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POSITION PAPER:

GHANA

Operations Research Program

The Center For Population and Family Health

January 1987

Ghana

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Demographic Facts

Population: 14.3 million (1985 estimate)[1]

By The Year 2000: 23.1 million[2]

Doubling Time: 22 years[1]

Population Growth Rate: 3.2%[1]
Urban Growth Rate: 5%[3]

Percent of Population Under The Age of 15: 48%[2]

Life Expectancy At Birth: 52 years[4]

Infant Mortality Rate: 97 - 107 deaths per 1000 live births[2]

Child Mortality: 15 deaths ages 1-4 per 1000 live births[3]

Urban/Rural Population: 38% urban / 62% rural[3]

Population Density: 54 persons/square mile
198 persons/square mile arable land[2]

Crude Birth Rate: 47/1000[4]

Crude Death Rate: 15/1000[3]

Socio-Economic Data

Per Capita Income: US$ 310[2]

Educational Attendance: 68%
77% male / 60% female (1979)[3]

Literacy 48% of adult population
59% of adult male population (1980)
37% of adult female population (1980)[3]

Labor Structure: agriculture: 60%
industry/commerce: 10%[6]

Fertility Figures

Female Population: aged 14 - 44 years: 20.9%[3]

Total Fertility Rate: 6.5 - 6.8[3,7]

Average Age at Menarche: 15.4 years[5]

Average Age at Marriage: 18.1 years[5]

Percent of Unions That Are Polygamous: 17% for women 20 years or less
42% for women 35+[5]

Average Age at First Birth: 19.7 years
75% have first birth by age 23[7]

Percent Married: 97.7% by age 25[5]

Maternal Mortality: 50/10,000 in Danfa Region[8]

Desired Number of Children: 6[6]

Percent of Women Wanting No More Children: 11.7% of all women
22% of women 35 -39[5]

Contraceptive Knowledge: 78% of urban and 63% of rural women have heard of a modern method

Contraceptive Prevalence: 9.5% of married women and 8.6% of all ever-married women use a modern method[5]

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I. DESCRIPTION AND BACKGROUND

Ghana, the first African country to achieve independence from colonial rule, lies between Côte d'Ivoire to the west and Togo to the east and has at present a population of just over 14 million. The lush coastal area gives way to tropical rain forest and, continuing north, to the arid savanna. The lower two-thirds of the land contains three-quarters of the people and is richer and better educated. The north is generally poorer, less literate, and is predominantly Moslem. There are over fifty languages spoken, including that of the Ashanti, a large and powerful kingdom.

Ghana's demographic and socio-economic situation is similar to other countries in sub-Saharan Africa. The population growth rate is 3.2%; life expectancy, 52 years; and per capita income, US $310 per year. Almost forty percent of the population is urban and 48% of the adult population is literate. Fertility is very high (TFR above 6), infant mortality is above 100, and about one-third of all deaths occur before the second birthday. In the 1979/80 WFS, contraceptive use was measured at 8.6 percent for efficient methods, about one-half of that being the pill.

To assert today that Ghana's basic social and economic indicators are comparable to those in other African countries is to recognize the severe hardships the country has faced in the last fifteen to twenty years. In the 1960's Ghana enjoyed a fairly high standard of living compared with other West African countries. Import and export activity was extensive. Ghana's well-developed infrastructure, including health and education systems, was the envy of its neighbors. The expertise of

Ghanaian teachers and other professionals is attested to by the continual high demand for their services in other countries. However, during the 1970's, poor management, decreasing export production, and increasing cost of imports, particularly oil, culminated in massive economic setbacks. The lowest point was reached in 1983 when production - of foodstuffs (due in part to drought), but also of minerals, and manufactured goods - plummetted, causing what was in essence an economic standstill. The infrastructure crumbled, skilled workers fled the country, and political instability increased.

The economic reforms initiated in 1982 by Flt. Lt. Jerry Rawlings' government began to show signs of success by 1984. Increased rainfall also helped the situation. Although there is still extreme poverty in Ghana and the economic situation is by no means good, the situation is improving. Economic activity has increased and some Ghanaians have 'come home' from their posts in other countries, providing much needed human resources. The attitude in Ghana today appears to be optimistic, if guardedly so, and determined.

