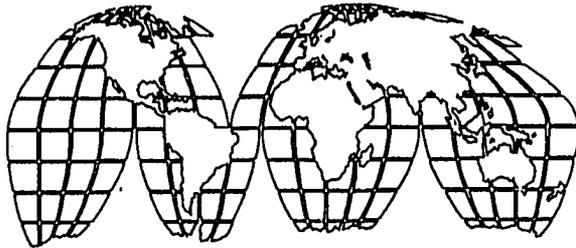


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A.I.D. Technical Report No. 13

Center for Development Information and Evaluation



**Evaluation of A.I.D.
Family Planning Programs**
Ghana Case Study

AGENCY FOR INTERNATIONAL DEVELOPMENT

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**Evaluation of A.I.D.
Family Planning Programs:
*Ghana Case Study***

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PREFACE

The current series of case studies of family planning being conducted by the Center for Development Information and Evaluation (CDIE) was initiated in October 1990. In all, CDIE has assessed A.I.D. programs in six countries (Kenya, the Philippines, Tunisia, Ghana, Honduras, and Pakistan). The six studies focus on issues above the project level and use a common scope of work and format in order to identify broad accomplishments in each country studied. Less attention has been given to inputs and outputs and more attention given to *results*. The case studies focus on completed, as opposed to ongoing, programs and projects.

This assessment of the 23-year history of the family planning program in Ghana (1968-1991) was undertaken in May 1992 by a four-person CDIE team. Much of the analysis of impact reflects data up to and including 1988—the year of the last Demographic and Health Survey available at the time of the team's field work. Since then, preliminary evidence from a recent (August 1993) consumer baseline study indicates an increase in modern contraceptive prevalence since 1988, from 5.2 percent to 15 percent among married women. This improvement is consistent with evidence from USAID/Accra program service statistics that shows nearly a tripling of couple years of protection from 1987 to 1991.

CDIE wishes to express appreciation to USAID/Accra for its assistance.

SUMMARY

The Center for Development Information and Evaluation (CDIE) initiated a series of assessments of Agency for International Development (A.I.D.) assistance to family planning programs in October 1990. The Ghana assessment, one of six, was undertaken by a four-person team during May 4-27, 1992. The team comprised two economists, a demographer, and a specialist in the delivery of family planning services; two members had prior experience working in Ghana.

The methodology for carrying out the assessment was relatively straightforward. It included a careful review of the literature (much of which had been summarized in the form of an annotated bibliography prior to beginning the in-country assessment); briefings from representatives of various institutions in Washington, D.C., who specialized in population policy and family planning; structured discussions carried out in Ghana with Government and nongovernment individuals familiar with Ghana's 23-year history of family planning; and site visits to regions of the country where family planning programs had been implemented.

The team made an especially strong effort to understand Ghana's family planning experience from the perspective of a large and diverse range of individuals, including those who had formulated Ghana's still-current population policy over two decades ago, those in the present Government and donor community who are administering family planning programs, and those in the public and commercial sectors who are actually providing family planning services to beneficiaries. The team was particularly fortunate to be able to discuss Ghana's family planning program with several of the chief architects of the 1969 policy.

During the 23-year period from 1968 to 1991, A.I.D. disbursed an estimated \$24.9 million to support 8 bilateral and 43 centrally funded population and family planning projects in Ghana. During the 14-year period from 1968 to 1982, A.I.D. provided about \$11.3 million, or about \$0.8 million per year, on average. U.S. assistance was suspended altogether from April 1983 to July 1984 and program performance consequently suffered. During the more recent 6-year period from 1985 to 1991, A.I.D. provided about \$13.6 million, or on average about \$2.3 million per year.

Ghana's national family planning program should therefore be viewed in two distinct phases: the earlier period from 1968 to about 1982 and the more recent period from 1985 to 1991. Although progress during the former period was essentially stagnant, there was improvement in the latter period. The number of family planning service delivery points expanded dramatically from 1987 to 1990, nearly all of the clinics distributing contraceptives are reporting regularly, and the Ghana Social Marketing Program has made significant progress in expanding the number of delivery points for contraceptives provided by the commercial sector. Program service statistics compiled by USAID/Ghana from the three major providers of contraceptives (Ministry of Health, Planned Parenthood Association of Ghana, and Ghana Social Marketing Program) show nearly a tripling of couple years of protection from 75,000 to 223,000 during the 4-year period 1987-1991.

However, it is widely recognized in Ghana that the results of the family planning program throughout most of the two periods have been very limited. Although contraceptive prevalence rate increased from 9.5 percent in 1979 to 12.9 percent in 1988, most of the increase was in traditional methods. The use of modern methods remained virtually unchanged: 5.5 percent in 1979 and 5.2 percent in 1988. Ghana's fertility rate also remained virtually constant: on average, Ghanaian women were having almost as many children in 1988 (6.4) as they were in 1965 (6.8).

The family planning programs during the more recent period, however, may be producing positive results. As of 1992, when the CDIE team carried out its field work, selective surveys have shown contraceptive prevalence rates ranging from 8 to 10 percent for 1990-1991 for modern methods; the team believed the lower end of the range to be more accurate¹. And because A.I.D. is the predominant donor agency in the area of family planning, some portion of this recent improvement may be directly attributable to A.I.D. In addition, A.I.D. assistance has contributed to an improved understanding of population dynamics in Ghana and to widespread knowledge of modern contraceptive methods, a necessary precursor to any future increase in contraceptive use.

