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GHANA

Volume III

ANNEXES - A. Role of Women

B. Health Sector Assessment (including Nutrition)

C. Population Sector Assessment

DEPARTMENT
OF
STATE

JANUARY 1975

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DEVELOPMENT ASSISTANCE PROGRAM - VOLUME III

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ANNEX A

THE ROLE OF WOMEN IN NATIONAL DEVELOPMENT IN GHANA

The scope of this preliminary study includes a statement on the role and status of women in Ghanaian society, and a survey of the ways women benefit and participate in those sectors of Ghanaian national life in which USAID/Ghana concentrates its work. In addition, other areas where the concerns of national development and the affairs of women are inter-related will be examined; movements, organizations, projects, programs and research related to women in Ghana will be described; and an annotated bibliography on women in economic development will be prepared. Some conclusions regarding developmental implications and needs for further research will be considered.

This first submission contains the general statement on the sociological, economic and legal status of women in Ghana, prepared by Jeanne North, and a beginning statement on the role of women in agriculture by Marian Fuchs-Carsch. The latter section will be elaborated as the result of further study, and these two sections will be part of the preliminary study to be completed March 1, 1975.

Sociological, Economic and Legal Status of Women in Ghana

The supreme role of women in Ghanaian society is that of bearers of children. Provision of care and attention for children follows closely in society's values. Women of outstanding professional attainment and governmental rank advise that such success is considered in their own circle as secondary to that of producer of children.[1/] The great honors traditional groups heap upon women when they produce ten children, the value put upon pregnancy if marriage is not possible, and the common acceptance of it as a precursor to marriage illustrate this cultural trait. It would be expected that the importance of progeny, which is universal, would be greater in this society in which ancestors are so revered, and ties and communications between the generations, living and dead, are a source of strength and guidance.

1/ Echoed in a speech by a woman Principal Secretary, and conversations

The Ghanaian women are assigned, too, the role of "homemaker." They and their children are entirely responsible for the care of the home, the children, and the preparation of food. In rural areas the latter entails carrying of water, growing and purchasing of food, and perhaps provision of fuel.

These three functions, we are told, are the ones society must values for women: childbearer, childcarer, and homemaker. Yet in all of Ghanaian society, women are expected to provide part of the economic and financial resources for the family. The woman is expected to provide at least some of her personal needs, and usually for those of her children and the family as a whole. This frequently entails her spending as much time on revenue production as her husband. The labors with which she earns her separate income and contributes to the family's productive capacity are in areas vital to the country's economic development. A study of her role in national development is therefore highly appropriate.

It is interesting that society does not put a corresponding value on this economic sphere of the Ghanaian woman's life from which its expectations are high. Fiscal autonomy between spouses is almost complete in some traditions in Ghana. Perhaps this discrepancy accounts for the relative lack of official attention to these pursuits, and such anomalies as the prevalence of speaking of "the farmer and his wife" (for instance), when all seem to agree that in much of the country the wife commonly puts at least as much time into farming as the husband, and many would estimate more. This terminology would not be used by the women concerned, according to a study in which all women respondents in three villages designated themselves as farmers, traders, etc. Even those who had been too old to work for some time claimed these occupations. Not one person termed herself a housewife.2/ (One would assume, however, that, if asked, their value would have echoed the society's relative to their status as mother.) Outside European influences have not been toward emphasizing or improving the jobs through which the Ghanaian women traditionally made her economic contribution. They have often had the opposite effect.

2/ M. Hardiman, "A Preliminary Study of the Role of Women in Some Akan Rural Communities," 1971, p.117, Legon Family Research Papers, University ofGhana, Legon, 1974.

Conflicting comments can be made on women's place in the economic sphere. Women are prominent and numerous as leaders in many areas of public life in Ghana. Opportunities for education, promotion and employment have been encouraged for women, but have lagged behind those available to men, as has been the practice in Western countries. Women executives claim that though women presumably have equality with their men colleagues, women must be better than the masculine competition (not a rare comment in the U.S.). We have observed attitudes of indignation and resentment on the part of men university students when their opinions were criticized by women students, and wonder about the carryover to professional life. In areas of deprivation, the scarcity of resources, plus the priority given to men and boys for existing opportunities has resulted in over-burdened, overlooked and underprivileged women. There is a great variation in the status of women in Ghana.

"The statutary laws of this country make no distinction between the civil rights and duties of women and those of men," in the words of Appeals Court Judge Annie Jiagge.[3] Women of full age whether married or not are free to sue and to be sued in their own right, free to enter into contracts, borrow money from the banks, purchase and dispose of property, enter any business transaction in their own right exactly as men. Women have full testamentary capacity and can administer an estate in case of intestacy on the same terms as men.

"No jobs in Ghana are specifically reserved for men. A woman in a position previously held by a man takes the salary and all fringe benefits attached to the post. In this country, there is equal pay for work of equal value and there are no tax concessions made for women on account of sex.

"Women are not barred from entering any of the higher educational institutions in this country. Women who know their rights take full advantage of them, but the majority are still illiterates, and not in a position to take their rightful place in society." Not only is there the limitation of illiteracy (70% of the country as a whole) to which Judge Jiagge refers, but also the impediment of custom to the use of the law by many who know about it. At the end of the speech from which this quote was lifted, very privileged, sophisticated ladies in the

3/ Paper given in a seminar, Accra, 1973.

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audience reiterated that the customary law which she had gone on to describe still limited their use of statutory law. This is, of course, because of the adherence of others in their family group to the traditional customs, if not any residual uncertainties of their own.

An understanding of family patterns is useful. Southern Ghanaian groups are traditionally organized in unilineal families. The Akans (Fanti, Ashanti) and some of the Gas are matrilineal and the rest of the Gas are patrilineal. Property holding, inheritance and family decision-making is organized around those with common blood relationship rather than between husband and wife. Moreover, in these at least potentially polygamous marriages, commonly the husbands and wives do not live together, but in the home of their own matri-kin or patri-kin. This is especially so in well-populated areas where both families live in the vicinity. Husband or wife travels to the other house to eat, cook or sleep.4/ They do not own property in common, even if both spouses work to acquire it (e.g., a farm). 5/ Each spouse contributes to household costs. At death, property is inherited by those related to the deceased through the mother, in the matrilineal system. A man's brother or his sister's son inherits his goods, not his wife or children. Commonly a woman's children and her matri-kin inherit from her in this system, not her spouse. In the paternal system, a man's children may be included in the inheritance, though the wife never is. The Ewes, another large southern ethnic group, have a family system variously described by different authorities.6/ 7/ It seems to be essentially patrilineal, but to have elements of both, and it tends to be more conjugal than the others mentioned. (In this system daughters, but still never widows, may inherit from fathers.)

4/ Meyer Fortes, "The Akan System Today, "p. 29, Legon Family Research Papers, No. 1, op cit

5/ Christine Oppong, "Akan Senior Serwa Families in Accra, A Study of Domestic Continuity and Change," p.4 of Changing Social Structure in Ghana; Ed. Jack Goody.

6/ D.K. Fiawoo, "Ewe Lineage and Kinship,"Legon Family Research Papers, No.1, op cit

7/ T. Kumekpor, "The Position of Maternal Relatives in the Kinship System of the Ewe, "Legon Family Research Papers, No. 1 op cit

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Observations differ as to the degree of economic independence or responsibility which is ordained for women, and the nature of the marriage relationship in the traditional systems. Dr. Ekow Daniels[8] is quoted as saying that "in the marriage laws of the western and eastern world, marriage may be said to be the basis of the family; in Ghana, marriage is rather an offshoot of the family system." Professor Fortes[9] states the Akan "women have a large degree of economic and legal independence and responsibility, especially in providing for their own children, working their own farms, and controlling their own households. Vercruijsse[10] and associates reported that in a study of seventeen Fante communities "income does not have the character of a supplement, and cannot even be conceived as being part of the family income. ...We cannot possibly put too much emphasis on the fact that every conceivable person earns his/her own living and that only a part of what each person produces or earns is contributed for common householding. Or to put it differently, if you can earn your own living, you only join others to the extent that you are interested in having one woman (a pair of women) cook for you. All of your other expenses do not enter into the arrangement, so that the use of the term 'household' can hardly be defended." As to duo-local residence of husband and wife, Hardiman's studies indicated that in one Akwapim village 112 men were household heads and 133 women headed households. One-fourth of the husbands of the female heads lived in the same town in other housing. One-half lived in other towns or villages much of the year. "Many own cocoa farms in other parts of the country and maintain their residences there." Male migration led to an increase of women heads of house,[11] but not to more female ownership of larger dwelling units or compounds. One-fourth of the women in the study were widows or divorcees, who in the main provided for themselves and their dependents bolstered by the matrilineage.[12]

8/ JackGoody, "Comparative Studies, Introduction, "p. 255, Legon Family Research Papers, No. 1, op cit

9/ Meyer Fortes, op cit, p. 30

10/ Emile V.W. Vercruijsse, "Composition of Households in Some Fante Communities, Legon Family Research Papers, No. 1, p.48, op cit

11/ "Household" was used here as a "cooking unit" or subfamily group of a large extended family compound.

12/ M. Hardiman, Legon Family Research Papers No.1, op cit, p. 109-110.

There is agreement that the common special and fiscal separateness of spouses is one side of the subject. Contrasting with these descriptions of exclusiveness, there seems to be common agreement that traditional spouses contribute specific kinds of work to the other; that there is a complementary nature to the farm work, for instance. (Wives always do all the carrying of water, and of produce in much of the country. Men always clear the land.) One authority in conversation outlined the heavier burden allotted to the woman in a traditional rural setting and added, "But there are reasonable men" who effect a very different pattern! Dr. Hardiman's material, cited above, indicates tha t if single family households are excluded, 41% of households in this study consist of husband, wife and children, and perhaps others. She reports that fathers who share the home with the mother are the ones to discipline and punish children, to make educational decisions, and to pay school fees. Another's report on research counts this a modern development: "Sometimes the mother's matri-kin may be responsible for their upkeep in schools, but today more and more of them are cared for (in school) by their fathers.[13] Some educated women in the city claim that the farm woman must turn all her earnings over to her husband, and then beg for her needs. A psychiatrist tells of the life-long responsibility a husband customarily assumes for a wife (continuing during mental illness). Another authority tells of the defference the wife gives the husband. "He is the boss," and for that reason she is concerned that he have the best of the food, etc. Oppong cautions that the lack of a conjugal living pattern regarding space and money should not be construed to mean that there is a lack of conjugal feeling. She believes that her studies indicate tha t value of a conjugal companionship is a long-standing cultural trait.[14]

13/J. Adomako-Saffoh, "Migrant Asante Cocoa Farmers and Their Families," LegonFamily Research Papers No. 1, op cit

14/Christine Oppong, "Norms and Variations: A Study of Ghanaian Students' Attitudes to Marriage and Family Living." June 1972 unpublished paper.

The societies in the north of Ghana are patrilineal. They consist of three or four generations of men living with their wives in a compound. The daughters marry out, and wives come from the neighboring communities. In these households, the husband, or head of the house, is expected to provide grain for his wife (wives). She is expected to grow or purchase other food needs and the requisite cooking implements. She is expected to acquire wealth of her own through her small cash plot, raising of animals, making of beer, trading, pot making.[15/] [16/] Patterns differ with different northern groups, but in general women participate much less equally in farming and have much less independence in the north. The practice of the wife's having a separate income obtains here also. Professor Goody relates the relative independence of women to family structure, and he states that "stronger emphasis exists on the woman's contribution within this area (agriculture) in areas where matrilineal inheritance of wealth obtains.[17/]"

Factors of change, education, Christianity, new crops (cocoa) have effected a change in the family patterns. Adomarkoh-Sarfoh describes the change taking place in outlying areas (Brong-Ahafo) where Ashanti people have migrated to establish new cocoa farms (which are more permanent in nature than subsistence farms which are not "established.") Apparently due to a cultural exchange with other residents of the area of other non-matrilineal family systems and to a pressure from wives whose assistance is required to establish a new farm, husbands are arranging for their wives and children to inherit the cocoa farms, or to give them a farm or a house during their lifetime to insure their ownership. This is not a change easily made, for not only must the wives and children give gifts to the matri-kin at the time the arrangement is agreed upon, but these arrangements are frequently contested and occupy much time of the customary courts.[18/] It is interesting that the near-universal custom that women be the headload carriers changes

15/ Interview with Mrs. Maude Kodylas, Food Research Institute Accra.

16/ Bogaards, J.N., Report on an Inquiry Into the Farms of Some Kusasi Farmers, p.31; report to K.A. Rigters, Project, Garu Agricultural Station, 1969.

17/ Jack Goody, The Social Organization of the Lowiili, Oxford University Press, 1967, pg. 33, 47.

18/ J. Adomako-Soffoh, op cit.

with respect to cocoa. Because it is a newer crop, less connected with custom, or because cocoa is more lucrative, or for other reasons, it is accepted and expected that men will do the head portage of this crop.[19]

The first Christian missionaries to work away from the coast, with traditional Ghanaians were those of the Basel Mission fromSwitzerland which was established in Akuapem (Akwapim) in 1835. Concerned about the instability of marriage, the resultant neglect of children and the problems facing the widow and children at the husband's death, the Mission led a crusade against the polygamous matrilineal system with its duo-residency spouses.[20] Church customary laws concerning marriage and inheritance were established which influenced the codified national law to come later.[21] Mission-established schools have had an effect on changing marriage patterns. Residence patterns were certainly changed. (Some observers claim that children of the early converts lived with spouces, and wives and children accompanied husbands when job assignments changed, but that grandchildren of these converts are living apart because of the spouses' modern professional ambition which conflicts with establishment of a single home.)

During this century, men and women leaders in and out of the church have been leaders to effect a societal change. Yet some observers maintain that there has been little change toward fundamental acceptance of the nuclear family in the last forty years.[22] In 1960, only four percent of the Akan marriages and 3.6 percent of Ewe marriages were under the Ordinance (which gives the conjugal bond primacy in law and inheritance, and does not permit polygamy).[23] There seems to be wide agreement from many academic authorities that for those with this heritage, the matrilineal system persists to different degrees among the modern conjugal (and Christian) couples.There seems to be a strong relationship between the number of generations of education in the family and the degree of commitment to

19/ Interview with E.Bortei-Doku, Faculty of Agriculture, University of Ghana.
20/ Kwamena Poh, "Church and Change in Akwapem," LFRP-1, op cit.
21/ In 1861 Mission regulations requiring monogamous marriage was applied to the Gold Coast.
22/ Meyer Fortes, "The Family, Bane or Blessing." An open lecture delivered at the University ofGhana, March 1971. Ghana Universities Press, Accra, and appendix to lecture of pamphlet excerpts.
23/ 1960 Ghana Census.

the conjugal family.[24] Women tend to favor the change a great deal more than do the men. Women tend increasingly to seek "their emotional and material satisfactions as wives, while the husbands continue to seek them with consanguines,"[25] and this itself is a source of conflict.[26] Professor Fortes says, "One of the striking things about these systems in India as well as in Africa is their tenacity in the face of modern social, industrial, cultural and political changes. ...They may be reduced in range, but, as we can see from the current state of affairs in Ghana, the basic orientations represented in them, the value system they incorporate, remain fundamentally unchanged. ...The women may complain and denounce the matrilineal family system here, as they do in other parts of Africa, but it is a system which traditionally gives them a degree of economic, political, and legal equality with men and a status of dignity that was never accorded to their sisters in classical patrilineal systems. The basis was there in the traditional system — symbolized in the office of the Queen Mother and shown up in the whole way of life — for the Akan woman to take advantage of the opportunities provided by modern social change to assert her freedom to teach, to own property, to have a voice in public matters, to remain married, or to go her own way. While the womenfolk of northern Ghana ... were never as free and as equal to their menfolk as Akan women were."[27]

The modern urban Ghanaian woman (as do those who study her) sees herself as anxious about the economic insecurity caused her and her children by the customary inheritance systems in a modern setting, and by the tendency to polygamy, official or otherwise on the parts of the husbands. Discussions on the status or rights of women focus on these issues or on that of child maintenance or household contributions usually, rather than on work or education opportunities.

24/ Christine Oppong, "Norms and Variations," op cit.
25/ R.C. Lloyd, The New Elites in Tropical Africa, Oxford 1966.
26/ M.Bird "Social Change in Kinship and Marriage Among the Yoruba of Western Nigeria" unpublished thesis (quoted by C. Oppong)
27/ Fortes, op cit, p. 6 and 8.

The rural woman, we are told, is more aware of her burdens which are increasing with modernization. (Introduction of new cash crops, and migration of the men to the cities leads to more responsibility on her part for food crops, without additional compensation. Schooling deprives her of the children's help on the farm. Increased acreage cultivation requires more weeding, etc., from her. Introduction of poultry raising requires more water portage of her.) She would like modernization in the form of clean well water, grinding mills, feeder roads, etc., which affect her work directly in a positive way. She wishes for more help from husband and brother, and less time and money on their part spent in drinking. She is in general, quicker to seek and adopt new ideas which will bring better results and less drudgery from her work.[28]

The above discussion illustrates some of the reasons that the Ghanaian woman is a conspicuous economic factor in the country. For the sake of her welfare and that of her dependents, and for the vitality of the nation's economy, official attention to her economic activity is indicated.