II. HEALTH AND POPULATION POLICY

In 1969, Ghana established the first official population policy in sub-Saharan Africa. The Ghana National Family Planning Program (GNFPP) was begun in the early 1970's to help meet the country's demographic goal of a population growth rate of 1.8 percent by the year 2000. However, as Dr. Fred Sai clearly articulated in his keynote address to the National Population Conference in Ghana in March 1986, subsequent activity has been insufficient to make that goal a reality. The GNFPP Secretariat is practically moribund. What services do exist have been provided by private organizations on a small scale. Nevertheless, active government participation in the National Population Conference has demonstrated that the government is determined to expand its role. An immediate goal is to increase contraceptive use through the MOH from two to six percent by the end of 1987.

In 1978, Ghana formulated a primary health care policy with a goal to provide PHC services to 80 percent of the population by 1990 and to concentrate on the health problems that account for 80 percent of avoidable morbidity and mortality. The strategy includes substantial community involvement, emphasis on service delivery at small health stations, and the institution of user fees to help finance the scheme. The strategy was to be phased in to all 68 health districts over time.

Although the Government remains committed to this policy, the economic difficulties, concomitant shortage of personnel, materials, and supplies, and difficulties of transport and communications made timely implementation impossible. Thus, in

1985, the government developed a short term plan for 1986-88, with maternal and child health and family planning as a priority area.

III. CURRENT INFRASTRUCTURE

Ghana's health structure follows its civil organization of ten regions divided into 68 districts. There are 108 regional hospitals, 28 of which are wholly or partly run by missions; 67 health centers, and 251 health posts or clinics. The distribution of these facilities by region is shown in Table I.

The PHC implementation strategy calls for an organizational structure that complements the existing health structure. A PHC coordinator is to be named in each region and is to be assisted by a PHC secretariat with members from the Epidemiology, MCH/FP, Environmental Health Education, and Health Statistics Divisions. In turn, each district will have a Health Management Team, made up of health professionals. The functions of the Regional PHC coordinator will be:

- To develop implementation schedules with the District Health Management Teams based on communities with a population of 500 and above.

- To ensure the distribution of data report forms and the monthly return of data from the health centers and districts.

- To plan with the PHC Secretariat integrated service delivery for

  - immunization of under fives
  - child welfare clinics
  - antenatal clinics
  - family planning
  - diarrhoea disease control program
  - health education and nutrition in the communities of size 500 and above.

- To despatch on weekly basis material needed for the above activities to the district for necessary action.

- To process data collected from the districts and report to National level.

The responsibilities of the district level staff will be:

- To inform communities of population size 500 and above of schedule for visits and activities to be carried out;

- To prepare a list of all children under five in these communities with the help of health brigades;

- To organize PHC activities and collect data on a weekly basis with health center staff using material and vehicle sent from regional level;

- To train village health workers.

(Source: "Ghana's Proposed PHC/EPI Service Delivery Strategy" p.2)

To facilitate implementation of this ambitious approach to the revitalization of health care delivery in Ghana, a two year program of extensive management training has been initiated. Regional staff will undergo several rounds of training by central MOH staff. In turn they will train district level staff to implement specific strategies for improving health care delivery. Based on information collected during field visits in Ghana, a reorientation of staff to effectively understand and manage primary health care activities is much needed.

TABLE I

DISTRIBUTION OF HEALTH FACILITIES

BY REGION

REGION	POP. 984	NO. OF DISTS.	HOSPITALS GOVT	HOSPITALS MISSION	HEALTH CENTERS	HEALTH POST/CLINIC	TOTAL FACILITIES
1. GREATER ACCRA	1,420,066	3	11	0	9	19	39
2. EASTERN	1,679,483	9	13	2	10	29	54
3. WESTERN	1,116,930	5	13	2	6	17	38
4. CENTRAL	1,145,520	7	8	3	5	35	51
5. ASHANTI	2,089,683	10	10	5	14	23	52
6. BRONG AHAFO	1,179,407	8	3	8	9	39	59
7. NORTHERN	1,162,645	7	6	2	0	31	39
8. UPPER EAST	771,584	4	3	0	2	7	12
9. UPPER WEST	439,161	3	4	0	1	7	12
10. VOLTA	1,201,095	8	9	6	11	44	70
TOTAL		64*	80	28	65	253	426

* NOTE: The number of districts was increased to 68 recently and the increase is not reflected in this table.

In addition to the service facilities listed, Ghana has two medical schools and a total of 32 nursing, midwifery, hygiene, and laboratory technician training schools.

