the Ghanaian economy. Its major objectives were:

1. to restore incentives for production of food, industrial raw materials and export commodities and thereby increase their output to modest but realistic levels;
2. to increase the availability of essential consumer goods and improve the distribution system;
3. to increase the overall availability of foreign exchange in the country, improve the allocation mechanism and channel it into the selected high priority activities;
4. to lower the rate of inflation by pursuing prudent fiscal, monetary and trade policies;
5. to rehabilitate the physical infrastructure of the country in support of directly productive activities; and
6. to undertake systematic analyses and studies leading towards a major restructuring of economic institutions in the country.

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Pursuant to the above objectives the following policies have so far been undertaken:

1. The exchange rate has been adjusted by steps from a rate of ¢2.75 per US dollar to a rate in August, 1990 of ¢330 to $1. The rate is now determined by a weekly auction at the Bank of Ghana. In addition, forex bureaux, established in 1988, also quote daily rates for the dollar and other major currencies in a legal parallel market.
2. Price controls have been removed on most commodities in the country.
3. Through a divestiture programme, the government has started selling off state-owned enterprises.
4. Effective September 1987, a liberalized system of determining borrowing and lending rates was introduced by the Central Bank for all commercial and secondary banks.
5. Government expenditure has been strongly restrained in both nominal and real terms, including redeployment/retrenchment of several thousand workers from state payrolls, at the same time that new taxes and enhanced revenue collection efforts have increased government revenue. Deficits have been eliminated, and since 1986, the recurrent budget has been in surplus to the tune of about 0.5% of GDP.
6. A new Investment Code (1985) provided some incentives to attract foreign capital and another one is being developed.

VI. Recent Economic Performance

The ERP/SAP seems to have salvaged the economy from a near bankrupt position; the negative growth rate of GDP throughout the 1970s and early 1980s was reversed. Since 1984, GDP has been registering positive growth rates. In 1984, the growth in real GDP recorded an all time high rate of 8.96%, and for the entire period 1984-1988, the rate of growth of output has averaged 5% per annum. All sectors had positive growth, while utilities and manufacturing showed the highest growth rates. This can be explained by the removal of subsidies on utilities and the rehabilitation of manufacturing establishments. Faced with a severe foreign exchange constraint, manufacturing capacity utilization fell below 25%. Easier access to foreign exchange through the auction and trade liberalization have made it possible for manufacturing concerns to obtain spare parts and raw materials. The average manufacturing capacity utilization rate has risen to around 35%. Some companies, like the breweries, are now operating at about 90% capacity. With rehabilitation and new investment, mining is also a sub-sector with high growth potential.

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Services are a sector with consistently high growth rates, with commerce as the fastest growing sub-sector. This raises questions about the sustainability of the on-going adjustment program because agriculture, which is the backbone of the economy, is growing at a very slow rate. With the exception of 1984 when good rains caused agricultural production to increase by about 42%, subsequent years have witnessed low growth rates averaging about 2% per annum. Cocoa production increased while non-cocoa agricultural production declined as the government has substantially increased the price it pays farmers for cocoa.

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Table 2

GROWTH OF GDP BY KIND OF ECONOMIC ACTIVITY AT CONSTANT 1975 PRICES
(Percentages)

	1981	1982	1983	1984	1985	1986	1987	1988
AGRICULTURE	-2.56	-3.25	19.11	9.71	0.65	3.31	0.04	3.58
INDUSTRY	-14.46	-16.67	-6.77	11.94	17.60	7.56	11.34	10.27
Mining and Quarrying	-7.34	-8.38	-13.64	13.49	6.45	-3.03	7.89	35.82
Manufacturing	-19.27	-20.49	-11.17	12.90	24.32	10.95	10.01	9.24
Electricity and Water	11.86	-8.11	-38.91	42.96	20.73	18.03	18.73	6.74
Construction	-4.79	-91.15	27.43	2.33	2.81	-2.66	15.02	4.55
SERVICES	2.73	4.65	4.54	6.63	7.52	6.50	9.38	7.83
W/sale and retail trade, Restaurants and hotels	-1.92	-10.38	-5.26	10.15	13.68	9.02	17.45	7.41
Transport, Storage and Communication	6.76	1.3	7.26	12.76	8.45	5.62	10.89	10.18
Finance, Insurance, Real Estate and Business Services	1.66	-1.38	14.12	9.26	2.58	7.66	5.48	6.73
Community, Social and Personal Services	15.23	-4.99	7.09	20.10	7.76	46.02	19.20	5.98
TOTAL GROSS DOMESTIC IN PURCHASER'S VALUE	-3.18	-5.85	-4.34	8.96	5.09	5.20	4.80	6.22

Source: Calculated from data obtained from IMF Financial Statistics and Quarterly Digest of Statistics, GSS, Accra, March, 1989.

VII. Employment and Earnings

Scarcity of data and problems in defining unemployment in Ghana make it difficult to quantify the current situation. Based on the standard definition which requires an active search for employment within the reference period, the 1984 census puts urban and rural open unemployment rates at 6.1% and 1.6% respectively. The structure of employment shows an increase in the share of agriculture from 57% in 1970 to 61% in 1984 while employment in all other sectors with the exception of commerce has fallen. Unemployment/underemployment in Ghana is likely to have increased because of the current redeployment/retrenchment program in the public sector.

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VIII. Fiscal Performance

The ERP introduced into Ghana a fiscal discipline that has yielded budgetary surprises over the last few years. For the first time since independence, the government current budget registered a surplus in 1986 and has continued to do so since. This is the result of policies aimed at eliminating inflationary pressures emanating from excessive government borrowing from the banking system. Some of these policies are:

a. removal of subsidies on most consumer items including petroleum products;
b. increase in stumpage fees and royalties;
c. removal of some of the subsidies on higher education;
d. introduction of fees in the health sector; and
e. increase in the efficiency of tax collection.

Table 3

SUMMARY OF GOVERNMENT FINANCES AS PERCENT OF GDP

	1982	1983	1984	1985	1986	1987	1988
Revenues	6.0	5.5	8.0	11.3	13.6	14.1	14.5
Recurrent Expenditures	9.3	7.4	8.6	11.2	11.9	10.8	10.5
Current Budget Savings	-3.3	-1.8	-0.6	0.1	1.7	4.3	4.0
Develop. Expenditures	0.9	0.6	1.2	2.1	1.9	2.5	3.1
Deficit/Surplus	-4.7	-2.7	-2.1	-2.7	-0.7	-0.3	0.9
Net Domestic Financing	4.3	2.3	1.1	1.2	1.0	-0.4	-0.6
Net Foreign Financing	0.3	0.4	1.0	1.5	-0.3	0.7	0.2

Source: GSS, Quarterly Digest of Statistics, Several Issues.

By 1988, revenue collection had increased to about 14.5% of GDP, up from a level of 5.5% of GDP in 1983. The main sources of the growth in revenue were cocoa taxation, resulting from depreciation of the exchange rate; improved collection from companies; and rationalization of the sales tax and excise tax structures. There was also restraint in government spending. Recurrent expenditures, which had expanded from 9.3 of GDP in 1983 to 11.9 in 1986 dropped to about 10.5 in 1988. The 1989 budget also is expected to produce a surplus even though personal income taxes were lowered and the Special Un-numbered License (SUL) tax has been abolished.

IX. Balance of Payments

Following the introduction of a series of measures in 1983, the current account improved in 1984 but turned negative in 1985 and has not been positive since. The balance of trade also has been negative since 1983. Capital inflows largely foreign aid have been responsible for the positive overall balance of payments.

The performance on the external payments accounts is due to the falling price of cocoa on the world market, worsening terms of trade, and increased imports resulting from trade liberalization and foreign aid. These same factors have also caused Ghana's trade account to be in deficit, contrary to the past record when on average it was positive.

Table 4

Balance of Payment
($Millions)

	1980	1981	1982	1983	1984	1985	1986	1987
Current Account	-55	508	-158	-230	-214	-264	-204	-224
Merchandise Trade								
Exports	1,104	711	641	439	567	632	749	827
Imports	972	1,021	631	539	681	729	805	1,012

Source: World Bank, Ghana: Structural Adjustment for Growth,1989.

X. Debt Burden

Ghana entered the ERP/SAP without a serious debt burden. Debt servicing as a percentage of export for 1970-1982 was below 10%. However, the debt service ratio has increased substantially since the introduction of the program, standing at 53% in 1987. The main reason for this is the loans from the Fund/Bank and other donors and the low response of the export sector to the price incentives provided under the ERP. The size of Ghana's debt is not as worrying as its structure. A lot of the debt is of short term maturity and carries non-concessionary rates. Ghana's biggest trading partner is the sterling zone, but much of the debt is denominated in either SDRs or dollars. This calls for prudent debt management in order to forestall loss of reserves.

XI. Poverty Profile

In spite of the impressive growth statistics, both the absolute and relative levels of poverty increased among the rural and urban populations during the adjustment period. An IFAD special mission report estimated that in 1970, 1.95 million rural people or 43% of the farming population were below the poverty line. A 1988 report estimated an increase in rural poverty to about 54% in 1986. Rough estimates provided by Reginald Green in a paper he presented at a conference in Khartoum in 1988 on "The Dimension of Adjustment" show a larger increase in poverty. According to his figures, the number of urban people below the poverty line increased from an average of 30-35% in the late 1970s to a range of 45-50% in the mid 1980s. For rural people, there is an equal increase in poverty. From a level of 60 to 65% in the late 1970s, it increased to between 67 and 72% in the mid 1980s. The extent of income disparity is evident from the 1987-88

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Ghana Living Standards Survey (GLSS). It shows that 30% of Ghanaians accounted for 58% of total aggregate expenditure for the first six months of 1987. This to a large extent must be due to the worsening of the terms of trade for rural produce, increasing costs of production resulting from exchange rate depreciation, and increasing relative prices of non-agricultural rural consumption items.

Data on social indicators of development are far behind current developments. For the information that is available, the picture is gloomy. There have been some minor improvement since independence: life expectancy has increased from 44.8 years in 1960 to 54.5 in 1980; the number of students in primary and secondary school as a percentage of the age group increased from 1960 to 1980. The situation probably has worsened since 1980. The GLSS indicates that on average 48% of all sick Ghanaians did not consult any kind of health provider. This may be due to the increased cost of health facilities. The GLSS shows that 57% of Ghanaians depend on rivers and lakes for their sources of water, 32% have no kind of toilet facilities, while 77% use kerosene or oil lamps as their source of lighting. The statistics are worse for the poorest 30% in Ghana. For the most recent period, the main significant development is the institution of full cost recovery procedures for health, education and other public utilities. These are expected to have a negative impact on access to these facilities, particularly in the rural areas. Real Government health expenditures per capita dropped from US$4.89 in 1978 to a low of US$1.08 in 1983 before rising to US$2.73 in 1985.

XII. PAMSCAD

In order to address the plight of the poor, especially those vulnerable groups who have been adversely affected by the adjustment program, the government instituted a Program of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD). The vulnerable groups targeted are:

i. rural households;
ii low income underemployed/unemployment urban households; and
iii. retrenched workers who lack productive employment.

Some of the interventions suggested under the program include income and nutrition supplements. Projects chosen under PAMSCAD are selected on the basis of having a strong poverty focus, and also high economic and social rates of return. The projects chosen include 'community initiative projects' designed to rehabilitate social and economic infrastructure, as well as 'employment generation projects'. In addition, there are projects designed to meet the basic needs (water and sanitation, health, nutrition and shelter) of vulnerable groups. PAMSCAD is also intended to minimize the increased costs to parents due to the removal of subsidies in secondary schools as part of the ongoing educational reform. The implementation of projects under PAMSCAD has been slow because donors have delayed the disbursement of the $84 million they pledged in February 1988 for the program.

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XIII. Future Prospects

Ghana's economy has stabilized under the Structural Adjustment Program. Growth in the economy, however, seems to have been mostly in the service sector and from greater utilization of existing capacity in manufacturing. Sustainability of the recovery depends on increased flows into the country from donors, faster growth in the agricultural sector and new private investment.

More investment is needed in the productive sectors such as manufacturing, mining and quarrying and construction. Government policy should also be directed at reversing the terms of trade in favor of food production. With agriculture contributing almost 50 percent of GDP, government must direct policy to sustain that sector.

Stringent fiscal and monetary policies are likely to continue in order to hold down inflationary pressures . The outlook for Ghana's external accounts looks bleak: with declining cocoa and gold prices, Ghana may continue to have deficits on external accounts.

Ghana has just started overhauling her educational system in order to increase access and quality. These objectives, however, will be difficult to achieve with the reductions in educational expenditures and the increased burden on already impoverished households. The donor community is helping Ghana by providing funds to support her educational program.

The government is making important efforts to rationalize its Primary Health Care system by using cost-recovery methods, and is moving vigorously to promote Family Planning utilizing the Private Sector.

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Appendix I

Indicators of Fiscal Performance 1965-1988 (Million ¢ 1980 Prices)

		Budget			Financing		
Year	GDP	Revenue	Expenditure	Balance	Domestic	BoG	External
1	2	3	4	5	6	7	8
1965	543.0	105.2	140.0	-34.8	30.7	n.a	1.1
1966	489.7	74.5	99.4	-24.8	21.6	n.a	8.4
1967	537.4	90.7	122.1	-31.4	23.9	n.a	6.1
1968	548.4	96.1	129.7	-33.5	23.9	n.a	9.0
1969	605.8	100.6	120.6	-20.0	13.0	n.a	8.2
1970	664.4	128.9	143.2	-14.7	13.2	n.a	14.1
1971	675.9	121.9	145.7	-23.8	19.5	n.a	6.5
1972	686.6	102.9	142.2	-39.3	19.3	-3.0	20.0
1973	729.4	81.7	120.6	-39.0	35.0	32.4	4.0
1974	817.5	102.5	136.8	-34.4	34.7	32.2	-0.4
1975	708.2	109.5	163.6	-54.2	54.1	81.8	0.1
1976	563.3	75.7	139.7	-64.0	63.8	56.2	0.2
1977	448.3	47.0	89.5	-42.4	41.9	57.7	0.5
1978	486.9	32.3	76.3	-44.0	39.9	9.7	1.6
1979	393.7	39.0	66.1	-27.0	27.0	5.7	-
1980	428.5	29.5	47.6	-18.1	15.2	32.3	2.9
1981	335.0	15.1	36.6	-21.7	20.0	8.4	1.7
1982	326.5	18.3	36.6	-18.3	16.7	2.6	1.5
1983	311.9	17.4	25.7	-8.4	6.5	0.8	1.6
1984	328.3	27.5	33.4	-5.9	3.7	2.9	2.2
1985	378.6	44.3	52.7	-8.3	4.4	2.3	3.9
1986	451.6	65.0	64.8	0.3	4.7	-0.2	-5.0
1987	471.2	70.1	64.5	5.6	-1.8	-3.7	-0.7
1988	508.6	73.9	69.2	4.8	-3.0	-3.1	1.1

Source: Compiled from IMF's International Financial Statistics, 1988 Yearbook, August, 1989 issue and from GSS's Quarterly Digest of Statistics, March 1989.

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Appendix II

Indicators of Fiscal Performance, 1965-1988 (Ratios)

	As Ratio of GDP			Financing as Ratio of Deficit		
				Internal	Bank of	External
Year	Revenue	Expenditure	Deficit	Loans	Ghana	Loans
1	2	3	4	5	6	7
1965	0.19	0.26	0.06	0.88	n.a.	0.03
1966	0.15	0.20	0.05	0.87	n.a.	0.34
1967	0.17	0.23	0.06	0.76	n.a.	0.19
1968	0.18	0.24	0.06	0.71	n.a.	0.27
1969	0.17	0.20	0.03	0.65	n.a.	0.41
1970	0.19	0.22	0.02	0.90	n.a.	0.96
1971	0.18	0.22	0.04	0.82	n.a.	0.27
1972	0.15	0.21	0.06	0.49	0.08	0.51
1973	0.11	0.17	0.05	0.90	0.83	0.01
1974	0.13	0.17	0.04	0.01	0.94	0.01
1975	0.15	0.23	0.08	1.00	1.51	0.00
1976	0.13	0.25	0.11	1.00	0.88	0.00
1977	0.13	0.23	0.09	0.99	0.36	0.011
1978	0.07	0.16	0.09	0.91	0.22	0.04
1979	0.10	0.17	0.07	0.00	0.21	-
1980	0.07	0.11	0.04	0.84	1.78	0.16
1981	0.05	0.11	0.06	0.92	0.38	0.08
1982	0.06	0.11	0.06	0.91	0.14	0.08
1983	0.06	0.08	0.03	0.78	0.09	0.20
1984	0.08	0.10	0.02	0.63	0.49	0.37
1985	0.12	0.14	0.02	0.53	0.27	0.46
1986	0.14	0.14	0.00+	17.78	0.60	18.78
1987	0.15	0.14	0.01+	0.32	0.66	0.13
1988	0.15	0.14	0.01+	0.62	0.64	0.23

+ Budget Surplus
Source: Computed from Appendix 1a.

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ECONOMIC ANALYSIS

I. INTRODUCTION

This economic analysis includes a review of the macro-economic impact, and cost-benefit analysis of the Family Planning and Health Program.

A. Macro-Economic Impact

The program assistance component of the Family Planning and Health Program includes a $13.0 million non-project assistance grant to the Government of Ghana to support Ghana's economic recovery. This component represents 43% of the total financial transfers to the Government of Ghana for implementation of the Family Planning and Health Program. The cash grant is expected to generate approximately 2.5 billion cedis through the Bank of Ghana auction, based on the most recent auction rate of around 315 cedis to U.S. dollar. Ghana's GDP is projected at 1,567 billion cedis for 1990. GOG's public expenditures have averaged 14% of GDP and at this level are projected at 219 billion cedis in 1990. These generations will average less than three-tenths of one percent of Government of Ghana's expenditures over the life of the program.

B. Cost-Benefit Analysis

1. Introduction

The use of cost-benefit analysis for the evaluation of a social activity, such as the Ghana Family Planning and Health Program, has always posed a problem because of the difficulty in quantifying some of the benefits. For example, the benefits accruing to families who avoid an unwanted child cannot be accurately measured. Other benefits, such as the increased power which women and the poor have over their lives, are clearly very important but also difficult to measure. As a result, A.I.D regulations do not require that projects like this have a positive internal rate of return. This program, however, has a positive internal rate of return of 18.8% even though only a few of the benefits of the project were quantified.

Cost of the Program: The Ghana Family Planning and Health Program has several components to its financial cost: Program Assistance, Project Assistance and Host Country contributions. The funds will be disbursed as follows:

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Table 1

Expenditures in $000's of USD

FY	Program Assistance	Project Assistance	Host Country Contributions Cash	In-Kind	Total
91	3,000	2,536	431	1,625	7,592
92	5,000	3,148	439	1,785	10,372
93	5,000	4,272	454	1,965	11,691
94	-	4,638	555	2,160	7,353
95	-	1,661	459	2,380	4,500
96		745	0	0	745
Total	13,000	17,000	2,338	9,915	42,253

The economic costs are smaller than the financial costs. Economic costs only reflect the additional resources devoted to the program. Some of the GOG in-kind contribution represents health clinics and midwives which would exist without the program. Hence, it is inappropriate to consider the full value of the GOG-in-kind contribution an incremental cost to the economy. It is estimated that half of the host country contribution falls into this category. The following table shows the adjusted costs.

Table 2

Economic Cost of Ghana Family Planning & Health Program

FY		000's of USD
1991		6,780
1992		6,480
1993		8,709
1994		6,273
1995		3,310
1996		745
	Total	32,297

2. Benefits of the Project

The primary benefit of family planning goes directly to the families who use it. The effects on the family are large but difficult to measure. Another mouth to feed may reduce the food intake of the rest of the family, thus exacerbating malnutrition and incidents of ill health. It may also mean that the family cannot afford to send children to school. The long run impact of such decisions cannot be accurately measured.

The project also has favourable impacts on several important social issues. It is more likely to help the poor than the rich since the upper class is more likely to know about and use family planning currently. Thus, it can reduce poverty and reduce income inequality.

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Population management has long-term implications for women and their role in development. Current studies on development acknowledge and stress the importance of women's participation in a country's development activities. However, the ability of women to be effective and full participants in development is limited by their overall health status. Population management through family planning improves women's health status by enabling women to control and manage their reproduction. Reducing the number of births, spacing births, and having healthier babies will decrease the physical strains associated with closely spaced, debilitating pregnancies, prolonged nursing and childcare. This works to improve the women's health as well as make more time available to them to engage in productive activities throughout their lives.

Slower population growth has beneficial effects on the environment, too. The country can only feed a limited member of people with existing technology and capital. Additional people may result in overworking fields and long run environmental damage.

Many experts believe that rapid growth in population makes it more difficult for a nation to develop. There is a limited amount of institutional capacity to educate people, care for their health needs, and provide other services. Higher population simply means spreading limited resources over more people.