Dr. Hardiman's comments are pertinent.[29] "In some cases, European administrators have helped to accentuate women's disability by concentrating agricultural training and land reform schemes on men. As Boserup says, 'The Europeans everywhere seem to have objected to the peculiar position of African women, which was so different from anything the Europeans were accustomed to.'"

Some of the economic roles are in the Western, or American, pattern. Women are doctors, lawyers and administrators. Many are teachers and nurses. In 1967, 19% of the Ghanaians in professional, technical and related fields were women, and 4% of those in the administrative, executive and management categories were women.[30] From 3% to 8% of the industrial workers are women, the majority middle school leavers. [31] [32]

28/ Hardiman, op cit, ECA papers and other sources.

29/ Hardiman, ibid p. 119

30/ Yearbook of Labor Statistics, 1967, ILO

31/ Etta Boserup, Women's Role in Economic Development, Oxford 1966, p.109 (quoting less than 3%).

32/ Margaret Piel, The Ghanaian Factory Worker: Industrial Man in Africa, Cambridge University Press, 1972, p.24. (8% of industrial workers in the sixteen industries she studied were women.)

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Many women earn through home enterprises familiar to westerners. Dress-making, baking, and poultry raising are common examples. Whereas for some these may be undertaken in addition to other economic activity, in many modern homes this provides a supplement to a successful family's income. (One European-educated, cosmopolitan, protective husband spoke of his surprise on discovering, when he left Ghana with his wife and children that in other countries a man pays for his wife's clothing!) As a group, women are not as well prepared educationally as men for their work in the modern life of the country. (See appendix of education statistics.)

In a pattern less familiar to the American are the two largest economically active group of women: the farmers and the traders. Some women are, of course, both, since in much of the rural area, women head-carry all the produce to the market where they sell it. This large and mostly uneducated group of farming women merit concern. When more food crops are needed, attention is drawn to the women who are responsible for much of the domestic (home) food supply, and who often have a part in growing or marketing the cash crops also. Moreover, those concerned for the poor and underpriviledged must look at this group of farm women for these reasons also. Resources of technical knowledge, improved implements, and suitable infrastructure should be directed to their use so that their efforts can be more productive for farm and family.

In Ghana, as well as in the rest of West Africa, women are prime movers in the distribution system, particularly of food (in addition to the local level) and textiles. Some say one-third of Ghana's women are in the trading business.[33/] [34/] (The 1960 census lists 1,567,968 as the number for all occupations for men, 991,414 as the number of all occupations for women, and 551,831 as the number of women in retail and wholesale trade). They purchase at source, transport; they are the

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33/ Kenneth Little, AfricanWomen in Towns, Cambridge, 1973, p.45.
34/ John C. Caldwell, Population Growth and Family Change in Africa: The New Urban Elite in Ghana, Australian Nat. Univ. Press, 1967.

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"middle-men", the large, and the petty traders. Largely uneducated, resourceful, politically powerful, many of them are personally successful. They perform a useful service to those who produce small quantities and to those with small incomes and no storage facilities who must purchase in small amounts. However, those who regard the food distribution system, in particular, a major concern to the development of agriculture and to the provision of adequate food for the country might wonder how these traders can be helped to better serve the economy.

The more general and succinct statements regarding women in economic development in Africa issued by ECA and are reinforced by a study of the Ghanaian situation. Reference to them is recommended: "Women and National Development in African Countries: Some Profound Contradictions." A position paper presented by the Human Resources Development Division, Women's Program Unit UNECA (sponsored by The Ford Foundation, 1973;) and "ECA Five-Year Program on Pre-Vocational and Vocational Training of Girls and Women." Toward Their Full Participation in Development," 1972 - 76.

ANNEX B

Health Sector Assessment

I. Introduction

II. Population

- A. General
- B. PopulationGrowth
- C. Attitudes
- D. Population Policy and Organization
- E. Population Programs

III. Nutrition

- A. General
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IV. National Health Status

- A. General
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V. GOG Health Structure and Policy

- A. Ministry of Health
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VI. Health Resources

A. Health Facilities

B. Health Manpower

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VII. Financing of the Health Services

VIII. Summary and Conclusions

IX. Development Strategy For USAID

A. Health Sector Goal

B. Proposals:

1. Planning and Management

a. Management of Rural Health Services

b. Training of Health Managers

2. Integrated Health Services (MCH)

a. Community Food & Health Centers

3. Health Resources Loan.

HEALTH SECTOR ASSESSMENT

Health - Population - Nutrition

I. Introduction

1. The sectoral assessment presented reflects data and findings of studies conducted by advisors/consultants from the University of California at Los Angeles, U.S. Public Health Service, U.S.Department of Health, Education and Welfare, and USAID plus experience from operational research under the on-going Danfa Rural Health and Family Planning Project (055). Principal sources referred to in this analysis are:

(a) Assignment Report - Management of Rural Health Services, July 24, 1974,Dr. Paul Zukin, UCLA.

(b) Report and Recommendations Regarding the Administration, Organization and Management of the Department of Health of Ghana, June 1, 1973, Dr. John J. Hanlon, USPHS and Dr. Alfred Davidson, AID/W.

(c) Syncrisis, The Dynamics of Health, Ghana, June 1974, L.G. Beamer and L.J. Gangloff, HEW.

(d) Field Trip Report, August 1974, Dr. J.S. Prince, USAID/Ghana

2. Included in the analysis is a review of population and nutrition programs as important sub-sectors or inter-related components of the health sector, e.g.:

(a) Ghana National Family Planning Program (GNFPP) established under the direction of the Ministry of Economic Planning is dependent upon the co-operation and smooth functioning of the Ministry of Health personnel and facilities especially as it relates to Maternal Child Health Services.

(b) Nutrition planning, evaluation, education, etc. is coordinated by the Ministry of Economic Planning. However, the Ministry of Health and

the Ministry of Agriculture have important implementing roles.

3. There are limitations to the present analysis explained by inadequacy of statistical data and more importantly by the lack of a published government plan 1/ setting priorities within the government and allocation of resources within the health sector. It is anticipated that USAID's Management of Rural Health Services Project (068) will play an important role in defining the Government's health strategy. During the course of this project a more comprehensive long-term strategy will evolve taking advantage of experience of other programs such as WHO, West German and Canadian.

4. It is agreed by most observers that although there is a relatively well developed resource base (manpower and facilities) the available rural health and related social services are severely strained. The distribution and efficiency in use of these resources is inadequate and first efforts must be made in re-organization, planning and management within the Ministry of Health, along with provision of carefully selected equipment and supply inputs to complement this effort.

II. Population 2/

A. General

1. Demographic Indicators:

	Ghana (Million)	U.S.
a. Population	8.6 - 10.0	—
b. Growth Rate	3.0 - 3.1%	0.62
c. Fertility	49 - 51	
Crude birth rate	49 - 51	15.6
Total Fertility Ratio	6.7 - 7.1	2.1

1/ The GOG Health Five-Year Plan (1974-1978) is expected to be issued in July 1975.

2/ For more complete analysis, see Population Sector Discussion.

1. Demographic Indicators (Contd.)

d. Mortality	Ghana	U.S.
infants less than 1 year	137	18.6
children 1-4 years	70	0.8
Crude death rates	19-20	9.4
life expectancy	47	71.4

In 1921, the population of Ghana was just over 2 million. By 1960 it had reached 7.1 million and in 1974 it is estimated to have been 10.0 million. The country is not densely populated, with an average of about 105 persons per square mile, but the population is growing at an estimated rate of 3.0 - 3.1 percent per year. With characteristic high fertility and declining mortality at the current growth rate, the population could double in just over 20 years.

Ghana is experiencing the seemingly worldwide phenomenon of a population shift from rural areas to the cities, in addition to the overall increase in population. Available data suggest that the two largest cities, Accra and Kumasi, grew by 22 percent and 39 percent, respectively in the five-year period from 1966-1970. Foreign (mostly to the cities) immigration has been largely stemmed by enforcement of the Alien Compliance Order of 1969, which brought about the departure of a number of aliens.

B. Population Growth

The high growth rate is having dire consequences for the economic and social development programs of the country. Per capita food production has been declining and the increased difficulty of achieving food self-sufficiency (Government's top priority) when there are approximately 300,000 more mouths to feed each year is obvious. The relationship between the burgeoning costs of providing adequate social infrastructure -- such as schools, health facilities and public housing -- and a burgeoning population is a direct one.

The problems posed by the explosive urban growth are serious and visible. The available health and social services of most urban centers are strained. Employment opportunities are limited. In any event, these conditions are conducive to the transmission of communicable diseases, with the spread of infections aggravated by poor sanitation. On the other hand, even with deplorable housing and senitation, the migrant does have some health services available that are usually completely lacking in the rural areas from which he came.

C. Attitudes

There are indications that prevailing attitudes towards ideal family size present a real stumbling block to population control. A study prepared by Dr. John C. Caldwell[3] shows that Ghanaian attitudes generally favor even larger families than in many of the other underdeveloped countries. The international range of "ideal" family size is 3.2 - 5.5 children, while in rural Ghana it is 7.5. Among the Ghanaian urban elite the range is 4.3 - 6.1 children. The percentage wanting four or more children in the international range is 25 - 80 percent; in rural Ghana it is 98 percent, in urban Ghana 94 percent, and among the urban elite 89 percent. Any change in this desire for a large family will require time and the introduction of well planned public education. While studies which seek to determine desired family size can be deceptive, (because respondents might answer in one way and act in another), the available data certainly support this strong pro-natalist tendency.

Reasons most often cited for wanting a large family include: additional labor on the farm or in the home, a mark of prestige or honor to the parents, support and comfort to parents in old age, and survival of the family line. Reasons cited for not having many children were most frequently the cost of supporting and the difficulties of raising them, crowding, noise, etc. These responses may indicate possible line of approach to promote the desirability of smaller families.

D. Population Policy and Organization

In 1968 the Ghana Manpower Board prepared a statement of national population policy which was published in 1969

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3 "Population Growth and Family Change in Africa: The New Urban Elite in Ghana". J.C. Caldwell, Australian National University Press, Canberra, 1968.

as an official policy paper.[4] This paper recognized the need for a national population policy as an integral part of national social and economic planning. This statement of policy did not include detailed recommendations on how to achieve specific objectives. Some of the major policy recommendations are as follows:

1. Details of the population program are to be developed by participation of national and regional, public and private entities.

2. Reduction of morbidity and mortality should be an important part of the program.

3. Quantitative goals should be set on the basis of reliable demographic data.

4. The Government will encourage and provide information and assistance to persons wishing to space or limit the size of their families, but this will be done through persuasion rather than coercion.

5. Efforts will be made to expand the non-domestic role of women in the economy to reduce pro-natalist influence.

6. Policies will be adopted to regulate internal migration and immigration.

7. Contracts with international public and private organizations will be developed to benefit from their experience and assistance in population program.

Shortly after this "White Paper" was published, the Government established the National Family Planning Program (NFPP). In recognition of the close relationship between family planning and socio-economic development, the Director and staff of NFPP are part of the Ministry of Finance and Economic Development. To coordinate the efforts of interested agencies and organizations, a non-operational advisory body, the National Family Planning Council, and a Medical Advisory Committee have been established to oversee

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[4] Population Planning for National Progress and Prosperity, March 1969, Ghana Publishing Corporation, Accra-Tema, Ghana

the technical aspects of the program. Members of the NFPC consist of representatives of all participating government ministries, and or private and volunteer agencies. There is also an Executive Committee, representing the Ministries of Finance and Economic Planning, Health, Labor and Social Welfare, Information, and Youth and Rural Development, which is responsible for directing and implementation of the program.

E. Population Programs

1. Population Program Support (064)

As a result of the GOG policy to promote family planning activities USAID has been a strong supporter of the program, providing the bulk of the program budget support (through FY 1973) in addition to contraceptives and training opportunities. The current project and future program is based upon the five year plan for family planning produced in 1973 but yet to be published. The emphasis of the program will be to upgrade those areas of the family planning program which have not met past expectations. The strengthening of the planning, evaluation and management of the program and expanding in-country training activities for all types of family planning workers are major areas of interest. Special attention is given to expansion of the commerical contraceptive program. Discussions continue on the establishment of a model family planning service system in one region of Ghana. In addition to providing quality service to a large population the model system would provide a setting for evaluating facets of the entire program, determining best solutions to eliminating bottlenecks, and provide an opportunity to apply Danfa Research findings. In short, the model system will provide the basis for planning the expansion of the family planning program to achieve full nationwide coverage.

2. Research

It is generally accepted in Africa that one of the major emphases in population programs should be their integration with the health system, particularly the Maternal and Child Health Services component. The Danfa Rural Health and Family Planning Research project represents a major effort to carefully test this and related hypotheses as follows:

Hypotheses:

a. Comprehensive health care, as delivered by the Danfa Project, will reduce child morbidity and mortality rates.

b. Family planning services within a program of comprehensive health services and health education are more effective in reducing fertility rates than family planning services without these additional components.

c. Family planning services coupled with health education are more effective in reducing fertility rates than family planning services provided without health education.

d. The introduction of family planning services utilized by the Danfa Project will result in a greater reduction of fertility rates than that elicited by the traditional family planning services presently available in the research area.

Note: For more details regarding this joint Ghana Medical School - UCLA-AID assisted project including issues related to the hypotheses, such as motivation for acceptance or rejection of family planning services, use of mobile outreach family planning teams, etc., refer to project study design and recently submitted revised PROP.

III. Nutrition

A. General

Most specialists estimate that the nutritional status of the population has not improved during the last 10 - 15 years. Net food availability has not increased significantly, if at all, while real purchasing power of low income groups for foodstuffs has probably decreased during the same period.

Nutritional deficiencies reported in surveys and by expert observation include protein calorie malnutrition, Vitamin A blindness, anemia, goitre, and undernutrition, in some cases resulting in marasmus. Malnutrition affects both adults and children. Reported weights of rural adults are about 20% less than urban counterparts, and growth curves of children approach 15 - 20% below norms after 4 - 6 months of age. As stated earlier, infant mortality is estimated at 133 per thousand live births.

Chronic hunger seasons occur when farmers exhaust their stored foods while awaiting the next harvest. Urban areas also suffer during this period because of rising prices and seasonal unemployment. These conditions are most severe in the Northern and Upper Regions. If perennial drought conditions continue, even more severe nutritional problems are likely to occur in the future in these and neighboring regions.

B. Nutrition Surveys

The most recent national nutrition survey was conducted in 1960-62 by Dr. P.H.L. Davy 5/ and there have been isolated nutrition consumption surveys since, giving probable estimates of nutrition status and food consumption patterns.

Protein calorie deficiencies according to these studies, are found to be common in all parts of the country; the lowest income families receive about 75% of their calorie requirements while the next most prosperous group receive about 85% of their needs. Children and pregnant and lactating mothers among these groups reported the greatest deficiencies,

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5/ Data presented in National Food and Nutrition Conference, March, 1974. (Conclusions drawn remain essentially valid to this day).

receiving only 48 - 55% of their requirements. On average for the population, approximately 1,868 calories were consumed per day, but far less is consumed by the rural dweller.

Protein deficiencies are equally alarming. On average for the country, about 60% of the protein requirements have been met, with shortfalls occurring among infants and young children most severely. About 30% of the protein is from animal sources, according to the survey. Based on food production and availability studies, about 70% of protein needs are met but only 12 - 15% of the protein comes from animal sources. Available data will not answer the question which is most limiting - proteins or calories? In general terms, Kwashiorkor, the product of a protein limiting diet, is more common in the South and Central areas where tubers are eaten, and marasmus is more common in the North. It is apparent from diet studies, however, that merely expanding availability of current diets will not solve either the protein or calorie deficit problem for infants and young children.

Other deficiencies such as Vitamin A and B, iodine and iron were found to be widespread, with Vitamin A deficiencies most prevalent in the North, along with goitre.

Generally the rural areas are reported to be in worse condition than urban areas, regardless of the season, except perhaps for the worst of the urban slums. With the rise in food prices, especially in cities outside of the Greater Accra area, urban dwellers may be at even greater risk than before. Northern areas are generally more severely afflicted than the coastal regions, with the central zone falling in between.

Severe seasonal malnutrition exists in the Northern and Upper Regions, and over the past few years, shortages have become more serious. Because many of the farmers are forced to sell livestock to purchase food during this period or to work for cash instead of planting their own crops, several years of successive shortages compound the problem. In a study in June 1973, in Bawku, only 55% of the groups of homes (compounds) surveyed had sufficient stores to

last until harvest and 24% had no food in their granaries and would be forced to sell all or part of their livestock to avoid famine. A similar study in April 1974 confirmed this trend. 6/

The shortages of food during planting and the crop care period exacerbates the effect of nutritional shortfalls since this is the time for harvest labor by the farm population. A study of one rural group recorded weight losses of 8 - 10% by adult laborers during this period. In another study in Nigeria, among villagers in conditions similar to those of Northern Ghana, rural laborers were found to work only 50% of the time they were in the fields. Researchers attributed the low productivity to the nutritional depletion of the workers.

Nutritionally related diseases afflict the Ghanaian population in similar patterns to those found in other developing countries. Infectious diseases, especially measles and malaria, intestinal, and respiratory diseases are the major killers of infants and young children since a vicious circle is set up between under-nutrition or malnutrition and these diseases. Diagnosed outright malnutrition-related conditions such as marasmus and kwashiorkor account for about 12 - 15% of infant deaths.