The fact remains that for most of the period from 1968 to the present, the effective demand for contraceptives was weak—in spite of a reasonably high and growing level of awareness—and the supply of contraceptives was limited primarily to urban areas, which comprise only about 30 percent of the population. This can be explained in part by the fact that the political and economic

¹A more recent (August 1993) consumer baseline study gives a preliminary estimate of 15 percent for modern methods.

environment in which A.I.D. assistance was provided to Ghana during most of the period was not conducive to the successful implementation of long-term development activities, such as family planning. Especially during the late 1970s and early 1980s, Ghana experienced a severe economic crisis accompanied by a deterioration of almost all Government and private services, including health services. There was a mass exodus of trained Ghanaians, including doctors. In addition, donor assistance (including U.S. assistance), which is almost always essential during the formative stages of a family planning program, was drastically curtailed. Under these circumstances any family planning program in any country is unlikely to succeed.

Three additional factors help explain why the effective demand for contraceptives has been weak; that is, why there has been such a wide gap between the proportion of women who wanted to delay or avoid their next pregnancy (68 percent) and those who in 1988 were actually using some form of contraception (13 percent).

First, for most of the past 23 years there has not been a consensus among the national leadership and senior decision-makers that the goals and objectives of family planning are of national priority. This situation was exacerbated by the frequent changes in Government and the fact that the military was in power during much of the period. This lack of overt, continuous political commitment is a major factor in explaining why progress in family planning in Ghana has been limited. The A.I.D.-funded Population Impact Project, which began in 1986 and is specifically designed to inform and influence policymakers, appears to have heightened the awareness of the current Government of the importance of an effective family planning program. Unfortunately, one cannot jump to the conclusion that the Government will exercise the leadership necessary to implement its 1969 population policy, which by all accounts is a clear and comprehensive policy statement.

Second, family planning counseling and a wide range of contraceptive methods have not been regularly accessible in both urban and rural areas from a convenient and trusted source that ensures clients' privacy. Contraceptives have typically been "available," especially in urban areas, except for some methods of contraception, such as sterilization (which is performed at only a few locations), and certain brands of contraception (supplies of which have become depleted on occasion). The problem has been that the principal providers of family planning supplies and services (the Ministry of Health, chemists shops and pharmacies, and a few nongovernmental organizations) have not distributed contraceptives with sufficient counseling by a trusted individual in a convenient location that affords adequate privacy. Family planning programs were finally integrated with maternal and child health and primary health care systems in 1986, long after the

A.I.D.-funded Danfa Comprehensive Rural Health and Family Planning Project had demonstrated that such integration improved accessibility.

Third, together with cultural attitudes (especially among men) favoring large families, the dominant role of men in Ghanaian society has tended to undermine the effectiveness of the country's family planning program.

Among the many factors that have affected the level of contraceptive use in Ghana, two seem to have the strongest relationship: urban versus rural residence and level of female education. Contraceptive prevalence among urban women was 19.6 percent in 1988, while prevalence among rural women was only 9.9 percent. Contraceptive use rises progressively from 8.5 percent among women with no education to 28.7 percent among those with higher education, with the most dramatic increase among women who have gone beyond middle-level education.

Ghana's family planning program is not financially self-sustainable and is not likely to become so in the foreseeable future. This means that the Government will need to continue to provide family planning services and contraceptive supplies at highly subsidized prices, especially in rural areas, if family planning is to continue.

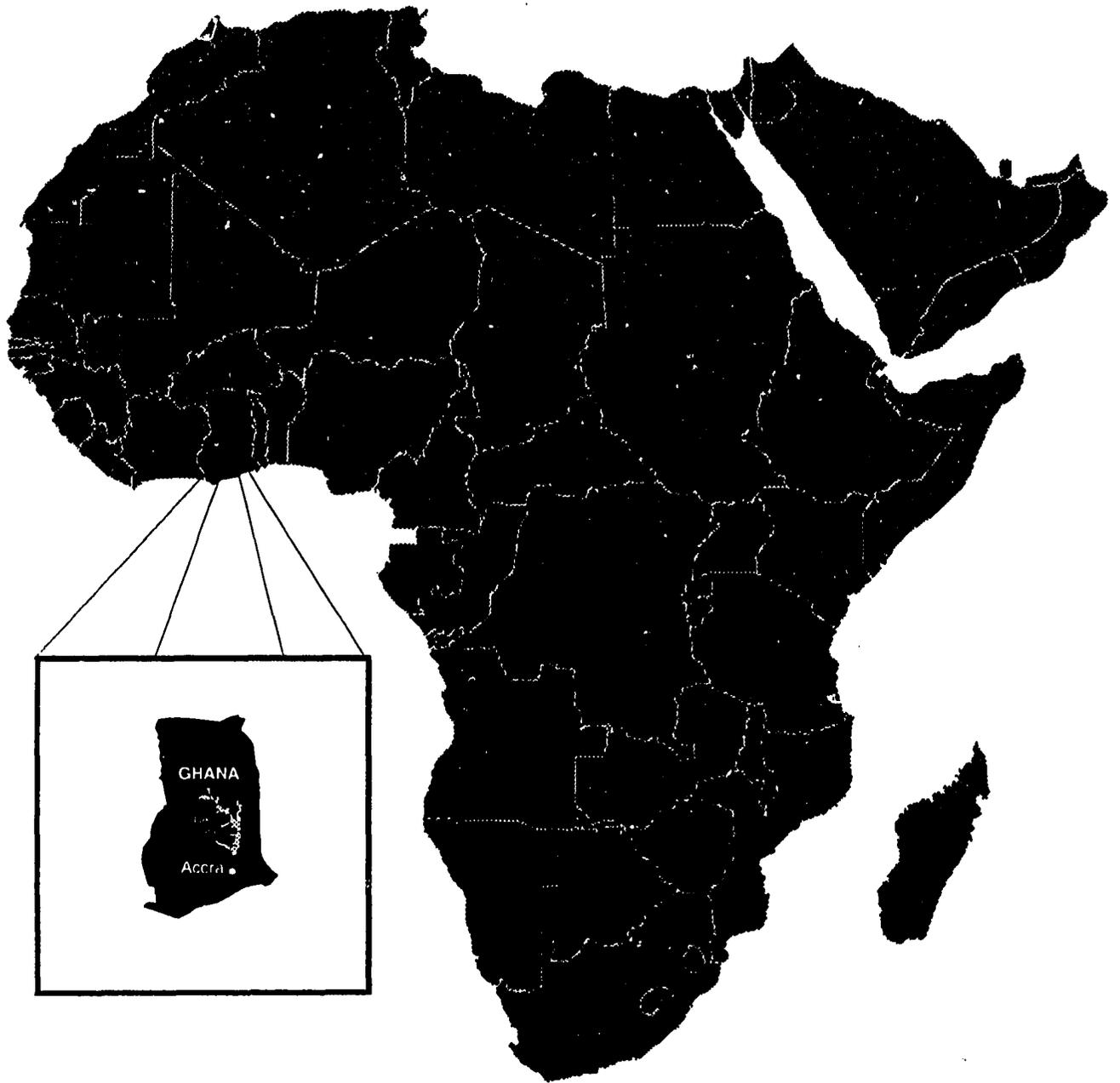
The real costs of the family planning program in Ghana are unknown, and they will remain unknown until annual data on expenditures and costs are collected. Similarly, the effect of price changes on the demand for contraceptives—including alternative types of contraceptives, alternative brands of the same contraceptive method, and alternative providers of contraceptives—is unknown, again because systematic data collection and analysis have not been conducted.