There are also secondary health benefits which will occur. These include:

- reduction in unwanted pregnancies with the attendant abortion risks.
- reduction in venereal diseases including AIDS.
- wider use of ancillary products such as the Oral Rehydration Salt (ORS) and the malaria tablets which will reduce incidence of sickness, reduce the required number of hospitals and provide a healthier and more productive workforce.

The major quantifiable benefit to be derived from the Ghana Family Planning and Health Program will be in terms of the savings on health and education from the reduced number of births.

3. Births Averted

The new marketing and promotional techniques under the project component will increase the contraceptive prevalence from 5% in 1989 to about 15.0% in 1994. Without the project, the population of Ghana is projected to grow at the rate of 3.6% per annum between 1989 and 1994 (See Table 3).

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Table 3

Year	Popn. Projections (000) (1) Without Intervention	(2) With Intervention	Reductions in Popn (000) (3)
1989	14,609		
1990	15,141		
1991	15,692		
1992	16,263	16,221	42
1993	16,854	16,768	86
1994	17,468	17,336	132
1995	18,102	17,894	208
1996	18,759	18,470	289
1997	19,440	19,064	376
1998	20,145	19,677	468
1999	20,876	20,311	565
2000	21,634	20,928	706
2001	22,420	21,564	856
2002	23,235	22,220	1,015
2003	24,079	22,895	1,184
2004	24,954	23,591	1,363
2005	25,896	24,304	1,592
2006	26,873	25,037	1,836
2007	27,888	25,794	2,094
2008	28,941	26,573	2,368
2009	30,033	27,375	2,658
2010	31,219	28,192	3,027

The introduction of the Ghana Family Planning and Health Program may reduce the population growth rate to about 3.1% per annum between 1991 and 2010. Column 2 in Table 3 shows the population projections assuming the program is successfully implemented.

Column 3 is the difference in population when there is no intervention and when there is an intervention.

4. Savings on Health

Population size and growth affect the resources available to provide health care services to the population. The Government of Ghana has set itself the task of achieving health for all by the year 2000. This would mean devoting a lot more resources to the health sector. Growth constraints on the economy has, however, not made it possible to increase expenditures on health. According to the 1988 budget estimates the national health bill was about $64 million; this works out to about $4.60 per capita. Assuming there is no increase in real cost, the third column of Table 4 calculates the health savings between 1992 and 2010.

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5. Savings on Education

A study commissioned by the World Bank on the Ghana Education Sector in 1985, estimated that the cost per pupil in primary school in Ghana is around $24 per year. In the calculation of savings on education it was assumed that the Government of Ghana maintains this per capita expenditure level throughout 2010. Calculations of savings on the education sector is presented in the sixth column of Table 4. It is assumed that the education savings will not be realized until such a time that the births so saved would have reached school-going age. We used the same cost per unit on primary school pupil to calculate for the 12 years (1999-2010) the child would have been in school. This leads to an understatement of the benefit since after six years of primary education the child enters secondary school with a higher per unit cost. Not all students enter secondary school, however, so the understatement of benefits is not large.

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Table 4

Savings Calculations for Health and Education

	Births Saved	Savings on Health ($000)	Pupils Not in School ($000)	Savings on Education ($000)	Total Savings ($000)
1992	42	192			192
1993	86	397			397
1994	132	607			607
1995	208	957			957
1996	289	1,330			1,330
1997	376	1,727	42	1,002	2,729
1998	468	2,151	86	2,074	4,224
1999	565	2,599	132	3,168	5,767
2000	706	3,248	208	4,993	8,241
2001	856	3,938	289	6,939	10,877
2002	1,015	4,671	376	9,012	13,683
2003	1,184	5,447	468	11,220	16,668
2004	1,363	6,270	565	13,560	19,830
2005	1,592	7,325	706	16,948	24,274
2006	1,836	8,446	856	20,547	28,993
2007	2,094	9,634	1,015	24,368	34,002
2008	2,368	10,893	1,184	28,421	39,314
2009	2,658	12,227	1,363	32,712	44,939
2010	3,027	13,924	1,592	38,220	52,144

6. Internal Rate of Return

Table 4 lists the benefits that accrue if the population project meets its goal of raising the contraceptive prevalence to 15% in 1994. The internal rate of return of the net benefits is 18.8% indicating that the project is extremely desirable. However, the assumptions underlying the analysis may be over optimistic. It is highly likely that the Government of Ghana (GOG) will have to spend additional money to maintain contraceptive prevalence at that level and those costs are not included in our analysis. However, it seems reasonable to expect that a substantial portion of the cost to GOG can be recovered through revenue from the sale of devices. A time frame for full cost recovery has not yet been developed. The institutional contractor will help GSMP design a cost recovery plan.

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7. Sensitivity Analysis

Even if the GOG spent no additional resources on population planning after the program is ended, the benefits of the plan should persist for years as the individuals trained by the program continued to provide advice and information. To evaluate the sensitivity of the cost/benefit analysis to this issue, a sensitivity analysis was conducted with a base case. Under the base case, it is assumed that without additional funding, the population prevalence of 15% can be maintained and the project generates benefits through 2010. The pessimistic case assumes that the prevalence rate reverts to 5% approximately 1 year after the end of the project.

Under these pessimistic assumptions, the internal rate of return is 13%. Clearly the project is highly desirable.

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ANNEX F

SOCIAL SOUNDNESS ANALYSIS

SOCIAL SOUNDNESS ANALYSIS

Population

The Republic of Ghana, covering 238,537 square kilometers (91,694 sq. mi., or about the size of Oregon), lies along the west coast of Africa, and is bordered by the Atlantic Ocean to the south, the Republic of Togo to the East, Burkina Faso to the North and Cote d'Ivoire to the west. Ghana is divided into ten administrative regions (see map at the beginning of the project paper), which are subdivided into 110 districts, which, under the present political structure, constitute the primary units of administration and political activity.

Geographically, Coastal Ghana is dominated by low-lying plains with alternating grass cover and mangrove. The west and southern interior consists mainly of tropical forest areas, the central Volta River region is covered with savannah woodland and swamps, and the north is primarily savannah, trailing off into increasingly arid areas being affected by the encroaching desert. About 19% of the land area is used for agriculture. Lake Volta, created by the Akosomba Dam across the Volta River, is the largest man-made lake in the world. The three ecological zones are the coastal savannah, the forest belt, and the northern savannah. This ecological environment determines the nature of population size, the density and clustering, current land use and major economic activities of the area.

In 1990, the population was estimated to be 14.8 million, giving a nationwide population density of about 62/sq. km. (161/sq. mi.). The population is predominately rural. In the 1985 census some 70% of the population was living in towns of less than 5000 inhabitants and about 86% in towns of less than 50,000. While this is very close to the overall urban/rural ratio for Africa, the population distribution varies markedly from other parts of the world. For example, Latin America's population is 69% urban and only 31% rural. The impact of this dispersion augmented by Ghana's poor transportation infrastructure increases isolation of rural populations. A major constraint to implementing any project is the logistical problem of moving supplies and services to the places where people are. For this reason, many social programs in Ghana are effectively limited to people who live in urban areas.

The population profile is typical for a developing country where youth predominate; 34% of the population is under age 10 and 57% under age 20. Mortality has been dropping for many years. The combination of a youthful population and falling mortality rates means that population growth has a momentum which will be difficult to arrest, even with the most successful family planning program imaginable.

Because so many Ghanaians are young, family planning messages need to be carefully targeted. 20.3% of the population is women of reproductive years (ages 15 to 45), and one fourth of this group is teenaged. Since most family planning messages are directed at older, married women, current communications do not reach those who are most in need of family planning information, services, and supplies, including those at risk both for unwanted pregnancy and for health complications of early pregnancy.

The Ghanaian population is composed of varied ethnic and linguistic groups. In 1960 some 17 major groups were identified based on language. The largest ethnic group, the Akan, constitutes 44% of the population and is concentrated in the Ashanti, Brong-Ahafo, Central, Western, and Eastern Regions. The Ewe, found mainly in Volta Region, account for 13%, with the Ga-Adangbe concentrated in Greater Accra and Eastern region accounting for 8%. In the Northern and Upper Regions are the Mole-Dagbani (16%), Grussi (2%), and Gurma (4%). Other smaller ethnic groups make up the remainder.

Censuses show that about 43% of Ghanaians are adherents of various forms of Christianity, about 12% Islamic, and the remaining 45% follow traditional religions, commonly referred to as 'animism'. While Islam is more common in the North, religious categories cut across tribal and geographic boundaries. However, even among faithful adherents of Christianity and Islam, traditional African beliefs and practices are the most important source of people's mores.

Socio-cultural Context

The behavior of people in society has been the cause and the consequence of the complex relationships of morals, customs, traditions, rituals, beliefs, and other ceremonies. These are generally manifested in institutions and patterned behaviorial forms which constitute the structure and value nexus of the society. An understanding of the cultural patterns enhance the chances of relating with them. However, given the population diversity, generalizations about culture that hold throughout Ghana are difficult to make. Most available ethnographic data describe the Akan. Hence the descriptions are most true for Akan tribes, but apply to some extent to other groups.

For family planning programs in Ghana, the most important aspect of culture is the individual's role in society. In Western countries, individuals are seen either as autonomous beings, or as members of nuclear families, and family planning messages are directed accordingly. While trends towards this are present among the urban elite in Ghana, the most important social grouping is the lineage. Throughout this document the terms 'lineage' and 'nuclear family' will be used to avoid confusion. There is no Twi word that exactly corresponds to the English concept of family.

A lineage is a group of people, including equally the living, the dead, and those not yet born, all of whom trace their descent to a common ancestor. This is true among both the matrilineal ethnic groups such as the Akan as well as the patrilineal groups such as the Ga and Ewe. Marriage is seen principally as the bringing together of people who will produce children and perpetuate the immediate and extended family, including ancestors. The children produced by any union are seen as belonging to the lineage and not to the parents. Thus for the Akan, children are part of their mother's lineage, and not their father's. Among some matrilineal groups this goes so far that a man is responsible for the care of his sister's children, but not his own. Traditionally, a marriage ceremony has little significance, particularly when compared to a girl's puberty initiation which marks her as being socially mature.

The strength of the lineage system is seen in its economic, ritual, jural and socializing institutions. In rural Ghanaian communities where the lineage has the most visible expression, the economic circumstances of a family member are shared by all members. The lineage head is the head of the family cult, and propitiates the ancestors on behalf of the lineage.

The authority of the lineage head is highly respected. The impact of the lineage is felt most strongly in the socialization of children. Although the biological paternity and maternity of children are recognized, children belong to the entire lineage. Children can thus move from house to house, eating, and seeking attention as the circumstances of the extended family dictate.

The important function of marriage is to have children and, in the traditional setting, to have them abundantly. Among the Akan, if a woman has a tenth child, a special ceremony is performed to acknowledge the extent to which the gods have blessed the family. A special sheep - badu guan - is presented to the wife, in addition to several gifts. If, after marriage, it takes a long time for a couple to bring forth children, questions are raised, and in-laws might wonder who or what is wrong. If the woman is unable to produce a child, this childlessness is viewed as a curse and is a major ground for divorce.

There is little evidence that polygyny is decreasing, except insofar as the practice is said to be more common in rural areas than in urban ones. (The technical term 'polygyny', meaning a relationship where a man may have more than one wife, is used in preference to the more common term 'polygamy', which can mean either multiple wives or multiple husbands. The latter relationship, known as 'polyandry', is quite rare, and to our knowledge, does not occur in Ghana.) The 1988 Demographic and Health Survey reported that 25% of men (21% urban, 27% rural) and 33% of women (28% urban, 34% rural) were in a polygynous relationship, which is essentially unchanged from 30% of men in a 1945 report and 26% in 1960.

The impact of polygyny on fertility is unclear. On the one hand, husbands in a polygynous marriage are supposed to be able to support all the children their wives can produce, and co-wives are said to be in competition to produce children. On the other hand, since polygynous relationships provide more opportunities for coition, they are said to permit a woman to space her children by maintaining abstinence for a prolonged period. Clearly, insufficient data are available to evaluate this. It may be that having more children - and more hands on the farms - account for polygyny's persistence in agricultural settings, and that lack of an economic advantage to large numbers of children accounts for the infrequent practice of polygyny in urban areas. A second form of polygyny occurs when a man living and working in an urban area takes a second city wife in addition to the rural wife. This type of polygyny is likely to result in decreased fertility for each wife, but particularly for the rural wife.

Village-level economic organization is based on clearly defined divisions of labor according to gender. While men cut trees and clear the land for farming purposes, women have responsibility for planting seeds. Men harvest the crops, but women sell, process (as with the catch in fishing communities), and distribute the produce. The table at the end of this section gives a visual representation of the reciprocity of labor in economic activities for Northern Ghana.

The workload of women in rural areas is so burdensome that very little time is left at their disposal to think about the health and well-being of themselves and their children. Consequently, children often suffer neglect and malnutrition, especially now that economic hardships are beginning to erode the functions of the linage system.

Despite the matrilineal system, household decision-making is often a male function. This is largely due to the fact that wage labor, and therefore disposable income, are largely in the male domain. Therefore, the economic structure gives rise to a male-dominated authority pattern in the home, especially in decision-making. This is significant because many women who otherwise might consider accepting family planning feel, that if they do so, their husbands will divorce them. In rural, traditional communities, this economic relationship is expressed in what is generally known as the dictatorship of the 'chop money'. Chop money is given to the woman, sometimes daily (early in the morning), or weekly, or even monthly. The man is thus seen as the breadwinner. Chop money helps to establish his authority as having the last say in decision-making, especially in issues relating to spacing of children or the use of farmsteads. Money that accrues to women from the sale of surplus farm produce is kept by them and used for the purchase of clothing for themselves and their children. It is also believed to be culturally acceptable that, out of the shopping money, a small amount will be kept by the wife as 'pin money'. When there is hardship in the home, the woman uses this amount to supplement family income. Traditionally, all goods acquired by a nuclear family become the property of the husband's matrilineage, leaving the wife

destitute--or at least thrown on the mercies of her own lineage--if her husband dies. Recently, however, national laws of inheritance have been changed to recognize the wife's rights to communal property.

Presumably because of the inherent conflict between the male-dominated nuclear family economics and the matrilineal inheritance and property system, many women seek additional security in trading or in service occupations, particularly catering. Even with little education or capital, women can parlay traditional roles and activities into productive activities. For example, about three quarters of all trading is in the hands of women. This gives a level of economic security that is afforded by neither the marital nor the matrilineal relationship.

Traditional Social Organization, Stratification and Leadership

In addition to lineage, other social institutions play important roles. Traditional authorities and stratification systems based on gender, age, chiefs, elders, and other criteria influence behavior. New hierarchies are being superimposed and overlap with the traditional ones. New or modern influential classes include church pastors or priests, teachers, nurses.

Every local community now has several religious groups of one type or the other: the traditional religious cults which often combine spirit mediumship and divination with herbal medicine; the Christian movements; and, particularly in the north, Islam. We include church leadership as a traditional form of authority, since Africa has long known charismatic leaders who derive their authority from the spiritual realm.

Modern Social Structure and Authority

Along with traditional culture are many modern structures and authorities. At the local level these include district assemblymen, local revolutionary organizations such as the Committees for the Defense of the Revolution and school teachers.

Information is diffused in society through people whose social position gives them credibility. All of those listed above are important opinion leaders in their communities, and are people whose support will assist in the promulgation of new ideas, such as family planning. Usually, each of these has a forum whereby his advice can be made known: the chief has his town crier, the teacher his schoolroom, the pastor his pulpit, and the district assemblyman the assembly. Identifying the most significant of these in each locality will be an important task for each IE&C campaign.

A number of organizations can serve to bridge the gap between the village and the nation. Many of these will be instrumental to implementing this project. The best example of these types of organizations is the Ghana Registered Midwives Association (GRMA). We have looked at it in the institutional section from an organizational point of view, but here we need to consider it as a part of the social fabric. GRMA is an association of people with like professional activities, who are learning that their individual success is improved by participating in a larger organization. To some extent, the GRMA replaces the lineage in establishing the midwife's social identity, authority and role. By using common signs, by meeting regularly, by developing information channels, by implementing effective disciplinary measures, the GRMA is a new social unit, and has given its authority to the individual midwife in her practice.

There are many other such organizations, of varying size. Some of them have been mentioned in the institutional analysis section. One that bears repeating is the Ghana Home Sciences Association, an association of 3000 members who, if it can be mobilized, information can be channelled to the schools and agricultural extension stations where they serve. A more significant group may be the December 31st Women's Movement, a quasi-political organization that reaches some of the smallest villages and works, particularly in markets, to improve women's lives. This organization has also expressed an interest in becoming more involved with family planning.

In some places new institutions, such as the Committees for the Defense of the Revolution or the District Assemblies, both wield local authority and have links to the national scene. Where these are effective organizations, their mobilization will greatly assist the implementation of any project.

At the village-level there are relatively few recognized means for disseminating information nationwide, except for radio. A few years ago a concerted campaign was launched to distribute single-station radios throughout the country so that Ghana Broadcasting Company could be received everywhere--but broadcasts from other sources could not. These are still an important source of information for villagers, and studies show that radio news and information are given a high degree of credibility. In the larger towns and cities, newspapers and television reach a few of the wealthier people, but it is difficult to say what their actual impact is in spearheading change.

Given all of this, Ghana is a country, a society, a people in a rapid phase of transition. While it is easy to describe 'traditional culture' as if it were a static entity, each village interprets its traditions differently and accords different status to them. In modern Ghana, the chieftaincy is often under attack--partly because other lineages want their own members installed, partly because of the character of elected chiefs, but mostly because of the current clash

between modern and traditional cultures. This should not be viewed as a hinderance, but as an environment where change can and is occurring. Development always takes place at the interface where modern and traditional cultures conflict. The point is to understand the relative contribution and importance of each element in the equation and to be able to structure an effective approach, both at the national and at the local level.

Potential for Family Planning Acceptance

Given the pro-natalist situation, the major question this annex must address is whether any family planning program can succeed. Certainly, some argue that Africa is a special case where family planning is much less likely to be adopted than in other parts of the world. These, however, are the same people who argued twenty years ago that Asians would never limit births, and a decade ago that Latino machismo would prevent family planning becoming widespread in Latin America. This document argues that Africa is simply at an earlier stage of accepting of family planning, and that it will follow a trajectory similar to other parts of the world. This is borne out by recent data from Kenya and Botswana, which now have total contraceptive prevalence rates of 27% and 30%. Even the Ondo State of Nigeria, which is more comparable to Ghana, showed a modern contraceptive prevalence rate of 10.8% in 1986.

The Ghanaian experience supports this interpretation. Several surveys, most recently that carried out by Columbia University with members of the Ghana Registered Midwives Association, have shown that merely making contraceptives available--by having an outlet through a chemical shop, Ministry of Health clinic or a midwife's practice--will result in a doubling of the current contraceptive prevalence rate, from about 5% to 10% of the population of the area. If this relationship holds true throughout Ghana, this project could reach half of its objective by simply making various contraceptives available, without any further information, education and communication campaigns or other forms of outreach.

The 1988 Demographic and Health Survey (DHS) specifically explored ideas about fertility and its control. The data suggest that there is a very high latent demand for Family Planning Services. This revealed that 73.8% of women and 76.4% of men knew of at least one modern method of contraception, and that 66.4% of women and 70.1% of men know a source of contraceptives. Indeed, 20.5% of women and 26.4% of men report having used a method of contraception at some time, even though only 5.2% of currently married women and 9.3% of men are currently using a modern method. In addition, 74% of women and 77% of men approve of family planning.

Another indicator of changing ideas about family planning is ideal family size. Women queried in the 1979/80 Ghana Fertility Survey answered that 6 children were ideal; the 1988 Ghana Demographic Health Survey (GDHS) found 5.3 to be the ideal size. This is lower than actual fertility, which is 6.1. It is also instructive to examine desired fertility by woman's age: younger women, in the age group 15-19, desire 4.7 children, while women in the age group 45-49 desire 6.5. If younger women can be motivated to reduce their fertility to their expressed ideal family size, much will have been accomplished. Unfortunately, the men surveyed still felt that larger families were better: those younger than thirty felt that 6 was the ideal family size, while those older than 50 felt that 10 was appropriate. The mean was 7.6. Clearly, additional information, education and communication (IE&C) is needed. The most important variable here was the level of formal education: men with higher education wanted 5.2 children, while men with no education wanted 10.4. The USAID funded Primary Education Project (PREP) will help address this by increasing the educational level of people in Ghana.