C. Nutrition Programs in Ghana

Using a narrow definition of "nutrition interventions" there are four basic activities in the country.

1. Supplemental Feeding

Using P.L. 480 Title II foods, supplemental feeding is conducted in Ministry of Health Maternal and Child Health Centers throughout the country reaching about 25,000 infants, pregnant and lactating mothers. Day Care Centers supervised by the Department of Social Welfare and Community Development also conduct feeding programs assisted by Title II foods. Catholic Relief Services, the principal donor agency for these programs, also has Parish-based pre-school

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6/ References? Report on the distribution of Relief foods during the hungary season Bawku District, Jill Gordon 4/3/74

programs which distribute food, monitor weights, and provide nutrition education. Food distribution also occurs in primary and middle schools, though to a much lesser extent than in pre-school programs, and in some orphanages and child care institutions. The Christian Service Committee has also in the past provided some Title II foods for pre-school children, though their primary emphasis is on rural development. CRS, CSC, and the World Food Program all have Food for Work programs though the objectives of these are not necessarily related directly to nutrition improvement.

2. Nutrition Education

The Ministries of Health, Agriculture, Education and Department of Social Welfare and Community Development each have nutrition education activities. The Ministry of Health has by far the most extensive outreach for nutrition education. With more than one hundred nutrition technical officers, whose tasks include nutrition education, the Division of Nutrition has national coverage. Like most other operating agencies in Ghana they are handicapped with inadequate planning, organization and transport. UNICEF has provided a few vehicles for several years, plus some materials but this assistance has not gone very far in relieving the shortages indicated.

The Department of Social Welfare and Community Development working through women's clubs at the village and neighborhood levels also provides nutrition education. The Ministry of Agriculture has some extension workers who conduct classes in food preparation and backyard gardening.

Nutrition education is rarely given to health professionals, since it is assumed that they know how and what to eat. Nurses, doctors, pharmacists, and para-professionals are key informants to the community but few receive more than a cursory training in practical nutrition for the low income population.

3. Nutrition Rehabilitation

The Ministry of Health through its system of hospitals and health centers conducts rehabilitation for the most severely affected children. There are approximately nine nutrition rehabilitation centers in the country. Although these facilities are able to treat only a fraction of the estimated 10,000 - 20,000 third degree malnutrition children in the country, they continue to absorb valuable resources in the Ministry of Health.

4. Research

In the University of Ghana at Legon and in the Food Research Institute of the Council of Scientific and Industrial Research, investigations are conducted about new food products and methods of improving traditional food preservation processes. Both groups have produced, in the laboratory, some interesting blends of locally grown legumes, grains, and seeds. However, neither group has the resources to move beyond the laboratory stage to investigate consumer acceptability and the prospects of producing these foods in large quantities either at the village level or nationally. Feeding trials have been conducted on several of the mixtures, and they appear to be promising as weaning foods, extenders of commercially produced flours and meals, and as foods for MCH programs.

Some research is carried out on treatment of malnourished children and related topics, but this has not been a major emphasis in Ghanaian medical research. Public health research such as that of the Danfa project may yield important data on the social, economic and medical circumstances of malnutrition.

The Ghanaian Government has recently given highest priority to increasing investment and productivity in the rural sector. Simultaneoulsy, authorities have recognized that income inequalities, inefficiencies in the food

distribution storage and preservation system, higher costs for imported foods and agricultural inputs are resulting in a deterioration of the nutritional status of the low income groups. Most recently, the invading desert in the North has become a matter of concern to some government agencies and to USAID. This has added a sense of urgency to the development of government policy to meet the emergency problems in the North and the long-term food supply shortage.

For more than ten years Ghana has been struggling with the development of a sound nutrition program, although resources for it have always been low in comparison with curative medical programs. In 1959 a National Food and Nutrition Board was established. Under its direction an intensive nutrition education program was begun, reaching into many parts of the country. Many of the staff of the Ministry of Health's present program were originally with the Food and Nutrition Board. The Board also carried out the only comprehensive National Nutrition Survey (1961 - 1962). The Board dissolved in 1966, but it has been responsible for training many nutritionists and nutrition technical officers, plus setting them firmly on the path of nutrition education, rehabilitation centers, and maternal and child health centers.

The Board was succeeded by the Nutrition Advisory Committee. This gave way shortly to the Nutrition Commission, which soon became inoperative. Up to this date, Ghanaians have remained suspicious about the utility of inter-ministerial nutrition groups, especially those without a budget, staff, and operating mandates. Although each operating agency, research institute, and teaching center admits the need for a coordinating group, there is considerable reluctance to delegate policy-making power to a new body or to an existing agency. Recent attempts to do this have either been ad hoc and temporary, or a failure.

Partly as a result of the above-described failings, the Ministry of Agriculture and Ministry of Health called a meeting in early 1974 creating the Food Aid Committee to develop a policy on current and future food assistance. Officials from the Ministries of

Agriculture, Health, Planning and Finance, Labor and Social Welfare and Education as well as donor agencies attended. Little was accomplished at the meeting, although the cause for its convocation -- the threatened reduction of U.S. food assistance-- has not disappeared, and there are numerous other new issues to be addressed, not the least of which is the growing emergency in the Upper and Northern Regions.

Subsequently, a working group of the Director of Medical Services, the Director of the Division of Nutrition in the Ministry of Health and Director of Agricultural Services in Ministry of Agriculture met to discuss the problems in the Bawku area. Decisions were postponed until further information could be received.

Most recently, the Government of Ghana organized and sponsored, with USAID's assistance, a national conference on Food and Nutrition, in April 1974. The conference recommended important changes in the basic strategy of the government to improve nutritional status. Three recommendations deserve special mention since they call for new initatives by the government and represent opportunities to which AID can respond in the near future. First, a nutrition planning "sector" was recommended to be formed in the Ministry of Economic Planning, charged with including nutrition goals in national development plans, developing and testing innovative programs for nutritional improvement, reviewing all agency plans to determine their impact on nutritional status, developing national nutrition plans in cooperation cith executing agencies, and collecting, analyzing, and disseminating information on nutrition.

Second, it was decided, increased assistance should be given to the small food crops farmer, especially in the production of high protein foods, through training in Farm Institutes, in primary and secondary schools, through improved storage at farm and regional levels, and improved technical assistance from extension agents. Thirdly, rationalization of the MCH program was urged as a high priority, with the

integration in it of health education, nutrition, family planning, and food assistance. Other recommendations related to monitoring national nutrition status and food supply, training of agricultural and nutrition field workers, immunization, development of local weaning foods to distribute in MCH centers, and applied research.

The recommendations represent the result of the deliberation of nearly 200 delegates from all regions of the country, representing all sectors of the government, including Finance and Planning.

The recommendations have been presented to the Commissioners for Health and Agriculture who in turn are presenting them to the Commissioner for Economic Planning. They will be incorporated into the Five Year Plan now being prepared.

These steps, plus the support given the conference indicate that concern about nutrition is increasing in the government.

"Operation Feed Yourself" is the principal government program to resolve the internal food supply problem. The formation of OFY was one of the first acts of the incumbent government when it took power in January 1972, but its impact to date is difficult to determine. Food production still does not meet demand and imports have increased in the last few years. Nevertheless, the emphasis in government investments in food production is a welcome change from previous policies of stressing industrial growth.

In summary, the Government of Ghana is concerned about improving the supply of food for internal consumption, but it would be inaccurate to say that there is a high level of awareness about the nutritional consequences of current policies or of the consequences for national development of the deteriorating nutritional status. On several occasions, committees and working groups have been formed to coordinate nutrition activities or develop a coherent national policy, but a serious and continuous effort has not yet been undertaken.

Hence, although one could say that the government has had a long interest in improving the nutritional status of the population it would be inaccurate to say that nutrition really ranks high among government priorities. One of the reasons for the failure of nutrition to receive recognition similar to that accorded education and other human resource activities has been the absence of effective advocacy and access to decision-makers. In addition, several Ghanaian policy makers remarked at the previously mentioned Nutrition Conference in March, 1974 and in interviews that the nutrition community is disorganized and often appears to recommend competing programs. Furthermore, another reason, according to these same sources, is that recommendations for action programs are frequently not presented in decisionable form, with adequate reference to probable costs and benefits which might arise from such programs. Finally, when nutrition programs are proposed they lack stated relationships to other higher ranking development goals such as lower food prices, increased agricultural production, and reduced foreign exchange expenditures, even though these relationships may be quite apparent to those working on the nutrition field. Consequently the programs are not given the priority treatment they deserve when it comes to funding and implementation.

IV. National Health Status:

A. General

Analysis of health status requires a reasonably adequate data base. Unfortunately such is not available in Ghana at the present time,[7] therefore it is necessary to rely, to a great extent, on individual professional judgement, reports of Medical Officers, and field trip reports in assessing actual health conditions. The data that are available other than those referred to in the introduction are derived from scattered samplings of hospital records and thus may give an unreliable view of the total problem inasmuch as the sampling is obviously incomplete. It still remains significantly true that less than thirty percent of the population have access to reasonably adequate curative services and a still smaller percentage of the population to preventive health services. Despite continued growth and expansion of the health care system the rural poor suffer a disproportionate burden of diseases from largely preventable causes.

The problems are being compounded rapidly by a steady increase in population growth exacerbated by a high and increasing proportion of dependent population less resistant to infectious diseases because of under-nutrition, mal-nutrition and parasitism.

Man made ecologic changes, e.g., expanding water resources schemes (water impoundment, hydroelectric dams, irrigation schemes) have propagated diseases and illness not previously endemic in certain areas, e.g., schistosomiasis. Disease control programs directed at malaria, tuberculosis, measles, leprosy, dracunciasis (guinea worm) to mention only a few have largely failed to achieve desired results except on a temporary basis. The sum result is a serious incapacitation from primarily preventable illness of most segments of the rural population both present and future.

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[7] With the notable exception of the extensive data becoming available from the Danfa Rural Health and Family Planning Research Program. First round analysis of the data developed from this project will be presented at the Annual Project Review in March, 1975.

B. Special Problem Areas:

Certain important elements in health coverage and disease problems deserve special mention:

1. Maternal and Child Health

Maternal Child Health coverage is incomplete and geographically and primarily limited to major cities. Thus it has not made a significant impact. In addition, many of the better MCH programs are dependent on external resources, e.g., religious Mission hospitals and clinics and PL 480, Title II, in conjunction with relief organizations such as Catholic Relief Services. Following is a summary of recommendations presented by the National Food and Nutrition Conference, April 8-10, 1974 attended by over 200 representatives in health related fields.

(a) Breastfeeding at least for one year should be promoted by vigorous government initiative. Government, through the Ministry of Health, should control the advertisement of powdered milks and imported baby foods, so that they do not displace the crucial habit of breastfeeding.

(b) Supplementary feeding especially of proteins, is necessary for children 7 to 36 months and for pregnant women in the country. Suitable local weaning foods are urgently needed, especially mixtures that can be made by the mother at home. The conference recommended that the whole question of weaning foods should be examined carefully and urgently by Government.

(c) Immunization -- Infectious diseases increase significantly the risk of malnutrition and vice versa. The Conference recommended that all pre-school children be protected by immunization against measles, tuberculosis, whooping cough, etc. This can be achieved by a vigorous national mass campaign as well as by MCH clinic-based activities on a permanent basis.

(d) MCH programs should be extended and improved. The coverage of present programs should be reviewed and rationalized, targets should be set, and expansion planned in such a way as to utilize the services efficiently. The equipment of these Centers should be improved, e.g., by the provision of Morley "Road to Health" weight charts to all pre-school children, weighing scales, and by cooperation in the use of vehicles. The

weighing scales as well as the vehicles will always need good maintenance.

(e) Health Education, Nutrition Education and Family Planning should be integrated with the Maternal and Child Health program.

(f) The rate of building nutrition rehabilitation centers for each district should be accelerated.

(g) It is important that all health workers in this field should have regular refresher courses.

2. Environmental Sanitation

A problem of major proportions. Water supply and sanitation facilities are almost universally deficient. Where water supplies exist, most are inadequate in both quality and quantity. Sewerage and sewage treatment are essentially non-existent or grossly deficient and this results at the very least in creation of major public health nuisances throughout the country.

In August, 1973 the government stated that approximately 40 percent of the population was supplied with piped water. The distribution of safe water, however, is uneven. It is estimated that nearly 60 percent of the present total is provided for Accra and other major cities while the rural communities probably receive only 10 percent of the national total. Residents of the larger cities have per capita water availability approaching that of the developed countries, while people in towns of less than 20,000 have only 10 percent of their requirements supplied. Villages have scarcely been touched by the national effort to provide safe water supplies.*

For the greater part of the country waste disposal facilities are entirely inadequate. None of the cities has a modern sewerage system although one is under construction in the Accra-Tema municipal area. Some areas are served by septic tanks or pit latrines; in others, ditches beside the street serve as open sewers. Human waste and garbage

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* However see section on "other donors" for account of Canadian Government assistance in this area.

are collected in the cities and buried on the outskirts. Collection is irregular and piles of waste provide breeding places and shelter for insects and vermin.

Ghana has received assistance from WHO and UNDP and from Canada ($12.5 million) to improve rural water supply and sanitation. The initial purpose of the WHO/UNDP/Canadian assistance was to develop a water supply and sewage disposal plan for the Accra-Tema metropolitan area. Recently, in an effort to equalize development and facilities in the rural areas, assistance by Canada and the national government's efforts have been directed more toward rural water supplies. (See External Assistance page .)

The overall level of national funding for environmental sanitation is very modest e.g., in the 1975 - 75 budget ¢3.020 million is allocated in current expenditures plus ¢95 thousant in capital expenditures for all environmental sanitation services including: sanitary engineering, sanitation services, enforcement of public health regulations, port health services and mosquito control which compares to ¢3,185 million for mental health (current expenditures) and ¢960 thousand for capital expenditures.

The incidence and prevalence of diseases related to poor environmental sanitation is not known with any certainty but there is wide agreement that it represents a serious problem to a population already weak and malnourished, and results in a reduced ability to work effectively in the fields or at school.

3. Disease control

Directly related to environmental sanitation is the overwhelming prevalence/incidence of intestinal parasitism and diseases such as schistosomiasis which affects an estimated 30 percent of the school population in the Volta Rivers and Lake regions. Control measures are almost non-existent in these areas. Other diseases and illnesses with high prevalence, incidence and incapacitation or case fatality include:

Malaria

Probably number one on the list with very high incidence and prevalence rates - mostly falciparum with A. Gambiae as principal vector and a very high and unspecified case/

fatality in young children. Control measures essentially non-existent except in a few locations in Volta Region and in largest towns where they are still probably quite ineffective.

Measles

Control measures minimal - there is little evidence that the previously organized measles control program is being continued very effectively. Breakdowns in jet guns and failures in the "cold chain" are major problems.

Onchocerciasis

A problem of major proportion in the entire Volta River drainage system. Control measures limited only to work being done by small staff at Onchocerciasis Control Center in Bolgatanga; but the large new IBRD plus multi-donor project expected to require about 20 years is scheduled to start very shortly. The Government has just established a National Onchocerciasis Control Committee.

Dracunciasis (guinea worm)

High prevalence and incidence. The disease is transmitted by infected cyclops-contaminated drinking water. Control measures are essentially non-existent in rural areas without piped water supplies.

Cholera

Probably endemic and with El Tor vibrio "seeded" in population of Keta district, Volta Region with some endemicity reported elsewhere. Major epidemic in Keta district occurred January - February 1974 with 105 cases said to be confirmed. Previous epidemic in same area about two to three years ago. Control measures mainly limited to epidemic situations.

Tuberculosis

Prevalence about one to two percent of population. Control measures minimal. Mass BCG vaccination not being undertaken although there is vaccination of newborn infants in many locations.

Leprosy

Prevalence about 1 percent of population. Control measures minimal although there are a number of well run leprosaria with well organized out-patient service.

Meningoccocus Meningitis

Major seasonal epidemics throughout with high case fatality. Control measures minimal though some effort has been made especially in Upper Region, to improve ventilation in huts and diminish overcrowding.

Lobar Pneumonia

In spite of warm climate, the disease seems to have a farily high incidence. There is little known about measures for controlling this disease in tropical climates but it is probably related to some extent to the same factors causing meningitis.

4. Mortality

A rewiew of leading causes of death re-emphasizes the inadequacy of the present health system. In spite of the fact that the causes of some 44 percent of the recorded deaths are not known, available data indicate that infectious and parasitic diseases are the major killers followed by nutritional disorders. In fact, more than one half of deaths reported can be attributed to infectious and parasitic diseases. The reported comparatively low proportion of deaths due to nutrition and metabolic disorders may be explained by the communities' unawareness of malnutrition as a contributing factor.

TABLE I

Deaths by Cause of Death (1968)[8]

1. Infective and Parasitic	32.8
2. Systemic disorders	15.8
3. Senility and Other Ill Defined Causes	4.1
4. Traumatic Disorders and Poisoning	2.2
5. Perinatal disorders, complications of pregnancy, etc.	0.9
6. Neoplasia	0.4
7. Nutritional and Metabolic Disorders	0.1
8. Not Reported	43.0
	100.0

Note: Sample of recorded deaths (1,395) considered small therefore subject to considerable error.