Ghana has been better off than most other African countries as regards trained health personnel. The table below shows the population per category of health staff and offers a reference group, where available.

TABLE II

POPULATION PER CATEGORY OF HEALTH WORKER

	1977a	1981-1983	Middle Income sub-Saharan countries
Population per:			
physician	9600	7160	11792
dental surgeon	176000	---	---
nurse	1347	770	2460
midwife	7040	---	---
hospital beds	782	580	981

a) Source: Morrow, R.H. "A primary health care strategy for Ghana", in Practical Health for All, David Morley, ed, Oxford, 1983, ch. 17.

The quantity and condition of existing resources within the MOH network are unclear in the aftermath of the 1983 economic collapse. Yet this information is important for planning within the MOH, and USAID/Accra is also eager to have it in order to plan its commodities purchases under the bilateral. CPFH has therefore provided technical assistance in the design and implementation of a Resource Inventory of the national

infrastructure. The Department of Community Medicine at Korle Bu Teaching Hospital in Accra has been commissioned to carry out the study. All ten regions will be visited by a study team who will go to the Regional Health Office, two district headquarters, eight health stations, and four villages. Stocks and flows of all contraceptive commodities will be counted down through the chain, as will personnel in place, their level of training, recent training experiences, and their IEC and service activities. The study is funded directly by USAID/Accra.

Unfortunately, due to the economic deterioration in recent years, the physical condition of many health facilities ranges only from acceptable to extremely poor. One regional hospital visited was typical of such hospitals elsewhere in Africa: the situation was by no means ideal but quality care could be provided. On the other hand, the condition of a health center that was also visited, chosen for being representative if not above the norm, was far less adequate. A large cement structure, this health center had once been part of an impressive compound complete with numerous staff houses, running water (from a water tower) and electricity. The facility had been neglected for years and the present staff were using only a few rooms; water and electricity were available only sporadically. The government has had no resources to maintain this and other facilities.

More directly relevant to Ministry of Health efforts to improve PHC services are the perceptual and attitudinal differences which appear to exist among health personnel at the various levels. From meetings with national and regional level

officials, it appeared that the concepts of PHC and family planning are well understood and embraced. From brief interviews with the health center staff, however, it was clear that this message had not yet reached them. Personnel at this level were doing their best to provide curative services with the meager resources they had, had not heard much about PHC, and were not really sure about what the few village health agents in their area were doing or were supposed to be doing. These health center workers provided some family planning services but maintained that women in their area were not interested. They were very rarely supervised and spent their own money for taxi fare to bring their monthly reports to regional centers and pick up supplies.

There did not appear to be any lack of willingness or interest on the part of the staff; most evident was simply poor morale, and confusion about anything that was outside their narrowly defined job responsibilities. The effective functioning of the district Health Management Teams will no doubt improve the situation, as the health center staff become better trained in PHC and are better supervised and supported.

IV. KAP GUIDES

Ghana is unusual for Africa in that data on knowledge, attitudes, and practices of the population, or subgroups thereof, regarding family planning are available from the mid-1960's through to the present.

A 1970 issue of Country Profiles presented some findings from KAP studies in Ghana in 1965 and 1966.

> "The results of these surveys .... indicate that knowledge of some method of contraception is relatively widespread; however, many of the traditional methods are ineffective and the use of the more modern methods is still very limited."

It must be remembered that in 1965 and 1966, there were no organized family planning services in Ghana. Indeed, the oral pill had only been available in the developed world for a few years. Yet, 65% of female secondary school graduates in urban areas knew of at least one method of birth control. The rate for all women in Accra was 11%. Moreover, 65% of the urban male elite, 54% of the urban female elite, and 23% of the rural respondents wanted to know more about family planning (Gaisie, S.K and Jones, S.B., Country Profiles: Ghana, Population Council and Columbia University, October, 1970, pp.2-3).

Another KAP survey was conducted in 1972 as part of the Danfa Project, an ambitious PHC research program conducted by the Ghana Medical School, the MOH, UCLA, and USAID. While the 1972 data are not directly comparable to previous data due to sampling designs and research procedures, and while Danfa can not be considered representative of rural Ghana since it is quite near Accra, the survey data are useful.

The data showed a significant increase in family planning knowledge from previous surveys, most likely due to the nationwide campaign in 1971. However, the survey found that

> "The picture that emerges is that,while there is widespread knowledge and approval of family planning, a desire for a large family with over six children continues and there is relatively little practice of family limitation."