Another means to measure latent demand for contraception is to examine birth spacing preference. Some authors state that traditionally social stigma has been attached to women who have children at less than two to three year intervals, although others question whether this is true. However, in the DHS, this topic was specifically explored. While the data are complex, in general they show that about a fifth of married women want to have another child within two years, 45% wish to postpone the next birth for two or more years, and 23% want no more children. The remainder are either infecund or do not know. Similar figures also apply to married men: 23% want another child within two years, 41% after waiting at least two years, and 19% want no more. Thus, 68% of Ghanaian married women of reproductive age, and 60% of married men express a desire for childbirth postponement or termination.

At one point recently radio and television advertising of family planning commodities was banned because a high official felt these were offensive. In light of this, it is interesting to note that 75% of women (83% urban, 70% rural) and 84% of men felt that it was acceptable to have messages about family planning on the radio!

However, despite this impressive amount of both knowledge and experience, nearly a quarter of non-using women who said they would be unhappy if they became pregnant stated that their reason for not using contraceptives was that they didn't have enough knowledge. (Other significant reasons were infrequent sex (10%) and health concerns (10%). A quarter of this sample didn't give a reason for non-use.) In all likelihood, this discrepancy is due to a sampling problem. The 1000 women in the non-users category are more likely to truly lack knowledge than the women chosen at random. Nonetheless, the fact that a quarter of the sample said that they would be unhappy if they became

pregnant at the present time means that there is a felt need that culturally appropriate IE&C can address. In all, 37% of currently non-using married women and 36% of men said that they intend to use contraception at some time in the future.

This portion of the social soundness document has clearly shown that there is a great potential for family planning in Ghana. The project must address the issue of how to translate the latent demand into actual actions. This is discussed in the Technical Analysis.

Other Health Interventions

To this point we have only discussed the social context of family planning. To what extent does the social context support or hinder a program promoting oral rehydration therapy and malaria treatment? Certainly the pro-natalist attitudes mentioned above will support any intervention that will promote child health. The Demographic and Health Survey (DHS) explored mother's behavior with regards to these two illnesses. It found that of children who had had diarrhea in the past two weeks, 33% were treated with ORS packets, 6% with a home sugar salt solution, 24% with traditional medicines, and 48% with other treatments. 12% received no treatment. (Since mothers may use more than one treatment, these total more than 100%.) 43% of these were seen at a medical facility. It is interesting that only a quarter of the children were treated with traditional medicines, although there may be many home remedies included in the 48% that reported 'other treatments'. Knowledge about the packets of ORS was much lower than for family planning methods, but was still substantial. 56% of women reported having heard about the oral rehydration packets.

In response to questions about the treatment of fever in children under age five the DHS reports that, 25% were treated for malaria, 9% with other antibiotics, 18% with traditional medicines, and 55% with a variety of other treatments, including aspirin. 56% of children were taken to a medical facility, and only 3.6% received no treatment.

A concern suggested by both of these surveys is that very young children are least likely to receive treatment. For diarrhea, 29% of those under six months received no treatment, including visits to medical facilities, and 13% received no treatment for fevers. The highest no treatment groups among older children was 12% no treatment for diarrhea and 3.8% no treatment for fever among those aged two to five years. This is serious since it is the youngest children who are most vulnerable to the ravages of diarrhea or malaria. Some cultural conceptions about the value of treating younger children should be explored during the course of the project.

These data indicate that there is no overwhelming problem introducing either ORS or malaria treatments in Ghana. Both products are already widely used, and the primary project goal is to expand the use to those who currently lack knowledge or supply, and to teach people to use appropriate amounts of the treatments.

Communication Strategies

In every culture there are a variety of mechanisms that can be used to communicate new information to people. Many of the traditional and modern modes have been referred to in various sections above. However, a recent (fieldwork 1986, published 1989) study of health communication bears examination. In this study of two villages in the Volta region (Ewe) the most credible sources of health information were health workers (69%) and the radio (21%). Traditional sources of information such as the town crier, who announces the chief's messages to the villages, were credited by at best 5% of the people surveyed. The Information Ministry communications van was a credible source for only 2.3% of the villagers, and newspapers only 2.4%. While these results must be taken with caution--in some areas the chief's messages are much more important that others--it indicates how information campaigns can be made more effective. Health workers must be convinced of the benefits of these programs, or they will undermine the entire effort. Similarly, broadcasting, particularly in local languages, is likely to be effective. However, official information vans and newspapers may be much less effective means of communication.

Beneficiaries

In this project there are three types of direct beneficiaries: individuals receiving services that they otherwise would not, individuals providing services, and organizations receiving assistance. Global claims about indirect beneficiaries can be made: 'All Ghanaians will share in the economic benefits brought about by an increased national per-capita income'. While this is neither quantifiable nor convincing, yet it may well be true.

Individual Beneficiaries

1. Women receiving family planning services. If the project achieves its stated goals of increasing modern contraceptive prevalence from 5.1 to 15%, then in the final year of the project, around 525,000 women and

will receive ORS in the final year of the project, and thus will be the direct beneficiaries of this element. Approximately a quarter of these would have died. Since each child will receive ORS on several occasions, it is impossible to calculate the total number of beneficiaries.

3. Children receiving chloroquine. The project goals are to increase the proper anti-malarial treatment of febrile episodes from 25% to 33%. About 370,000 children will benefit from this project element during the last year of the project. Many of these would otherwise have died.

4. Direct beneficiaries from the services part of the project are primarily people who can make informed choices about family planning and the other health interventions, even if they do not choose to use them. These cannot be calculated.

5. The TBA training program and the assistance to GRMA will result in safer deliveries for mothers receiving the assistance of these professionals. Again, the numbers of beneficiaries cannot be calculated.

Service Provision Beneficiaries

1. Retailers and wholesalers of goods and services. The project intends to maintain or develop 5,000 outlets for its commodities over the life of the project. Since a major goal is to increase revenues at each level of the system, the sales staff at each point of sales will benefit from the revenues generated by the sales of project goods. A conservative estimate is that 5,000 will benefit. In reality, since each worker supports 4 to 5 other people, the number of beneficiaries will be much larger.

2. Registered Midwives. An additional 250 midwives will receive training in good midwifery and business practices. These will be beneficiaries, as well as their clients.

3. Traditional Birth Attendants. The 3,000 TBA's trained under the existing project will continue to receive supervision, monitoring and supplies in the new project. In addition, another 3,000 will be trained, monitored and supplied. This is a total of 6,000 beneficiaries, to which are added the dependents of the TBA's and their clients who will receive better services.

Organizational Beneficiaries

Many organizations will receive benefits which will help them perform their tasks and assist their members and client groups.
These have been outlined in the institutional analysis and in the technical analysis. It is very difficult to calculate numbers here, particularly insofar as individual members benefit from support given to an organization.

Women in Development

In Ghana, women have played significant roles in household management and child care interventions. Individual women are major beneficiaries of this project. It is only recently that the idea of women as a force in socio-economic development has been generally acknowledged. This project is heavily committed to women in development--indeed, so much so that it could equally be viewed as a women in development project as a family planning and health project. Benefits to women accrue in a variety of fields:

Health Benefits: These have been outlined in the Technical appendix, pages 20-22 and do not need repeating here. However, it should be pointed out that reducing fertility from seven to four children will reduce a woman's chance of dying during pregnancy by 43%. While it is difficult to quantify, it is estimated that women with more than five pregnancies experience between 1.5 and 3 times the morbidity of women with fewer children. In addition, contraceptives, particularly oral contraceptives have a direct beneficial effect by reducing iron deficiency and possibly the incidence of Pelvic Inflammatory Disease.

Empowerment: Giving a woman control of her reproduction helps her to realize that she can control other areas of her life to her benefit. This is a freeing concept that is crucial if women are to take a full role in personal and national development.

One important aspect of this project is to assist voluntary organizations, such has been done with the Ghana Registered Midwives Project and the Market Women's project. Similar work may be possible with Traditional Birth Attendants. Women in rural areas are already becoming involved in more or less formal cooperatives, and these may also be used as a channel for project activities. This is important because if women in the rural communities come together into cooperatives, and begin to have access to credit facilities as well as appropriate technology, over time they will have more leisure time and more money at their disposal to care for their own health and their children's. Exposure to adult education, which is also a policy of the government, will give women functional literacy to enable them understand dates, times, dosage of drugs, when to report to a health care center, and instructions on how and when specific contraceptives or medicines ought to be administered. The impact of this empowerment is far reaching.

Income: Since most retail activities (up to 85% according to some authors) in Ghana are conducted by women, support to the private retail sector will directly benefit these women. These numbers could conceivably go as high as 10,000 women who experience a direct addition to their input, in addition to the thousands of women who experience fewer demands on their finances because of fewer children. The previous project has directed business training at both Registered Midwives and Market Women, to help them gain control of their financial management, and is attempting to quantify the project impact on their income. Unfortunately, since most of them operate on a 'cigar box' financial management system, it is difficult to collect baseline data.

Education: Higher education is one if not the most important element leading to successfully integrating women into the national mainstream. Currently, many young women are being deprived of the opportunity to get a full education because their parents fear that they will become pregnant. Interestingly, attitudes towards family planning for adolescents has changed over the past few years. Whereas previously family planning outreach workers were seen as corruptors of youth, they are now often welcomed as people who can help solve the problems that young women (and men) face. In conjunction with the Primary Education Program, and the World Bank support to the education sector, this project will have a significant impact on women's educational opportunities.

Support to Women's Organizations: The National Council for Women and Development (NCWD) has been in existence since 1975. This is the official governmental umbrella for all women's groups in this country. With national headquarters in Accra, the Council has 10 regional coordinating offices in the regional capitals. Cooperative women's organizations that need governmental assistance are expected to be affiliated to the NCWD. The NCWD serves as a useful channel for transmitting information (especially on health and hygiene) to women's organizations at the regional and district levels, and usually acts in collaboration with the Ministry of Health. The NCWD has benefited from the previous USAID project and is expected to be a significant participant in the current project.

Since the 1981 December Revolution, the 31 December Women's Movement has engaged grassroots country-wide mobilization of women for self-improvement activities. Cottage industries, child care centers, and other projects have been encouraged by the Movement, whose president is the P.N.D.C. Chairman's wife. This Movement appears to have more credibility among rural women, and the project may find it to be a valuable resource. At its rallies, the Movement advises its members to try to have only the number of children they can adequately care for.

Previous reference has been made to work with the Ghana Registered Midwives Association (Annex C), with Traditional Birth Attendants, and with Market Women. These are all women's organizations and will continue to contribute to Women in Development goals.

Since the project is concerned with gender issues, all data in the monitoring and evaluation section will allow analysis by gender, insofar as this disaggregation does not adversely affect data collection.

Obstacles to Project Goals

Given the history of family planning in Ghana, there are no apparent obstacles to achieving the project's goals. Politically, Ghana appears to be stable. Macro and microeconomic progress is being made as the government continues its Economic Recovery Program, so the private sector economic goals appear to be feasible.

Within the Government, support for these efforts is strong. With family planning's inclusion on the national political agenda and following establishment of the national population authority, it is unlikely that advertising bans will be imposed, as happened three years ago.

At this point it is unclear how much opposition will come from the Pharmacy Board over the policy reforms that are to be accomplished,although this project will have the effect of reducing the amount of control that the Pharmacy Board has over the distribution of Vaginal Foaming Tablets, ORS, Chloroquine, and Oral Contraceptive Pills. The MOH has already begun sounding the Board out on its attitudes towards deregulation of these products.

Within the Ministry of Health, deregulating prices remains a concern. Many government officials are cautious about profit motives, and express reservations when recommendations for establishing a profit motive for distributing essential goods is made. This will require close monitoring so the impact can be documented. It would be unfortunate if gross profiteering on these commodities endangered further expansion of this market.

To date no significant groups are opposed the project, including traditional leaders and religious groups. Some Catholics do not approve of every method, but there is still support for natural family planning methods.

In the past, fearing corruption of their youth, some parent and church groups have opposed teaching family planning methods to adolescents. While this fear is still present, these communities are recognizing that adolescent sexuality and resulting pregnancies are an ever more serious threat. With the growing recognition that secondary school education is needed for girls, outreach programs to teenagers, which are needed if they are to complete school without becoming pregnant, no longer elicit much opposition.

Spread Effects

Since this is not a demonstration project, nor one that is limited to a single part of Ghana, the question of spread effects is not as important as it otherwise would be. Indeed, the project is deliberately addressing the question of how to extend the gains of the previous project to a wider circle of beneficiaries. Specifically, unlike five years ago, contraception and health commodities are available in urban areas in all parts of the country. Now the goal to spread goods and services out into the rural areas. A primary means of doing this will be to identify traders who are already active in distributing other commodities to rural areas and to piggy-back on their distribution networks. This is detailed further in the technical analysis section.

One important aspect of this project's spread effect is broadening its scope to include both oral rehydration salts and malaria treatment, and not merely to concentrate on family planning. There are two important contributions that will increase the project's scope. The first is that family planning projects in other parts of the world have demonstrated a synergistic effect when family planning products are linked with other desired health products. In this situation, results from distributing both types of commodities exceed what would be expected from distributing either alone. The second contribution is that increasing the number of profitable social marketing products will increase the profit to the individual sales person and will encourage her/him to make the full range available to clients.

Conclusion: Socio-Cultural Feasibility

Several forces in the social and cultural setting make this project feasible. The local authority structures are intact, thereby ensuring continuity of order and peace in the rural communities, they also ensure that a favorable climate for operation of health delivery systems and family planning arrangements exists.

Although a Population Policy has long-been established in Ghana, the political will to take bold action on this issue, which is critical to national development, is present for the first time. The personal involvement of members of the Government in population discussions, and Mrs. Rawlings' leadership in championing women's issues, are favorable indicators of high level support for these activities.

While historically Ghana has been pro-natalist, this has also been true of most of Africa and, indeed, most of the world. Evidence presented here shows that the need for family planning has been recognized at all levels. Traditions are changing in a way that makes this project compatible with the emerging ethos.

The project's mix of modern family planning with child survival intervention makes it more acceptable. For a society that stresses the need for children, it is sound to convince a population that, if they have fewer children, their children have greater chance for survival.

Previously, women of child-bearing age have been the main targets of family planning. To be sound, the project should seek to give serious attention to such groups as teenage girls and boys. Men, too, appear to have been historically less targeted and should be included in project target groups.

Therefore, based on the above-stated understanding of the current situation and projections of the directions that Ghana will take in the future, we feel that this project is socially sound.

TABLE 1
TRADITIONAL ROLES OF MEN AND WOMEN

MEN	WOMEN
1. Tilling of farm - hoeing, weeding etc.	1. Pulling out of weeds
2. Raising of yams etc., mounds	2. Sowing
3. Clearing of farms	3. Cooking
4. Cattle rearing (shepherds)	4. Selling of farm produce and cooked food
5. Hunting	5. Fetching water for domestic use
6. Cutting of trees for firewood	6. Fetching firewood
7. Building and rebuilding of houses - walls and thatching	7. Pito (brewing and distribution)
8. Blacksmithing	8. Shea-butter making
9. Charcoal making	9. Processing of dawadawa (seasoning for soup)
10. Fishing, especially river fish	10. Harvesting of farm crops (especially millet and maize)
11. Weaving - mats/baskets	11. Gathering fruits - sheanuts, dawadawa, etc.
12. Harvesting of yams	12. Winnowing
13. Weaving of materials for traditional clothes	13. Seed processing for the following season
14. Tailoring (traditional)	14. All domestic chores, including massaging of husbands
15. Burials (undertakers)	15. Cotton spinning
16. Poultry keeping	16. Sewing (traditional)
17. Harvesting farm crops	17. Traditional midwifery
18. Selling of fresh meat (butchers); women are allowed to sell fresh meat on regular basis cooked meat is only sold by women and not men.	18. Poultry keeping
	19. Plastering of houses, graveling of courtyards and flooring rooms
	20. Maintenance of back-yard gardens.

Source: 'The Traditional and Modern Roles of Women in the Economic and Social Development of Northern Ghana: Preliminary Findings' by Raymond B. Beaning and John S. Nebula, in Seminar Proceedings, Ghana National Council on Women and Development. September 1978, Vol. 1 pp. 75- 99.

ANNEX G

IMPLEMENTATION PLANS

ANNEX G

IMPLEMENTATION SCHEDULE

I. IMPLEMENTATION SCHEDULE FOR POLICY-BASED PROGRAM ASSISTANCE

	Event	Responsible Party	Time Frame
1.	PAAD authorized and Grant Agreement signed.	USAID/GOG	0 month
2.	Policy dialogue with GOG on legal establishment of national population authority.	USAID Dir	+ 1-6
3.	Policy dialogue with MOH, Pharmacy Board re deregulation of contraceptives.	USAID/GOG	+ 1-6
4.	Conditions precedent to initial project disbursement of funds fulfilled.	GOG	+ 3
5.	First quarterly report to USAID due.	GOG	+ 3
6.	Tranche review.	USAID/GOG	+ 3
7.	National population authority with secretariat appointed legally constituted with funding. First part of Tranche #1 conditions met.	GOG	+ 4
8.	Regulatory conditions met on the importation, marketing and distribution of contraceptive products. (Second part of Tranche #1 conditions met).	GOG	+ 6
9.	Conditions for Tranche #1 met.	GOG	+ 6
10.	Issuance of PIL to certify conditions met and disbursement of Tranche #1.	USAID	+ 6

	Event	Responsible Party	Time Frame
11.	Tranche #1 auctioned and generations deposited into MFEP special account and USAID Trust Fund Account.		+ 6
12.	GOG adopts regulations to allow trained health providers to distribute OCs.	GOG/MOH	+ 6
13.	Initiation of short-term technical assistance to national population authority.	Contractor	+ 6
14.	Quarterly report due to USAID.	GOG	+ 6
15.	Annual plan for use of local currency submitted to USAID.	GOG	+ 8
16.	Tranche review.	USAID/GOG	+ 9
17.	National population authority (NPA) and secretariat fully functioning with permanent funding.	GOG	+ 12
18.	National population authority issues scope of work for establishing demographic targets.	GOG/NPA	+ 12
19.	National population authority establishes demographic targets.		+ 12-24
20.	National population authority issues scope-of-work for preparation of national population implementation plan.	GOG/NPA	+ 12-24
21.	National population authority issues scope-of-work to study the effect of deregulating the distribution of OCs.	GOG/NPA	+ 12
22.	Conditions for Tranche #2 met.	GOG	+ 12
23.	Issuance of PIL to certify conditions met and disbursement of Tranche #2.	USAID	+ 12

	Event	Responsible Party	Time Frame
24.	Funds auctioned.	GOG	+ 12
25.	Auction generations deposited in MFEP special account and USAID Trust Fund Account.	GOG	+ 12
26.	First annual review.	USAID/GOG	+ 12
27.	Technical assistance provided to national population authority as required.	Contractor	+ 12-24
28.	GOG adopts demographic targets and procedures for periodic review.	GOG/NPA	+ 12-24
29.	GOG adopts national population implementation plan and procedures for periodic review.	GOG/NPA	+ 12-24
30.	National population authority reviews results of OC deregulation study and makes recommendation.	GOG/NPA/ Pharmacy Board	+ 12-24
31.	Annual plan for use of local currency submitted to USAID	GOG	+ 18
32.	Tranche review	USAID/GOG	+ 21
33.	Conditions met for Tranche #3.	GOG/NPA	+ 24
34.	External mid-term evaluation.	USAID/GOG	+ 30
35.	Annual plan for use of local currency submitted to USAID	GOG	+ 33
36.	Issuance of PIL to certify fulfillment of conditions for Tranche #3 and disbursement of funds.	USAID	+ 36
37.	Annual review.	USAID/GOG	+ 36
38.	Initiate implementation of national population plan.	GOG/NPA	+ 36 ongoing
39.	Tranche #3 funds auctioned and generations deposited in MFEP special account and USAID Trust Fund Account.	GOG/MFEP	+ 36

	Event	Responsible Party	Time Frame
40.	National population authority initiates ongoing public information campaign on population and family planning policy.	GOG/NPA	+ 36 ongoing
41.	Annual project review.	USAID/GOG	+ 36
42.	Annual project review.	USAID/GOG	+ 48
43.	Final external evaluation.	USAID/GOG	+ 65

II. IMPLEMENTATION SCHEDULE FOR PROJECT ACTIVITIES

	Event	Responsible Party	Time Frame
	Year 1		
1.	Project authorized and Grant Agreement signed.	USAID/GOG	0 month
2.	Request for Proposals issued.	USAID	+ 1
3.	Policy Dialogue with GOG on legal establishment of national population authority.	USAID Dir	+ 1-6
4.	Policy dialogue with MOH, Pharmacy Board re deregulation of contraceptives.	USAID/GOG various	+ 1-6
5.	Conditions precedent to project initial disbursement fulfilled.	GOG	+ 3
6.	Initiate procurement of contraceptives.	USAID	+ 3
7.	Sign agreements with ACNM and AVSC.	USAID/ACNM/ AVSC	+ 3
8.	First quarterly report to USAID due.	GOG	+ 3
9.	Review of contractors proposals and selection.	USAID/GOG	+ 3-4
10.	AVSC and ACNM initiate in-country activities.	AVSC/ACNM	+ 4-28
11.	National population authority with secretariat appointed legally constituted with funding. First part of Tranche #1 conditions met.	GOG	+ 4
12.	Quarterly report due.	Contractor	+ 6
13.	Quarterly report due to project technical committee.	Contractor	+ 6