GLOSSARY

A.I.D.	U.S. Agency for International Development
CDIE	A.I.D. Center for Development Information and Evaluation
Cedi	unit of currency in Ghana
CNM	community nurse-midwife
COCOBOD	Ghana Cocoa Board
CYP	couple years of protection
DANAFCO	Danish African Company Inc.
GDP	gross domestic product
GNFPP	Ghana National Family Planning Program
GRMA	Ghana Registered Midwives Association
GSMP	Ghana Social Marketing Program
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
L-M Scale	Lapham-Mauldin Family Planning Program Effort Scale
MCH/FP	Maternal and Child Health/Family Planning
NGO	nongovernmental organization
PASA	Participating Agency Service Agreement
PNDC	Provisional National Defense Council

PPAG	Planned Parenthood Association of Ghana
TBA	traditional birth attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID/Accra	A.I.D. Mission in Ghana

MAP OF GHANA



1. INTRODUCTION

A four-person team carried out an assessment of Ghana's family planning program during May 4-27, 1992. Before leaving for Ghana the team interviewed knowledgeable people, including people from A.I.D. in Washington, D.C., and reviewed a large body of published and unpublished material. The review of documents included Project Papers, project evaluations, and other materials concerning family planning and related population matters covering more than two decades.

In Ghana, the team not only worked in Accra but also traveled to Volta, Eastern, Central, and Western Regions to visit various providers of family planning services and commodities, including the Ministry of Health, nongovernmental organizations (NGOs), and commercial providers. Over 60 individuals were interviewed in Accra and over 50 were interviewed in the 4 regions.

Section 2 of the report describes the country setting (including the economic, political, and sociocultural environment) in which family planning activities have been implemented in Ghana; Section 3 summarizes Ghana's family planning program and A.I.D. and other donor assistance to family planning over the past two decades; Section 4 reports on program performance (including the effectiveness, efficiency, and sustainability of A.I.D.'s investments in family planning); Section 5 reports on longer term development impact; and Section 6 provides conclusions. The report includes several substantive appendixes that provide an indepth analysis of certain aspects of the assessment, including evaluation methodology (Appendix A), family planning from the beneficiary's perspective (Appendix C), and use of the Lapham-Mauldin Scale (Appendix D). Appendix B is a summary of the field trip and Appendix E describes A.I.D.-supported population and family planning programs in Ghana from 1968 to 1991.

2. COUNTRY SETTING

Sociocultural Background

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

About 70 percent of Ghana's 16 million people reside in rural areas, which are defined as villages or towns with fewer than 5,000 people. Population density is about 110 people per square mile. Over 99 percent of the population is African; the balance is of European and other extraction. There are more than 100 different ethnic groups, each with its own language and culture. Because of the great diversity of dialects, no native national language exists. English, the official language, is used in schools, business, and government. Most Ghanaians are multilingual.

Ghana is divided into 10 administrative regions: Greater Accra, Central, Western, Ashanti, Eastern, Volta, Brong-Ahafo, Northern, Upper West, and Upper East. Most of the population resides in the southern and central portions of the country.

Political and Economic Overview

In 1957 Ghana gained independence from Britain. Three years later it became a republic, and Kwame Nkrumah was elected president. In 1960 the economic and social infrastructure of Ghana was one of the most highly developed in sub-Saharan Africa. At that time Ghana was ranked as a middle-income country with a per capita gross domestic product (GDP) of about \$600. The Nkrumah Government voiced a strong commitment to social equity, but its top priorities were government enterprises, economic infrastructure, and industrial

development. As economic controls became more intrusive in the early 1960s, rural producers increasingly subsidized urban consumption and industrial investment. The economy began to run into serious trouble in the mid-1960s, which led to a military coup, and a new Government, the National Liberation Council, took power in 1967.

The initial emphasis of the National Liberation Council (and the Busia Government that followed it) was on policy reform, market liberalization, and private sector development. However, substantial resources supported the salaries and benefits of civil servants and amenities for the urban population. The political costs of broad policy reform proved too high, and the freely elected Busia Government was overthrown in 1972.