The data also showed significant differences in desires and

intent between men and women. The men wanted on average three more children than did women, and were thought unlikely to be receptive to arguments in favor of family planning. Particularly in view of the marriage patterns that emerged, which showed unions to be neither long-lasting nor monogamous, the study concluded that in rural Ghana, women are the key to family planning efforts (Becker, D.W., Neuman, A.K., Ofosu Amaah, S, Nicholas D.D. and Blunenfeld S.N. "Attitudes Towards Family Size and Family Planning in Rural Ghana - Danfa Project: 1972 Survey Findings" Journal of Biosocial Science (1978) 10, 59-79).

Despite these early findings, as the Danfa Project progressed, it was noted that over half of the acceptors in the project region were men. This was a surprising finding: in 1975 a study focusing on male family planning acceptors was undertaken. It was found that men played an important role in couples' family planning use. The study also showed that although 25 per cent of the women studied used the IUD or pill without their husband's knowledge or consent, most did not. In addition, 9 per cent of female acceptors studied stopped using family planning because their partner objected. Male interest in contraception was high in cases of extramarital relationships, and at least in certain segments of the population, may be increasing in general (Lamptey, P, Nicholas D.D., Ofosu-Amaah, S, and Louvre P. "An Evaluation of Male Contraceptive Acceptance in Rural Ghana," Studies in Family Planning 9(8): 222-6.)

The 1979-80 Ghana Fertility Survey indicated a continued demand for large families. However, the proportions of women who said they wanted no more children were 10 percent in the rural

area, 12 percent in small and mid-sized urban areas, and 16 percent in large urban areas.

Recent anecdotal information indicates that the economic hardships of the last several years have caused people to think seriously about not having more children. Health service providers report an increased demand for family planning. The government family planning program in the Eastern Region, which includes static and some outreach services, served 5149 acceptors during the third quarter of 1985. About 20 percent of these were new users, and 80 percent continuing users. The family planning nurse in the regional hospital indicated that she sees many clients from the villages surrounding the regional center but that these women are surely the most motivated or most well-off since coming to town is an expensive and time-consuming affair.

V. POPULATION AND FAMILY PLANNING ORGANIZATIONS

Besides the MOH, a number of international and local, private organizations are active in family planning. Some of the latter are or have been supported by international organizations. A brief description of their family planning activities follows.

USAID and the MOH signed a $10.8 million population bilateral project in 1986. USAID will provide $7 million of the total, the MOH will contribute $3.3 million, and the balance will come from centrally funded organizations. The bulk of the funds will go toward contraceptive commodities, some of which will be routed through the private sector and some through the public sector.

The private sector component, The Social Marketing Program, has been undertaken by DANAFCO, Ghana's largest pharmaceutical distributor, and LINTAS, a leading advertising and marketing firm, with technical assistance from SOMARC. Under the project, some 3800 pharmacists and chemical sellers will receive training in contraceptive sales and will be regularly supplied with pills, condoms, and foam. This project provides pills without prescription, and since the MOH and the Pharmacy Board of Ghana are concerned about the medical safety issue, a strong monitoring system has been instituted.

The preliminary results of the Ghana Social Marketing Program have been very promising. Extensive supplies of condoms have been distributed through the market network and plans are proceeding to distribute other contraceptives, as well as locally made oral rehydration packets, through the same network. The MOH is supportive of this private sector initiative, and possibilities exist for developing support linkages between the public and private sectors.

The public sector aspect of the bilateral agreement will involve every level of the MOH (central, regional, and district health structures), but will emphasize services in the villages. This will complement the social marketing outlets in cities and towns and it also coincides with the MOH's PHC strategy which aims to reach that portion of the population not presently covered by the health infrastructure.

FPIA is assisting the private Ghana Registered Midwives' Association in a survey of its members as a first step to its becoming active in family planning.

UNFPA has funded a $3 million four-year project, of which half is for maternal and child health and family planning, and half is for data collection and analysis of the 1984 census. Pending approval by UNFPA (as of December 1985) is an additional project to assess the impact of the national population policy, and to prepare a multisectoral plan for population, human resources, and development planning.

Other international organizations have indirectly affected family planning activities through their impact on the health system. **UNICEF** supports immunization and diarrheal disease progrms. **WHO** and the **Swiss government** had provided grants to improve the system of drug production, procurement, storage, and distribution. **The Saudi Fund for Development** and the **African Development Bank** have approved loans for the rehabilitation and construction of health facilities. **The World Bank** has proposed a loan for the rehabilitation of facilities as well.