	Event	Responsible Party	Time Frame
14.	Contractor team in country, set up and initiates project activities, procures commodities.	Contractor	+ 7
15.	Initiation of short-term technical assistance to national population authority.	Contractor/USAID	+ 7
16.	Social marketing (SM) advisory group constituted.	Contractor/ Project Tech. Committee	+ 8
17.	Contractor annual workplan developed, and approved.	Contractor/ Project Tech. Committee	+ 7 -10
18.	Quarterly report due.	Contractor	+ 9
19.	Marketing plan developed and approved.	Project tech. comm/sm advis. group/contractor	+ 10
20.	Design and conduct study to evaluate IE&C campaign effectiveness.	Contractor/HED	+ 8-12
21.	Project monitoring system developed and functioning.	Contractor, project tech. committee	+ 10
22.	Identify long range research and evaluation needs.	Contractor/GSMP	+ 8-10
23.	Tender issued for ad agency for campaigns and ongoing market research.	Contractor	+ 11-12
24.	Promotional materials developed for contraceptive sales to retailers.	Contractor	+ 11-18
25.	National population authority and secretariat fully functioning with permanent funding.	GOG	+ 12

	Event	Responsible Party	Time Frame
26.	Annual project review.	Project tech. committee	+ 12
27.	National population authority issues scope of work for establishing demographic targets.	GOG/NPA	+ 12
28.	National population authority establishes demographic targets.	GOG/NPA	+ 12
29.	National population authority issues scope-of-work for preparation of national population implementation plan.	GOG/NPA	+ 12
30.	National population authority issues scope-of-work to study the effect of deregulating the distribution of OCs.	GOG/NPA	+ 12
31.	Recommendation on issuing tender for handling and storage of contraceptives.	Contractor	+ 12
32.	Potential sites identified for employer-based family planning services.	Contractor/GSMP	+ 12
33.	Sources identified and tender issued for packaging and warehousing of GSMP products.	Contractor	+ 12
	Year 2		
34.	Sign agreements for packaging and distribution of ORS.	Contractor	+ 12
35.	Development of plan for contraceptive distribution through health NGOs.	Contractor/NGOs	+ 12-15
36.	Training plan developed for NGOs, HED.		+ 13
37.	Quarterly report due.	Contractor	+ 15

263+

	Event	Responsible Party	Time Frame
38.	Annual audit of return to project fund.	USAID	+ 15
39.	Plan developed with non-health NGOs for contraceptive distribution.	Contractor/GSMP	+ 15
40.	Market research conducted packaging and brand names of GSMP products.	Contractor/GSMP	+ 13
41.	Market research to determine product name and packaging for chloroquine treatment.	Contractor/GSMP	+ 13
42.	HED staff identified for short term training.	Contractor/HED	+ 14
43.	Additional commercial distributors identified and promotional campaign for retailers initiated; agreements signed.	Contractor/GSMP	+ 13
44.	Contracts with chloroquine manufacturers for brand name and packaging under GSMP logo.	Contractor/GSMP	+ 16-18
45.	IE&C campaign initiated.	MOH/HED	+ 15-18
46.	Initiate second order of contraceptives.	USAID/HPN	+ 15
47.	Identify 10 MDs and 40 midwives for possible Norplant training.	MOH/HPN	+ 16
48.	Develop 1992 workplan.	Contractor/Proj. Tech. Committee	+ 18
49.	Quarterly report due.	Contractor/AVSC /ACNM	+ 18
50.	First advertising and promotional campaign developed.	Contractor/GSMP	+ 18
51.	Market research on contraceptive pricing initiated.	Contractor/GSMP	+ 18
52.	Market research on ORS pricing.	Contractor/GSMP	+ 18

	Event	Responsible Party	Time Frame
	Year 3		
53.	Quarterly report due.	Contractor/GOG	+ 18
54.	Second advertising campaign.	Contractor/GSMP	+ 24
55.	Second annual workplan due.	Contractor	+ 24
56.	Second annual internal review.	Project Tech. Committee	+ 24
57.	Annual audit return to project fund.	USAID	+ 24
58.	National population authority initiates promulgation of national population plan.	GOG/NPA	+ 25 ongoing
59.	Technical Assistance to national population authority on policy IE&C campaign.	Contractor	+ 25 ongoing
60.	Local audit of project activities.	Contractor/ local firm	+ 25
61.	Contractor prepares GSMP to assume project management.	Contractor/GSMP	+ 25 ongoing
62.	Assessment of advertising campaign and overall marketing plan.	Contractor/ SM Advisory group	+ 25
63.	Technical assistance continues to NGOs, HED, distributors, etc.	Contractor	+ 25 ongoing
64.	Initiate third and last order of contraceptives.	USAID/HPN	+ 27
65.	Initiate second ad campaign.	Contractor/GSMP	+ 30
66.	Develop 1993 workplan.	Contractor/GSMP	+ 30
67.	External mid-term evaluation.	USAID/GOG	+ 30
68.	HED initiates second IE&C campaign with technical assistance from contractor.	Contractor/HED	+ 30

265+

	Event	Responsible Party	Time Frame
	Year 4		
69.	Contractor assists GSMP with fourth year workplan.	Contractor/GSMP	+ 35-36
70.	Annual audit return to project fund.	USAID	+ 36
71.	Annual project review (of evaluation findings).	Project Tech. Committee	+ 36
72.	GSMP assumes project management.	Contractor/GSMP	+ 37
73.	Continuation of advertising and promotional campaigns; IE&C campaigns, technical assistance to NGOs, distributors, training for health care providers; contraceptive, ORS and chloroquine treatment, sales monitoring quarterly report, monitoring of return to project funds; ongoing project monitoring, annual audit of return to project fund, annual audit of MOH's procurement, storage and distribution of contraceptives.	USAID	+ 37 ongoing
74.	Local audit of project activities.	GSMP/Local Firm	+ 43
	Year 5		
75.	Continuation of ongoing activities including monitoring, reviews and audits.		+ 48-60 ongoing
	Year 6		
76.	Continuation of ongoing activities including monitoring, reviews and audits.		+ 60-72
77.	Demographic Health Survey update.	Ghana Statistical Unit/USAID/ Contractor	+ 60
78.	Final external evaluation.	USAID/GOG	+ 65
79.	Project closeout and final reporting.		+ 65-72
80.	Project completion.		+ 72

ANNEX H

ILLUSTRATIVE COMPOSITION OF THE NATIONAL POPULATION AUTHORITY

ANNEX H

Illustrative Composition of the National Population Authority and Illustrative Budget

The following is an outline of the illustrative composition of the national population authority and secretariat. This outline includes the technical, administrative and management staff which should enable the national population authority to carry out its mandate. The actual staff size and its configuration and its placement within the Government of Ghana's administrative structure will be determined by the Government of Ghana in meeting the policy conditions under the program assistance component of the Family Planning and Health Program.

Illustrative Staff

1. National Population Authority: The authority will be comprised of a director, deputy director, secretarial and administrative staff and driver.

2. Secretariat: The secretariat of the national population authority will be comprised of a director and a group of staff technical specialists (demographer, geographer, population policy analyst, and media specialist), secretarial and administrative staff and drivers. Short-term local technical expertise may be employed occasionally by the secretariat where in-house specialty expertise is lacking.

Illustrative Annual Budget*

1. National Population Authority	
a. Personnel	
1. Director	$15,000
2. Deputy Director	10,000
3. Secretaries (2)	2,400
4. Administrative Assistant	1,800
5. Driver	900
b. Supplies	5,000
c. Transport Support	1,500
	$36,600
2. Technical Secretariat	
a. Personnel	
1. Directors (2)	10,000
2. Permanent Technical Staff	40,000
3. Administrative Assistant	1,800
4. Secretaries (3)	3,600
5. Short-term Local Technical Consultant (1 person month)	3,000
6. Drivers (2)	1,800
b. Administrative Services	3,500
c. Supplies	5,000
d. Transport Support	3,000
e. In-country Seminars and Policy IE&C campaigns	8,000
Subtotal	$79,700
Total	$116,300

*With inflation factor of 5% per year total budget over life of project is approximately $685,000.

Additional Inputs

Provisions have been made in other line items for foreign currency acquisition of vehicles, data processing equipment and short-term technical assistance over the life of the project.

ANNEX I

SHORT-TERM TECHNICAL ASSISTANCE

ANNEX I

SHORT-TERM TECHNICAL ASSISTANCE

Illustrative list of Short-term Technical Assistance to be procured by the Competitively-selected Contractor.

Area of projected need	Type of STTA	Person/months Yr1	Yr2	Yr3	Yr4	Yr5	Total
Overseas procurement							
NGOs	Logistics, accounting systems, organization bldg, and managerial experts.	4	4	3	3	1	15
Local advertising subcontractor	Market surveyors and researchers, social marketing experts, family planning communications advisors	3	3	3	3	2	14
Ministry of Health Commodity storage & distribution facility	Commodities handling, inventory and distribution experts.	1	2	1	1	1	6
Health Education Division	Family planning communications, campaign planning, impact monitoring and health education experts.	6	5	7	7	2	27
		Total person/months					62
Local procurement							
Return to Project Fund	Accounting assistance.	3	3	3	3	3	15
National population authority	Demographers, population planners, family planning advisors.	6	6	6	6	6	30
		Total person months					45

Funds have been budgeted based on the person/months shown. It is anticipated that certain of the types of expertise budgeted for under overseas procurement may become available locally during the life of the project.

ANNEX J
BUDGET TABLES

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
SUMMARY BUDGET

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS
PROJECT MGT., GSMP, MOH SUPPORT, NGO SUPPORT							
CONTRACTOR							
A. U.S. PERSONNEL							
1. LONG TERM	160,052	317,957	349,562	318,598	19,473	21,420	1,187,062
2. SHORT TERM	140,000	432,390	288,000	292,600	174,000	145,000	1,471,990
3. OTHER DIRECT COSTS	3,000	3,300	3,630	3,993	4,392	4,832	23,147
C. COMMOD. & EQUIP.	317,500	16,500	18,150	19,965			372,115
D. PARTICIPANT TRNG.	33,727	111,298	122,428	134,671	148,138	108,634	658,896
E. LOCAL COSTS							
1. LOCAL PROCURE.	135,803	161,115	177,473	195,419	215,121	152,193	1,037,124
2. OPERATING COSTS	24,311	80,227	88,249	89,488	96,240	70,173	448,688
3. LOCAL PERSONNEL	78,439	110,000	121,000	123,100	146,410	161,051	750,000
							5,949,022
LONG TERM METHODS TRAINING							
CENTRAL BUY-IN							
U.S. PERSONNEL	53,200	63,870	78,440	83,000	70,700		349,210
COMMOD. & EQUIP.	28,000	28,600	29,200	39,000	21,400		146,200
PARTICIPANT TRAINING	2,400	2,400	2,400				7,200
LOCAL COSTS	59,000	69,400	81,500	73,400	50,200		333,500
							836,110
GOG							
TRAINEE TRAVEL	2,100	2,650	2,900	2,350	1,200		11,200
TRAINEE PER DIEM	12,000	16,200	17,750	16,000	9,800		71,750
TRAINEE SUPPLIES	520	660	720	600	150		2,650
							85,600
TBA TRAINING							
ACNM							
TRAINEE SUPPLIES	520	660	720	600	150		2,650
U.S. PERSONNEL	91,263	165,989	135,783	89,978	168,851		651,864
COMMODITIES AND EQUIP.	27,662	9,749	7,798	7,846	7,899		60,954
							712,818
GOG							
TRAINEE TRAVEL	51,040	52,360	51,040	51,040	51,040		256,520
TRAINEE PER DIEM	48,400	55,000	48,400	48,400	48,400		248,600
OTHER	144,600	135,896	154,080	137,377	160,474		732,427
							1,237,547
ASSISTANCE TO GRMA							
ACNM							
U.S. PERSONNEL	175,310	176,476	207,506	203,810	240,888		1,003,990
COMMODITIES AND EQUIP.	59,500	750	3,500	1,680	750		66,180
PARTICIPANT TRAINING		59,400					59,400
LOCAL COST	125,206	93,345	122,274	139,383	108,818		589,026
							1,718,596

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ANNEX J 1 CONT

DEMOGRAPHIC AND HEALTH SURVEY UP-DATE

AIDS BY-IN

U.S. PERSONNEL				48,200			48,200
LOCAL COST				251,800			251,800
							300,000
GOG							
ENUMERATORS				30,000			30,000
TRANSPORT				10,000			10,000
PER DIEM				75,000			75,000
							115,000

POPULATION IMPACT PROJECT

OPTIONS PROJECT

U.S. PERSONNEL	60,600	67,346	74,081	53,772	59,150		314,949
COMMODITIES	11,640	12,804	14,084	10,329	11,361		60,218
LOCAL COST	14,400	15,840	17,424	12,778	14,055		74,497
							449,664
GOG							
PIP PERSONNEL COSTS	17,000	18,700	20,570	22,627	24,890		103,787
LOCALLY IEC COSTS	10,000	11,000	12,100	13,310	14,641		61,051
OTHER	8,000	8,800	9,680	10,648	11,713		48,841
							213,679
FINANCIAL REVIEWS		15,000	16,500	18,200	20,000	22,000	91,700
EVALUATIONS			120,000			150,000	270,000
CONTRACTOR SUPPORT	171,977						171,977
CONTRACEPTIVES	978,000	1,118,000	2,032,000	2,372,000			6,500,000
							6,861,872
TOTALS BY YEAR	3,042,633	3,433,682	4,428,942	5,010,962	1,900,304	835,303	18,651,826
AID TOTALS	2,748,973	3,132,416	4,111,702	4,593,610	1,577,996	835,303	17,000,000
GOG TOTALS	293,660	301,266	317,240	417,352	322,308	0	1,651,826

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ANNEX J 2

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
CONTRACTOR

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS		
I. DOLLAR COSTS									
A. PERSONNEL COSTS									
1. HOME OFFICE SUPP.	3,333	11,000	12,100	13,310	14,641	16,105	70,489		
2. LONG TERM TA (2 PEOPLE X 3 YEARS)								long term totals:	
a) SALARY								91	160,052
1) BASE PAY	36,667	121,000	133,100	97,607			388,373	92	317,957
2) BENEFITS	3,940	11,013	11,972	9,160			36,085	93	349,562
3) ALLOWANCES								94	318,598
a. EDUCATION	13,100	28,820	31,702	17,436			91,058	95	19,473
b. HARDSHIP DIFF.	9,167	30,250	33,275	24,402			97,093	96	21,420
c. COLA	400	1,320	1,452	1,065			4,237		
b) SHIPMENT OF EFFECTS									
1) UAB	6,000			7,986			13,986		
2) HHE	19,000			25,289			44,289		
3) POV	3,500			4,659			8,159		
c) STORAGE IN U.S.	1,333	4,400	4,840	3,549			14,123		
d) INT'L TRAVEL									
1) R AND R TRAVEL									
a. AIRFARES		17,600	19,360				36,960		
b. PER DIEM									
2) HOME LEAVE TRAVEL									
a. AIR FARES									
b. PER DIEM									
3) TRAVEL TO AND FROM POST									
a. AIR FARES	16,000			21,296			37,296		
b. PER DIEM	2,080			2,768			4,848		
e) MISCELLANEOUS DIRECT COSTS									
1) MED EVAC INS.	800	2,640	2,904	2,130			8,474		
2) MEDICAL EXAMS	1,600						1,600		
3) SHOTS	120	132	145	106			504		
4) DBA INSURANCE	3,300	10,890	11,979	8,785			34,954		
3. OVERHEAD	39,712	78,892	86,733	79,051	1,832	5,315	294,534		
4. SHORT TERM TA									
(SEE ILLUSTRATIVE SHORT TERM TA PLAN)								commodities totals	
	140,000	431,090	288,000	292,600	171,000	145,000	1,471,990	91	317,500
B. OTHER DIRECT COSTS								92	16,500
1. TELEX, FAX, PHONE	3,000	3,300	3,630	3,993	1,332	4,832	23,147	93	18,150
II. COMMODITIES AND EQUIPMENT								94	19,965
1. COMPUTER EQUIP.	37,500						37,500	95	0
2. VEHICLES	275,000						275,000	96	0
3. IEC MATERIALS	5,000	16,500	18,150	19,965			59,615		

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ANNEX J 2 CONT.

PARTICIPANT TRAINING

1. WORKSHOPS, CONFERENCES, SEMINARS									
a) REGISTRATION FEE	1,200	3,960	4,356	4,792	5,271	3,865	23,444	part.trng	totals
b) AIR FARE	4,800	15,840	17,424	19,166	21,083	15,461	93,774	91	33,727
c) PER DIEM	4,160	13,728	15,101	16,611	18,272	13,399	81,271	92	111,298
2. SHORT COURSES								93	122,428
a) TUITION & FEES	11,667	38,500	42,350	46,585	51,244	37,579	227,924	94	134,571
b) AIR FARE	2,800	9,240	10,164	11,180	12,298	9,019	54,702	95	148,138
c) PER DIEM	9,100	30,030	33,033	36,336	39,970	29,311	177,781	96	108,634

. LOCAL COSTS

. ESTABLISHMENT COSTS

1. OFFICE FURNITURE	6,633						6,633	Local proc	totals
2. OFFICE MACHINES	9,400						9,400	91	135,883
3. TELEPHONE SYSTEM	10,000						10,000	92	161,115
4. HOUSE FURNITURE	36,000						36,000	93	177,473
OPERATING COSTS								94	195,419
1. VEHICLE OPERATIONS AND MAINTENANCE								95	215,121
a) PETROL	400	1,320	1,452	1,597	1,757	1,288	7,815	96	152,193
b) MAINTENANCE	444	1,467	1,613	1,775	1,952	1,432	8,683		
c) INSURANCE	200	660	726	799	878	644	3,907	oper.cost	tota.
2. OFFICE SPACE								91	24,311
a) RENT	8,000	26,400	29,040	31,944	35,138	25,768	156,291	92	80,227
b) UTILITIES	2,000	6,600	7,260	7,986	8,785	6,442	39,073	93	88,249
c) MAINTENANCE	333	1,100	1,210	1,331	1,464	1,074	6,512	94	89,488
3. HOUSING FOR RESIDENT ADVISORS								95	96,240
a) RENT	4,000	13,200	14,520	15,972	17,569	12,884	78,145	96	70,173
b) UTILIITIES	2,000	6,600	7,260	7,986	8,785	6,442	39,073		
c) MAINTENANCE	333	1,100	1,210	1,331	1,464	1,074	6,512		
4. EXP. OFFICE SUPP.	1,000	3,300	3,630	3,993	4,392	3,221	19,536		
5. OFF. MACH. MAINT.	1,200	3,960	4,356	4,792	5271	3,865	23,444		
6. LOCAL TRAVEL OF ALL PERSONNEL									
a) FARES	1,600	5,280	5,808	5,324	4685	3,221	25,918		
b) PER DIEM	2,800	9,240	10,164	4,659	4099	2,818	33,780		

LOCAL PROCUREMENT FOR PROJECT ACTIVITIES

. SERVICES							
a) ADVER. CAMPAIGNS	31,250	103,125	113,438	124,781	137,259	100,657	610,510
b) COMMOD.LOGISTICS	4,520	5,190	5,955	6,750	7,585		30,000
2. SUPPLIES & EQUIP.	5,000	16,500	18,150	19,965	21,962	16,105	97,682
3. CONSULTING SERV.	33,000	36,300	39,930	43,923	48,315	35,431	236,900

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ANNEX J 2 CONT

LOCAL PERSONNEL

SEE ANNEX M)								local pers totals	
. SOCIAL MARKETING PERSONNEL								91	78,439
a) SALARIES/ALLOWANCES	19,610	27,500	30,250	33,275	36,603	40,262	187,500	92	110,000
								93	121,000
								94	133,100
								95	146,411
. PROJECT MANAGEMENT UNIT PERSONNEL								96	161,050
a) SALARIES/ALLOWANCES	39,219	55,000	60,500	66,550	73,205	80,526	375,000		
			1,786	1,965	2,161	1,585	9,612		
. NGO SUPPORT PERSONNEL									
a) SALARIES/ALLOWANCES	19,610	27,500	30,250	33,275	36,603	40,262	187,500		
AL BY YEAR	892,832	1,232,787	1,168,492	1,187,834	803,774	663,303	663,303		