The next political regime, led by Colonel Acheampong, abandoned efforts at market-oriented reform and returned to direct controls. He was replaced by General Akuffo in 1978, who was subsequently replaced by Flight Lieutenant Rawlings in a 1979 coup. After a brief campaign against corruption, Rawlings handed power to the democratically elected Government of Dr. Hilla Limann but reclaimed it 2 years later, in 1981, when the economy continued to deteriorate. Since then, the Provisional National Defense Council (PNDC) has maintained power under Rawlings' leadership.

By the 1970s the relatively high standard of living enjoyed by Ghanaians had been eroded by inappropriate development policies and strategies. Industrial development based on import substitution had resulted in an industrial structure dominated by large-scale, capital-intensive, and inefficient state-owned enterprises. Cocoa, the backbone of the economy, was so heavily taxed that Ghana's share of world production fell from 25 percent in 1974-1975 to 9 percent 10 years later, against a backdrop of falling world cocoa prices.

Over the 1970-1980 period, Ghana experienced an average decline in real GDP of 0.2 percent per year; average real income per person fell by 3 percent per year. Inflation was 100 percent per year, and world cocoa prices fell to their lowest level in 10 years. At the time of the second Rawlings coup in December 1981, economic activity had come to a virtual standstill. Rawlings initially tried to reduce real prices through price controls and to obtain productivity gains through exhortation; both measures proved inadequate. GDP declined 2.9 percent in 1981, 6.7 percent in 1982, and 4.5 percent in 1983. A World Bank study showed Ghana to have the most distorted economy in sub-Saharan Africa in the early 1980s.

The Economic Recovery Program: 1983-1992

In response to the deteriorating economic situation, the Government of Ghana, in coordination with the International Monetary Fund, launched in 1983 one of Africa's most stringent economic recovery programs. The chief objectives of the program were to achieve macroeconomic stability and improve the country's balance of payments, thereby putting the economy back on the path to positive real growth. A three-phase program began with a stabilization phase in 1983-1986, followed by a structural adjustment phase in 1987-1990, and finally an enabling environment phase.

The stabilization phase focused on stabilizing basic macroeconomic indicators. The policy actions allowed the real value of the cedi to fall by 90 percent, turned the budget from a deficit of 2.7 percent of GDP to a surplus of 0.1 percent of GDP, reduced the number of workers of the Ghana Cocoa Board (COCOBOD) by 16,000, quadrupled the producer price of cocoa, phased out most price controls, eliminated most governmental subsidies, and increased government salaries. As a result, the economy grew 20 percent in 3 years from 1984 through 1986.

The structural adjustment phase focused on restoring and upgrading essential infrastructure, implementing institutional and policy reforms in the cocoa sector and the state-owned enterprise sector, liberalizing trade policy, and improving public sector management. During this phase the COCOBOD staff was further reduced by 5,000 to 43,000, the import regime was liberalized, and 39 state-owned enterprises were divested. In the public sector, the Government laid off 12,000 employees in both 1987 and 1988, 14,000 in 1989, and 12,000 in both 1990 and 1991. Civil service wages were rationalized so that the ratio between the highest and lowest paid worker was raised from 6.7:1 in 1987-1988 to 9.1:1 in 1991. A foreign exchange auction was also introduced as a key measure of the program, and macroeconomic and banking sector reforms were continued.

As measured by a wide range of macroeconomic indicators, Ghana's economic recovery program has been a major success and is commonly viewed in the donor community as a model for other developing countries. The exchange rate has been devalued to realistic levels and the balance of payments is near equilibrium despite a 31 percent decline in the terms of trade between 1987 and 1990. Growth rates in GDP averaged more than 5 percent per year during this period, and the Government achieved overall fiscal surpluses in 1987-1990.

Despite dramatic successes to date, numerous problems persist. The International Monetary Fund, the World Bank, and the Government of Ghana

have increasingly recognized that private sector involvement must be increased for the country to achieve self-sustaining growth. Consequently, beginning in 1991, the enabling environment phase was begun to emphasize measures for encouraging higher levels of private savings and investment. A number of these measures were announced in the PNDC Budget Statement for 1991, including reduced tax rates on corporate income, capital gains, and interest income. The maximum personal tax rate was reduced from 50 percent to 25 percent, and corporate tax rebates were increased for firms that export.

3. FAMILY PLANNING IN GHANA

The Ghana Family Planning Program

Policy Development

Modern family planning in Ghana began in the early 1960s, quietly and slowly with a few individuals. The movement was cautious because the first leader of independent Ghana, Kwame Nkrumah, encouraged population expansion as part of his economic development program. Despite this policy, a few groups emerged to provide family planning information and services. The Christian Council of Ghana, the first such group, opened the Family Advice Center in Accra in 1961. In 1966 the Christian Council of Ghana and other groups joined with doctors, social workers, and well-known personalities to create the Planned Parenthood Association of Ghana (PPAG).

In 1967 the new National Liberation Council Government began to develop a population policy, and in 1969 a policy paper entitled "Population Planning for National Progress and Prosperity" was published. The Ghanaian policy recognized that family planning was an intrinsic part of economic development and that there were severe economic and health effects of large families. The objectives of the implementation plan were as follows:

- Reduce the rate of population growth from a projected level of 3.9 percent to 1.7 percent by the year 2000
- Achieve a 50 percent reduction in completed family size by lowering the fertility rate from a range of 7 to 8 in 1970 to 5 by 1985 and to 4 by the year 2000
- Recruit as contraceptive users 40 percent of the entire female population by 1990 and 65 percent by the year 2000

The population policy called for the establishment of the Ghana National Family Planning Program (GNFPP), which was placed in the Ministry of Finance and Economic Planning in 1970 and given overall responsibility for

planning and coordinating public and private sector family planning activities. However, until the mid-1980s Ghana had no comprehensive national strategy for implementing the family planning activities and no sense of urgency about the program. GNFPP was ineffectual in coordinating national efforts, and implementing agencies responded slowly, often to conflicting, donor demands. Moreover, there was considerable political instability and economic deterioration leading ultimately to economic collapse. Thus, during this period, the political and economic climate in Ghana was not conducive to policy implementation.