The profiles of local organizations which are active in family planning are presented below:

Department of Community Health
Korle Bu Teaching Hospital, Accra

Korle Bu is the main medical teaching facility in Ghana; there is one other at the University of Science and Technology at Kumasi. The Department of Community Health at Korle Bu, headed by Dr. Ashitey, maintains teaching, research, and clinical duties. The Department enjoys excellent relations with the MOH.

As part of its teaching activities, the Department administers a program of field placements for medical students on

rotation. Groups of 6-10 final year students spend 10 weeks in an area in the Eastern Region about 23 miles from Accra. A recent group is working on a schistosomiasis survey. Also, 60-70 third year students spend 5 weeks working with the Department; recent projects have included community needs and resources assessments.

Some of the current Department staff have field research experience from having been involved in the Danfa Project (which the Department administered). Recent research activities have included a survey of 15,000 households undertaken with UNICEF in 15 districts throughout Ghana. The Department is also undertaking the USAID/Accra-funded MOH Resources Inventory, for which CPFH provided technical assistance, as described above.

The Department has a 128K Wang computer. Staff include Dr. Richard Biritwum, a medical statistician who has recently returned to Ghana after several years in East Africa, and Mrs. Tetteh, who has an MPH from Berkeley and who served as a supervisor on the UNICEF study.

Regional Institute of Population Studies (RIPS)

RIPS is a unit of the University of Ghana at Legon and is supported by UNFPA. The program offers Bachelor's, Master's, and Ph.D. degrees in Population Studies. From 1971, when it was started, to 1985, 327 students from 23 countries have been enrolled. In the 1984/85 academic year, the enrollment was 27 students.

Dr. Ben Gyepi-Garbrah is a faculty member of RIPS. He has recently returned to Ghana from the U.S., where he received a

Ph.D. in Population Studies from Harvard. He has been in the U.S. for the past nine years. Before leaving Ghana, he was heavily involved in the 1970 census, working in all aspects of the planning and field work throughout Ghana.

Besides his activities at RIPS, Dr. Gyepi-Garbrah is affiliated with several Ghanaian and international organizations working in population. He is assisting GIMPA in a short course on population (see next profile); is working with Mr. Owusu at the Central Bureau of Statistics; served as the coordinator for the National Conference on Population and National Reconstruction in March, 1986; and. with Pathfinder funding, has produced a series of factbooks on adolescent pregnancy in sub-Saharan African countries.

Ghana Institute of Management and Public Administration (GIMPA)

GIMPA is located close to the University campus at Legon. It is an autonomous, non-profit organization but is linked to the University through its staff. The well-maintained facilities include classrooms, offices, dormitories (103 rooms), and a dining unit.

GIMPA serves three functions. First and foremost, it is a training institute providing short and long term courses in management and public administration. It employs 25 faculty members. The majority of the courses held are at post-graduate level and are attended by civil servants from Ghana and from other countries. A short course (i.e. one month) in population and communications management was first held in 1984 and again in

November 1985. The more recent course was being assisted by UNFPA; additional UNFPA funds are being requested for continued training programs. One of the long courses (nine months) to a certificate in public administration.

The second GIMPA activity is research. Six fulltime research staff and four National Service workers (recent high school or university graduates who are required to perform a total of two years of public work) are presently attached to GIMPA. The training staff is also active in research.

The third function is consultation to public or private organizations. This is also undertaken by the general faculty.

Dr. Sylvester Kwakye is a faculty member who received his Ph.D. from Donald Bogue's program at the University of Chicago. His dissertation was on population and communication; he was instrumental in introducing the courses on population topics to GIMPA. He maintains a strong interest in population research and would like to collaborate on long or short term projects.

Planned Parenthood Association of Ghana (PPAG)

PPAG is active in seven of the ten regions of Ghana (Greater Accra, Eastern, Central, Northern, Ashanti, Brong-Ahafo, and Western). The choice of sites within a region is determined by the relative lack of government services in family planning.

PPAG operates a CBD program. Approximately 120 sites are operated currently. The CBD agents are selected according to their personality, ability to learn the methods, and their credibility within the community. They have so far included teachers, TBAs, traditional doctors, and drugstore vendors. They

are brought to a nearby town for three days of training in local language, and return to their communities with stocks of contraceptives. They presently supply foam and condoms. Some agents, usually the educated ones, also resupply the pill. The Executive Director does not recommend that any agents supply the pill to first time users: the latter are asked to get a doctor's prescription.