The crude death rate in the late 1960's is estimated to have ranged from 8 - 10/thousand in the Accra area to between 26 - 27/thousand in the Upper Region. Life expectancy is estimated to be 47 years. However, the range between rural and urban life expectancy is indicative of the quality of life in rural Ghana, e.g., in the Upper Region it is about 36 compared to 60 - 65 for Accra.

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[8] Results of the 1968/69 National Demographic Sample Survey - Determinents of Population Growth in Ghana, S.K. Gaisie, February 1973, presented for PH.D. Thesis Australian National University.

TABLE II

ESTIMATED LIFE EXPECTANCY AT BIRTH SEX, REGION AND RESIDENCE 1968 - 1969

REGION	Urban-Rural		Urban		Rural	
	Male	Female	Male	Female	Male	Female
All Regions	45.6	48.3	54.1	57.7	40.4	44.7 [1]
Accra Capital District	63.4	65.7	-	-	-	-
Eastern	45.2	50.3	-	-	-	-
Central	42.3	45.7	-	-	-	-
Western	42.9	46.3	-	-	-	-
Volta	52.4	56.4	-	-	-	-
Ashanti	50.2	53.9	-	-	-	-
Brong Ahafo	44.6	49.2	-	-	-	-
Northern	35.9	38.7	-	-	-	-
Upper	34.3	38.3	-	-	-	-

Notes: (1) Sources: (Gaisie 1973: 207 - 209)

(2) Ashanti and Volta figures appear to have been slightly biased upwards

Estimates of infant mortality rates in the mid-1960's appear to be 133/thousand live births. The 1971 supplementary enquiry yielded an estimated infant mortality of 122 per thousand live births.

Efforts to arrive at the true degree of infant mortality are hampered by deficient registration or under reporting. However, the recorded estimated infant mortality rates by region and residence serves as a useful index of the status of health and the degree of success of health programs. For example, a glance at Table III will show the marked difference between urban and rural mortality rates typical of most African countries.

TABLE III

Infant Mortality Rates by Regions

Regions	Urban/Rural			Urban			Rural		
	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female
All Regions	133	145	121	98	107	89	148	161	135
Accra Capital District	56	61	50	53	58	47	106	115	96
Eastern	124	135	113	120	130	110	135	147	123
Central	141	153	128	126	134	118	155	166	143
Western	111	121	101	87	96	79	118	128	107
Volta	130	144	125	104	112	95	140	153	127
Ashanti	124	135	113	87	96	79	133	145	121
Brong-Ahafo	142	154	129	126	134	113	153	165	140
Northern	168	188	157	129	140	117	207	225	188
Upper	192	209	174	111	120	101	208	226	189

Source: (Gaisie 1973: 174)

V. GOG Health Structure and Policy

A. Ministry of Health (MOH)

The Ministry of Health is headed by the Commissioner of Health who is assisted by a Director of Medical Services, in charge of technical matters, and a Principal Secretary in charge of administration. The Ministry has five administrative and eleven technical divisions which include: health legislation, health planning statistics and documentation, control of communicable diseases, nutritional health service, medical care, health laboratory services, dental health services, mental health services, health education, medical manpower and training. There are nine administrative regions in the country, each headed by a Regional Medical Officer. All public health activities within the region are the responsibility of this officer.

The MOH 1974/75 budget submission states that the Government is providing for the separation of functions between the Ministry of Health and a "Department of Health." The primary functions of the Ministry would be establishment of general policy, liaison with other Ministries, etc, while the Department of Health would be concerned with implementation of policy, i.e., formulation of programs, execution, monitoring and evaluation. It is also planned that within the Ministry a special Health Planning and Budget Unit would be established to coordinate regional health plans and evaluate Rural Health Services.

B. Government Policy

In the budget presented by the Ministry for 1974 - 75, it is stated that in the various services provided by the Ministry, "emphasis is being placed on the development of basic health services which aim at providing for the rural folk who constitute 75% of the total population of the country".

The Ghana Government has affirmed on many occasions that investment in man is at least as important as physical investment in the development process, and that the interaction between health and national development is self evident.

The overall fundamental GOG premises and policies are: (a) emphasis upon "self'reliance", (b) emphasis upon rural development, (c) greater decentralization, (d) greater organizational stremlining and efficiency, (e) improved and extended long term planning, and (f) greater inter-departmental and inter-agency cooperation and coordination of effort.

This basic policy outline has continued through the years and, within this context a number of health goals and targets have been specified by the government but no truly effective general implementation plan or mechanism for the health component has been provided. Changing authority in the Ministry of Health may have actually resulted in some stagnation and probably deterioration in the health services, especially the rural health service, in the last twenty years.

In October 1973 a "Five Year Health Planning Committee" was established with the mandate to produce a health plan by January 1, 1974. The materials prepared were reviewed by Dr. E.G. Beausoleil, Deputy Director of Medical Service of the Ministry of Health who prepared a paper entitled "Plan for the Development of the Health Services In Ghana 1975 - 1980" which was completed in April 1974. This paper presents a reasonable appraisal of major health issues and problems and could be used as the basis on which to frame a firm health policy. This could then lead to the setting of priorities and these to the establishment of realistic goals/targets and an action plan. However, the Plan has not yet been acted upon officially.

C. Planning and Management

One regional five year "Plan" submitted in February 1974 by a Regional Medical Officer begins, "Ever since independence one (health) plan or another has been formulated with each era --- strangely enough, none of the laudible plans have materialized and the expectations of the people remain unfulfilled". This rather pessimistic appraisal of health planning has been voiced by bureaucrats and health professionals at all levels. In essence, all previous health planning efforts have turned out to be intellectual exercises which have ended up on the shelf.

The Zukin survey report outlines by category the related management problems i.e., use of human, financial and capital resources. Not surprisingly, serious lack of direction and communication at all levels of the system are reported.

The fact that such a state of affairs is not consistent with any approach to development and equity is beginning to evidence itself in some discussions and news articles, e.g., concern for immunization against various diseases and the serious nature of mother/child health and malnutrition. The concept that family planning and nutrition must be integrated

with agriculture and health policy is publicly recognized. However, in the absence of a functional planning and management mechanism the system cannot respond. The conclusions that can be drawn from reports, casual observation and analysis of available data reveal that organizational deficiencies at the central and regional level constitute the primary constraints to a potentially viable health program for the entire country.

The ineffectiveness of Ghana's health system is primarily attributed to poorly designed programs which fail to place resources in the areas of greatest need; to the absence of effective budgeting, supervision, evaluation and follow-up; to major deficiencies in logistics and transport and some significant shortages of resources to carry out the key tasks. The effect is a demoralized system of professional personnel who need to be organized, directed, given clear responsibility, rewarded for achievement, supported in a timely way with vital resources, and made to feel that they are a part of a re-vitalized institution.

VI. Health Resources

A. Health Facilities

The recent survey by Drs. J.S. Prince, Paul Zukin and Kwasi Nimo in the Upper, Northern, Volta, Central and Eastern Regions details the great variation in quality and quantity of services in the peripheral areas of the country. In the short run, their recommendations do not call for major expansion of facilities but rather the revamping of the management and staffing of present facilities. In addition, the seriously inadequate logistic support of rural facilities (with notable exception of pharmaceutical supplies) appears to be a major constraint to the system.

TABLE V *

REGIONAL DISTRIBUTION OF HOSPITALS, HEALTH CENTERS AND HEALTH POSTS - 1970

REGION	Hospitals				HEALTH CENTERS	HEALTH POSTS
	GOVERNMENT AND QUASI-GOVERNMENT	MISSION	MINES	PRIVATE		
WESTERN	7	3	-	1	4 4	-
CENTRAL	8	3	1	-	2	-
GREATER ACCRA	10	-	-	2	7	-
EASTERN	10	4	2	1	8	-
VOLTA	7	6	-	-	4	9
ASHANTI	6	6	3	11	6	-
BRONG-AHAFO	2	7	-	-	6	2
NORTHERN	7	1	-	1	6	-
UPPER	4	3	-	-	3	-
ALL REGIONS	61	33	6	16	46	11

* Tables V thru X, Some Aspects of Population and Health in Ghana, Dr. E.G. Beausoleil, MOH, 1974.

B, Health Manpower

In the last twenty years there has been a marked increase in the number of health personnel and health facilities in Ghana; however, the geographic distribution and allocation of these resources leaves much to be desired (see Tables V, VI, VII, and VIII*). The rural areas which provide the principal agricultural, mineral, etc. resources for the country are the primary victims of its organizational inadequacies. Findingways of improving the balance of health service delivery system between urban and rural areas is therefore of increasing importance.

TABLE VI*

Numerical Comparison of Health Facilities 1952 - 1973

Category	1952	1973
Local Authority Dressing Stations	102	114
Government and Quasi Government Hospitals	33	61
Health Posts	NA	11
Rural Health Centers	3	46
Mission Hospitals	3	33
Mine Hospitals	5	6
Private Hospitals & Maternity Homes	7	16
Urban Health Centers	NA	10
Government Dispensaries	22	NA

* Tables V thru X, Some Aspects of Population and Health in Ghana, Dr. E.G. Beausoleil, MOH, 1974.

TABLE VII

DISTRIBUTION OF PHYSICIANS, NURSES AND HOSPITAL BEDS BY REGIONS
1970

REGION	POPULATION PER PHYSICIAN	POPULATION PER HOSPITAL BED	POPULATION PER NURSE
GREATER ACCRA	6,355	290	952
WESTERN	13,052	1,000	2,258
EASTERN	45,059	968	4,005
CENTRAL	55,633	1,351	3,273
ASHANTI	118,996	886	6,073
NORTHERN	142,801	1,643	3,292
VOLTA	155,722	725	4,066
BRONG-AHAFO	163,876	1,519	8,710
UPPER	1,107,840	1,209	5,426
ALL REGIONS	23,196	829	3,092

TABLE VII

Sample of Distribtuion of Some Health Workers Public and Private Sector, 1971
(Non-Nationals - Expatriates, Primarily Missionaries)

	(1) Capital (Accra)			(2) Other towns of over 20,000 population			(3) Localities of less than 20,000 population			(4) Whole Country		
	Nat.	Non Nat.	total	Nat.	Non Nat.	Total	Nat.	Non Nat.	Total	Nat.	Non Nat.	Total
1. Physicians in health cnts.	186	53	259	147	58	205	64	207	271	397	318	715
2. Health Superintendents	13	--	13	30	--	30	186	--	186	229	--	229
3. Dental Surgeons	16	3	19	21	1	22	2	--	2	39	4	43
4. Dental Assts.	16	--	16	15	--	15	4	--	4	35	--	35
5. Midwives	608	--	608	546	6	552	1610	185	1795	2764	191	2955
6. Nurses	1558	1	1559	1547	--	1547	4139	100	--	7244	101	7345
7. Auxiliary Nurses	150	--	150	198	--	198	719	--	719	1067	--	1067
8. Sanitarians	16	--	16	50	--	50	154	--	154	220	--	220
9. Auxiliary Sanitarians	161	--	161	104	--	104	--	--	--	205	--	205

TABLE VII (con'd.)

	(1) Capital (Accra)			(2) Other towns of over 20,000 population			(3) Localities of less than 20,000 population			(4) Whole Country		
	Nat.	Non Nat.	Total	Nat.	Non Nat.	Total	Nat.	Non Nat.	Total	Nat.	Non Nat.	Total
10. Laboratory Technicians	84	--	84	70	--	70	31	--	31	185	--	185
11. Pharmacists	214	--	214	149	--	149	60	--	60	423	--	423

The actual staffing of health personnel in rural areas is further distorted when one considers that physicians working in localities of less than 20,000 population are predominantly non-Ghanaian. Thus the relatively large percentage increase in professional and sub-professional personnel over the past 20 years has not resulted in a proportionate benefit to the rural population.

The problems and conditions of service in rural areas are factors at the heart of this mal-distribution of health personnel. Some of these deficiencies are found in living conditions, salaries, lack of career incentives, lack of logistic support, failure to delegate authority with responsibility, and in summary a high degree of frustration with the "system".

In comparison with other developing countries Ghana does have a good base for development of an adequate health care system with a relatively large number of health facilities, trained personnel in various disciplines, and also the many who have been trained in areas related to preventive health care. However, the fact still remains that where relative but adequate resources exist they are primarily non-Ghanaian administered or under the supervision of expatriate staff. Until the mal-distribution of Ghanaian health manpower and realistic service facilities is corrected there will be very little improvement in this situation.

C. Health Training:

Medical

In 1964, the Ghana Medical School was established. It graduated its first class in 1969. During the 1969-1970 academic year there were 263 students at the medical school. The Government hopes to increase the size of each class to 100 in five years. By 1975 it is planned that a post-graduate course will be established for advanced training in public health.

The objectives proposed by the school included orientation of the training of physicians toward preventive and social medicine and toward the problems encountered in working with limited facilities in rural areas. However, from the information provided in Table VII it would appear that the training and orientation has not had the desired effect.

Table IX shows a comparison of output of physicians for the Ghana Medical School with several types of para-medical personnel.

TABLE IX

Output of Certain Categories of Health Service Personnel from Local Training Institutions in 1973

Category	Number
Physicians	38
Health Inspectors	28
X-Ray Operators	19
Laboratory Technicians	11

Nursing

Training for State Registered nurses is available at two hospitals in the country and training for other nurses is offered at some 20 other facilities.

In 1962 WHO began to assist Ghana in training community health nurses and also established a post-basic nursing course at the University of Ghana to train tutors, nursing administrators and supervisors. In addition, there are at present three community health nurse training schools, one located in the Northern Region at Tamale, one in the Volta Region at Hohoe and one in the Eastern Region at Akin-Oda. The following table shows the distribution of yearly output of these types of health personnel.

TABLE X

Category	No. of Schools	Duration of Course	Full Capacity	Annual Intake	Approximate Yearly Output
Nursing (S.R.N.)	2	3 yrs.	496	150	133
Enrolled Nursing	12	2 yrs.	751	605	605
Midwifery	4	1-2½ yrs.	386	212	207
Public Health Nursing	1	1 yr.	13	13	13
Community Health Nursing	3	2 yrs.	146	73	73

Other Health Training

Laboratory technicans are trained at Korle Bu hospital, health inspectors, Grade I (Sanitarians) are trained at the School of Hygiene, now located on the Korle Bu compound and Health Center Superintendents are trained at a major facility in Kintampo (Brong-Ahafo Region), originally with WHO assistance.

There are no training facilities for dentists in the country; however, there is a school of Pharmacy of the College of Science and Technology in Kumasi.

D. External Assistance

Ghana receives development assistance from a variety of sources including: UNDP, IBRD, U.N. specialized agencies (WHO, UNICEF, and FAO), OAU, Federal Republic of Germany, Japan, Egypt, France, Netherlands, United Kingdom and very importantly religious missions and private voluntary agencies.

1. Multilateral

By far the largest project involving Ghana is the seven country Regional (Volta Basin) 20 years,$120 million onchocerciasis control project under IBRD/WHO administration. Other WHO assisted programs are:

Onchocerciasis

WHO has three Ghanaian entomologists working with the Regional Medical Office in the Upper Region. This is, independent of the IBRD/WHO administered onchocerciasis control program.

Schistosomiasis

This project involves a seven-man team including a sociologist and epidemiologist. The work is being carried on in the Keta District of the Volta Region.

Rural Water Supply and Environmental Health

A two-man team including a sanitary engineer is working in six areas of the Ashanti region (mostly around the city of Kumasi) assisting in development of wells, latrines, etc., for individual farmers and extended family groupings.

Nutrition

WHO has a physician working in FAO headquarters on an inter-regional project entitled the Joint FAO-WHO-OAU Regional Food and Nutritional Commission.

Training Programs.

The post basic nursing and health education training programs have been terminated but WHO is assisting with the post basic engineering (water engineering) program at the Kumasi University of Science and Technology. In addition to these training activities, WHO has sponsored various seminars in the country on health matters, the latest seminar (November 12-19, 1974) being on immunization involving Anglophone countries in Africa.

Malaria

WHO has assisted with malaria eradication (1956-57). Unfortunately, after a few years it was considered that this effort would be"a waste of time" unless the eradication program could be tied to a suitable infrastructure in the Ministry of Health. Since this was lacking, the project was discontinued.

Community Participation in Solving Health Problems

A new project to be located in Brong-Ahafo region. WHO will provide a four-man staff oriented toward the social sciences and not to include a physician. The main purpose of the project is to see whether community energies can be "released" toward total rural development including health as one of the essential factors.

2. Bilateral

Several bilateral donors are engaged in health and/or medical assistance projects in Ghana. The two important bilateral donors are Canadian International Development Agency (CIDA) and the Federal German Republic Technical Assistance Program.

CIDA

CIDA's principal emphasis is on provision of better water supplies. They are working on two projects in this area one in the Upper Region and the other in the Accra-Tema area. The four year project in the Upper Region which began about 15 months ago is designed to provide safe and adequate water supplies to three urban areas in that region-- Bolgatanga, Bawku and Wa and to all smaller

towns between 500 and 1,500 population. For the smaller communities about 1,100 new drilled wells will be provided on a "turn-key basis" and another 500 existing drilled wells will be "refurbished".