In 1986, however, interest in population policy and development issues was revived. Senior-level professionals from a wide spectrum of Ghanaian society met that year at the National Conference on Population and National Reconstruction, which produced recommendations referred to as the 1986 Legon Plan of Action on Population. The conference identified several problems that had hampered successful implementation of the 1969 population policy, including what participants interpreted as an "unfortunate" focus exclusively on the policy's family planning element, although the policy had many other aspects. As a result of the conference, the Government looked anew at the implementation of a comprehensive population program covering such areas as basic data collection and analysis; maternal and child health and family planning; information, education, and communication (IEC); population and family life education; women, population, and development; population and human resources policy; measures to strengthen the Secretariat of GNFPP; establishment of a National Population Council; integration of population variables into agricultural policy; and implementation of the monitoring and evaluation of program impacts.

In 1989 a National Population Conference was held to commemorate the 20th anniversary of Ghana's population policy and to review specific achievements and shortcomings in policy implementation. There was general agreement that a gap existed between rhetoric and implementation and that, although the basic tenets of the policy remained valid, several issues of the 1990s, such as the environment, the aged, AIDS, and the role of the newly established district assemblies, needed to be recognized. The conference recommended the establishment of a National Population and Human Resources Board to coordinate all population activities.

The national population policy has recently been incorporated into the new constitution of Ghana as a "directive principle," with a provision that the Government will pursue the policy and report to Parliament annually on progress. There is optimism that this move will begin to close the gap between rhetoric and implementation.

Program Implementation

Difficulties in implementation have characterized Ghana's family planning program over much of the period since the 1969 promulgation of the population policy. These difficulties reflect not only the general political and economic instability of the time but serious managerial, organizational, institutional, human relations, and logistical constraints as well.

For example, it was clear from the beginning that GNFPP faced problems that seriously effected program implementation. Two operating divisions were established within GNFPP to encourage, coordinate, fund, and help design public and private sector service delivery activities and IEC. The Ministry of Health was expected to assume a major role in providing family planning services. In addition PPAG and other NGOs would provide services from a network of clinics and through community-based agents, and the Ghana Social Marketing Program (GSMP) would provide contraceptives through the Danish African Company, Inc. (DANAFCO), a private pharmaceutical company. The National Manpower Board would be responsible for the non-family planning components of the population policy.

Although the Ministry of Health was aware of its vital role as the main provider of family planning services, it was lukewarm to the program, in part because the program's organizational structure gave the coordinating role to the GNFPP Secretariat. The Ministry of Health also was preoccupied with starting a primary health care system, which was itself fraught with organizational and structural problems compounded by an exodus of trained Ghanaian physicians and a deterioration of all services, including health services. Furthermore, the process of integrating family planning into the primary health care system was complicated by the fact that all primary health care interventions were funded as separate programs by different donors. Thus, it was not until 1977 that the Ministry of Health changed the name of the Maternal and Child Health Division to the Maternal and Child Health/Family Planning (MCH/FP) Division, and it was not until 1986 that family planning was officially included as part of the mix of primary health care interventions. It was probably the A.I.D.-funded Danfa Comprehensive Rural Health and Family Planning Project, implemented by the University of California, Los Angeles and the University of Ghana Medical School, that contributed most to the Government's decision to integrate family planning with primary health care.

A.I.D. had been one of the major supporters of GNFPP in the 1970s, but by 1985, when A.I.D. resumed assistance to Ghana, GNFPP was largely nonoperational and A.I.D. began to support the Ministry of Health instead. At the same time, A.I.D. contracted with DANAFCO to distribute contraceptives

under GSMP. Thus, beginning about 1985, and coinciding with increased A.I.D. support, there has been an improvement in family planning in Ghana; but before that, program implementation left much to be desired.

A.I.D. Assistance: 1968-1991

A.I.D. expenditures in support of population and family planning activities in Ghana totaled approximately \$24.9 million from 1968 to 1991. Of this, recorded expenditures for both bilateral and centrally funded projects were \$17.4 million; the remainder, \$7.5 million, represents USAID/Accra's estimate of undercounted expenditures of centrally funded projects. This undercounting was due to several factors: financial records were simply not available for the earlier years for several projects, including participant training, which has always been a major A.I.D. activity in Ghana; many of the records that were available were incomplete for the early 1980s when the Mission was essentially closed; and it was impossible to disaggregate expenditures attributable solely to Ghana for several centrally funded projects.

Table 1 lists each project implemented in Ghana during 1968-1991 for which there are recorded expenditures. These include 8 bilateral and regional projects (totaling about \$12.4 million) and 43 centrally funded projects (\$5.0 million of which is attributable to Ghana). A thorough description of the activities implemented through 1988 has been compiled by Prince (1988); Appendix E provides a summary description of each project.