The CBD agents sell the contraceptives and return all the money to PPAG. They are then paid a commission based on their sales. Repayment and accountability cause some problems but there are few losses, and the benefits of the program are judged to outweigh these losses. The program is not quite self-sufficient.

Target areas for CBD activity are plantations, water works, villages, and schools and universities. The plantations and water works have large groups of families living close together. In villages, the community leaders are approached and their agreement sought, but the community rarely selects the agent. The targetted schools include the National Vocational Training Institutes which are located throughout the country. These are viewed as important sites for contraceptive distribution as well as good centers for recruitment of agents for other areas and groups.

The prospective CBD sites are scouted out by Project Assistants, who are paid PPAG employees. They number about 100 but only some are active in the CBD work. These Assistants also supervise and resupply the CBD agents once they are trained.

Those agents not involved in CBD perform the motivation and distribution themselves in several villages. Currently, most Project Assistants have a primary school background and have been given six weeks of training in family planning methods and IEC. Given the increasing need for better data collection and analysis for CBD expansion, PPAG wants to replace these workers with high school graduates.

The Project Assistants report to the Assistant Program Officer in the region who, in turn, reports to the Regional Coordinator. Each Regional Office also has a family planning nurse who provides contraceptives out of a PPAG or MOH clinic. PPAG has also conducted a male motivation campaign of lectures and t-shirt giveaways.

Association of People for Practical Life Education (APPLE)

APPLE is a private non-profit organization, headed by Brother Russel, an American. They have programs in agriculture, fisheries, and bee-keeping, among other things, and have become interested in family planning in villages.

APPLE received funding from FPIA/Nairobi in 1983 to start a village outreach program. This activity is centered in one district of Brong-Ahafo Region, 98 miles from Kumasi. There are a total of six "outreach girls" who are posted in towns and who provide family planning counseling and contraceptives door to door in the towns, and in 5-10 surrounding villages each. They sell jelly, foam, and condoms, and refer IUD and pill clients to a clinic in town. Of the six outreach workers, four are paid a set salary under the FPIA grant, and two work on commission,

receiving half of the selling price of the contraceptives. There has been no comparison of the effectiveness of the two systems. They have so far counted about 3500 acceptors but do not have figures on continuation.

The workers are middle school graduates and average about 22 years of age. They receive 10 days training in IEC and contraceptive methods.

APPLE has been asked by the Secretary of Health of the Brong-Ahafo region to expand the outreach program to the other eight districts of the region. They plan to expand to one more district soon.

VI. MAJOR OBSTACLES AND OPPORTUNITIES

The major obstacle facing the effective implementation of programs in Ghana for the past many years has been the poor economy. The total unavailability of basic goods - gasoline, spare parts, paper - or their availability only at exorbitant prices, made internationally funded projects extremely difficult or prohibitively expensive. This, coupled with the shortage of trained staff and the general poor morale of workers who simply could not live on their official salaries caused many organizations to look elsewhere for project opportunities.

The `routine' difficulties of working in Africa are also present, of course. The infrastructure is wanting, communications are rarely easy, and management and supervision systems are lax.

Ghana, however, is a unique country and it offers several advantages for implementing health and family planning programs. First, by all reports, the economy has improved and is fairly stable. Thus, the costs of doing business in Ghana are now manageable. Second, the government and private organizations have an impressive roster of well-trained and dedicated professionals, some of whom have been living in Ghana for many years and others who have recently returned. Some of these professionals, such as Dr. Gyepi-Garbrah and Dr. Kwakye have been trained in doctoral population programs in the U.S., others have advanced degrees in public health or sociology, and many medical doctors have studied and worked abroad. The wide range of experiences these professionals offer will undoubtedly improve

new and ongoing population programs, particularly since many of these individuals are in positions of importance.

Third, in the years since 1969 and the enunciation of the population policy, Ghana has had experience with family planning programs. Unlike the situation in so many other African countries, Ghanaian officials have long accepted the need for family planning and are willing to try new approaches.

Fourth, the socio-demographic conditions in the country are likely to favor increased family planning acceptance. Compared to other countries, the population is more urban (40%), more educated (48% of the adult population is literate and over 50% of school-age children attend school), and much more aware of family planning methods. In addition, the economic hardships have engendered a common refrain of `Life is too hard to have many children.' These factors may predispose the population to accept family planning services.