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ANNEX J 3

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
AID PROVIDED INPUTS

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS
AUDITS							
LOCAL		15,000	16,500	18,200	20,000	22,000	91,700
EVALUATIONS			120,000			150,000	270,000
CONTRACTOR SUPPORT FURNISHING AND EQUIPMENT							
LOCAL		2,977					2,977
US		169,000					169,000
CONTRACEPTIVES							
CONDOMS	332,000	365,000	628,000	680,000			2,005,000
PILLS	234,000	268,000	502,000	670,000			1,674,000
IUDS	16,000	19,000	32,000	36,000			103,000
VFTS	396,000	466,000	870,000	986,000			2,718,000
TOTAL CONTRACEPTIVES	978,000	1,118,000	2,032,000	2,372,000			5,500,000
TOTAL	978,000	1,133,000	2,168,500	2,390,200	20,000	172,000	7,033,677

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ANNEX J 4

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
ASSISTANCE TO BRMA

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	Total
ACNM							
TOTAL PERSONNEL COSTS							
HQ SUPPORT COSTS							
PROJECT DIRECTOR	60,000	66,000	72,600	79,860	87,850		366,310
ADMIN STAFF	76,000	83,600	91,960	100,150	110,165		461,875
OVERSEAS							
SHORT TERM TA	7,510	5,426	8,086		2,653		23,675
INT'L TRAVEL							
PER DIEM	7,800	8,250	9,450	7,800	9,420		42,720
AIR FARE	18,000	9,900	21,780	12,000	26,400		88,080
OTHER DIRECT COSTS	6,000	3,300	3,630	4,000	4,400		21,330
EQUIPMENT							
MEDICAL SUPPLIES	45,000						45,000
OTHER	10,500						10,500
TRAINING MATERIALS	4,000	750	3,500	1,680	750		10,680
PARTICIPANT TRAINING							
INT'L CONFER WORKSHOPS		59,400					59,400
LOCAL COST							
TA LOCAL TRAVEL	5,500	6,050	6,655	7,321	8,053		33,578
LOCAL EQUIP.& MAINT.	33,280	12,100	13,310	14,641	16,105		89,436
TEACHING MATERIAL	23,137	15,303	5,897	26,157	3,160		73,653
TRAINING COSTS	24,793	15,727	42,913	28,773	10,087		122,293
LOCAL PERSONNEL	28,496	33,165	41,399	49,181	56,773		209,014
OTHER DIRECT COSTS	10,000	11,000	12,100	13,310	14,641		61,051
TOTALS BY YEAR	360,016	329,971	333,280	344,873	350,456		1,718,596

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ANNEX J 5

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
TBA TRAINING

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS
ACNM							
TOTAL PERSONNEL COSTS							
HQ SUPPORT COSTS							
PROJECT DIRECTOR	16,500	24,076	26,482	17,479	19,226		103,763
ADMIN STAFF	11,250	43,480	46,525	42,494	45,469		189,218
OTHER DIRECT COSTS	12,502	14,098	13,433	13,433	13,433		66,899
OVERSEAS							
SHORT TERM TA	19,711	16,598	6,916				43,225
INT'L TRAVEL							
PER DIEM	12,000	19,192	13,832	7,262	72,103		124,389
AIR FARE	19,300	48,545	28,595	9,310	18,620		124,370
EQUIPMENT							
COMPUTERS, ETC.	18,618						18,618
EQUIP. MAINT.	399	439	483	531	584		2,436
TRAINING MATERIALS	8,645	9,310	7,315	7,315	7,315		39,900
AID TOTALS	118,925	175,738	143,581	97,824	176,750		712,818
GOG							
TRAINEE TRAVEL	51,040	52,360	51,040	51,040	51,040		256,520
TRAINEE PER DIEM	48,400	55,000	48,400	48,400	48,400		248,600
OTHER	144,600	135,896	154,080	137,377	160,474		732,427
GOG TOTALS	244,040	243,256	253,520	236,817	259,914		1,237,547

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ANNEX J 6

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
GHANA DEMOGRAPHIC AND HEALTH SURVEY

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996
DHS BUY-IN						
TOTAL PERSONNEL COSTS						
HQ SUPPORT COSTS						
PROJECT DIRECTOR				4,200		
ADMIN STAFF				2,500		
OVERSEAS						
SHORT TERM TA				24,000		
INT'L TRAVEL						
PER DIEM				8,000		
AIR FARE				9,500		
LOCAL COSTS						
PER DIEM				61,500		
STAFF TRAINING				69,000		
DATA PROCESSING				33,600		
PRINTING				51,500		
OTHER DIRECT COSTS				36,200		
AID TOTALS	0	0	0	300,000	0	0
GOG						
ENUMERATORS						
SALARY				30,000		
TRANSPORT				10,000		
PER DIEM				75,000		
	0	0	0	115,000	0	0

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ANNEX J 7

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
LONG TERM METHODS TRAINING

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS
CENTRAL BUY-IN							
TOTAL PERSONNEL COSTS							
HQ SUPPORT COSTS							
PROJECT DIRECTOR	6,450	7,100	7,800	8,500	7,100		36,950
ADMIN STAFF	10,550	11,600	12,400	14,100	14,900		63,550
OVERSEAS							
SHORT TERM TA	24,500	32,200	44,800	43,400	37,100		182,000
INT'L TRAVEL							
PER DIEM	5,100	5,670	6,140	7,500	5,000		29,410
AIR FARE	6,600	7,300	7,300	9,500	6,600		37,300
EQUIPMENT							
MEDICAL SUPP. & EQUIP.	27,000	27,000	27,000	36,000	18,000		135,000
MEDICAL EQUIP.	1,000	1,600	2,200	3,000	3,400		11,200
PARTICIPANT TRAINING							
INT'L TRAINING	2,400	2,400	2,400				7,200
LOCAL TRAINING	8,400	14,000	16,000	19,200	18,000		75,600
WORKSHOPS	23,400	23,400	26,000	13,000			85,800
SEMINARS	2,000	2,000	2,800	2,800	3,100		12,700
LOCAL COSTS							
LOCAL EQUIP.	6,000	6,000	6,000	8,000	4,000		30,000
TEACHING MATERIAL	9,600	14,400	20,400	14,400	17,100		75,900
RENOVATIONS	9,600	9,600	10,300	16,000	8,000		53,500
AID TOTALS	142,600	164,270	191,540	195,400	142,300		836,110
GOG							
TRAINEE TRAVEL	2,100	2,650	2,900	2,350	1,200		11,200
TRAINEE PER DIEM	12,000	16,200	17,750	16,000	9,800		71,750
TRAINEE SUPPLIES	520	660	720	600	150		2,650
GOG TOTALS	14,620	19,510	21,370	18,950	11,150		85,600

ANNEX J 8

FAMILY PLANNING AND HEALTH PROJECT
DETAILED COST ESTIMATES
POPULATION IMPACT PROJECT

ITEM/YEAR	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995	FY 1996	TOTALS
OPTIONS PROJECT							
TOTAL PERSONNEL COSTS							
HQ SUPPORT COSTS							
PROJECT DIRECTOR	21,000	23,100	25,410	18,634	20,497		108,641
ADMIN STAFF	13,800	15,180	16,698	12,245	13,470		71,393
OVERSEAS							
SHORT TERM TA	21,240	23,364	25,700	18,847	20,732		109,883
INT'L TRAVEL							
PER DIEM	3,120	4,118	4'530	2,768	3,045		17,582
AIR FARE	1,440	1,584	1,742	1,278	1,406		7,450
COMMODITIES							
IEC PRODUCTION - US	6,000	6,600	7,260	5,324	5,856		31,040
IEC SUPPLIES - US	5,640	6,204	6,824	5,005	5,505		29,178
LOCAL SEMINARS, ETC.	14,400	15,840	17,424	12,778	14,055		74,497
AID TOTAL	86,640	95,990	105,589	76,879	84,566		449,665
GOG							
PIP PERSONNEL COSTS	17,000	18,700	20,570	22,627	24,890		103,787
LOCAL IEC EXPENSES	10,000	11,000	12,100	13,310	14,641		61,051
OTHER	8,000	8,800	9,680	10,648	11,713		48,841
GOG TOTAL	35,000	38,500	42,350	46,585	51,244		213,679

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ANNEX K

PROCUREMENT PLAN TABLE

ANNEX K

PROCUREMENT PLAN TABLE

	Item	Quantity	Budget	Probable Source
1.	USAID			
a.	Institutional contrac		$5,949,022	USA
b.	ACNM services		2,431,414	USA
c.	AVSC services		836,110	USA
d.	Contraceptives			
	condoms		2,005,000	USA
	pills		1,674,000	USA
	IUDs		103,000	USA
	vaginal foaming tablets		2,718,000	USA
e.	Financial reviews		91,700	Ghana
f.	Evaluations		270,000	USA/Ghana
g.	Buy-in to Options Project			
	IE&C production		31,040	USA
	IE&C supplies		29,178	USA
	short-term T.A.		134,915	USA
	home office support		180,034	USA
	local seminars		74,497	Ghana
h.	Buy-in to Demographic Health Survey		300,000	USA
i.	Contractor household furnishings and equipment			
	1. Foreign Exchange Costs		168,797	USA
	a. 2 furniture sets @$16,825			
	b. 2 sets of carpets and pads @$960			
	c. 2 refrigerators @$727			
	d. 2 freezers @$527			
	e. 2 washing machines @$300			
	f. 2 dryers @$279			
	g. 2 stoves @$368			
	h. 2 water heaters @$520			
	i. 2 sets of air conditioners @$5,484			
	j. 2 vacuum cleaners @$147			
	k. 2 water filters @$140			
	l. 2 generators @$16,156			
	m. 2 radios @$1,285			
	n. 2 battery sets @$112			
	o. freight and charges			

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Item	Quantity	Budget	Probable Source
2. Local costs		3,200	Ghana
a. 2 sets of drapes @$1,250			
b. 2 sets of patio furniture @$350			
2. INSTITUTIONAL CONTRACTOR			
a. U.S. personnel			
(1) long term	72 p-m	1,187,062	USA
(2) short term	62 p-m	1,471,990	
b. Local Personnel			
(1) long term		750,000	Ghana
(2) short term	45 p-m	236,900	Ghana
(3) consulting services			
(a) advertising campaigns		610,510	Ghana
(b) commodity logistics		30,000	Ghana
c. Participant training			
(1) workshops		198,489	USA/Ghana
(2) short courses		460,407	USA/Africa
d. Imported commodities/equipment			
(1) vehicles			
sedans	3	45,000	Japan
4 wheel drives	6	150,000	Japan
vans	2	50,000	Japan
flatbed truck	1	30,000	Japan
(2) computers (PC 386)	5	37,500	USA
(3) IE&C materials		59,615	USA/Ghana/ Africa Region
(4) International telex, fax and telephone		23,147	USA
e. Local supplies and equipment			
(1) social marketing, IE&C supplies & equipment		97,682	Ghana
(2) office furnishings and equipment		62,033	Ghana
f. Other local operating costs			
(1) vehicle operations and maintenance		20,405	Ghana
(2) office space		201,876	Ghana
(3) expendable supplies		19,536	Ghana
(4) equipment maintenance		23,444	Ghana
(5) local travel		59,698	Ghana

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	Item	Quantity	Budget	Probable Source
3.	ACHM			
a.	U.S. personnel (1) long-term and short-term T.A.		1,655,854	USA
b.	Participant training (international conferences and workshops)		59,400	USA
c.	Commodities computer, and project related equipment for training		127,134	USA/Ghana
d.	Local costs local travel teaching equipment teaching materials local training and related costs		589,026	
4.	AVSC			
a.	Personnel (1) long-term and short-term T.A.		349,210	USA
b.	Participant training		7,200	USA
c.	Local training (workshops and seminars)		174,100	Ghana
d.	Commodities medical supplies and equipment, local training equipment and materials		305,600	USA or Africa Region
		TOTAL	17,000,000	

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ANNEX L

PID APPROVAL CABLE

(5) ACTION AID2 INFO:AMB DCM P/E

VZCZCAR0872
RR RUEHAR
DE RUEHC #5667/01 2752101
ZNR UUUUU ZZH
R 022101Z OCT 89
FM SECSTATE WASHDC
TO RUEHAR/AMEMBASSY ACCRA 7779
INFO RUEHAB/AMEMBASSY ABIDJAN 9801
BT
UNCLAS SECTION 01 OF 02 STATE 315667

ACTION COPY

RECEIVED
USAID/GHANA

AIDAC ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

SUBJECT: ECPR GUIDANCE GHANA FAMILY PLANNING AND HEALTH PROJECT (641-0119)

1. THE ECPR MET ON 29 AUGUST 1989 AND APPROVED PID FOR SUBJECT PROJECT AT A LEVEL OF UP TO DOLS 25.0 MILLION. OFFICES REPRESENTED AT THE ECPR INCLUDED AFR/PD/CCWAP, AFR/CCWA, AFR/TR/HPN, AFR/NDI, GC/AFR, PPC/PBPR, ST/POP/FPSD AND ST/POP/IT. MISSION DIRECTOR TOWERS REPRESENTED USAID DURING THE REVIEW. THE FOLLOWING GUIDANCE IS PROVIDED FOR MISSION ACTION DURING THE PP DESIGN.

DATE REC'D 11-7-89
REPLY DUE
ACTION TO HPN

2. PROBLEM IDENTIFICATION - THE PID MAKES A STRONG CASE FOR THE NEED FOR FAMILY PLANNING ASSISTANCE AND INCLUDES SUFFICIENT INFORMATION REGARDING THE POPULATION AND HEALTH PROBLEMS JUSTIFYING THIS NEED. HOWEVER, THE PID IS UNCLEAR ABOUT WHY, AFTER MORE THAN 15 YEARS OF AID ASSISTANCE IN THE HEALTH AND FAMILY PLANNING SECTORS IN GHANA, CONTRACEPTIVE ACCEPTOR RATES REMAIN ALONG THE LOWEST IN THE REGION. THE PP WILL NEED TO INCLUDE A THOROUGH ANALYSIS OF LESSONS LEARNED FROM PREVIOUS AID ASSISTANCE EFFORTS IN GHANA TO VERIFY THAT THE

INTERVENTIONS BEING PROPOSED ARE BASED UPON A COMPLETE UNDERSTANDING OF THE PROBLEMS IDENTIFIED.

2. PROJECT COMPLEXITY - THE OVERALL SCOPE OF THE PROJECT AND THE ACTIVITIES PROPOSED ARE AMBITIOUS AND COMPLEX. THE MISSION PROPOSES TO PROVIDE ASSISTANCE IN FAMILY PLANNING AND HEALTH THROUGH THE PUBLIC AND PRIVATE SECTORS UTILIZING BOTH PROJECT AND NON-PROJECT ASSISTANCE MODALITIES. THE ECPR NOTED THAT THE PP WOULD BE STRONGER IF THE DESIGN WERE SIMPLIFIED WITH MORE FOCUSSED AND LIMITED INTERVENTIONS. THE PP WILL NEED TO PRESENT DETAILED ANALYSES AND IMPLEMENTATION PLANS SHOWING HOW ALL THAT IS BEING PROPOSED CAN BE ACCOMPLISHED.

3. NONPROJECT ASSISTANCE COMPONENT (NPA) - THE PID INDICATES THAT THE HEALTH AND POPULATION POLICY

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ENVIRONMENT IN GHANA IS ALREADY QUITE FAVORABLE FOR THE TYPES OF PROJECT INTERVENTIONS BEING PROPOSED AND IS UNCLEAR ABOUT WHAT SPECIFIC POLICY REFORMS WOULD BE ADDRESSED TO JUSTIFY THIS COMPONENT. THE PID DID NOT MAKE A CONVINCING CASE FOR HOW THE NONPROJECT ASSISTANCE COMPONENT ADDED ANYTHING TO THE PROJECT THAT COULD NOT BE ACCOMPLISHED BY A MORE TRADITIONAL PROJECT ASSISTANCE APPROACH. THE ECPR DECIDED THAT UNLESS THE MISSION CAN PRESENT A STRONG JUSTIFICATION FOR THIS COMPONENT IN THE PP, THE COMPONENT WOULD BE DROPPED. IF THE MISSION WISHES TO INCLUDE A NONPROJECT ASSISTANCE COMPONENT, THE PP DESIGN TEAM WILL NEED TO CLEARLY ARTICULATE THE SECTORAL ISSUES BEING ADDRESSED FOCUSING STRONGLY ON WHAT WILL BE THE POLICY REFORM AREAS OR MAKE THE CASE THAT NON-CONDITIONED SECTOR ASSISTANCE IS APPROPRIATE. IF CONDITIONALITY IS REQUIRED, THE PP WILL NEED TO SPECIFY WHAT CONDITIONALITY WILL BE REQUIRED TO TRIGGER THE DOLLAR DISBURSEMENTS AND INCLUDE A DETAILED LOCAL CURRENCY PLAN. THE LOCAL CURRENCY PLAN WILL NEED TO DISTINGUSH BETWEEN THE LOCAL CURRENCY PROVIDED BY THE GOG AS MATCHING FOR THE DOLLAR DISBURSEMENTS AND THE LOCAL CURRENCY GENERATED BY THE CONTRACEPTIVE SALES PROGRAM. MISSION SHOULD REFER TO CURRENT BUREAU GUIDANCE FOR NONPROJECT ASSISTANCE UNDER THE DFA (SEE HEADQUARTERS MANAGEMENT NOTICE NO. 88-44 DATED JULY 12, 1988). IF AN NPA COMPONENT IS PROPOSED IN THE PP AND IS SUBSEQUENTLY DROPPED DURING THE PP REVIEW/APPROVAL PROCESS, THE LOP BUDGET WILL BE REDUCED ACCORDINGLY.

4. HEALTH INTERVENTIONS - THE ECPR NOTED THAT THE FOCUS OF THIS PROJECT SHOULD BE ON FAMILY PLANNING AND INCREASING THE AVAILABILITY OF FAMILY PLANNING SERVICES TO ALL THOSE IN NEED. PROJECT HEALTH INTERVENTIONS SHOULD BE LIMITED TO ONLY THOSE ACTIVITIES WHICH DIRECTLY SUPPORT THE PRIVATE SECTOR CSM COMPONENT.

5. MINISTRY OF HEALTH (MOH) ROLE - THE PP SHOULD INCLUDE A DETAILED ANALYSIS OF THE ROLE OF THE MINISTRY OF HEALTH IN THIS PROJECT. AS INDICATED EARLIER, THE ECPR NOTED THAT THE FOCUS OF THIS PROJECT IS ON GETTING FAMILY PLANNING SERVICES AND COMMODITIES TO PEOPLE IN NEED. WHILE THE MINISTRY OF HEALTH MAY BE AN IMPORTANT ACTOR IN THIS PROJECT, THE PP DESIGN SHOULD MAKE CLEAR THAT PLANNED PROJECT INTERVENTIONS WILL NOT PROVIDE MAJOR INSTITUTION BUILDING ASSISTANCE TO THE MOH. SUCH ASSISTANCE WOULD BE MORE APPROPRIATE FOR THE WORLD BANK OR OTHER DONORS.

6. SUSTAINABILITY - THE ECPR NOTED THAT THE PRIVATE SECTOR COMPONENT OF THIS PROJECT WILL BE CRUCIAL TO THE LONG TERM SUSTAINABILITY OF THE ENTIRE EFFORT. IN THIS

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RELATED, IT WAS NOTED THAT THE PROJECT CONTINUES TO RELY ON SUBSIDIZED CONTRACEPTIVES IN THE PRIVATE SECTOR. THE PP SHOULD EXAMINE THIS ISSUE IN MORE DETAIL AND INCLUDE A PLAN FOR THE PHASED REDUCTION OF SUBSIDIZED CONTRACEPTIVES TO THE PRIVATE SECTOR. WHILE THE PRIVATE SECTOR MAY NOT BE ABLE TO ASSUME COMPLETE FINANCIAL RESPONSIBILITY FOR CONTRACEPTIVES DURING THE LIFE OF PROJECT, THE PP SHOULD INCLUDE SOME ESTIMATE OF HOW THIS MIGHT BE POSSIBLE.

7. MANAGEMENT - A QUESTION WAS RAISED REGARDING WHETHER THE MISSION HAD SUFFICIENT STAFF RESOURCES TO MANAGE A PROJECT OF THIS COMPLEXITY WHICH IS ATTEMPTING TO ADDRESS A VARIETY OF INSTITUTIONAL, TECHNICAL AND POLICY RELATED AREAS. THE PP WILL NEED TO ADDRESS THIS CONCERN AND INCLUDE A DETAILED MISSION MANAGEMENT PLAN. CONSIDERATION SHOULD BE GIVEN TO HAVING A PROJECT FUNDED MANAGER FOR THE ENTIRE PROJECT IN ADDITION TO THE INSTITUTIONAL CONTRACTORS FOR THE PUBLIC AND PRIVATE SECTOR COMPONENTS.