It is anticipated that some 500,000 people will benefit from the program. The project provides for five maintenance centers in the Upper Region with the main one being located in Bolgatanga and with two mobile workshops and an adequate supply of spare parts. The total cost of this project is estimated at $12.5 million.

In addition to the Upper Region project, CIDA has entered into a consortium with World Bank and ADB to assist Ghana Water and Sewerage Corporation with a $20 million project to develop a safe and adequate water supply for the Accra-Tema area. The project agreement has been signed and the project is to be completed by the end of 1979 and should provide an adequate supply for the area until 1985.*

Federal German Republic

The FRG health program is located exclusively in the Northern Region. The five-year project is designed to assist in the development of health services for rural populations in that region, i.e., the development and running of rural health services, local health posts, training of para-medical personnel and various measures aimed at disease control in the region. The project staff consists of one physician and six volunteer nurses and nurse mid-wives. An additional physician (surgeon) is "pending". Note: This project complements the USAID Rural Health Management Project and proposed National Training of the regional and Ministry of Health Administrators. Consequently, there is no duplication and the two projects should be complementary if handled properly.

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* This appears to be a very short life span for a system of this magnitude but it is undoubtedly a reflection of the rapid rate of expected population and industrial growth in the area through 1985. We assume that the design provides for later additions by the Ghana Government as this becomes necessary.

Volag Work in Health Field

1. Church Hospital Association of Ghana

For some time religious mission medical institutions in Ghana have coordinated their work, more or less, with the programs of the Ministry of Health. This has been done mainly through Hospital Advisory Committees set up in the Regional Medical Offices and chaired by the Regional Medical Officers. Religious mission hospitals working through these committees are called "agency hospitals".

About three years ago, however, the Ministry of Health decided that this mechanism for promoting coordination of and cooperation with the church hospitals in the country was not really adequate because a number of these hospitals did not choose to come under the supervision of the Regional Hospital Advisory Committee.

In order to get around this the Ministry of Health encouraged the religious missions working in Ghana to establish some kind of association which, working closely with the appropriate agencies of the Government, would see to it that the medical activities of the missions were in keeping with Ghana's overall priorities in delivery of health services.

To make this easier the Ministry of Health released a "top-notch" hospital secretary to the religious organizations and, on September 14, 1972, the Church Hospital Association of Ghana was formed and the Ministry of Health hospital secretary became the Executive Secretary of the Association.

In order to make this possible from a financial point of view the missions were able to obtain a grant from "Bread for the World", a German religious organization with headquarters in Stuttgart, West Germany.

The Executive Secretary, as a result, was employed by the Association about 18 months ago and seems to have done an excellent job not only in encouraging the religious missions to join the Church Hospital Association but, as well in promoting active cooperation between the various church hospitals and clinics around the country and the appropriate Regional Medical Offices.

There are 30 such Association Hospitals, 8 clinics (2 of which provide maternity services only) and one "orthopedic training center". In fact, the only religious

organization not yet a member of the Church Hospital Association is the Salvation Army and it is anticipated that this organization will be joining the Association in the next few weeks.

One interesting sidelight to this activity is the fact that the Association has received inquiries from about three or four other African countries with a view, we suppose, of making similar arrangements in those countries.

Drs. Prince and Zukin in visiting a number of Regional Medical Offices and Regional Health and Medical facilities in Ghana last May-June, pointed out the important part which these religious Mission facilities play in providing rural health services. One could hardly expect that this would be much less true in the future, and therefore the availability of a coordinating mechanism such as that described above is of great potential value to the smooth functioning of these services.

2. Catholic Relief Services (CRS)

CRS operates a small nutrition improvement program (PL 480 Title II) directed primarily at 75,000 mothers and young children. The aim is not only to offer nutritional supplements and education in better nutritional and preventive health practices, but also to provide some of the wherewithal to put these practices into effect through local food demonstrations, lectures and use of the Morley child's health and weight charts. Nearly 50% MCH program is concentrated in the Northern and Upper Regions where the need is greatest (see Table below).

CRS is also currently reaching 72,500 primary school and day-care center children and 5,000 economic and community development workers with nutrition food supplements. In FY 1974, a total of 10.9 million lbs. of Title II commodities worth $884,000 were distributed by CRS. It is estimated that the amount will increase to nearly 13 million lbs. in FY 75 ($1.3 million). (See Table 10.)

No attempt is made to evaluate the technical performance of all these external assistance programs. However, although it appears that they are of major significance in helping the Government solve some its health and related problems there are, additional areas of significant need that are not yet receiving sufficient attention from the GOG and external donors e.g., health education, nutrition, MCH, rural environmental sanitation.

CRS TITLE II PROGRAM FY's 1974 and 1975 1/

	M R H		School Feeding		Other Child Feeding Food-for-Work			
	FY 74	FY 75	FY 74	FY 75	FY 74	FY 75	FY 74	FY 75
Greater Accra	1,200	1,200	1,700	800	2,300	2,300	-	-
Ashanti	9,050	9,250	1,000	960	1,100	1,000	-	-
Brong Ahafo	6,600	7,000	2,930	1,900	300	300	-	-
Central	6,150	6,300	3,220	2,600	650	650	827	1,000
Eastern	5,100	5,200	10,000	5,000	2,450	2,450	300	430
Western	3,000	5,000	3,100	2,540	900	900	50	100
Northern	7,725	14,000	13,000	11,000	850	850	360	1,400
Volta	6,150	7,050	6,650	4,000	1,900	1,900	247	270
Upper	14,025	20,000	40,400	31,200	50	50	1,270	1,800
All Regions	59,000	75,000	82,000	62,000	10,500	10,500	2,854	5,000

VIII. Financing of the Health Services

An analysis of the budget from FY 1971 to 1975 indicates that funds for health services have increased by 50% over the last 5 years.

Fiscal Year	Total National Budget (Million ¢)	Percent Allocated to Health
1970/71	486.7	7.1
1971/72	535.5	6.3
1972/73	845.1	7.7
1973/74	649.3	8.4
1974/75	962.2 (estimated)	8.5

Although the total budget has risen over the last years the percentage level of yearly increases allocated to health has been small. For the period 1974/75, health budget ranked third compared to other operating Ministries following Works and Housing and Education. In 1974/75 Health ranked fourth falling behind defence. The following Table gives a sample of the allocation of these health resources which appears to favor the urban population.

Per Capital Expenditures for Health by Region (1973/74)

	Region	Population	Expenditure	Exp. (Rank)
1.	Central	890,135	¢8.81	(1)
2.	Greater Accra	851,614	7.39	(2)
3.	Western	770,087	6.89	(3)
4.	Volta	947,268	6.27	(4)
5.	Ashanti	1,481,698	6.04	(5)
6.	Eastern	1,261,661	5.83	(6)
7.	Northern	727,618	5.70	(7)
8.	Upper	862,723	5.59	(8)
9.	Brong-Ahafo	766,509	4.93	(9)
	All Regions	8,559,723	6.35	

The following table gives a comparison of expenditures within the health sector for the 1973/74 and 1974/75 fiscal years:

Ministry of Health, Current and Capital Expenditures Budget

Program	Allocation (Million ¢) (1973/74)	(1974/75)	Percent of Total 1974/75 Health Budget
General Services:			
General Administration	7.384	27.325	33.3
Budget & Planning Division	.025	.036	6.1
Common Services	1.819	2.607	3.2
Regional Health Administration	1.069	1.251	1.5
Stores	1.114	1.718	2.1
Health Education	.278	.211	.3
Center for Health Statistics	.066	.131	.2
Training	3.300	5.016	6.1
Health Department	.272	-	-
Internal Audit	.009	.013	6.1
Research Center for Plant Medicine	.055	.170	.2
Total	15.390	38.472	46.9
Korle Bu Teaching Hospital:			
General Administration	.633	1.291	1.6
Medical/Dental Services	4.100	3.629	4.4
General Services	1.680	3.036	3.7
Total	6.413	7.956	9.7
Ministry of Health (Medical/ Dental Services):			
Dental Services	.674	.858	1.0
Environmental Health Services	2.439	3.115	3.8
Epidemiological Division	2.420	2.989	3.6
Health Laboratories	.843	.925	1.1
Maternal and Child Health	1.184	1.535	1.9
Medical Care	20.413	21.104	25.7
Mental Health	4.197	4.145	5.0
Nutrition Services	.408	.561	.7
Total	32.577	35.262	42.8
Grand Total	54.380	81.690	100.0

Source: The Annual Estimates for 1974/75, Part I, Vol. IX, Health, Ministry of Finance and Economic Planning, July, 1974. Some observations can be made concerning these budget classifications and two year trends.

1. Under General Services the category, General Administration, which shows such a dramatic increase over the previous year (400 percent), is not mainly "administrative" as that term is generally understood. Rather, it covers the contributions to various health organizations and the subventions to the Mission hospitals. Other increases are attributed to inflationary pressures affecting personnel salaries, Transport and maintenance and drug imports. The great bulk of the increase in this category (¢19,111,000) is to provide drugs and medical equipment.

2. The total budget of ¢81.7 million is broken down into Current Expenditures - ¢69.6 million, and Capital Expenditures - ¢12,746,000. Thus 15.6 percent of the total budget is scheduled for construction and other capital projects.

3. Composite expenditures for Planning, Health Education, Environmental Health, Epidemiology, Nutrition, and Maternal and Child Health, which are problem areas of such vast scope, receive only 10 percent of the total budget. Mental Health, on the other hand, is allocated 5.0 percent of the total.

4. The budget for Medical Care absorbs 25.7 percent of the total. This expenditure, although partially directed to health centers and health posts, is mainly devoted to urban hospitals and curative services. Between this portion of the budget and that part devoted to Korle Bu Hospital, more than 35 percent of the total budget is directed toward curative services.

Separate and distinct Budgets are provided for: (000)

		FY 74	FY 75
1.	Ghana Medical School	¢1,600	¢1,980
2.	National Family Planning	¢ 737	¢ 959

Other government training institutions such as the University of Cape Coast and the University Science and Technology do have important Health Training facilities however no budget breakdown is provided for health activities.

VIII. Summary - Conclusions

The scope of problems encountered in this analysis is large and classification in order of priorities is difficult. However, in spite of the constraints an attempt can nevertheless be made to summarize and comment on key categories in some order of significance as follows:-

1. Population

Family planning is highly dependent on health services since better health and improved chances of infant survival probably lie at the root of motivational change towards smaller families. Also FP provided through the health services permits an appropriate setting to counteract criticism that FP services are given without concern for felt needs for better health care and may therefore constitute discrimination along racial lines.

2. Morbidity and Mortality

Despite insufficient information on a country-wide basis there is sufficient sample data available to indicate that acute communicable diseases like measles, arthropod borne diseases like malaria, parasitic infestation, and related diseases occur in over 50% of children, contributing to a large extent to the high infant and childhood mortality rates. Yet the significance of this problem does not appear to have caused as great concern as might be indicated especially with respect to the rural poor.

3. Nutrition

Physical and mental development is crucial to the process of development. In Ghana shortages in nutritive components in the diet are especially obvious in women and children, whose caloric intake is estimated at 50 percent of requirements.

4. Environmental Conditions

Combined pollution-related and nutritional etiology (unsafe water supply, excreta disposal and generally poor environmental hygiene and malnutrition) are responsible for the highest incidence and prevalence of disease in children.

5. Functional (Organization and Administration)

Regardless of the order of the key categories, there is no separability of the relationship that exists between rapid population growth, malnutrition, environmental degradation and the absence of delivery of health services to the rural areas. The ordering of priorities would pose great difficulty where it not for the fact that the same inadequacies in planning and management patterns cut through

the entire structure. Hence, viewing technical assistance as the cognitive process it should be one is forced to the conclusion that the way to begin the problem-solving in this case is to focus on the health planning and management mechanism.

Reports dating back to the early 1960s comment on the poor utilization of available health resources but implementation of recommendations in this regard have been singularly unsuccessful. Furthermore, despite a relatively large cadre of professionals there appears to be limited understanding of the concept of planning, problem identification or systems. The same nagging reports and statistics quoted above are available to all; however, the will to act effectively or reform appears to be absent or minimal. From experience and lack of success in attempting to modernize the system with western techniques it is obvious that between the spoken word and actual implementation there is a major gap in our knowledge of attitudes, relationships, and the decision making process in Ghana. Nevertheless we feel that by means of whatever ingenuity we can muster we are obliged to pursue the problem further and attempt a solution to be arrived at jointly with appropriate GOG Agencies/Authorities.

IX. Development Strategy for USAID

In line with what has been stated above, identification of approaches to assistance in improvement of health status in Ghana requires first that there must be understanding of key variables (values) political, economic and social as perceived by the GOG officials responsible; secondly, common reference points must be found which both donor and host Government can relate to or identify with. Consequently, the first element in our strategy is to work out a means whereby our staff and any contractor or consultant personnel can develop a free and more or less frank dialogue with Ministry of Health, Ministry of Economic Planning and other appropriate staffs or individuals involved in the decision-making processes related to improving delivery of rural health services. This approach will include efforts to make ourselves helpful to Ministry of Health and other officials as appropriate on field trips, in meetings, committees, formal and informal situations etc. In short, we feel we must gain the confidence of host government officials both in our professional competence and in our true concern for helping them meet problems which they

consider important in a manner which they consider acceptable. The next step in this process is to promote the internalization of constructive solutions to present or emerging problems i.e. to seek to make solutions which we have suggested acceptable to the host government itself so that it will actively wish to pursue them. This process may proceed parallel to or in advance of the strategic approaches described below but it must commence now since it is known to be time-consuming. 9/ As a result, appropriate Mission staff have already begun the effort.

The following material is predicated upon the success of efforts outlined above and on the assumption that in fact the GOG officials concerned will not only agree with the points of view expressed but pursue them actively.

A. Health Sector Goal:

To assist the Government of Ghana in delivering low cost effective health services to a large proportion of the poorer population living in rural areas.

Discussion

Within the wide spectrum of problems described above USAID views improved planning and management as the most critical function that must be addressed starting at the central organization of the MOH but reaching down to its most peripheral components . Within the operational area special efforts must be directed toward the provision of care to mothers and children (MCH/FP/Nutrition), and in regard to improvements in the sanitary quality of the rural environment.

Action Required:

Discuss with the Government and other donors the proposed basic strategy for the health sector and define the best means by which required U.S. resources beyond those already committed and agreed upon, may be brought into play in the support of a program which would address effectively the problems outlined above. This discussion which as indicated, has already been under way for some time would include but not necessarily be limited to the following proposals:-

B. Proposals:

1. Planning and Management

a. Management of Rural Health Services (signed project)
Purpose: To strengthen the planning, management

9/ "The Dynamics of Planned Change", R. Lippit, J. Watson - 1956 (publisher not available here)

and implementation of programs for delivery of rural health services in order to obtain the maximum benefit in terms of human well-being from resources committed to the sector.

Discussion: Over the years several important reports on the health sector as indicated previously, have each recommended (1) the strengthening of the administration and (2) decentralization of services. The proposed Health Planning and Budget Unit is designed to assist M.O.H central staff and senior regional health personnel, concerned with general policy and the formulation of broad programs and plans, to determine objectives, priorities strategies and details of implementation and budgetary requirements. An important component function will be the coordination of health plans developed by the Regional Medical Offices appropriate consideration of these plans with the Regional Medical Officers and their staffs, well in advance of finalization at the central level. An additional function will be consideration of measures necessary to improve management systems seem appropriate (involving possible reorganization of M.O.H administration structure).

Actions Required: (1) Consult further with the Ministry of Health concerning the implementation of Health Planning Project for which a Senior Advisor will be recruited to meet the Ministry's needs. Reaffirm project plan as set forth in project agreement. Examine the inter-relationship of this project with the purposes and operational modes of the Danfa Rural Health and Family Planning Project and the National Family Planning Program Support Project since they are designed to have mutually re-enforcing effects; (2) Designate the Head of the Planning Unit (or other suitable entity) to function as counterpart to Senior Advisor; (3) Facilitate the work of the transport maintenance advisor by ensuring that all preliminary work is done at the transport services centers as outlined in the first report of February 1974 for Tema Workshop.

b. Training of Health Managers (proposal)

Purpose: To design and execute a program for training of central regional and district health personnel in the formulation, management and practical implementation of health delivery systems.

Discussion: The general administration, direction and coordination of the various rural health services is carried out in the regions primarily by the Regional Medical Officers who are the official representatives of the Ministry. In theory these senior medical personnel are responsible for the formulation of General Policy and implementation of health policy in their particular regions. However, it appears that M.O.H. Headquarter's staff need exposure to and experience with sound management principles such as the delegation of authority along with responsibility so that the Regional Medical Officers can function without constant reference to higher authority for policy and budget determinations etc. The proposed training would address this problem along with the need for experience in the identification of objectives, programming to meet objectives and implementation of these programs. Hence, training for key personnel who operate at both Central and Regional levels is required and should have considerable impact on some of the problems previously described.

As a first effort, budgeting, planning, programming, problem solving and decision-making techniques can be provided through simulated experiences in seminars and discussions geared to development of the team concept. The effort described is thus expected to complement the activities of the Management of Rural Health Services Program both at the central headquarters and in the regions as well.

Action Required: Explore the utility of setting up a practical training program (comparable to the ARMS and DAA programs for similar training in the agriculture area) to ensure a well trained cadre to plan, manage and execute rural health service programs.