This assistance has been provided through a number of channels including the following:

- Direct bilateral projects with the Government of Ghana and its relevant ministries
- Centrally funded projects through A.I.D.'s Office of Population
- Cooperative arrangements and grants through international, U.S.-based, and local private voluntary organizations, such as the International Planned Parenthood Federation (IPPF) and the Population Council
- Cooperative agreements with other bilateral country agencies

Table 1. Summary of A.I.D. Assistance to Family Planning in Ghana, 1968-1991

Project Title/Number	Date	Expenditures (in US\$ thousands)
BILATERAL/REGIONAL PROJECTS		
Family Planning and Demographic Data Development (641-0051)	1968-1972	244
Danfa Comprehensive Rural Health and Family Planning Project: Family Planning Component (641-0055)	1969-1981	602
Population Program Support (641-0064)	1971-1982	2,433
University Teaching of Population Dynamics (698-1157-0360)	1972-1977	112
Programs in Population Dynamics (641-0087)	1977-1982	526
Family Health Initiatives (698-0462)	1982-1987	<u>500</u>
Subtotal		4,417
Contraceptive Supplies Project (641-0109)	1985-1992	7,000
Family Health Initiatives II (698-0662)	1987-1991	<u>950</u>
Subtotal		7,950
Total Bilateral/Regional Projects	1968-1991	<u>12,367</u>
CENTRALLY FUNDED PROJECTS		
Expansion of Postpartum Family Planning Program	1969-1972	150
Participant Training for Population and Family Planning-Related Activities	1969-1978	n/a
Family Planning International Assistance		
Christian Council of Ghana	1973-1977	238
YMCA	1979	29
Association of People for Practical Life Education	1980	30
African Health Training Institutes Project (932-0359)	1973-1978	338
Program Grant to Population Council	1973-1978	62
Family Planning Assistance Through Home Economics	1973-1980	20
Family Planning Education Through Adult Literacy Programs	1974-1980	
World Education, Phase I	1974-1977	94
World Education, Phase II	1977-1980	304
International Development of Qualified Social Work Manpower for Population/Family Planning Activities	1976	n/a
Training for Family Planning Managers	1976-1979	n/a
Contraceptive Retail Sales	1976-1980	n/a
United Nations Population Fund (UNFPA) (about 27 percent of A.I.D. contributions fund projects in Ghana)	1977-1979	61
Physicians Postgraduate Training in Reproductive Health	1977-1980	118
University Teaching of Population Dynamics II	1978-1979	n/a
Ghana Fertility Survey, 1979	1979	218
Program for Voluntary Sterilization	1979	n/a
Family Planning Services (the Pathfinder Fund)	1980	n/a
Strengthening International Population Communication and Training	1980	15
Grant to IPPF (for PPAG)	n/a	n/a
Population Information Program	n/a	<u>n/a</u>
Subtotal		1,677

Table 1. Summary of A.I.D. Assistance to Family Planning in Ghana, 1968-1991 (cont.)

Project Title/Number	Date	Expenditures (in US\$ thousands)
Program for International Training in Health (936-3031)	1984-1986	5
Demographic and Health Surveys (936-3023)	1984-1989	93
Family Planning Services (the Pathfinder Fund) (936-3042)	1988	11
RAPID II (936-3017)	1988	4
Program in Voluntary Sterilization (932-0968)	1988-1989	105
Population Communication Services (936-3004)	1988-1989	330
Contraceptive Social Marketing I (936-3028)	1988-1989	296
Family Planning Logistics Management (Centers for Disease Control PASA) (936-3038)	1988-1989	101
Family Planning Management Training (936-3039)	1988-1989	81
Population Program Development and Support (932-0502)	1988-1990	121
Family Planning International Assistance (932-0955)	1988-1990	132
Central Contraceptive Procurement (936-3018)	1988-1990	32
Africa Operations Research Regional: Strategies* for Improving Service Delivery (936-3030)	1988-1991	848
Population Information Program (936-3032)*	1988-1991	264
Family Planning Enterprise Program (936-3034)*	1988-1991	286
Population Policy Initiatives (936-3035)*	1988-1991	637
Family Health International (936-3041)*	1988-1991	119
Training in Reproductive Health* (Johns Hopkins Program of International Education in Gynecology and Obstetrics) (936-3045)	1988-1991	394
RAPID III (936-3046)*	1988-1991	162
Association for Voluntary Surgical* Contraception Program (936-3049)	1989-1991	300
Contraceptive Social Marketing II (936-3051)*	1989-1991	447
Population Services Internship Program (936-3033)	1991	45
Extending Family Planning Services Through Women Managers (936-3037)	1991	10
Population Communication Services II (936-3052)*	1991	58
Central Contraceptive Procurement (936-3057) (included in Contraceptive Supplies Project)	1991	0
Subtotal		4,881
Less Mission Buy-Ins*		- 1,534
Subtotal (revised)		3,347
Total Centrally Funded Projects	1968-1991	<u>5,024</u>
Recorded Expenditures	1968-1991	17,391
Estimated Expenditures	1968-1991	<u>7,500</u>
Total Expenditures	1968-1991	24,891

*USAID/Accra has estimated that, on average, Mission buy-ins provided about one-half of the funding for these 10 centrally funded projects. To avoid double counting, almost half (\$1.534 million) of the expenditures reported for the 10 projects has been subtracted from the subtotal for centrally funded projects, resulting in a revised subtotal. Expenditures under the Danfa Comprehensive Rural Health and Family Planning Project (\$602,000) are based on USAID/Accra's estimate that only about 10 percent of total resources provided under this project were used for family planning.

- Cooperative agreements and Participating Agency Service Agreements (PASAs) with other U.S. Government agencies, such as the Bureau of the Census
- Partial funding of the activities of official international agencies

A.I.D. population and family planning assistance to Ghana can be divided into two distinct phases, pre-1983 and post-1984. In the spring of 1983, because of the worsening political relationship between the United States and Ghana, bilateral development assistance was suspended and population assistance did not resume until 1985 with the Contraceptive Supplies Project.