8. PROJECT DURATION - THE FCPR NOTED REDSO/WCA SUGGESTION OF A 7 YEAR LOP INSTEAD OF THE PROPOSED 5 YEAR LOP. THIS ISSUE SHOULD BE ADDRESSED DURING THE PP DESIGN.

9. APPROVAL VENUE - IN VIEW OF THE COMPLEXITY OF THE PROJECT AND THE MISSION'S PREFERENCE FOR AID/W REVIEW,

THE PP WILL BE APPROVED IN AID/W AFTER APPROPRIATE REDSO REVIEW. BAKER
BT
#5667

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ANNEX M

SCOPES OF WORK

ANNEX M

SCOPE OF WORK

GHANA FAMILY PLANNING AND HEALTH PROGRAM

(641-0118)

PRIME CONTRACTOR

I. Background

The Ghana Family Planning and Health Program is being implemented as a follow-on contract to the Ghana Contraceptive Supplies Project (641-0109), which ran from 1985 to 1991.

II. Objective:

The Goal of the program is to lower fertility of the Ghanaian population through maternal and child health interventions. The purpose of the program is to increase the use of and demand for family planning goods and services through expanding the public and private sector capacity for providing family planning and maternal and child health services and supplies. The specific objective of the contractor is to implement directly or assist with the implementation of all aspects of the program.

The core of the project assistance is the expansion of the existing Ghana Social Marketing Program, whose responsibility is the sale and distribution of a variety of family planning commodities. This project is expected to effect a 15% modern contraceptive prevalence rate, primarily by strengthening the private sector's ability to distribute commodities in a supportive policy environment, and by strengthening the Ministry of Health's ability to support and supplement the private sector.

The project addresses a wide variety of family planning and health concerns. In the field of family planning, condoms, vaginal foaming tablets, oral contraceptives, intra-uterine devices, surgical contraception, natural family planning methods, and, when available, Norplant or other new approved family planning methods will be provided. In addition, the project will promote the use of Oral Rehydration Salts for diarrhea/dehydration, and Chloroquine for acute malarial episodes.

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III. Tasks:

Project activities include both public and private sector components. This division facilitates project planning, budgeting, management and implementation. The basic elements of each of these components are: a) delivery of family planning services and marketing of contraceptives and other health commodities; b) information, education and communication (IE&C) on family planning and maternal and child health; and c) training, supervision and monitoring of family planning service providers.

A. Private Sector Component:

1. Social Marketing Component:

(a) Management of supplies:

The entire social marketing component will be the responsibility of the contractor, who will have operational responsibility for implementing a complete program of social marketing. While some of these duties can be subcontracted, the contractor has ultimate responsibility to ensure their performance. These include receiving, clearing and storing AID supplied contraceptives and other commodities, procuring locally produced commodities, conducting marketing studies, test marketing products, designing and testing product names and packaging, designing, testing and implementing advertising campaigns; and distributing products through multiple channels.

The contractor will create a social marketing unit by establishing associations with local firms (subcontracts, joint ventures, partnerships as appropriate). This will be under the direction of a resident expatriate specialist who has the skills needed to implement this part of the project. The above activities will be implemented largely by subcontracting for services and by entering into distribution and sales agreements with appropriate organizations such as accounting, advertising, marketing and distribution firms, as well as other non-governmental organizations.

The contractor's social marketing unit will assist the Ghanaian organizations to strengthen their capacity to handle the particular aspects of social marketing for which their services have been contracted. The contractor will also be responsible for developing and implementing a plan for training the local personnel of its local associates and gradually transferring responsibility for the management and implementation of the social marketing program to its Ghanaian affiliates. This transfer is expected to be achieved in 36 months.

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(b) Packaging and Manufacturing

The contractor will monitor all aspects of in-country packaging and manufacturing that is performed for products distributed by the Ghana Social Marketing Program. Manufacturing primarily applies to the preparation of ORS and Chloroquine. The contractor initially will investigate commercial organizations to determine qualified and interested organizations to compete for a contract to provide packaging, repackaging and other manufacturing services currently provided by DANAFCO, a local pharmaceutical manufacturer and distributor. Technical assistance will be arranged by the contractor to ensure quality control and good manufacturing practices will be arranged, and control mechanisms will be established to ensure that all GSMP products are of highest quality.

(c) Distribution and sales of commodities

The contractor will review the existing arrangements for distribution and marketing and will develop a work plan within three months to strengthen and support the system. If indicated, existing contracts can be terminated with USAID concurrance, and others implemented.

In addition to the existing pharmaceutical distribution system that currently reaches 3500 pharmacies and chemical shops throughout the country, the contractor will explore and develop other commercial distribution networks. By the end of the project, the social marketing program should have a total of 10,000 distribution points and at least one in each of Ghana's 110 districts. These should be receiving supplies regularly and submitting appropriate reports.

The contractor will establish appropriate tracking information systems to be able to evaluate the impact of pricing on each commodity. Pricing decisions based on this will enable the maximum price incentive to dealers as well as maintaining affordability and broad distribution.

(d) Market Women and other Traders

The contractor will place special emphasis on developing distribution networks through the informal trading sector, particularly the rural market network. These will be part of the distribution network listed above.

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(e) Advertising

The contractor will advertise and promote all GSMP products to the public through all channels. The same marketing techniques used for commercial products will be used in the social marketing campaigns. Prior to any new advertising, the contractor will analyze and redefine the target populations for GSMP products. Plans for promotion and advertising of the individual products will be based on the targets established, results of prior and new research, and marketing and sales objectives.

The contractor will procure any materials and supplies required for satisfactory development of promotional materials which are not available in Ghana.

The contractor is expected to carry out at least five national advertising campaigns for each GSMP FP/MCH product, and to analyze the impact of each campaign on comsumer demand.

2. Assistance to NGOs

The contractor will develop a subunit under the social marketing program to liaise with and assist NGOs and PVOs that are active in Ghanaian communities. Most of these will require organizational assistance in management, as well as training for the activities their members will engage in. In addition to the NGOs that seek out assistance, the contractor will identify important NGOs and will endeavor to enlist them in promoting family planning and maternal and child health. Many of these NGOs are associations of non-clinical individuals, and will need training to become Community Based Distribution agents.

Those NGOs that have clinical capacity, such as the Private Medical Practitioners Association-Ghana, the Christian Health Association of Ghana, and the Ghana Nurses Association will receive the appropriate level of clinical training, in addition to the administrative and managerial support listed above.

A crucial task is coordinating the flow of supplies from the distribution networks above to the NGOs. Each situation will require individual arrangements.

It is expected that by the end of the project, 15 NGOs will be active in providing Family Planning/Maternal and Child Health information, services and supplies.

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3. Industrial Health Plans

The contractor will liaise with the industries that provide health services to their employees and will endeavor to persuade them to add family planning services to their benefits. By the end of the project, it is expected that five such industrial family planning units will exist.

4. Management Information Systems

To assist with the management and reporting of all these activities, the contractor will develop a micro-computer based management information system, which will track receipt and distribution of the project commodities. It will be able to produce reports on the functioning of each element of the system, and will permit the evaluation of the efficacy and efficiency of various modes of distribution.

5. Relations to other Contractors

In addition to the activities directly under the supervision of the contractor, a number of other cooperative agreements will be awarded for the performance of specific objectives. The contractor will make arrangements with each Cooperating Agency, with advice from USAID, to receive information on their activities under the project, and to coordinate efforts.

B. Public Sector Activities

1. Distribution of Commodities

In the project AID will continue to supply MOH with contraceptive commodities. Logistics management is the responsibility of MOH, although the contractor is expected to monitor quarterly reports and assist with projections of need and re-ordering of AID supplied commodities. Should the contractor uncover problems at any point in the importation, storage and distribution system, the contractor should arrange technical assistance to alleviate the difficulties.

2. Return to Project Funds.

The contractor will assist MOH to study, review, and set prices for the sales of AID provided products. As needed accounting and managerial technical assistance will be provided to establish good institutional practices. This will be done in coordination with other donors active in strengthening the managerial capacity of the MOH.

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3. Institution Building in the Health Education Division

The contractor will provide techincal assistance to the Health Education Division (HED) of the Ministry in the development and implementation of information, education and communication campaigns. This will largely be an institution building effort, and will involve both technical assistance and short-term training. All of the issues raised above under the "Advertising" section under the private sector will be taken into account while developing these campaigns.
HED is expected to carry out three nationwide campaigns during the course of the project. Local costs for the campaigns will be the responsibility of the Ministry of Health, although imported materials for the campaign will be the responsibility of the contractor.

4. National Population Authority

The contractor will provide assistance to the authority to help it establish its secretariat and to the secretariat once it is formed. In addition to technical assistance, imported equipment such as computers and vehicles will be provided.

The purpose of the assistance is to enable the national population authority to meet the conditions for release of the program assistance cash grants.

IV. Reports and Deliverables:

The contractor will report regularly to the USAID Health, Population and Nutrition Office. Regular reporting includes quarterly progress reports indicating implementation status and achievement of benchmarks, quarterly financial reports, annual workplans, special studies, and final report. The contractor will develop and submit the first annual workplan for joint review by USAID and the project technical committee three months after the initiation of in-country activities. The plan should include, inter alia, plans for scheduled major activities, attainment of benchmarks, training and technical assistance. First year contractor activities will include also the development of a contraceptive marketing plan, assistance to the Health Education Division (HED) for information, education and communication (IE&C) activities, the development of a project management information system and the procurement of all project commodities, excluding USAID-procured contraceptives.

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V. Personnel:

The Institutional Contractor will provide two long-term expatriates, Chief of Party and Social Marketing advisor, and will sub-contract to a Ghanaian firm for management support and for the operation of the Social Marketing Program.

All employees are expected to be fluent in English. Some Ghanaian employees may have other specific language requirements.

A. Chief of Party

The chief of party has responsibility for the accomplishment of all project goals. His duties are primarily managerial. Qualifications for this position include:

1. A master's or higher degree in a relevant subject

2. Ten years third world project management experience, preferably in Africa, with at least five years managing population projects.

3. Excellent writing and basic computer (word processing, spreadsheet, data base) skills.

B. Social Marketing Advisor

The social marketing advisor will be responsible for the social marketing aspects of the project, with primary responsibility for the advertising and IE&C campaigns.

1. A master's or higher degree in marketing, mass communication, or a related field.

2. Five years experience in family planning social marketing projects, preferably in Africa, program and campaign development and market research.

3. Excellent writing and research skills, including computer skills.

C. Ghanaian Staff

Skill and experience requirements for each position will be done by the contractor. Since the counterparts for the two expatriate positions are expected to have an important implementation role in the final years of the project, USAID will concur on individuals selected for these positions.

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1. Social Marketing

The contractor will create a social marketing unit to manage implementation of a full range of social marketing activities under the Ghana Social Marketing Program. The social marketing unit will be staffed by Ghanaians obtained through an agreement between the contractor and a Ghanaian firm in whose offices the unit will be housed. The expatriate social marketing adviser will direct the activities of the unit while developing this management capability within the Ghanaian firm.

2. The contractor's project management unit will handle the following project management and monitoring responsibilities:

a. AID procured commodities - monitoring the receipt and distribution of contraceptive commodities procured by AID for the MOH and for the contractor's social marketing activities. The management unit will assure that the MOH logistics system is functioning particularly with regard to storage conditions and record keeping and provide technical assistance if necessary. The unit also will assist the MOH in preparing an annual request for contraceptives to ensure that method mix and quantities are reasonable and take into account orders requested by the private sector. The management unit will develop and maintain a micro-computer based management information system, linked to the system developed to monitor social marketing activities.

b. Support to other input providers - the Association for Voluntary Surgical Contraception (AVSC), the American College of Nurse-Midwives (ACNM) and the Impact Project contractor will enter into agreements with the contractor. These agreements will elaborate the monitoring and support responsibilities and activities to be undertaken by the contractor in support of these organizations. The contractor, in cooperation with the MOH, AVSC and ACNM, will develop a detailed annual implementation plan and schedule for all input providers. This will enable better coordination and timing of activities and facilitate monitoring and evaluation of implementation progress.

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c. Collection of project data - the contractor will collect data which is requires to track both project implementation progress and project impact. Data will allow disaggregation by gender. The data will include both baseline data at the outset of the project and new data at regular intervals. Primarily, the required data will be generated by existing MOH, NGO and commercial sector data collection activities, contractor reports and the contractor's management information system. To the extent that significant data is not available from existing sources, the contractor will make arrangements to obtain data first hand when secondary sources are not available. The data will be used by the contractor to produce regular progress and special analytical reports for USAID and the Government of Ghana. The data will be made available to independent evaluators engaged by USAID during the life of the project.

d. Financial Management Services - the contractor will monitor the Return to Project Fund established by the MOH to capture the proceeds from the sale of A.I.D.-supplied contraceptives. The contractor will provide technical assistance to overcome problems which may be indicated in financial assessment, audit and procurement reports.

e. Services to the contractor - the contractor will provide in the management unit the capability to maintain the contractor's financial records, prepare vouchers for payment under its contract with A.I.D., arrange for the financial assessment of firms and organizations providing services to the contractor or receiving and disbursing funds on behalf of the contractor.

VI. Logistics:

A. Contractor

The contractor is responsible for all logistical support for the activities undertaken.

B. USAID

USAID will provide contraceptive supplies according to the schedule worked out between the Contractor, the GSMP, the MOH and USAID. USAID will make initial arrangements for housing, furnishings and certain contractor support services which will be financed under the project. After the start-up period, the contractor will be responsible for all support services.

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VII. Level of Effort:

A. The length of project is six years. However, given the lag time between project agreement signing and the arrival of the contractor time, actual implementation is expected to occur over five years.

B. In-country expatriate personnel are expected to be present for the first three years, and to train Ghanaian replacements in that time. Subsequently, additional short-term technical assistance and home office backstopping as required will institute the contractor's remaining involvement.

C. An Illustrative list of short-term technical assistance requirements is given in Annex I of the project paper. A total of 62 person-months is anticipated.

ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION: SUPPORT FOR LONG-TERM METHODS OF CONTRACEPTION IN GHANA

I. GOAL:

To improve the availability and quality of long-term methods of contraception in Ghana.

II. OBJECTIVES AND ACTIVITIES:

The Association for Voluntary Surgical Contraception will increase accessibility and availability of Voluntary Surgical Contraception (VSC) in Ghana by:

A. Establishing VSC centers in nine hospitals and maintain services in six previously established centers, including minor renovations required to provide suitable facilities.

B. Procure needed equipment and replacements for the above service sites both locally and from the United States.

C. Train one Physician/Nurse team in minilaparotomy under local anaesthesia techniques internationally and 32 such teams locally to provide services in the above centers. Provide Quality Assurance Expertise to ensure that these 33 and 18 previously trained teams provide good quality service.

D. Train 60 new counselors in counseling for long term contraception and continue to supervise and monitor 80 previously trained counselors.

E. Provide VSC Services to 7,000 clients over the term of the project.

F. Upon approval of Norplant by the United States Food and Drug Administration and its availability through USAID, develop a plan for the introduction of Norplant into Ghana with the goal of providing at least 1,000 women with this means of contraception.

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THE AMERICAN COLLEGE OF NURSE-MIDWIVES (ACNM) "NATIONAL PROGRAM FOR TRADITIONAL BIRTH ATTENDANTS II," PROJECT (TBAs)

I. GOAL:

To improve the health of women and children through increased access to quality maternal and child health and family planning services provided by private sector TBAs who receive training, supervision, support and continuing education in a national TAB program.

II. OBJECTIVES AND ACTIVITIES:

The ACNM will:

A. Strengthen and support the capability of the National TBA (NTBA) program secretariat to coordinate, support, monitor and evaluate the National TBA program.

1. Evaluate NTBA capacity and train NTBA staff to carry out administrative activities such as office management; coordination of training; continuing education and service support activities; coordination with Regional Ministry of Health (RMOH) and other collaborating agencies; budgeting; and short-term and long-term planning.

2. Acquire equipment and materials needed to support the programmatic and administrative activities of the NTBA program.

3. Establish a library of reference materials at the NTBA program secretariat.

4. Conduct an annual three-day planning meeting of the secretariat, MOH and RMOH representatives, and representatives of collaborating agencies (GRMA, UNFPA, UNICEF, etc.).

5. Provide basic computer training courses for NTBA program staff.

B. Strengthen and expand the system for monitoring, supporting, and evaluating the National TBA program.

1. Conduct support visits to monitor and support program activities:

a. Conduct one eight-day NTBA secretariat program support visit to the RMOH in five regions, each year.

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b. Conduct two fifteen-day RMOH program support visits to district and level B institutions in five regions, each year.

2. Conduct monitoring system support visits to evaluate and strengthen the system for collecting, analyzing and disseminating TBA services statistics:

a. Conduct a three-day NTBA secretariat monitoring system support visit to the RMOH four times in year one, and three times in years two through five, in five regions.

b. Conduct RMOH monitoring system support visits to district and level B institutions forty days per year, in five regions.

3. Assess the impact of the NTBA program on the quality and scope of TBA practices:

a. Conduct a qualitative study in two communities to assess TBA practices prior to and following TBA training.

b. Conduct a quantitative study in two or more regions to assess TBA practices over five years' time.

C. Provide materials and technical support needed for training of an additional 3,000 TBAs master trainers (MTs) and existing Trainers.

D. Plan, conduct and evaluate two three-day continuing education sessions for MTs and Trainers in five regions, each year.

1. Plan, conduct and evaluate two three-day continuing education sessions for MTs and Trainers in five regions, each year.

2. Develop, field test and publish five continuing education (CE) manuals that will supplement the Trainers Manual and Manual for the Training of TBAs in Ghana.

3. Plan, conduct and evaluate three CE sessions for TBAs per 60 trainers, in five regions each year.

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E. Plan and conduct an orientation for up to 40 midwifery tutors and 40 midwifery clinical instructor on the role of Traditional Birth Attendants in the modern health care system, the National TBA program, and the role of the midwife as a trainer and supervis of TBAs.

1. Develop materials for the midwifery tutors a clinical instructors orientation.
2. Conduct two one-day orientation sessions for up to 20 midwifery tutors and 20 clinical instructors.

F. Plan, conduct and evaluate a program for up to 10 Public Health Nurse (PHN) tutors on the role of the TBAs in the modern health care system, the National TI program, the role of the midwife as a trainer and supervisor of TBAs, the role of the PHN as a trainer and supervisor of TBA trainers, and ways to introduce the training of trainers into the PHN curriculum.

1. Plan, conduct, and evaluate a one-day orientation meeting for up to 10 PHN tutors.

2. Include up to 10 PHN tutors as Master Trainei participants in the MTPS and training of trainers (TOTs) in the new region.

3. Plan, conduct and evaluate a three day curriculum development and implementation workshop for up to 10 PHN tutors.

4. Conduct a follow-up support visit by the NTBA secretariat to the PHN Training School to evaluate and assist with the introduction of the TOTs into the PHN curriculum.

G. Plan, conduct and evaluate TBA training and CE for up to 500 additional TBAs in five regions.

1. Plan, conduct, and evaluate 600 TBA training sessions, in six regions (60 trainers per region times 10 sessions).

2. Plan, conduct, and evaluate two CE sessions for TBAs in year two, and three CE sessions for TBAs in years three through five, in six regions (60 trainers per region times 11 sessions).

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AMERICAN COLLEGE OF NURSE MIDWIVES (ACNM) SUPPORT TO THE GHANA REGISTERED MIDWIVES ASSOCIATION SUBPORJECT

I. GOAL:

To improve the health of mothers and children through increased access to quality family planning/maternal child health (MOH/FP) services provided by public and private sector midwives whose scope of work is broadened through in-service training, continuing education and evaluation activities of the GRMA.

II. OBJECTIVES AND ACTIVITIES:

The ACNM will:

1. Improve the management and administrative capabilities of the GRMA to ensure sustainability of the organization and expanded member services.

   A. Carry out administrative activities such as office management, planning/coordination of service support and other functions, coordination of other collaborating agencies, budgeting, and short and long term planning that support the growth of the GRMA and its project.

   B. Acquire equipment needed to support GRMA training and administrative activities.

   C. Conduct one three-week regional representative workshop on management and supervision.

   D. Conduct two five-day meetings each year of all regional representatives and the secretariat.

   E. Provide management training for GRMA administrators.

   F. Provide basic computer training courses for GRMA staff.

2. Plan, conduct and evaluate training for up to 200 public/private sector midwives in basic family planning.

   A. Field test and publish an FP manual.

   B. Develop, field test and publish a manual for training of trainers (TOT) of midwives of FP/MCH providers.

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C. Conduct one three-week TOT for up to 6 FP/MCH trainers.

D. Conduct eight two-week basic FP workshops for up to 200 midwives.

E. Coordinate eight three-day Basic Business Skill workshops for up to 200 midwives.

F. Coordinate eight three-day refresher Business Skill workshops for up to 200 midwives.

3. Expand and diversify the current GRMA continuing education system.

A. Develop up to 10 continuing education modules.

B. Provide continuing education activities at the GRMA annual national meeting, monthly regional meetings and during support visits.