2. (a) Intersectoral Nutrition Planning and Nutrition Interventions

Purpose: The purpose of this project is to demonstrate the effectiveness of intersectoral planning in the improvement of nutritional status and the conditions under which certain interventions are effective in the improvement of nutritional status for low income groups.

Discussion: With USAID assistance through a contract with TransCentury, GOG held a National Nutrition Conference in March, 1974. The Conference recommended establishment of a Nutrition Sector (Unit) in the Ministry of Economic Development. This unit would serve as Secretariat for a larger National Nutrition Council. Both the Unit and Council are now approved officially by GOG and in process of formation. As a result it is anticipated that the intersectoral nutrition planning referred to above will receive new emphasis in the near future.

In addition to the planning element, Mission strategy in this field includes training, commodity purchase and technical assistance in the design and implementation of specific nutrition interventions. The scheduling of our assistance will be responsive to signals from the government that their interest is sustained and they are willing to allocate resources to the successful completion of the interventions. However, we will emphasize and limit our financial assistance to those interventions which are in keeping with our over-all strategy in the health/nutrition/population field, namely to concentrate resources towards alleviating problems which are of major importance to the rural poor in a manner which is practical and feasible within existing or expected GOG capabilities. Obviously involvement of volags and constructive intersectoral "release" of community energies in this direction, as described in the following proposal, may be one way of dealing with the problem.

(b) Integrated Health/Nutrition/Rural Development Voluntary Agency Assisted Community Food and Health Education Centers

Purpose: Provide health education and care to mothers and children to reduce morbidity and primary infections through an integrated food-health program involving community self-help action in sanitation, health education, nutrition education and family planning.

Discussion: Considering the health and food problems in the rural areas and the inability of the "system" to respond to the needs, a mechanism must be developed to reach the most vulnerable group--mothers and children. Consideration must be given to the interrelations among health problems, rural development, food production, nutrition and family planning. Such an integrated community based program recognizes the need for support and coordination with other operational Ministries in particular the Ministries of Agricultural Education and the Department of Social Welfare and Community Development. The limited MCH activities undertaken by CRS in the Upper Region follows this approach, combining community self-help programs, and appears to be very successful and acceptable to all.

Contemplated in line with the above is an expanded PVO administered program which would provide training, administrative support and basic commodities. Experience in health education, nutrition and family planning can be drawn from ongoing CRS and Danfa activities. This approach will require concurrence and support from Regional Commissioners but would alleviate the burden of support placed on the Ministry of Health's system which at this time cannot respond. This process at the grassroots level which people understand and from which they see tangible benefits arising would also perhaps assist the MOH in identifying mechanisms which could be adapted to dovetail with the governmentally supported rural health and family planning programs as these are developed and to reduce the budgetary requirements of these official programs.

Action Required: Discuss with PVO's interest and strategy for implementation. Consult with Regional Commissioners, WHO*

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*WHO is about to embark on a community development program with MOH. Hence coordination with this program would be essential.

and Ministry officials (Health, Agriculture, etc.) on interest and feasibility. Select pilot area and conduct baseline studies.

3. Health Resources Loan:

Purpose: To provide needed resources that would improve the health and well-being of poorer people either as part of programs of the Ministry of Health or in substantive areas such as water supply and distribution which complement Ministry programs but come under the auspices of the Ghana Water and Sewerage Corporation or other agencies.

Discussions: Whatever mix of services the GOG decides to include in its expanded rural health program, i.e. services ranging from basic curative medicine to comprehensive health care, a minimum support program must be provided to encourage/attract rural health workers. Examples of the scope of the support package might be:

1. Support for the development of the full range of infrastructure for health in a given region including: transport, communications, immunization equipment and supplies, basic health center/post equipment, including a reasonable library of technical books and periodicals, water supply and distribution facilities, sanitation installation, etc. All the foregoing would need to be associated with a clearly delineated plan for a broad coverage preventive/promotive health services delivery system; a management development and staff training plan; and a maintenance program to ensure effective use of facilities/equipment and efficient long term follow through on the entire program.

2. A national plan for expanded health service coverage emphasizing low cost, broad coverage preventive and promotive service to the poorest people where AID might cover foreign exchange inputs (e.g. transport, communications, immunization and basic health post equipment and equipment and supplies) and a decreasing proportion of local costs over a five year period. This as in the Regional pilot program described under (1) would need to be related to well-articulated strategy and linked to management

development and staff training programs which would give maximum assurance of efficient execution and significant impact on improving the well-being of the majority of the rural population.

Action Required: Define the best means to supplement available local resources with funds under concessional loan terms which would make a positive and concrete impact upon development progress in the area of expanded/improved rural health services.

ANNEX C

Population Sector Assessment

I Population Setting

A. Demographic Indicators

B. Data Base & Demographic Capability

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Population Sector Assessment

I. Demographic Setting

Ghana's population is growing at a fast and apparently accelerating rate while economic growth has been slight in the past fifteen years. The result is a slow but steady deterioration in the well-being of its people. The population side of the equation between people and output presents disturbing trends. Census results for 1960 and 1970 suggest that the Ghana-born population grew at about 2.8 percent per annum.[1] More recent indications suggest an accelerating rate of 3 percent or more due to declining mortality rates. Population may, therefore, double in as little as twenty years.

A. Demographic Indicators:

	Ghana[1]	US[2]
1. Population	8.6 - 10.0 million	----
2. Growth Rate	3.0 - 3.1 %	.76
3. Fertility		
Crude Birth Rate	49 - 51	17.0
Total Fertility Rate	6.7 - 7.1	2.1
4. Mortality		
Infants less than 1 year	137	18.6
Children 1-4 yrs.	70	0.8
Crude Death Rates	19 - 20	9.4
Life Expectancy	47	71

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[1] Determinants of Population Growth in Ghana (1968/69), Gaisie, S.K. Doctoral Dissertation, Australian National University, February, 1973.

[2] Statistical Abstract of the US, 1973, Government Printing Office, Washington, D.C. Table 9, p. 11, Table 78 page 57, Table 81, page 59 .

B. Data Base and Demographic Capability

Ghana has a small cadre of well-trained active demographers. Some of them are credited with excellent publications on the demographic trends in the country. However, to date the major demographic materials on Ghana include the 1960 and 1970 censuses, and the 1968 USAID sponsored demographic sample survey, Determinants of Population Growth in Ghana.[3] Unfortunately, little Government use has been made of such demographic information for planning purposes.

There are other weaknesses in the demographic area. Of paramount and overriding importance is lack of sufficient trained personnel. This problem forced cancellation of a post-enumeration survey to check content errors of the 1970 census. Since 1970, facilities for training in demography have been expanded notably through the establishment of the University of Ghana Population Dynamics Program and E.C.A.-sponsored Regional Institute for Population Studies (RIPS). Another important problem relates to data processing. To date the published volumes ofthe 1970 census contain mainly population statistics of localities and very little analysis of the data.

C. Demographic Factors

In 1921, the population of Ghana was just over 2 million. By 1960 it had reached 7.1 million and in 1974 it is estimated to be close to 10.0 million. The country is not densely populated, with an average of about 105 persons per square mile.

The crude birth rate of Ghana is estimated to be 49 - 51 per 1,000 and the crude death rate 19 - 20 per 1,000, giving a rate of natural increase of at least 3 percent per year. During the 1960's, the mortality rate showed a decline and this trend will continue with improved health service, thereby increasing the population growth rate unless there is an accompanying drop in the birth rate. It is recognized throughout Government that such a rate of growth adversely affects per capita income, employment opportunities, and the costs of provision of social services such as education and health. (See Population Policy page 9 .)*

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[3] Op. cit.

* Population Planning for National Progress and Prosperity-Ghana Population Policy, March 1969, Ghana Publishing Corp.

Estimated sex breakdowns of the 1972 population show that females were in the minority and comprised 49.5 percent of the total population, versus 50.5 percent for males. This contrasts with trends in other parts of the world, where more females than males are born. The difference in the population of Ghana can be ascribed, in part, to the large preponderance of males in the immigrant population (a ratio of 170 males to 100 females). These immigrants, who made up over 8 percent of the total population in 1960 came mostly from the neighboring countries of Togo, Upper Volta and Nigeria. The sex ratio also varies in different parts of the country, suggesting internal male migration to areas of greater economic opportunity. For example, males are relatively more numerous in the newly developed cocoa planting areas of the west and central lowlands, while females predominate in the more isolated and underdeveloped northern part of the country.

Some inferences have also been drawn regarding the age breakdown. It was estimated that in the late 1960's half of the population was under 18 years of age. This is in general agreement with the population breakdown of Ghana by age and sex which was prepared following the 1960 census. At this time, the population 19 years of age and under was 53 percent of the total (compared to about 39 percent in the U.S.) and the population aged 14 and under was 45 percent of the total. Considered another way, if 45 percent of the population is in this age group between birth and 14 years, and 3 percent in the group aged 65 and above, that leaves 52 percent in the economically active age groups between ages 15 and 64 or 48 percent dependent population.

II. Population Growth

A. Factors of Population Growth

1. Attitudes:

There are indications that prevailing attitudes towards ideal family size present a real stumbling block to population control. A study prepared by Dr. John C. Caldwell, The Control of Family Size in Tropical Africa, shows that Ghanaian attitudes generally favor even larger families than in many of the other underdeveloped countries. The international range of "ideal" family size is 3.2 - 5.0 children, while in rural Ghana it is 7.5. Among the Ghanaian urban elite the range is 4.3 - 6.1 children. The percentage wanting four or more children in the international range is 25 - 80 percent;

in rural Ghana it is 98 percent, in urban Ghana 94 percent, and among the urban elite 89 percent. Any change in this desire for a large family will require time , the introduction of well planned public education and perhaps other changes such as better health services and reduced infant mortality giving rural mothers a reasonable expectation that their children will live. While studies which seek to determine desired family size can be deceptive, because respondents might answer in one way and act in another, the available data certainly support this strong pro-natalist tendency.

Reasons most often cited for wanting a large family include: additional labor on the farm or in the home, a mark of prestige or honor to the parents, support and comfort to parents in old age, and survival of the family line. Reasons cited for not having many children were most frequently the cost of supporting and the difficulties of raising them, crowding, noise, etc. These responses may indicate possible lines of approach to promote the desirability of small families.

2. Migration:

Accra proper has an estimated population of 850,000 and Kumasi, the second largest city, has some 350,000 inhabitants; four other cities have populations of over 100,000. The population in cities of over 5,000 is estimated to be about 30 percent of the total, but cities are growing more rapidly than rural areas. Available data suggest that the two largest cities, Accra and Kumasi, grew by 22 percent and 39 percent, respectively in the five-year period from 1966 to 1970. Foreign immigration has been largely stemmed by enforcement of the Alien Compliance Order of 1969, which brought about the deportation of a number of aliens.

The problems posed by such explosive growth are serious. The available health and social services are strained and the rural-urban migrants often arrive lacking urban skills. With employment opportunities limited they find themselves on the fringes of the social and economic society to which they aspire. Much of the urban growth, in fact, has been in the form of shanty towns just within or outside the city limits. Dwellings are constructed of any available material and environmental sanitation is often completely lacking. Sometimes the new arrival settles temporarily,

or permanently, with a barely established member of the extended family. This results in additional crowding of scarce housing. Such conditions are conducive to the transmission of communicable diseases, with the spread of infections aggravated by poor sanitation. On the other hand, even with deplorable housing and sanitation, the migrant does have some health services available that may have been completely lacking in the areas from which he came.

B. Relationships between Population Growth and Development

The relationship between the burgeoning costs of providing adequate social infrastructure -- such as schools, health facilities and public housing -- and a burgeoning population is a direct one. But some aspects of the relation between population and economic development also deserve notice. The following touches on some of the effects the high rate of growth is having on economic and social conditions of the country:

1. Relationship to National Income:

If there is no net external investment, the per capita income would fall 8 percent at present fertility levels and expected lower death rates between 1970 and 1985. With a fertility rate decline of 1 percent per annum, per capita income would rise by 9 percent and with a decline of 2 percent per annum, it would rise by 24 percent. In addition, the rapidly expanding population phenomenon has an effect on economic stability and the balance of payments situation of the country and these problems are being multiplied by energy related inflationary pressures and rising costs of imports. For example, the cost of imports of foodstuffs, raw materials, machinery, transport equipment, spares and petroleum, the major import items grew from ¢369 million in 1972 and ¢536 million in 1973 and the 1974 (8 months) figure stood at ¢630 million. Such increases are in part related to numbers of people and consequent rising demand for imports. The exportation of the major items, cocoa, timber and products of the mining sector is either inversely related to the growing population or is neutral.[4]

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[4] Mined products such as gold and diamonds are "neutral". Cocoa competes for land with growing foodstuffs requirement. Timber for export not only has to compete, for land, with domestic foodstuffs but also with an increasing demand for domestic usage of the timber itself.

2. Relationship to the Size and Quality of the Labor Force

The labor force of Ghana is about 40 percent of the total population, or about 3.5 million people. This force has been growing faster than job opportunities. During the next five years, about 800,000 persons will be added to the labor force. Making allowances for retirements and deaths, this means that about 130,000 to 140,000 persons will enter an already crowded labor market annually. Most of them will be young, inexperienced workers, many of whom will come from the rural areas to the already overcrowded cities. Projections show that the increase to the labor force would be on the order of 2.8 percent annually between 1965 and 1970, and 3.7 percent annually after 1970. Even with a decline in fertility there would be little reduction of the labor supply for 15 years.

3. Relationship to Agriculture

The bulk of Ghana's labor force is employed in agriculture and related activities. This situation will undoubtedly continue for some time. Indications are that government plans for the agricultural sector project a growth rate of 3 - 4 percent compared to a population growth of about 3 percent per year. Even if this agricultural growth rate is realized, it does not mean that employment opportunities will expand by an equal percentage. It is estimated that, under the most favorable circumstances, farm labor will not be able to absorb more than 50,000 - 60,000 persons per year. The strain on food supplies to feed 300,000 more mouths per year will be serious.

4. Relationship to Education

Enrollment and expenditures for public education have grown at a rapid rate during the last decade. Public outlays budgeted for education in FY 1975 are estimated at ¢121.5 million, up from ¢104.3 million in FY 1974. (1N¢ New Cedi, approximately equal to US$.87 at the time.) The figure for 1974 - 75 represents some 13 percent of the government's total current and capital expenditure budget. Primary, middle and secondary school enrollments have climbed from about 600,000 in 1960 - 61 to about 2.0 million in 1972, more than doubling the load on education facilities in less than a decade.

5. Relationship to Delivery of Health Services

In keeping with most developing nations the life expectancy of Ghanaian people has primarily, as a result of the gradually improving application of more modern methods of public health and medical practice, increased markedly in the past 50 years. In fact, as stated in the policy paper "Population Planning for National Progress and Prosperity" analyses indicate that the expectation of life at birth for the average person has risen from about 28 years in 1921 to 48 in 1970. This represents an increase of about a half year of life expectancy on the average with each passing year, a rate which if continued will give a life expectancy of 53 years in 1975. This is a highly desirable trend, but it means that if it continues and fertility does not decline, the rate of population growth will continue to climb above the present rate of three percent a year.

The Population Policy Statement (See Section III) states "that improved health and nutrition are among the major goals of development and will be vigorously pursued. Government assigns highest priority to providing more health serv ices and improving their quality. The emphasis will be on protecting the safety of drinking water, adopting better methods of sanitation and refuse disposal, and giving more inoculations, butter maternal and child care, and expanded health education. As these programs are implemented, the most probable result will be an improvement in health and a decline in rates of sickness and death, particularly infant deaths."

It is clear that health measures will continue to be pushed, as a matter of policy, by the GOG. If one takes into consideration the increasing effectiveness of these measures (e.g. the recently completed eradication of smallpox and the advent of highly effective measles vaccination program) to mention only "the tip of the iceberg" one can only conclude that the trend towards increased life expectancy so dramatically evident in the past will become even more pronounced in the future. Thus, "death control" without concommitmant fertility control would lead inevitably, and sooner than later, to all the consequences of rapid population growth referred to in the quoted "White Paper".[5]

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[5] Population Planning for National Progress and Prosperity, pages 7 - 13.

Paradoxically one of the consequences is "the negative effect of excess childbearing on individual and family health and welfare". Consequently, although health measures will increase life expectancy and the quality of life on the one hand they reduce it on the other unless fertility control is part of the program.

Conclusive statistical evidence of the latter effect is not yet widely available in Africa. However, knowing what we do about the conditions required for continuing health of children and mothers the conclusion seems inescapable. In addition, Cantrell, in a 5 year prospective study of a rural district sampling in Senegal[6] showed a clear inverse relationship between age of weaning and childhood mortality (ages 1 - 4). If the child is "weaned during the following pregnancy the probability of death within one year of weaning increases from 50 to 150 %. "

Finally, one should point out under this heading that the most careful consideration should be given to the question of how and where within the Ghanaian socio-cultural milieu and the Ghanaian social service infrastructure, family planning services should be introduced. Unfortunately, the "White Paper" previously referred to raises the question[7] as to "whether Ghanaians will accept family planning" and points out that "certainly the large family norm seems well established in the population and most women would probably like to have 5 or 6 children". But the paper never really zeroes in on the basic issues involved, vis a vis health programs except to say that "A population program will require close linkage with the national health program" and "the vigorous pursuit of further means to reduce the still high rates of morbidity and mortality will be an important aspect of population policy and programmes.[8]

Without going into extensive detail on this issue suffice to say that, as pointed out in the WHO Technical

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[6] "Breast Feeding, Mortality in Childhood and Fertility in a Rural Zone of Senegal", P. Cantrell, Population Studies, Vol. XXV No. 3, November 1971.