During the 14 years from 1968 to 1982, A.I.D. provided about \$11.3 million in population and family planning assistance or about \$0.8 million per year, on average. Of this, \$4.4 million was funded bilaterally and \$6.9 million was centrally funded. (This calculation assumes that the expenditures estimated for undercounted centrally funded projects [\$7.5 million] were distributed evenly over the 20 years during which expenditures occurred, averaging \$375,000 per year.)

During the 6 years from 1985 to 1991, A.I.D. provided about \$13.6 million of population and family planning assistance or about \$2.3 million per year, on average. Approximately \$8 million of this was provided bilaterally and about \$5.6 million was centrally funded. Measured in current dollars, A.I.D. gave, on average, almost three times the level of family planning assistance annually to Ghana after 1984 as before 1983. The importance of bilaterally funded (relative to centrally funded) activities was substantially greater during the second period (59 percent of the total) than during the first period (39 percent of the total). In addition many of the projects funded before 1983 focused on demographic training and increased understanding of population dynamics and did not contribute directly to an expansion of family planning.

In the early 1970s the A.I.D. population officers played a key role in trying to invigorate the family planning program, although these efforts eventually succumbed to the adverse political and economic situation. For example, A.I.D. reduced support of GNFPP, which did not seem to be providing effective direction and leadership to the program, and began to channel population assistance directly through the Ministry of Health. Also early in the program, A.I.D. attempted to broaden the approach to contraceptive availability through a social marketing project. Although the project was not sustained through the 1970s (several evaluations indicated that the lack of willingness on the part of

government and parastatal marketing agencies to set sufficient incentive prices was a key cause of the project's failure), important lessons were learned and subsequently applied in the mid-1980s.

A U.S./Ghana evaluation team reviewed A.I.D.'s involvement in the Government of Ghana family planning program during the 1968-1980 period and reached the following conclusions:

- The Government of Ghana maintained its commitment to the national population policy.
- A.I.D.-supported training activities greatly strengthened program capacity.
- The availability of family planning services and supplies remained limited, especially in rural areas, because of deficiencies in management and transportation and lack of collaboration among ministries.
- Reporting deficiencies made it difficult to assess the number of persons receiving services and using contraception.

These conclusions and those from other evaluations were taken into consideration in 1985 when A.I.D. renewed its program. For example, the Mission recognized the need for greater support from the political leadership and, therefore, designed the Population Impact Project to inform and influence policymakers. The project appears to have heightened awareness of and support for family planning among the current governmental leaders.

Other A.I.D. evaluations had identified the problems caused by lack of accessibility, which resulted in part from the overly medical nature of the distribution system. With its renewed program efforts in the mid-1980s, A.I.D. took the initiative to expand accessibility through commercial channels by introducing GSMP.

Although several A.I.D. evaluations (including the final evaluation of the Danfa Project) had reported the need for greater community-based distribution efforts, recommendations were never effectively implemented. A.I.D. supported training for family planning personnel to provide more sensitive counseling but did not actively pursue community-based distribution activities. The A.I.D.-supported training of traditional birth attendants (TBAs) partially filled this need, but only recently have large-scale community-based distribution activities received much attention.

Many evaluations of the Ghana family planning program (by A.I.D. and other donors, as well as by the Government) have addressed men's pronatalist attitudes. However, except for PPAG, which organized the first large-scale effort to target men in an education campaign, very little has been done to involve men in family planning.

A.I.D. considered the lessons of these evaluations, including lessons concerning sustainability, in designing the 5 year, \$30 million Family Planning and Health Program (1991-1996), which is the next phase of A.I.D. population assistance to Ghana.

Other Donor Assistance

The 1990 MCH/FP Annual Report of the Ministry of Health indicates that the Ghanaian Government provided 39 percent of the MCH/FP budget for 1990; donors and NGOs provided the rest. A.I.D. has been the largest donor in support of population and family planning activities in Ghana; however, it is impossible to attribute results of the MCH/FP program to A.I.D. or any other donor. It is also impossible to estimate what proportion of couple years of protection (CYP) can be attributed to any particular set of inputs. Although A.I.D. has been the largest provider of contraceptives (the United Nations Population Fund [UNFPA], IPPF, and the World Bank have also provided specific contraceptives), training and service delivery operations, which multiple donors have supported, are also important contributors to CYP. Similarly, although A.I.D. was the only donor supporting GSMP, which no doubt was responsible for a certain proportion of CYP, other donor and Government activities have contributed to IEC elements, which helped create demand for contraceptives supplied by GSMP in the first place.

United Nations Population Fund

UNFPA reported total cumulative expenditures for population programs in Ghana from 1972 to 1990 of \$5.71 million.

From 1972 to 1983 UNFPA expenditures totaled \$1.74 million and were used to provide technical assistance, training, equipment, and analytical support (UNFPA 1981). In June 1985 a 4 year, \$3 million program was approved to provide a wide range of support for maternal and child health and family planning, population and family life education, basic data collection and analysis, population and human resources development planning, and population research and training. Of this amount, \$468,000 was specifically allocated to assist the

national MCH/FP program through a joint Ministry of Health, United Nations International Children's Emergency Fund (UNICEF), and UNFPA program with the Margaret Sanger Center. In 1989 a second effort to strengthen the MCH/FP program was initiated with the Royal Tropical Institute to promote the "risk approach" in health care and to expand MCH/FP service outlets.