4. Provide professional, individual and service support for up to 400 maternity homes in FP/MCH practice.

A. Provide essential FP/MCH equipment for up to 400 FP/MCH centers run by midwives.

B. Establish 10 regional libraries and upgrade the GRMA national library.

C. Plan, implement and evaluate public relations and communication activities.

5. Develop, implement and evaluate a system for standardization of quality FP service delivery.

A. Develop minimum GRMA facility standards and FP service protocols/procedures.

B. Develop a voluntary system for continuing education verification of midwives in FP/MCH activities.

C. Plan and conduct evaluation surveys of FP practices of GRMA trained midwives.

D. Develop tools for monitoring the continued quality of FP practices.

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E. Monitor and support the provision of FP services provided by midwives trained through the GRMA by conducting up to 600 support visits.

6. Plan, conduct and evaluate training for up to 45 private sector midwives in intra-uterine contraceptive device (IUCD) management updates.

A. Plan and conduct an evaluation survey of IUCD services of Ibadan trained GRMA midwives.

B. Develop tools for monitoring the continued quality of IUCD services.

C. Develop, field test and publish a manual for an IUCD refresher course.

D. Conduct one two-week workshop to prepare up to 10 IUCD preceptors.

E. Conduct four five-day refresher workshops for up to 35 IUCD providers.

7. Provide international exposure/experience for the GRMA.

A. Write at least one article describing the project model and its results in a professional journal.

B. Present a report on the results of the GRMA model project at two international conferences.

C. Support the GRMA Director in travel for consultation with other African midwifery associations.

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ANNEX N

GOG REQUEST FOR ASSISTANCE

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Our Ref. No. USAID/G/19.7

Your Ref. No.

Tel. No.

ACTION COPY

REPUBLIC OF GHANA

MINISTRY OF FINANCE AND ECONOMIC PLANNING
P.O. BOX M.40
ACCRA

RECEIVED
30 JUL 1990
USAID / GHANA

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HFN-240

Dear Mr. Towery,

REQUEST FOR FINANCIAL ASSISTANCE GRANT
OF $25 MILLION FOR FAMILY PLANNING AND HEALTH

The Government of Ghana hereby requests a financial assistance grant of approximately US$25 million to help improve the delivery and increase the use of family planning and maternal and child health services and supplies in Ghana. The programme will serve to improve the health of mothers and children by helping to ensure that critical family planning and maternal and child health services and supplies are available on a sustainable basis in Ghana.

The grant would provide US$17.0 million to finance the purchase of contraceptives and to support activities, such as technical assistance, training, information, education and communication compaigns and social marketing activities, to increase the capacity of private and public sector health care providers to deliver family planning and maternal and child health services.

An additional US$8.0 million would be provided as a cash grant to be released in three tranches, through the foreign exchange auction, upon the performance of policy and regulation reforms in the population and health sectors. The counterpart funds which would be generated from the cash grant would provide budgetary support for the family planning, maternal and child health and other related primary health care activities.

In support of this programme, the Government of Ghana would contribute a cedi equivalent of US$9.9 million in kind to cover the cost of staff, facilities, administration, equipment and supplies. A cedi equivalent of US$2.3 million in cash will be provided to cover the local costs for training traditional birth attendants; training health professionals in long-term contraceptive methods; hiring local personnel of the Population Impact Project at the University of Ghana.

Additionally, the Government of Ghana would finance the operation of a "National Population Authority" estimated at the cedi equivalent of $685,000 over the life of the programme, to coordinate the national population and family planning effort.

I believe that a Family Planning and Health Programme will greatly assist us to reach our health and population goals, and we look forward to negotiating and implementing such a proposed programme with USAID as soon as possible.

Yours sincerely,

DR. KWESI BOTCHWEY
PNDC SECRETARY FOR FINANCE
AND ECONOMIC PLANNING

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MR GARY TOWERY
A.I.D. REPRESENTATIVE
USAID, A C C R A.

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ANNEX O

STATUTORY CHECKLIST

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country, to United States Government personnel or their dependents or from entering the United States unlawfully?

No.

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs

Ghana is not considered a major illicit drug producing or a major drug transit country.

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are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

No. 3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to N/A

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Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? No.

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No.

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6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

6(a). NO

6(b). NO

NO

NO

FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

NO

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC?

Ghana has an investment guaranty agreement with OPIC.

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

9(a). NO

9(b). N/A

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10.	FAA Sec. 620(q); FY 1990 Appropriations Act, Sec. 518 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?	No.
11.	FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	N/A.
12.	FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	No.
13.	FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)	Ghana is not in arrears in its UN obligations.

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No. 14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?

No. 15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No. 16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No. 17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No. 18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)

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19.	FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?	No.
20.	ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	Ghana has not yet entered reservations. The matter was taken into account by the A.I.D. Administrator at the time of approval of the Agency's OYB.
21.	FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	No.
22.	FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	Yes.

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B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

No

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No

b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

2. Economic Support Fund Country Criteria

n/a

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

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5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?

   n/a

2. FAA Sec. 611(a). Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   Yes. All relevant plans have been carried out and a reasonably firm estimate of cost of assistance has been established.

3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

   Conditionality for Tranche 1 of the non project assistance program requires the GOG to change classification of certain drugs to exempt or less dangerous categories. The Pharmacy Board which oversees this action has indicated that they anticipate no problems in meeting this condition as it was already being considered by the Pharmacy Board.

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4.	FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	n/a
5.	FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	n/a
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	no
7.	FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	Program relies primarily on the mobilization of private sector organizations/ businesses to support family planni and maternal/child health activities. Additionally, a ca grant will be auctioned by the Bank of Ghana, which wi provide private sec tor businesses acce to critical foreign exchange which will support private investment, export and trade.
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	

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9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

29% of the cost of the program is financed by GOG in-kind and cash contributions. GOG is financing all local costs related to assistance to public sector health professionals.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

no

11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

no

12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

no

13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other

no.

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wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? — n/a

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? — yes

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? — yes

17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? — n/a

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18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Confirmation of the signing of the agreemen and the full text of th agreement will be sent State L/T and AID/Leg within 60 days of the agreement's entry into force.

19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?

no

20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes. As a family planning program, the majori of assistance is geared women. Women health prof sionals also willbe trai

21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

Yes.

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Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?	yes
Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?	yes
If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?	yes

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B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	n/a
b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	n/a
c. FAA Sec. 281(b). [illegible] the extent to which the activity re[illegible] the particular needs, desi[illegible] and capacities of the people of the c[illegible] utilizes the country's intellec[illegible] resources to encourage institutio[illegible]elopment; and supports civic educa[illegible] training in skills required for [illegible] participation in gover[illegible] and political processes es[illegible]al to self-government.	Program responds to the local need for family plan services and commodities. Local resources will be utilized to implement a substantial portion of the program, thereby strengthe ing in-country expertise i the promotion and delivery of family planning service

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d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources or to the increase of productive capacities and self-sustaining economic growth?	Yes. Program assistance component provides foreign exchange to GOG foreign exchange auction which supports the econom recovery program.
e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.	Program focuses on providing family planning servi and supplies to the poor who primarily reside in rural areas. Women's access to family planning services will allow them to manage their family size and resources, whic will enable them to live more economically productive lives.
f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?	Yes. Source of funding is DFA.
g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for	yes

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use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U. S. Government?

h. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? — n/a

i. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? — yes

j. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? — yes

k. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government. — Yes. Program responds a local need for famil planning and maternal child health services. Local resources will b utilized in program implementation which w build an in-country capacity to promote an delivery FP/MCH servic

l. FY 1990 Appropriations Act, under heading "Population, DA," and Sec. 535. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? — no.

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Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	no
Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	no.
Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	yes
In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	no
Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	no
m. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	yes
n. FY 1990 Appropriations Act Sec. 579. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and	Approximately $2.5 million will go toward financing cooperative agreement with women-owned organization. Oth Gray Amendment entities are being targeted for prequalification and shortlisting by the Mission.

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private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

o. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a

A categorical exclusion has been granted.

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condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; and (11)/utilize the resources and abilities of all relevant U.S. government agencies?

p. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project: (1) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (2)/take full account of the environmental impacts of the proposed activities on biological diversity? n/a

q. FAA Sec. 118(c)(14). Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? no

r. FAA Sec. 118(c)(15). Will assistance be used for: (1) activities which would result in the conversion of forest lands to the rearing of livestock; (2) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (3) the no

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colonization of forest lands; or (4) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

s. FY 1990 Appropriations Act Sec. 534(a). If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? n/a

t. FY 1990 Appropriations Act Sec. 534(b). If assistance relates to energy, will such assistance focus on improved energy efficiency, increased use of renewable energy resources, and national energy plans (such as least-cost energy plans) which include investment in end-use efficiency and renewable energy resources? n/a

Describe and give conclusions as to how such assistance will: (1) increase the energy expertise of A.I.D. staff, (2) help to develop analyses of energy-sector actions to minimize emissions of greenhouse gases at least cost, (3) develop energy-sector plans that employ end-use analysis and other techniques to identify cost-effective actions to minimize reliance on fossil fuels, (4) help to analyze fully environmental impacts (including impact on global warming), (5) improve efficiency in production, transmission, distribution, and use of energy, (6) assist in exploiting nonconventional renewable energy resources, including wind, solar, small-hydro, geo-thermal, and advanced

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biomass systems, (7) expand efforts to meet the energy needs of the rural poor, (8) encourage host countries to sponsor meetings with United States energy efficiency experts to discuss the use of least-cost planning techniques, (9) help to develop a cadre of United States experts capable of providing technical assistance to developing countries on energy issues, and (10) strengthen cooperation on energy issues with the Department of Energy, EPA, World Bank, and Development Assistance Committee of the OECD.

u. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA" (as interpreted by conference report upon original enactment). If assistance will come from the Sub-Saharan Africa DA account, is it: (1) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (2) being provided in accordance with the policies contained in section 102 of the FAA; (3) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (4) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take

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into account, in assisted policy reforms, the need to protect vulnerable groups; (5) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

v. International Development Act Sec. 711, FAA Sec. 463. If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (1) the world's oceans and atmosphere, (2) animal and plant species, and (3) parks and reserves; or describe how the exchange will promote: (4) natural resource management, (5) local conservation programs, (6) conservation training programs, (7) public commitment to conservation, (8) land and ecosystem management, and (9) regenerative approaches in farming, forestry, fishing, and watershed management. n/a

w. FY 1990 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? n/a

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2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. n/a

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? n/a

c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? n/a

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? n/a

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? n/a

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? n/a

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3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

CROSS REFERENCES:	IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED?	Yes.

A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE

1.	FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.	Congressional Notification
2.	FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	No further legislative action is required by the Government of Ghana.
3.	FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.	No. The program focuses on country-specific policies and activities not subject to regional execution. However, the program is supportive of World Bank, UNICEF, and UNFPA policies and goals through their family planning and health programs in Ghana.

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4. FAA Sec. 601(a). Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.	The program supports the public and private sectors and will facilitate and increase in the flow of international trade by increasing the amount of foreign exchange available to both sectors.
5. FAA Sec. 601(b). Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The program is not expected to have an effect on U.S. private investment. However, it will have an effect on U.S. priva trade to the extent that A.I.D. will finance the importation of contraceptives.
6. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds?	N/A

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

1. Nonproject Criteria for Economic Support Fund	N/A
a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?	
b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities?	

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c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? N/A

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

e. FY 1990 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 592. If assistance is in the form of a cash transfer: (a) Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements? (c) Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available? (d) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance? N/A

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2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a). Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

1) The program expects to piggyback on existing public health facilities, NGO operations, trader/market women marketing systems and employer-based health systems to increase modern contraceptive prevalence, increase access to ORS and anti-malarial treatments; 2) TA to traditional birth attendants promote safer deliveries, and through TA to midwives association promote good midwifery and good business practices; 3) supports expansion of existing social marketing program and complements MOH reorientation to preventive care and integrated primary care systems; 4) women's associations and cooperatives are active and will be used as conduits for project activities, and benefits will accrue to them in general through improved health, empowerment, education, income & org. support; 5) No direct effect.

b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

N/A

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out

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under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

(2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

Social marketing activities and public sector health activities have been integrated. Social marketing will include the full range of ac ivities relating to the imp tation/distribution/sale of family planning products. NGOs, women's associations cooperatives, market women, traders and employer-based health providers, tradition. birth attendants, licensed midwives, public health cent workers are at the core of a integrated primary care syst

(3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education

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and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(4) [106] for energy, private voluntary organizations, and selected development problems; if so, extent activity is: N/A

(i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and (b) facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

(ii) concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster and programs of disaster preparedness;

(v) for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

(vi) for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

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(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)?	N/A

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ANNEX P

REQUEST FOR EXEMPTION FROM REQUIREMENTS OF SECTION 592(B)(2)
OF FY 1991 APPROPRIATIONS ACT

ANNEX P

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D.C. 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: Timothy J. Bork, AFR/PD

SUBJECT: Ghana Family Planning and Health Program (641-0118), Exemption from the Requirements of Section 592(b)(1) of the 1990 Foreign Operations, Export Financing, and Related Programs Appropriations Act

Problem: Your approval is required to include in the Congressional Notification for the subject program an exemption from the dollar tracking requirement of Section 592(b)(1) of the 1990 Foreign Operations, Export Financing, and Related Programs Appropriations Act (the Appropriations Act). The ECPR has decided to recommend the Ghana Family Planning and Health Program for approval by the AA/AFR as a FY 1991 new start. The PAAD/PP documentation is being finalized by AFR/PD before forwarding it to you for approval.

Background: The Ghana Family Planning and Health Program (FPHP) is designed to assist the Government of Ghana (GOG) in increasing the use of and demand for family planning through expanding the public and private sector capacity for providing family planning and maternal child health (MCH) services, supplies and information. The $30 million life-of-program funding for the FPHP will provide $13 million in nonproject assistance (NPA) and $17 million in project assistance. The NPA cash grant will be provided to the GOG in three tranches upon successful accomplishment of three sets of conditionality.

Discussion: When the Economic Recovery Program (ERP) began in 1983, Ghana's foreign exchange regime was characterized by foreign exchange (FX) rationing through import licensing, currency controls, fixed and grossly overvalued exchange rates, a booming black market and lack of FX for personal transactions. ERP's centerpiece has been the focus on achieving a flexible exchange and liberalized trade system to restore market incentives in the economy.

The Bank of Ghana (BOG) weekly foreign exchange auction was instituted in 1986 as an interim mechanism for developing a market-based system of allocating FX and liberalizing the trade regime. It has facilitated the re-orientation of foreign exchange allocation from administrative controls and licensing to a market-based system.

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The auction is used mainly for financing imports. Private importers submit a pro forma invoice and bid documentation indicating the types and amounts of foreign currency requested and the local currency (cedi) rate offered in dollar terms. The importer also is required to submit a bank guarantee or authorization that permits the Bank of Ghana (BOG) to debit the bank's account with 100 per cent of the cedi equivalent of a successful bid. The bids are lodged with the BOG in time for the auction to be conducted on Friday afternoons.

Clearing the auction is supervised by a foreign exchange auction committee (consisting of representatives from the BOG and the private sector) which determines eligibility of applications. The auction market is cleared when the requests for FX for that week matches the allocation of FX to the market during the week. The official market exchange rate is the marginal exchange rate for the US dollar at which the supply of FX satisfies the demand. This rate applies to all official FX transactions for the following week.
The exchange rate of the cedi to other currencies than the US dollar is determined by the BOG based on the average weekly exchange rate of those currencies to the dollar in the international market.

The weekly auction is basically an interbank market through commercial banks. The commercial banks bid for blocks of foreign exchange on behalf of their customers. Ghana utilizes a FX auction and FX trading system that is open to all persons and nondirective (i.e. substantially free of government controls). Presently, the auction basically is handled entirely by the private sector.

The results of the auction are made available every Friday afternoon, and published in the press on Saturdays, indicating the numbers of bidders and successful bids, highest and lowest bids offered, the marginal rate and the total FX supplied by the BOG and level of demand during the week. With this information and the list of successful bidders, the BOG matches the requests for various foreign currencies with the available sources of funds, taking into consideration donor restrictions on commodities and source/content.

After matching funds, the BOG transfers the foreign exchange into a blocked account in the name of the bidder's bank which pays the BOG the full cedi value of the FX. The bidder's bank finances the import transaction upon the bidder paying the full cedi equivalent of the FX or fulfilling financing arrangements satisfactory to the bank.

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All firms and individuals meeting the eligibility criteria are free to participate in the auction market. The requirement to obtain import licenses in order to access the FX auction has been abolished. This has eliminated the major source of bureaucratic intervention. Auction transactions are conducted openly and are open to observers. Access to the auction has been widened to include funding of all imports, except five categories on a negative list (beer and stout, cigarettes, cement pipes, roofing sheets, and asbestos and fibers) and imports prohibited for non-trade reasons. All bona-fide requests for FX for business travel and transfers of profits and dividends are also eligible. Thus, only a few restrictions (relating mostly to invisible transactions) on payments and transfers for current international transactions remain in effect as of the end of 1989. Reflecting the low level of imported inputs in agriculture, agriculture receives less than 10 per cent of auction funds. Use of the auction for the importation of consumer goods is limited. Ghanaian industry receives about 50 per cent (the largest share) of the auction funds. Auction funds can only be used to import drugs that appear on the Ministry of Health essential drugs list. Since contracetives are not on this list, commercial importers face an adverse currency exchange climate in addition to ordinary customs duties. The Ghana Mission monitors the Bank of Ghana (BOG) weekly auction system, and it believes that the system is sufficiently transparent to discourage or minimize manipulation by individuals in the public or private sector.

The BOG began licensing institutions, including banks and individuals to operate Forex bureaus in February 1988. At present, there are over 140 bureaus in operation countrywide. Forex bureaus are permitted to deal in eight major currencies. The supply of and demand for FX at the bureaus are market-determined at daily prices freely quoted by each bureau. Bureaus obtain their supply of FX from private sources, including retained FX earnings of some exporters (excluding cocoa and mining), remittances, interest earnings, private foreign savings, and FX held by the public.

All import transactions are permitted at the Forex bureaus. Money is changed over the counter, transactions take place on a strictly confidential basis, and no records are kept on clients. No documentation other than simple encashment or sales receipts are demanded on transactions with the bureaus. Bureaus are only required to report to the BOG monthly on total purchases and sales of currencies and their respective rates. Beyond this, their operations are entirely free of bureaucratic encumbrances. For donors, using the Forex bureaus would be very difficult because there are no established arrangements

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for obtaining information required by the parent agencies. Even information on the amount of the donor's grant actually sold and local currency generated would be impossible to obtain from the bureaus since they do not report on sources.

Since establishment of the auction in 1986, both the World Bank and the International Monetary Fund (IMF) have strongly urged bilateral donors to follow their lead in using the auction and to move increasingly toward quick-disbursing forms of program assistance that can be channeled through the auction. Most donors do so. The difference between auction and Forex Bureau rates has decreased from 54 cedis per dollar in July 1988 to 20 cedis by August 1990. The Ghana Mission believes that there will be further convergence over the coming months.

The auction has functioned well in reorienting the nature of the foreign exchange (FX) system. Econometric analysis of the auction market by International Bank for Reconstruction and Development (IBRD) demonstrated that the weekly marginal rate is significantly affected by the rate determined, as well as unmet demand at the previous auction, which signifies market behavior. Transactions at the bureaus respond entirely to market forces. During 1989 and 1990, the spread between the auction and bureau exchange rates has narrowed considerably, reflecting the effects of GOG measures to integrate the two markets. Since the beginning of the FX auction, the auction rate has increased about 168 per cent compared with an increase in bureau/parallel market rate of 77 per cent.

Dollar tranches will be disbursed into a single, separate and non-commingled BOG interest-bearing account in New York. All dollars will be withdrawn by utilizing letters of credit through weekly auctions. Interest earned by the account will be utilized in the same manner as the principal and sold through the weekly auction. The Bank of Ghana (BOG) will report to the Ghana Mission and the Ministry of Finance and Economic Planning (MFEP) the auction of dollars, including dollar amounts of the letters of credit, exchange rates, and the amount of local currency generated. Within 30 days following the auction of the dollars, the BOG will deposit the local currency equivalent (determined by the exchange rate on the date the dollars are sold) into an interest-bearing MFEP account in Ghana.