[7] Population Planning for National Progress and Prosperity, para. 4.13, page 17.

[8] Ibid para. 5.7, 5.8, page 19.

Report # 428 [9] "There are many advantages, both administrative and technical, in integrating family planning into MCH services". We accept this as an essential element, of the many steps required to assist the GOG in establishing and implementing an effective family planning program. Thus, in summary, it seems rather well-established that:

1. Health measures without fertility control will, in the African and Ghanaian setting, most likely prove to have a large counter-productive element in the long run as far as the health of mothers and children is concerned.

2. Child spacing and, particularly, steps to promote continuation of breast feeding and delay of weaning until the child reaches at least 18 months of age would themselves constitute a major improvement in the public health armamentarium.

3. Fertility control measures which fail to include maternal and child health activities in the total spectrum of such measures will probably fail to reach a large portion of the population at risk.

Mission strategy in approaching the manner and extent of its assistance to GOG in the family planning area places great stress on these latter two issues within the overall issue of inter-relationship between family planning and the delivery of health services, especially to the most rural and least well-off segments of Ghanaian society.

III. Population Policy and NFPP Organization

A. Policy [10]

Ghanaian population growth attracted attention after the 1960 census showed an increase of two-thirds over the 1948 census. Atlhough President Nkrumah believed the economy could support that rate of growth, the 1963 Seven-Year Development Plan warned that the rapid population

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[9] The Organization and Administration of Maternal Child Health Services, WHO, Technical Report Series, Geneva 1969, page 20.

[10] Source: Draft 5 year plan, NFPP, 1973.

increase would impede development and strain the economy. After the overthrow of Nkrumah, the 1966 - 69 Military Government took definite steps toward formulating a population control program. This interest was stimulated by a study sponsored by the Ghana Academy of Science and the Ford Foundation, A Study of Contemporary Ghana,[11] which appeared in 1966 and 1967. The study pointed out the economic savings that could be realized by reducing the rate of population growth. The Two-Year Development Plan published in 1968 referred to the intention to establish family planning services. In the same year the Ghana Manpower Board prepared a statement of national population policy which was published in 1969 as an official policy paper, Population Planning for National Progress and Prosperity. This paper recognized the need for a national population policy as an integral part of national social and economic planning and included some recommendations on how to achieve specific objectives albeit details were, of course, to be developed later. Some of the major policy recommendations are summarized as follows:

1. Details of the population program were to be developed by participation of national and regional, public and private entities.

2. Reduction of morbidity and mortality were to be an important part of the program.

3. Quantitative goals were to be set on the basis of reliable demographic data.

4. The Government would encourage and provide information and assistance to persons wishing to space or limit the size of their families, but this would be done through persuasion rather than coercion.

5. Efforts would be made to expand the non-domestic role of women in the economy to reduce pro-natalist influence.

6. Policies would be adopted to regulate internal migration and immigration.

7. Agreements with international public and private organizations would be developed to benefit from their experience and assistance in population programs.

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[11] A Study of Contemporary Ghana, Volume Two, Some Aspects of Social Structure, Birmingham, Neustadt and Omaboe, George Allen and Unwin Ltd., London

B. Organization:

The planners recognizing the close relationship between family planning and socio-economic development established the National Family Planning program as part of the Ministry of Economic Planning . There is a National Family Planning Council which is Advisory to the Programme and has very broad representation, embracing all major identifiable national bodies, professional, educational religious and cultural. Although this body has no executive functions and meets very infrequently (about two or three times yearly) it is nevertheless seen as an important instrument through which accredited representatives of the country's major identifiable groups with diverse interests, could pronounce responsibly, periodically, on the operations of the National Family Planning Programme.

The Council has three important Advisory Committees namely:

1. A Programme Advisory Committee which comprises heads of the major participating agencies of the Programme and assists the Executive Director in conducting the affaris of the Programme.

2. A Medical Advisory Committee.

3. An Information and Education Advisory Committee.

4. A Research and Evaluation Advisory Committee which advise on technical aspects of the Programme.

The plan was to provide family planning services throughout the entire network of Ministry of Health facilities, including the government hospitals, which are reasonably well distributed, (at least in the southern part of the country). These hospitals would also serve as family planning training centers for medical and auxiliary health personnel. Sufficiently trained professional medical personnel versed in family planning concepts are in short supply in Ghana, therefore, auxiliaries were to be used to the extent possible especially in rural areas.

In theory, the Ministry of Health was to have the responsibility for provision of contraceptive services, health education and basic training of the necessary

health personnel. The Ministries of Information, Education and Agriculture would be responsible for some aspects of the public information and education component of the program.

In the private sector two family planning organizations, i.e., the PPAG and the Christian Council had indicated willingness to participate actively in the work of the Programme. As a result, the PPAG now provides an important part of the contraceptive services offered in the National Programme and plays a significant role in the training of fieldworkers and in the promotion of information and educational campaigns. A similar role is played by the Christian Council which also offers counselling services to engaged and married couples.

C . Comment

Although several members of the ruling National Redemption Council (NRC) including the Chairman and Head of State, have on many occasions spoken on the problems of rapid population growth and delivered speeches which express Government support for a population program, such speeches and exhortations are not translated into any real action plan involving and encouraging concerned Ministries.

The Ministry of Health, for the most part, has preferred to ignore family planning or has considered it an extra burden to be avoided rather than acknowledging it as a vital part of maternal and child health care. In any case, it is very clear that the Ministry 's weakness in planning and management would have a direct negative bearing on the success of the family planning program even if and when the latter becomes an accepted and normal part of an integrated MCH/family planning program.

IV. NFPP Five Year Development Plan

A. Summary

In 1973, the Population Dynamics Program of the University ofGhana arranged for a U.S. advisor to assist the NFPP in developing a five year plan. The Ministry of Economic Planning received the document for a review and approval over a year ago but no reaction to the draft is yet available.

The overall goal of the plan is to reduce the rate of natural increase of the Ghanaian population from its present level of 3.0 per cent per year to 1.75 per cent per year by the year 2000. However, even though the rates of natural increase will be almost halved, total population size will by 2,000, be about double its 1974 reported size.

In the interim and in pursuance of this long term goal to reduce population growth rates the plan calls for an intensified NFPP effort to service more effectively the FP needs of that portion of the population that wants its services while at the same time creating an environment conducive to generating increased demand for FP services. Specifically, the plan calls for the following operational and supportive targets as intermediate objectives:

(i) FP clinics offering full range of services should be increased to 200.

(ii) Commercial outlets for distributing non-prescription contraceptives should be expanded and strengthened beyond the present 600 GNTC retail outlets.

(iii) Day clinics should be established at district and village levels using mobile health and FP teams.

(iv) Each FP clinic should be staffed as follows: One FP nurse, two FP auxilliaries, one community health educator, one clerk and two field-workers.

(v) Traditional birth attendants should be recruited and trained for the provision of health and FP services at the village level.

(vi) Training of physicians, FP nurses and auxilliaries and community health nurses will be intensified at the rates of 50, 45 and 120 per annum respectively.

(vii) In addition part-time and full-time fieldworkers will be recruited and trained at the rates of 99 and 100 per year respectively.

B. Comments on Five Year Plan on Population

An analysis of the plan shows some weaknesses:

1. Whereas the document describes concisely both long term and intermediate operational objectives, the plan fails to outline the operating steps necessary to meet the objectives and the policy changes (primarily personnel policies) required to implement the program. The implementation plan is primarily a forecast of proposed annual inputs from GOG and donor agencies.

2. The GNFPP structure includes a National Family Planning Council and a Program Advisory Committee, with various sub-advisory committees. The concept is well intended in that its members are multidisciplinary and could provide a needed forum for promotion and integration of the various aspects of the program in the various private and government agencies. The extent to which the advisory system will work, however, is dependent on the managerial and administrative capacity of the Secretariat which is already burdened with operational problems and has had difficulty in providing the necessary leadership to coordinate such activities.

3. The immediate objective of the plan (1974-1978) is to intensify the service component and to increase the demand for family planning services. Considering the present staffing and distribution system, it is doubtful if this objective can be reached in the absence for the time being of a solid linkage to the health services, and without an accelerated training program for FP workers and re-organization of the commercial supply system.

4. The plan emphasizes the need for changes in the attitudes of the people towards acceptance of family planning as a means to progress and a better life. In this regard research, and the Information and Education components must be substantially improved.

5. The extent to which the plan will be viable will depend on the development of a strategy or plan of action which utilizes all the available resources of the Government including the essential Ministry of Health component and which accords to the program the degree of high-priority governmental support absolutely essential for optimum implementation. It is fortunate that Ghana does have a published statement supporting population control as a matter of national policy and a relatively good base of human resources and facilities for training the personnel necessary to implement the policy. However, government personnel policy changes are needed to attract and retain these personnel in the government services and, above all, a solution must be found to the present counter-productive conflicts of policy and interest between the various agencies which must participate in the program for it to be effective.

C. Financial Support

The NFPP has enjoyed adequate budget support with major program budget support (Title II 104 (h) provided through AID. This U.S. local currency support has been phased out and FY-74/75 requirements have become a regular part of the GOG budget. Annual budgets of the GNFPP have been as follows:

FY 1971	-	¢320,000 104(h)
FY 1972	-	505,000 104(h)
FY 1973	-	500,000 104(h)
FY 1974	-	737,000
FY 1975	-	959,000 (Estimated)

V. External Assistance/Family Planning Programs

A. U.S. Assistance

To date, the largest proportion of program costs have come from outside sources. The U.S. is by far the largest donor. Under the PopulationSupport Project (068) contraceptives for both clinic and commercial distribution are provided in addition to training opportunities and program budget support (the latter now completed). The largest single effort is the ongoing Danfa Rural Health and Family Planning Project (055) described below under 'Research.' Related and important to the success of the entire program is the assistance to be provided to the MOH under the USAID Management of Rural Health Services Project (068). This project is directed at improving the planning and management capability of the MOH and will also be important in implementation of Danfa Health/FP research findings. The AID/W supported (UNC) Population Dynamics Project at the University ofGhana, has assisted the NFPP in developing its five-year plan which is to become a part of the overall GOG Five Year Plan.

B. Other Bilateral and International Assistance

Other bilateral donors include the British ODA, and Canadian CIDA which assist in the Information and Education area by providing technical assistance and some commodities. International donors - IPPF, FPIA support local private organizations (under NFPP supervision) which offer more FP services at the moment that the official program. The NFPA has in the past provided training opportunities and vehicles to the NFPP. Ford Foundation has recently commenced providing considerable technical assistance to NFPP in administration and has made the services of one of its local staff available to GNFPP for this purpose.

C. Research

Danfa Rural Health and Family Planning Project

The Danfa Project is a comprehensive rural health and family planning demonstration, teaching, and research program initially developed by the Department of Preventive and Social Medicine of the Ghana Medical School in 1965, and implemented under contractual agreement with UCLA and the Agency for International Development in 1970. During its estimated eight year duration, the project will assist the Ghanaian government in identifying ways to improve the health and welfare of the rural population by means of enhanced effectiveness in the delivery of health care and family planning services. Part of this program

consists of helping to train medical students, graduate physicians, and other categories of health personnel to work in a team framework in rural areas.

Health conditions and practices in four selected areas are currently being studied. Villagers' attitudes and practices concerning family planning are being studied and results of these studies will aid the National Family Planning Program. A detailed analysis of cost-effectiveness is being undertaken to provide Ghana's Ministry of Health and the Ghana National Family Planning Program with information necessary to utilize available resources to the best advantage. Socio-economic studies are also being carried out as part of the Project in an effort to determine the impact of socio-economic factors on the acceptance of family planning. Among other things this information will be useful in determining whether there are certain socio-economic factors which must be present before the rural population is willing to accept family planning.

The project represents a major effort to carefully evaluate three alternative approaches to implementing the national family planning policy in a rural area. Service methods are utilized which are seen as lying within the present and anticipated near-future fiscal and manpower potential of Ghana. Most of the project's research and evaluation activities, are not intended to be continued beyond the present project, although elements of the research phase such as record systems procedures, functional analysis, etc. may be built into ongoing MCH evaluation activities eventually.

VI. Status

A. General

As a result of the policy to promote family planning activities, and the availability of donor assistance, there has been activity among government, educational and private organizations in Ghana. This may be summarised as follows: 1) The Secretariat, in its role as coordinator of the entire NFPP, has been active in mass communications, such as its "family planning week" in which the importance of spacing births is promoted through such mass media advertising as radio, TV, newspapers, billboards, speeches, community meetings and displays. 2) The Secretariat operates the principal ongoing family planning training programs in the country. This program has trained nearly 200 FP nurses and auxilliaries, and over 1,000 part-time field workers. In addition, several other personnel of participating agencies have

given brief orientations in family planning. An active participant has been the Department of Social Welfare and CommunityDevelopment which has conducted FP training for some 900 field workers. (See Table 2, page 28 - NFPP Local Training Program, 1970-1974). 3) The NFPP operates a subsidized commercial distribution system for contraceptives and supports this system through national advertising campaigns. The Ghana National Trading Corporation (GNTC), the largest nation-wide distribution firm is under agreement to distribute foam and condoms through its 600 retail outlets. In addition, there are a further 2,000 private retail outlets distributing condoms and/or foam. Arrangements are being made to expand the commercial program through utilization of some other nation-wide distribution firms like the United Africa Company (UAC), Union Trading Company (UTC) and Pioneer Tobacco Company (PTC). 4) The number of FP acceptors has increased but acceptor rates are still insignificant in terms of the total fertile female population. InFY1971, there were 20,470 acceptors recruited through the various FP clinics. Complete figures in non-clinic acceptors were not available, but it was estimated on the basis of sale of 532,080 kits of foam that a further 40,000 people may have accepted FP, not counting those using condoms. In FY 72, clinic acceptors rose to 25,400 and 32,000 in FY73. To date, cumulative number of new acceptors stands at 119,228. No information is available on continuing contraceptors (See Table 2 page 23 of this assessment for Summary Report on Acceptors of FP Services.)

B. Progress to Date and Assessment

1. Contraceptive Distribution

At the start of the family planning program oral contraceptives were available in the private sector but their high cost limited their use to the highly motivated middle class. The level of use of condoms and IUDs at the time was not known, but the estimated total number of fertile Ghanaian women and of all adult males using some form of contraception was probably less than a few percent of the total population in those age groups even though studies have shown that knowledge of some method of contraception was relatively widespread.

The pill, one of the most effective contraceptives ranks highest in present usage, accounting for nearly 50% of all methods used. Demand for IUDs has declined in recent years to only 13% of all methods used. Other contraceptives available

include foam and foam tablets, diaphram, injectables and condoms. However, despite the availability of these modern contraceptives, the traditional rhythm method still prevails as a form of contraception. Gaisie's "National Demographic Sample Survey - 1968/69" showed that the commonest method still used is rhythm. Of the 21,484 women interviewed, 516 (2.4%) practiced some form of birth control and of these, 412 (80%) used the rhythm method. We assume that the national ratio of contraceptors now is much greater than the 2.4% considering the increased information and promotion of family planning since 1969. Preliminary data from the Danfa research program has shown acceptor rates in one area offering Comprehensive Health and FP services at 15%.

In the commercial contraceptive distribution program, nation-wide coverage is yet to be achieved. Only one of the several nation-wide distribution firms has been utilized to date. Even then, these retail outlets have until very recently been without contraceptives whereas the central warehouses were nearly always over-stocked. Currently, it is estimated that the commercial program is reaching only 10,000 - 12,000 contraceptors. There is a need for constant monitoring of retail outlets to ensure constant availability and promotion of the contraceptives. With increased use of other nation-wide distributing firms,and with foam and condoms provided at subsidized prices, demand should increase.

Contraceptive utilization is summarized in following Table 1 recently received from the GNFPP Secretariat.

TABLE 1

SUMMARY REPORT ON ACCEPTORS OF FAMILY PLANNING SERVICES JULY - SEPT., 1974

By Agency	No. of New Acceptors July	August	September	Cumulative To Date	Cumulative Total Visits
MOH	1,076	1,027	882	54,869	178,833
PPAG	1,929	885	1,533	46,869	195,224
* CCMFL	327	290	338	8,923	27,665
OTHER	352	195	181	8,849	41,707
	2,684	2,297	2,934	111,228	443,429
By Method					
IUD	263	237	216	15,676	
PILL	1,797	1,384	1,463	60,565	
OTHER	1,624	776	1,255	42,987	
	3,684	2,397	2,934	119,228	
By Region					
Western	318	397	314	15,308	48,934
Central	288	322	512	9,328	32,219
Greater Accra	994	566	651	33,805	135,893
Eastern	362	301	334	14,376	51,321
Volta	273	331	279	7,586	17,556
Ashanti	1,030	155	611	26,656	108,932
Brong Ahafo	180	196	62	6,948	28,904
Northern	162	129	134	3,619	12,722
Upper	77	-	19	1,602	6,948
Totals	3,684	2,397	2,934	119,228	443,429

*Christian Council for Mother and Family Life

2. Family Planning Services

a. Coverage:

The present number of FP clinics (183) is not unduly low. However, geographic distribution tends to be in the south with large populations up-country served with only a few clinics. Moreover services are not continously available throughout the week: in most cases, clinics are opened for about 1 - 1½ hours a day once or twice a week. This is particularly so in MOH clinics (85) where adequate motivation and training is a major problem. Abrupt and untimely transfer of personnel without necessary arrangements for replacements further limits availability of services in these clinics. The low number of contraceptors recruited since 1970 (119,228) is an indicator of poor coverage. This figure represents less than 2% of the total fertile female population.