Fifth, there is an active private sector in Ghana. Although services in the rural areas will most likely remain the domain of the government, private services also play an important role, especially in towns and cities. Many doctors, midwives, and nurses have private practices, and pharmacists and chemical sellers supply much of the population with prescription and non-prescription drugs. Both public and private channels can be supported as they are complementary.

Sixth, the successful launching of the Ghana Social Marketing Program and the well-attended and highly publicized Ghana National Conference on Population and National Reconstruction in March, 1986 have brought population issues to

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the forefront. The conference provided a public forum for influential decision makers from both private and public sectors to thoroughly discuss population issues affecting Ghana today. As highlighted by Dr. Fred Sai in his keynote address, the promise of the 1969 population policy formulated for Ghana has not been fulfilled through subsequent development of programs to make family planning services widely and readily available. Conference participants attempted to redress the situation by formulating a series of recommendations that will be published as part of the conference proceedings. Because of extensive media coverage, the conference also served to heighten public awareness of population problems and possible solutions within the Ghanaian context. The conference was timed to occur just one week before the launching of the extensive contraceptive social marketing project in Ghana.

VII. SUGGESTED CPFH STRATEGIES

The MOH and USAID/Accra have asked CPFH to assist the MOH in implementing its rural PHC strategy. The strategy includes community based distribution of selected drugs, including some contraceptives, and encourages a high degree of community involvement. The strategy is ambitious and, as yet, largely untested.

It is well within CPFH's expertise and capability to respond to this request with an operations research project in a rural pilot area. The purpose of such a project would be to test, within selected villages, implementation of the MOH plan so as to provide advance information on which features work well and which need reworking. The pilot area should be limited in size so that thorough monitoring and evaluation can be assured. After discussing a number of progammatic issues which are of concern to the MOH -among them supervision, community participation, and integrated service delivery - the involvement of traditional birth attendants in the delivery of MCH and family planning services emerged as the most viable substantive issue for an operations research study. Recognizing that only 20% of births in Ghana are attended by medical personnel with some training in modern obstetrical practices, the MOH is committed to an extensive effort to increase and improve the training of TBAs. To this end, the American College of Nurse Midwives has provided technical assistance in developing a training curriculum that will be used to upgrade TBA skills and knowledge. An operations research study could be conducted in a delimited area where this

training will occur. In addition to providing quantitative measures of the impact of this training on MCH/FP practices, qualitative studies could be conducted both to document the process involved in incorporating TBAs into a broader range of health service delivery responsibilities and to more fully understand TBA and client perceptions of the services being made available.

The MOH is best placed to provide health and family planning services to the rural population. Thus, CPFH's primary strategy should be to assist the MOH in their efforts. However, as a secondary strategy, CPFH should pursue the possibility of working with private organizations. One organization which has expressed interest in a collaborative operations research project is the Ghana Registered Midwives' Association (GRMA).

The GRMA is a professional association of midwives in private practice. Currently they do not provide family planning services, but according to the Association President, who attended the June 1986 CPFH Management Workshop in New York, many are extremely eager to begin. The Association would serve to coordinate family planning training, supply, evaluation, and research activities for its members. The Association is presently working on a survey of its members' activities; this is seen as the first step toward strengthening its institutional capability and is being supported by FPIA and John Snow, Inc. As the Association's activities develop, both USAID/Accra and the Association would be interested in having CPFH collaborate on an operations research activity to monitor and improve the service delivery. Evidence suggests that the midwives' private practices

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are important service sites in Ghana, and that the Association could serve as an excellent coordinating body for operations research activities.

Other opportunities in the private sector also exist. The Planned Parenthood Association of Ghana is now the largest prov:der of clinical family planning services in the country and has outreach and CBD programs as well. Its willingness to test innovative strategies makes PPAG of interest to CPFH, and collaboration should be inv... ted at a future date.

An operations research pr ...t which would link the private and public sectors could be organized between the Ghana Social Marketing Program and the MOH. The MOH has expressed some interest in developing links between its rural program and the social marketing program which will mainly serve towns and cities. Efforts could also be made to study the extent to which the Ghana Social Marketing Program is able to penetrate villages and provide a viable source of contraceptive and other MCH supplies (ORS) for midwives and their clients. Operations research could be useful in developing and testing the impact of such links and would be most useful once the social marketing system is firmly established.