Section 592(b)(1) of the Appropriations Act stipulates that a country recipient of cash transfers or cash disbursing nonproject sector assistance must establish a separate account for the receipt of such funds and must not commingle these funds with monies from other sources. In addition, Section 592(b)(3) requires A.I.D. to submit a Congressional

Notification (CN) at least 15 days prior to the obligation of any Economic Support Funds (ESF) or Development Assistance/Development Fund for Africa (DFA) nonproject sector assistance. The notification has to include a detailed description of the proposed specific uses for the dollars. Further, Section 592(b)(4) permits an exemption from the dollar tracking requirements of the Act for nonproject assistance through the CN process. The primary criterion for exemption from the dollar tracking requirement of Section 592(b)(1) of the Appropriations Act, as set forth in State 050769 (subject: "Preliminary Africa Bureau Guidance on Separate Accounts and Dollar Tracking for DA and DFA-Financed Nonproject Sector Assistance Programs"), is the degree of interference that implementing the requirements of Section 592(b) would impose on the recipient country's foreign exchange allocation system. The preceding discussion constitutes justification for allowing an exemption from Section 592(b)(1) separate account dollar tracking requirement for the nonproject sector assistance to be provided under the DFA-financed Ghana Family Planning and Health Program.

Recommendation: That you exercise your authority as A.I.D. Assistant Administrator for Africa and approve the inclusion of an exemption from the requirements of Section 592(b)(1) of the 1990 Foreign Operations, Export Financing, and Related Programs Appropriations Act in the Congressional Notification for the Ghana Family Planning and Health Program.

Approved: Warren Buckley

Disapproved: _____

Date: OCT. 17, 1990

Clearances:

DAA/AFR:ELSaiers		Date	10/16/90
AFR/PD/CCWAP:AGetson	(Draft)	Date	10/4/90
AFR/DP/PAR:SAllen	(Draft)	Date	10/5/90
AFR/CCWA:MGolden	(Draft)	Date	10/5/90
GC/AFR:PJohnson		Date	[illegible]

PREPARED BY:AFR/PD/CCWAP:WDARKINS:10/11/90:79067:(0600K)

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ANNEX R

LOCAL COST FINANCING DETERMINATION

UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT
MISSION TO GHANA

Ring Road East Near Danquah Circle
P.O. Box 1630
ACCRA—GHANA
TELEPHONE 775346

ACTION MEMORANDUM FOR THE ACTING AID REPRESENTATIVE

Date: August 3, 1990

From: Lynn A. Keeys, PDO

Subject: Local Currency Financing under the Family Planning and Health Program (641-0118)

Issue: You are requested to make a determination that prices for commodities and services to be procured locally under the Family Planning and Health Program are reasonable.

Background: Handbook 1B, Chapter 18(A)(1)(c) requires that the Principal AID Officer make a determination, based on a reasonable analysis of the supply and price of indigenous and shelf item goods and services expected to be required, that such prices are reasonable, taking into account comparable delivery terms and prices from eligible sources, and the implementation schedule of the project.

Description: The Family Planning and Health Program will finance $3,580,000 of local goods and services. The budgeted amount covers the cost of local technical personnel and professional services for project implementation, local financial audits, local training costs, including travel, per diem and expendable training supplies and local costs for supporting U.S. long-term and short-term personnel. The estimated costs for locally procuring technical assistance services and supplies are reasonable, based on the experience of the World Bank and other donors working in the population sector in Ghana, and on the costs for such goods and materials under the Contraceptive Supplies Project and other similar ongoing A.I.D. projects in Ghana.

Recommendation: It is recommended that you make the determination that the prices of indigenous and locally available imported goods and services are reasonable, by signing below.

Approved: Edward W. Brydile

Disapproved: _____

Date: 3 Aug 90

Clearances: CONT:WGrizzard
EXO:DAwad

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ANNEX S

ECPR GUIDANCE CABLE

OUTGOING TELEGRAM

AGENCY FOR INT'L DEV. TELECOMMUNICATIONS CENTER

PAGE 01 OF 02 STATE 346936 4446 018328 A107432
OR: I N A D-32

ORIGIN OFFICE AFPD-04
INFO AFCW-03 AFDP-06 AFCO-02 AFTR-05 AAAF-03 AFPE-07 OL-01
CAST-20 POPR-01 PPPB-02 GC-01 GCAF-02 ES-01 AAID-01
STHE-03 POP-04 HHS-09 TELE-01 PRED-01 AGEE-01
/059 A0 13/0034Z

INFO LOG-00 AF-00 OES-09 /011 R

DRAFTED BY: AID/AFR/PD/CCWAP:WHAMMINK/WDARKINS:8562K
APPROVED BY: AID/A-AA/AFR:WGBOLLINGER
AFR/TR/HPN:GMERRITT (DRAFT) GC/AFR:PJOHNSON (DRAFT)
AFR/CCWA:MGOLDEN (DRAFT) AFR/PD/CCWAP:AGETSON
AFR/PD:TBORK AFR/DP/PAB:DWILSON (DRAFT)
AFR/DP/PAR:JWOLGIN (DRAFT) AFR/MDI:JPURCELL (DRAFT)
AID DAA/AFR:ELCWIERS

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TO AMEMBASSY ACCRA IMMEDIATE
INFO AMEMBASSY ABIDJAN IMMEDIATE

UNCLAS STATE 346936

AIDAC ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

SUBJECT: GHANA FAMILY PLANNING AND HEALTH PROGRAM (641-0118) PP/PAAD ECPR MEETING

1. OVERVIEW: THE AFRICA BUREAU ECPR MEETING FOR SUBJECT PROGRAM WAS HELD ON SEPTEMBER 28. THE MEETING WAS CHAIRED BY T. BORK, DIRECTOR, AFR/PD AND INCLUDED REPRESENTATIVES FROM AFR/PD/CCWAP, AFR/CCWA, AFR/TR/HPN, ST/POP, GC/AFR, AFR/MDI, AFR/DP/PAR, AFR/DP/PAB AND THREE REPRESENTATIVES FROM THE MISSION INCLUDING FORMER AID REPRESENTATIVE GARY TOWERY. THE ECPR RECOMMENDED TO THE ACTING AA/AFR TO APPROVE SUBJECT PROGRAM PURSUANT TO SEVERAL CHANGES IN THE PP/PAAD AS DISCUSSED BELOW. THE PAAD AND THE PP WILL BE AUTHORIZED IN AID/W. THE ECPR CONGRATULATES THE MISSION ON AN EXCELLENT DESIGN WHICH INCORPORATES NPA SECTOR CONDITIONALITY AND PROJECT ASSISTANCE IN ONE COHERENT, WELL-REASONED DOCUMENT WITH APPROPRIATE AND DETAILED ANALYSES AND RATIONALE.

2. SINCE THE PP AND PAAD WILL BE AUTHORIZED IN AID/W, THE PURPOSE OF THIS CABLE IS TO PROVIDE MISSION WITH A SUMMARY OF DECISIONS MADE AT ECPR MEETING AND REQUEST ANY MISSION COMMENTS PRIOR TO FINALIZATION OF THE

PP/PAAD DOCUMENT BASED ON THESE DECISIONS.

3. FOLLOWING IS A RECAPITULATION OF THE ISSUES REVIEWED AT THE ECPR AND ECPR RECOMMENDATIONS ACCEPTED BY THE A/AA/AFR:

A. THE ECPR SPENT CONSIDERABLE TIME DISCUSSING THE NPA FIRST-TRANCHE CPS. ECPR GENERALLY FELT THAT FIRSTTRANCHE CPS WERE CLEAR AND WELL-REASONED IN PP/PAAD. ALBEIT FAIRLY TOUGH AND PROBABLY DIFFICULT TO CARRY OUT. ALSO, ECPR WAS IMPRESSED BY LEVEL OF ANALYSIS SHOWN IN SECTION III B. THE ECPR STRONGLY CAUTIONS THE MISSION TO ASSURE THAT THE RELATIVELY FEW CONDITIONS FOR FIRSTTRANCHE CPS CAN BE CARRIED OUT WITHIN A REASONABLE TIME PERIOD. MISSION SHOULD CAREFULLY REVIEW THE CONDITIONS WITH HOST COUNTRY COUNTERPARTS PRIOR TO SIGNING THE PROGRAM AGREEMENT TO ASSURE THAT THEY CAN BE CARRIED OUT AS SO STATED IN THE

AGREEMENT.

B. LEVEL OF FUNDING FOR NPA: ECPR SUPPORTS MISSION REQUEST FOR INCREASE OF PROGRAM ASSISTANCE BY DOLS FIVE MILLION FOR A TOTAL OF DOLS 13 MILLION, WITHIN MISSION OYB AMOUNT. ECPR UNDERSTANDING FROM MISSION REPRESENTATIVES IS THAT MISSION WOULD LIKE TO INCLUDE TOTAL DOLS 13 MILLION PROGRAM ASSISTANCE IN ORIGINAL PAAD DOCUMENT. THEREFORE, PP/PAAD MUST BE REVISED TO REFLECT THE JUSTIFICATION FOR THE ENTIRE DOLS 13 MILLION AND A CLEAR PLAN ON HOW THESE FUNDS WILL BE TRANCHED. PLEASE ADVISE SOONEST MISSION THINKING FOR PP/PAAD REVISION CONCERNING PREFERENCE FOR TRANCHING INCREASED NONPROJECT ASSISTANCE.

C. NATIONAL POPULATION AUTHORITY: A.I.D. HAS HAD SIGNIFICANT PROBLEMS IN SEVERAL COUNTRIES WITH SUPRA-MINISTERIAL POPULATION COUNCILS OR AUTHORITIES. EXPERIENCE IN KENYA, EGYPT AND SOME OTHER COUNTRIES IS THAT THEY CAN BLOCK ACTIVITIES RATHER THAN FACILITATE IMPLEMENTATION OR PLANNING. LEADERSHIP IS CRITICAL. ALSO, CLEAR RESPONSIBILITIES BETWEEN THE AUTHORITY AND LINE MINISTRIES MUST BE DELINEATED AND SUPPORTED AT THE HIGHEST GOVERNMENT LEVELS. ECPR NOTED THAT THE NPA IS A GHANAIAN INITIATIVE THAT HAS TAKEN SHAPE OVER THE PAST SEVERAL YEARS BECAUSE OF THE LACK OF OVERALL NATIONAL COORDINATION AND DIRECTION. AGAIN, ECPR CAUTIONS THE MISSION TO TAKE A SPECIAL INTEREST IN QUESTIONS OF RESPONSIBILITIES AND LEADERSHIP OF THE NPA WHILE CONTINUING POLICY DIALOGUE WITH THE GOG ON THIS ISSUE.

D. LOCAL CURRENCY (LC) GENERATIONS: THE PROGRAM PLANS TO UTILIZE NPA LOCAL CURRENCY GENERATIONS TO PROVIDE GENERAL HEALTH SECTOR SUPPORT THROUGH THE MINISTRY OF HEALTH BUDGET. LC GENERATIONS WILL ALSO SUPPORT THE NPA. AT THE SAME TIME, THE PP/PAAD MAKES IT CLEAR THAT THE MISSION WILL APPROVE ANNUAL PLANS FOR PROGRAMMING OF LOCAL CURRENCY AND HAS TARGETED CERTAIN QUOTE SUB-SECTORS UNQUOTE IN THE HEALTH SECTOR (SHOWN ON PAGE 28 OF PP/PAAD) THAT EMPHASIZE PREVENTIVE HEALTH CARE.

A.I.D. IS EXPECTED TO ISSUE REVISED LOCAL CURRENCY POLICY SOON, INCLUDING NEW GUIDANCE TO IMPROVE A.I.D. MONITORING AND ACCOUNTABILITY OVER HOST COUNTRY-OWNED LOCAL CURRENCY. THE GUIDANCE REQUIRES THAT MISSIONS CARRY OUT A DETAILED FINANCIAL ASSESSMENT OF THE CAPABILITY OF THE HOST COUNTRY AGENCY RESPONSIBLE FOR THE MANAGEMENT AND ACCOUNTABILITY OF THE LOCAL CURRENCY SPECIAL ACCOUNT. FURTHER, THE DRAFT GUIDANCE PROVIDES DIFFERENT AID TRACKING REQUIREMENTS DEPENDING ON THE PROGRAMMING OF THE LC FUNDS (I.E. PROJECTIZED, GENERAL SECTOR SUPPORT, GENERAL BUDGET SUPPORT). GENERAL SECTOR SUPPORT REQUIRES A MEDIUM TO HIGH LEVEL OF CONFIDENCE IN THE FINANCIAL AND BUDGETING SYSTEMS OF THE HOST GOVERNMENT AND OF THE HOST GOVERNMENT AGENCY DESIGNATED TO RECEIVE THE LOCAL CURRENCY, INASMUCH AS THE MISSION NEED NOT TRACE THE FUNDS TO SPECIFIC BUDGETARY OR ENDUSE ITEMS.

ALTHOUGH ECPR UNDERSTANDS MISSION CONCERN TO ASSURE THAT LC GENERATIONS ARE NOT USED BY MOH FOR CURATIVE FACILITIES, ECPR CAUTIONS AGAINST MISSION INVOLVEMENT TO DEDICATE WHERE IN THE MOH BUDGET THE LC GENERATIONS SHOULD GO. THE GUIDING PRINCIPLE IS THAT AID DOES NOT EXPECT MISSION TO TRACK AND ACCOUNT FOR LC AS FAR DOWN AS MISSION WAS INVOLVED IN PROGRAMMING. ECPR STRONGLY ENCOURAGES MISSION TO PROVIDE GENERAL SECTOR SUPPORT TO THE FULLEST EXTENT POSSIBLE AND CONSISTENT WITH AID LOCAL CURRENCY POLICY IN FORCE AT THE TIME. HOWEVER SHOULD CURRENT OR FUTURE A.I.D. LOCAL CURRENCY POLICY

PRECLUDE GENERAL SECTOR SUPPORT OR RENDER IT INFEASIBLE. THE MISSION SHOULD DETERMINE [illegible] CONCURRENCE BEFORE PURSUING AVAILABLE A.I.D. LOCAL CURRENCY POLICY ALTERNATIVES.

E. HIV/AIDS: IT IS BUREAU POLICY TO BILATERALIZE ALL HPN ACTIVITIES AS MUCH AS POSSIBLE. INSTEAD OF CONTINUING ALL HIV/AIDS ACTIVITIES THROUGH FUTURE BUY-INS, ECPR RECOMMENDS THAT MISSION INCLUDE

AUTHORIZATION FOR EXPECTED HIV/AIDS ACTIVITIES UNDER SUBJECT PROGRAM IN VIEW OF CLOSE RELATIONSHIP BETWEEN HIV PREVENTION ACTIVITIES AND THE PLANNED SOCIAL MARKETING OF CONDOMS. TO THIS END, ECPR RECOMMENDS AND THIS CABLE PROVIDES MISSION WITH DELEGATION OF AUTHORITY TO APPROVE AN AMENDMENT TO THE PROJECT AUTHORIZATION AND PROJECT PAPER (SUBJECT TO REDSO/WCA CONCURRENCE) OF UP TO DOLS FIVE MILLION FOR HIV/AIDS ACTIVITIES OVER THE CURRENT LOP OF SIX YEARS. THE AMENDMENT SHOULD FOLLOW A.I.D. HANDBOOK THREE REQUIREMENTS AND THE INTERVENTIONS SHOULD BE CLEARLY JUSTIFIED AND DELINEATED IN THE AMENDMENT.

F. EXEMPTION FROM DOLLAR TRACKING: ECPR RECOMMENDED APPROVAL OF THE JUSTIFICATION FOR THE EXEMPTION AS SHOWN IN ANNEX P OF THE PP/PAAD AND THE CN WILL BE WRITTEN ACCORDINGLY.

4. IN ADDITION, THE MISSION SHOULD BE AWARE OF THE FOLLOWING ECPR CONCERNS:

A. PROGRAM SUSTAINABILITY: THE PP/PAAD STATES THAT GOVERNMENT SUPPORT FOR COST RECOVERY RELATED TO FAMILY PLANNING REMAINS A SERIOUS PROBLEM. COST RECOVERY PROPOSALS IN THE PP/PAAD (RETURN TO PROJECT FUND) ARE CLEARLY INADEQUATE TO ASSURE FULL FINANCIAL SUSTAINABILITY. FINALLY, A.I.D.'S FINANCIAL ASSISTANCE TO THE MINISTRY OF HEALTH BUDGET THROUGH LOCAL CURRENCY GENERATIONS WILL ONLY LAST AS LONG AS THE PROGRAM AND NO PROVISIONS ARE MADE TO MOVE THE GOVERNMENT OF GHANA TO INCREASE ITS HEALTH BUDGET TO COVER THESE RECURRENT COSTS AFTER 1996. THE MISSION REPRESENTATIVE HAS AGREED TO: (1) AMEND THE PP/PAAD TO MAKE CLEAR THAT FAMILY PLANNING IN GHANA IS A LONG-TERM EFFORT AND (2) ENSURE THAT THE PP/PAAD SECTION ON SUSTAINABILITY DESCRIBES WHAT THE PROJECT ANTICIPATES ACHIEVING BY 1996 IN TERMS OF BOTH SUSTAINABILITY OF IMPACT AND SUSTAINABILITY OF ACTIVITIES.

B. SUFFICIENT AND SUFFICIENTLY TARGETED TRAINING AND INFORMATION: CORRECT INFORMATION MUST ACCOMPANY SUPPLY OF CONTRACEPTIVES, CHLOROQUINE AND ORAL REHYDRATION SOLUTIONS (ORS). CERTAIN COUNTRY STUDIES HAVE SHOWN THAT INCORRECT OR SCARCE INFORMATION IS PROVIDED ALONG WITH CONTRACEPTIVES EVEN IN THOSE COUNTRIES WITH GOOD SUPPLY CHANNELS. THE PROJECT NEEDS TO FOCUS MORE ATTENTION ON TRAINING THE SUPPLIERS OF CONTRACEPTIVES, ORS AND CHLOROQUINE AT EVERY LEVEL. THIS BECOMES EVEN

MORE IMPORTANT IF ORAL CONTRACEPTIVES AND CHLOROQUINE ARE TAKEN OFF THE RESTRICTED DRUGS LIST.

THE MISSION REPRESENTATIVE HAS AGREED THAT THE PROJECT ASSISTANCE COMPONENT WILL EMPHASIZE QUALITY CONTROL AS MORE PRODUCTS ARE TAKEN OFF OF THE RESTRICTED DRUGS LIST AND EMPHASIZE TRAINING AND INFORMATION AT EVERY LEVEL TO ASSURE THAT THE CORRECT INFORMATION IS AVAILABLE TO USERS ALONG WITH THE SUPPLY OF CONTRACEPTIVES, CHLOROQUINE OR ORS. THE PP/PAAD WILL BE REVISED TO INCORPORATE THESE EMPHASES.

C. MONITORING AND EVALUATION: GIVEN THE SP AND DPS REQUIREMENTS FOR TRACKING AND REPORTING ON PROGRAM IMPACT, ECPR RECOMMENDS MISSION EMPHASIZE THIS COMPONENT OF THE FAMILY PLANNING AND HEALTH PROGRAM. ALTHOUGH PP/PAAD CALLS FOR THE CONTRACTOR TO BE RESPONSIBLE FOR MONITORING AND TRACKING, ECPR RECOMMENDS THAT MISSION EMPHASIZE INVOLVEMENT OF GHANAIANS AT EVERY STAGE OF MONITORING AND EVALUATION PROCESS.

5. IN SUMMARY, THIS CABLE:

(A) PROVIDES SUMMARY OF ECPR MEETING ON SUBJECT PROGRAM AND GUIDANCE FOR BOTH MISSION AND AFR/PD/CCWAP USE IN FINALIZING PP/PAAD DOCUMENTS;

(B) PROVIDES AFRICA BUREAU APPROVAL OF INCREASE OF PROGRAM ASSISTANCE COMPONENT BY DOLS FIVE MILLION FOR TOTAL NPA OF DOLS 13 MILLION AND REQUESTS MISSION INPUT IN REVISION OF ORIGINAL PP/PAAD TO INCORPORATE THIS CHANGE;

(C) PROVIDES A/AA/AFR DELEGATION OF AUTHORITY TO GHANA AID REPRESENTATIVE TO AMEND SUBJECT PROJECT PAPER AND PROJECT AUTHORIZATION (SUBJECT TO REDSO/WCA CONCURRENCE) FOR UP TO DOLS FIVE MILLION FOR HIV/AIDS ACTIVITIES TO BE CARRIED OUT UNDER THE PROJECT IN ACCORDANCE WITH A.I.D. HANDBOOK THREE AND OTHER AID AND AFRICA BUREAU REQUIREMENTS FOR PP AMENDMENTS;

(D) PROVIDES APPROVAL FOR JUSTIFICATION FOR THE EXEMPTION OF DOLLAR TRACKING AND ASSURES MISSION THAT EXEMPTION REQUEST WILL BE INCLUDED IN CN;

(E) PROVIDES GUIDANCE TO MISSION ON LOCAL CURRENCY PROGRAMMING FOR SUBJECT PROGRAM AND RECOMMENDS GENERAL SECTOR SUPPORT STRATEGY; AND

(F) HIGHLY COMMENDS MISSION FOR AN EXCELLENT PP/PAAD DOCUMENT.

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