The fiscal year 1972/73 witnessed an increase in the total outlets for family planning services. However, activity in 1973/74 was disappointing.

These outlets are broken down by agency as follows:-

	1971/72	1972/73	1973/74
Ministry of Health Clinics	72	85	85
PPAG	18	19	21
Christian Council (CCMFL)	4	7	12
Other (Mission, Private And Danfa Project)	44	49	49
	138	160	167

b. Relationships and Integrated Services

The relationship between health and FP services is an important problem being faced by the NFPP secretariat which acknowledges that only certain elements of the program can be effectively controlled by the NFPP and the others are outside of its control and must rely on participating agency support especially, the MOH. The concensus is that the appropriate framework for a large segment of the family planning effort lies within the health infrastructure. The reasoning, partly economic, is that Ghana cannot afford to fund or duplicate manpower and facilities to develop specialized national family planning services in parallel with comprehensive MOH health services. In Ghana, the realization has grown over the last few years that only in the

context of family health will family planning be acceptable to a majority of the population. Experience in the Danfa Research area seems to have already confirmed that FP can be highly acceptable if offered as a health and family welfare measure. Integrated health/FP services also side-step criticisms of FP as a "Western imperialist conspiracy" to keep down "Third World" populations.

In the original plans of the GNFPP, the Ministry of Health as a participating agency was to cooperate by making its hospitals and other health facilities as well as staff available for FP services, which were to be embodied as part and parcel of all maternal and child health (MCH) services. Seen in this perspective, FP should represent one of the most important adaptive mechanisms in public health to achieve the modernization goal of individual physical, mental, and social well-being.

Unfortunately, even though the MOH has made some health facilities and personnel available to the NFPP there has not been any effective move fully to integrate FP into health programs either at the Ministerial or operational levels. Thus both MOH management and clinic personnel have tended to consider FP services as non-related and additional work to be done without remuneration. In terms of new acceptors recruited, MOH facilities (85) account for less than 40%, whereas the solely FP clinics operated by PPAG and CCMFL (33) account for nearly 60% of acceptors.

3. Information, Education and Communication

Illiteracy, poor communication and the continuing high burden of disease and death in young children preclude the rapid acceptance of FP services. In a country where cultural norms still ascribe great social prestige to the number of children born and alive, motivation campaigns need to be more adapted to suit a population, 70% of which is illitrate.

The publicity efforts of the NFPP seem to be affecting urban populations. Public information on the available services is channeled through news media, including film strips, pamphlets, and audio-visual material. The theme used throughout is respectability, availability, convenience and safety of family planning methods. However, it appears from past and recent GNFPP reports and from Mission staff field reports, that the IEC program is still not reaching a significant proportion of the rural population.

4. Summary

In summary, the results of the GNFPP program to date have been quite poor. Of the targets established in the 1970/75 GNFPP/USAID Population Program Support project (064), the 167 clinics actually offering family planning services slightly exceeds the target of 160 but only 79 FP nurses and 90 FP auxiliaries and community health nurses have been trained by all participating agencies as compared to the 120 and 420 projected (See Table 2) and only one third of the 96,000 new acceptors projected were actually attracted to the program. In the commercial sector it was planned that by 1972, 5,000 retail outlets were to be selling subsidized contraceptives but as yet, the 600 outlets of the Ghana National Trading Corporation are the sole distributor and their efforts can only be described as grossly inadequate although a recently re-negotiated agreement with GNFPP may have a favorable influence. Thus except for the number of clinics offering services (with admittedly low efficiency), less than half of projected targets have been reached.

TABLE 2

NFPP
LOCAL TRAINING PROGRAMMES 1970-1974

A.	Ministry of Health		
		Types of course	No Trained
	1.	Doctors	-
	2.	Family Planning Nurse	48
	3.	Family Planning Auxiliaries	70
	4.	Community Health Nurses	20
		Total	138
B.	Department of S.W.&C.D.*		
	1.	Briefing for part-time field workers	768
	2.	Training for full time field workers	149
		Total	917
C.	Information Services Department		
	1.	Briefing for part-time field workers	33
D.	Ministry of Agric. - Cocoa Division		
	1.	Briefing for part-time field workers	22
E.	P.P.A.G.		
	1.	Family Planning Nurses	12
F.	Christian Council		
	1.	Family Planning Nurses	9
G.	Military Hospital		
	1.	Family Planning Nurse	1
H.	Danfa Project		
	1.	Family Planning Nurse	1
I.	Private		
	1.	Family Planning Nurses	8
J.	Centre for Civic Education (Now defunct)		
	1.	Briefing for part-time field workers	120

*Social Welfare and Community Development

VII. Future Assistance

A. General Comments

1. The Ghanaian program is considered by most observers as the most potentially viable program in West Africa. The principal constraints have been identified and can be corrected with moderate external assistance inputs and full cooperation/support from the GOG. However, the program has only now reached the stage of maturity at which the proposed inputs make sense and can be properly absorbed and utilized, i.e., budget, organization and basic infrastructure is in place. We believe furthermore that there can be a reemergence of enthusiasm and priority on the part of the participating agencies (Health, Education, Agriculture, etc.) for common action through an integrated sector approach, i.e., family planning within broader maternal and child health services within a comprehensive health and nutrition program.

2. It is important to note that in development of the capacity to deliver MCH/FP services, the USAID program already has a valuable resource in the ongoing studies and research of the Danfa project. There is an excellent opportunity to apply Danfa project experience on a larger scale. Already some elements have been shown as viable, e.g., organization and training of traditional birth attendants (TBA's); design of manual for staff job description and evaluation; data gathering and data processing; "extended program" (mobile unit provision of FP information and services); FP acceptor follow-up procedures, etc. In addition, the ongoing Danfa socio-economic studies will provide valuable data for the information and education activities and other aspects of the program.

B. Major Issues

1. Vital and health statistical data in Ghana are incomplete and deficient. There is no reliable information on FP acceptors, and continuation rates.

2. Available health resources are not being used effectively. Acceptance of FP as an important component of health care especially within MCH is lacking. Extremely high infant mortality and morbidity are indications of poor Health/FP coverage and probably constitute a major restraint on acceptance of FP services by rural families.

3. Poor transport, communication, ignorance, harsh and inimical environment, poor nutritional status, unhealthy habits and practices and a number of cultural factors (including, in many rural areas strong pro-natalist tendencies) are all constraints to delivery and acceptance of FP services and more research is required to find solutions to these problems although several possible approaches have already been demonstrated by existing research (Danfa and other projects).

4. Reappraisal, reorganization, strengthening of NFPP Secretariat should be considered. Executive Director is overburdened with operational responsibilities.

5. Ongoing Danfa research indicates that communication and/or information on Health/FP concepts does not effectively travel over a radius of 5 - 15 miles from even the most efficient (Danfa) Health/FP establishments. Consideration must be given to massive upgrading of outreach through other agency extension service (Agriculture, Education) and with mobile service support from fixed health/FP facilities.

6. Effectiveness of improved planning and management as well as an intensive commercial distribution system and increased activities of the voluntary agency FP component (PPAG and CCG) should be tested on a pilot basis over a large geographic area to determine whether implementation on a national scale of any or all of these elements is desirable.

C. A.I.D. Strategy

Reference is made to the population priorities paper prepared by the Ghana Mission and PHA/POP in 1973 which provides demographic data, fertility patterns and Action Agenda. The priorities listed in the action agenda are summarized below:

1. Complete planning process---consultants needed--ensure that results of Danfa project research are fed into planning process---

2. Further improvement of the commercial distribution program--- assist by sending consultants---

3. Mount effective IE&C campaign---GNFPP could mount this with assistance from USAID and CIDA.

4. Initiate research program---AID can utilize existing contracts---funds are available in central contracts---

In addition to the above efforts will be made to strengthen the integrated health service approach within the MOH as one of the essential elements in a total delivery system involving the GNFPP, MOH and joint MOH/ Ministry of Economic Development Nutrition Unit. The USAID-planned assistance in modernizing planning and management structures in GNFPP and MOH and the activities of the Nutrition Unit, will complement each other; and the success of each is critical to the attainment of the sector goal. It is also planned that Title II resources will be focused on support of these programs as appropriate. Other supporting USAID activities will involve management training at the Ministry of Agriculture and closer coordination with the AID-centrally funded University Teaching of Population Dynamics project.

The conceptual exposition of the approach described is as follows:-

1. The intermediate goal is to make family planning services and information available and accessible to all, particularly in the rural areas. Ways must be found to expand family planning information, provide for more efficient use of MOH medical professional and para-professional manpower in delivering integrated MCH/FP services, improve and extend FP services of volags and vastly increase availability and use of non-prescription contraceptives.

2. The development of GOG health administration planning and management competence and skills is crucial to USAID's overall strategy for an effective population program. As an integral part of general health care, a

successful family planning program depends, to a considerable extent, on the availability of skilled health personnel and competent management and administration. The Management of Rural Health Services Project (068) becomes central to achieving advances in the entire health delivery system. This important effort to improve MOH planning/management competence should also be used to assist the NFPP in improving management and evaluation skills and enchancing cooperation and cordination between it , the MOH, the University of Ghana Medical School and the volags. The presence of USAID-funded management/ planning advisor/consultant in the MOH will give us a strategic advantage in assistance with development of this cooperative coordinative mechanism.

3. Success of the program will depend to a considerable extent as well on the ability of the NFPP secretariat effectively to plan and program FP resources and coordinate activities of all the participating agencies including the commercial firms undertaking distribution of non-prescription contraceptives. The Program Advisory Committee of the NFPP which is responsible for broad execution of policies and comprises representatives of the major participating agencies is fully functional. Its main objective at the moment is to identify an MOH official who will assist in implementing committee decisions relating to MOH. The inter-agency composition of the Program Advisory Committee holds out long-term prospects of increased commitment to the program by the participating agencies and consequently the willingness of agency heads to deploy more resources and personnel as appropriately required for program success.

The above conceptual scheme may be summarized in the following "organogram"-

		USAID	Other Donors
1.	Administration Management and Training	x	x (Ford Foundation)
2.	Program support, especially contraceptives and development of a Regional pilot area of concentrated effort		
3.	Commercial Contraceptive Distribution	x	
4.	Information and Education		x (BODA, CIDA)
5.	Research and Evaluation	x	

6. Additional Support to Volags x (Also AID/W)

In connection with implementing the types of assistance outlined above it should be pointed out however that certain short-term management consultant services are appropriate to specific components of the NFPP secretariat. But long-term consultant services must be carefully programmed because of present circumstances which dictate a low profile in bilateral assistance due to sensitivity to population issues by some interest groups. The present Ford Foundation assistance in this area may therefore be very appropriate.

D. Plan of Action

1. Administration and Training

In order to make this program work the administrative unit of the GNFPP will need to be strengthened to include an expanded planning and management unit which will be responsible for direction and coordination of the present divisions and will be delegated authority to implement the program. Under the present organization, the Executive Director carries pperational responsibilities whereas his role might more properly place greater emphasis on policy and ministerial coordination plus coordination of advisory councils and external donors.

During the planning period a full five-year participant training schedule should be developed for administrators, professionals and trainers. One option to overseas planning and management training of FP personnel is for expansion and utilization of the Agriculture Management/Manpower training concept (as in Project 070) using similar training personnel with additional MCH/FP qualifications and the same facilities.

2. Program Support

If the program proves increasingly successful the demand for and utilization of contraceptives should rise rapidly. To keep the pipeline full continued U.S.-program support, particularly in this area, will be needed for life of the project.

3. Commercial Supply and Distribution

Procedures must be developed to coordinate government/commercial outlet supply of contraceptives to the end users. Involved would be evaluation of Government and commercial warehousing outlets, transport, road systems, etc. Research to determine more efficient types of commercial contraceptive supply systems should be pursued to enhance client coverage. In this program, emphasis will continue to be on expanded distribution not only through nation-wide distribution agencies but also through private chemists and retailers.

4. Information and Education

This element of the project will focus on expansion of awareness of services available, locations of clinics and sources for non-prescription contraceptives. The main education objective, of course, is the creation of an awareness of the desirability of spacing or limitation of births. This information and education can be provided by all levels of MOH/FP personnel plus "agents" of other agencies. If the program is to succeed it will require the full involvement of all government personnel and expansion of the training/orientation programs, press relations, education materials production, etc. Note: The GNFPP budget given in the Five-Year Plan for this component is the largest recurring item and calls for extensive other donor assistance (British, Candian).

5. Research and Evaluation

Research needs, priorities and schedules must evolve with the program. The effects of certain interventions tried on a Regional (Governmental Unit) basis would be desirable. The aim, in general will be to enhance development and use of appropriate research and application of research findings such as those from the Danfa project, through effective program planning and evaluation. For example, research in determining how best motivation for FP can be achieved in a country with 70 percent illiterate population will provide information that can be utilized to modify present program directions to achieve more desirable results.

6. Continued Support to Volags

Since most AID assistance in this area (FP volag activity) is AID/W-based USAID action will be mainly

through promoting and assisting in any appropriate way, the functioning of volags as integral components of GNFPP.

7. New Activities

The more unique elements of the program are designed either to alleviate problems alluded to earlier as not being dealt with adequately by GNFPP or are being introduced because of experience and findings by the Danfa Rural Health Project. These include:

a. Since the use of a single large wholesale distributor for getting commercial contraceptives to the public has been less than successful we will propose the use of small retail outlets through the same wholesale system as other ubiquitous low-cost consumer items such as tobacco, common medicaments etc. In this way it is hoped the impediment to widespread coverage of the population due to a dearth of rural health facilities, transport and the aforementioned motivation and cooperation with MOH personnel will be partly finessed.

b. One region of Ghana will receive special attention in order to deploy a FP network which reaches a large percentage of the population with good services in an accelerated time frame. 11/ This model region besides providing quality MCH/FP services will serve a threefold purpose: (a) it can surface, in a compact area, potential bottlenecks of a full-blown nationwide program; (b) it will provide the GNFPP with valuable management experience in eliminating these bottlenecks, 12/ and (c) perhaps most importantly it will demonstrate the feasibility of making good FP services available to large segments of the rural population.

11/ The Five-Year Plan as originally drafted does not include this model Region concept. However, later discussion with GNFPP has initiated this proposal. Additional discussion will be necessary in order to develop a viable strategy and location.

12/ The Danfa Rural Health Project can provide useful inputs on a level from the health center down but it does not deal with the problems of supervision, logistics, etc., from the Ministry of Health level through Regional and District Offices nor does it have any implementing responsibilities in the MOH.

c. As indicated above, some clinic staffs will also form one or more mobile teams on a regular schedule. (Results of the analysis by the Danfa Project indicate that mobile teams offering only FP services are a promising adjunct to a MCH/FP program's efforts to reach the rural population.) Considering that vehicles are expensive and and the repair facilities of the GOG in rural areas are notoriously ineffective, in places where reliable private local transportation is available it is planned that the FP teams will utilize private transport as a cost-saving measure although availability of such transport will certainly be a moot point until tested.

d. Besides training for motivators in other Ministries, training and sensitization of the supervisory and management staff of these Ministries will be organized to elicit their wholehearted support to the GNFPP.

E. Partial Indicators of achievement - summary statement

The FP delivery system as envisioned by the end of the five-year period will have as its base the following major elements:

1. The management, planning and support staff of the GNFPP will be strengthened: training and retraining of managers and planners will help to ensure the effectiveness of the delivery system.

2. The research and evaluation unit will provide continuous up-to-date information on the status of the program and will undertake studies to measure the effectiveness of various interventions. This information will lead to improvements in the planning and service operations of the NFPP and the decision-making capability of the administrative unit.

3. There will be a vastly expanded commercial distribution program to provide access to contraceptives in areas remote from an FP clinic. These will be marketed at highly subsidized prices to ensure that they can be afforded by a large proportion of the rural population.

4. Two hundred MOH facilities (and an unstated but appreciable number of volag facilities) offering integrated FP services will be in operation. The FP staff at these facilities will include one family planning nurse, two FP auxiliaries, one community health nurse, two FP fieldworkers and one clerk (or suitable variant of this pattern in volag facilities). Members of this same staff will also form mobile teams as appropriate to provide regular family planning services to the hinterland surrounding fixed facilities. (The latter activity is to be carried out first on a pilot basis in one region.)

5. In order to inform and motivate potential contraceptors the GNFPP will provide training and remuneration (when necessary) for a cadre of I.E. and C. personnel from the Ministries of Education, Agriculture and Information, the Department of Social Welfare and Community Development and will increasingly utilize Volags and, where feasible, the traditional birth attendants, to provide both I.E. and C. and family planning services.