In June 1990 UNFPA approved a \$10 million country program for Ghana for 1991-1995. Goals of the program are to strengthen policy implementation through analysis of policy options, reinforce the institutional capabilities of the Ministry of Finance and Economic Planning, and enhance the Ministry's capacity to integrate population factors into the economic recovery program and overall development policy. The program also seeks medium-term reduction in maternal and child mortality through increasing the coverage and quality of maternal and child health and family planning services, upgrading the Ministry of Health's management and planning capabilities in maternal and child health and family planning, and establishing an effective and decentralized training program. The 1991 budget is \$2.67 million. Thus, the UNFPA program in Ghana has been increasing but is spread across a broad range of activities.

World Bank

The World Bank Health and Education Rehabilitation Project provided a \$15 million International Development Association credit to Ghana during the period from April 1986 to December 1991. The health component (which includes family planning) was for \$10 million and was designed to (1) strengthen the delivery of health, nutrition, and family planning services by rehabilitating rural and urban health centers, by supporting in-service training, and by financing vehicles, equipment, and operating costs and (2) strengthen health sector management and planning by funding sector studies, staff development, technical assistance, office equipment, transport, and communications. The project complemented UNFPA and A.I.D. support for family planning and population activities by financing the design and testing of a classification and referral system according to the level of a woman's obstetrical or reproductive risk and other population-related activities.

The World Bank Second Health and Population Project was approved in 1991 with an International Development Association credit of \$27 million over the period from June 1991 to December 1995. The project will support the qualitative improvement, reform, and extension of coverage of family planning and health services of the Ministry of Health and the leading NGOs: \$23 million to the Ministry of Health, \$2.8 million to PPAG, and \$1.2 million to other

NGOs (World Bank 1990). Of the total project budget, \$4.7 million is specifically allocated to family planning activities to purchase equipment and supplies that will be distributed through Ministry of Health and PPAG service delivery points.

Nongovernment Organizations

PPAG is the leading NGO in family planning, with 46 clinics in 8 regions and 63 nonclinical outlets. Its funding, primarily through IPPF, is approximately \$0.9 million per year. PPAG has planned a substantial expansion in both its clinical and nonclinical programs, but this expansion will depend primarily on increased support through the World Bank Second Health and Population Project.

Other NGOs active in family planning in Ghana include the National Catholic Secretariat, the YMCA, the Ghana National Association of Teachers, the Catholic Relief Services, and the Christian Council of Ghana, which has been funded primarily by the World Council of Churches and Family Planning International Assistance (Kwansa 1986).

Key Events

- 1891 First of six censuses conducted every 10 years during the British Colonial Administration until 1941 when they were interrupted by the Second World War. The population in 1891 was 764,613; it increased to 4.1 million by 1948. Independent Ghana conducted censuses in 1960, 1970, and 1984.
- 1957 Ghana receives its independence from Great Britain.
- 1960 Demographic surveys conducted by the Department of Demography and Social Science with funding from the Ford Foundation and Population Council.
- 1960 Census conducted; population is 6.5 million.
- 1961 The Committee on Christian Marriage and Family Life of the Christian Council of Ghana opens the first Family Advice Center in Accra; by 1967, the Committee has five such centers.
- 1966 PPAG formed.

- 1967 Kwame Nkrumah is overthrown by a military coup; the National Liberation Council takes power.
- 1967 Ghana is the first sub-Saharan African nation to sign the World Leaders' Declaration on Population on Human Rights Day.
- 1968 The Ministry of Health names a subcommittee of the Maternal and Child Health Committee to advise on family planning.
- 1968 Health chapter of the 1968 2 year Development Plan states that the Government, in cooperation with PPAG, will provide family planning and fertility control services to those who desire them at all health facilities.
- 1968 The National Liberation Council establishes the Ghana Manpower Board, which appoints a select committee to examine Ghana's population and consider a population policy.
- 1969- 1972 Country administered by freely elected Busia Government.
- 1969 PPAG attains full membership in IPPF.
- 1969 Official policy on "Population Planning for National Progress and Prosperity" adopted.
- 1970 Government establishes GNFPP to coordinate the population policy; A.I.D. provides financial support to GNFPP through a 5 year agreement.
- 1970- 1979 Major A.I.D.-funded project, Danfa Comprehensive Rural Health and Family Planning, is implemented.
- 1970 Census conducted; population is 8.6 million.
- 1971- 1982 A.I.D. provides Population Program support.
- 1972 Busia Government overthrown by political regime led by Colonel Acheampong.
- 1972- 1982 A.I.D. Program in Population Dynamics.

- 1977 Maternal and Child Health Division of the Ministry of Health becomes the MCH/FP Division.
- 1978 Acheampong regime replaced by General Akuffo.
- 1979 Akuffo regime replaced by Flight Lieutenant Rawlings in a coup.
- 1979 After a brief but memorable campaign against corruption, Rawlings hands over power to the democratically elected Government of Dr. Hilla Limann.
- 1979-1980 Ghana Fertility Survey conducted.
- 1981 Limann Government replaced by Rawlings and PNDC.
- 1982-1987 A.I.D. Family Health Initiatives Project implemented.
- 1983-1984 A.I.D. assistance to Ghana suspended.
- 1984 Census conducted; population is 12.2 million.
- 1985-1991 A.I.D. population activities reestablished with implementation of the Contraceptive Supply Project (designed in (1979)).
- 1986 National Conference on Population and National Reconstruction.
- 1986 Legon Plan of Action on Population approved.
- 1986 MCH/FP Division of the Ministry of Health includes family planning services in the mix of primary health care services and adopts policy to extend such services to all women and children in Ghana.
- 1988 Ghana Demographic and Health Survey conducted.
- 1988-1990 A.I.D. Contraceptive Procurement.

- 1989 National Population Conference held to commemorate the 20th anniversary of the Ghana population policy.
- 1992 A.I.D.-funded Family Planning and Health Project valued at \$30 million over 5 years is initiated.

4. DEVELOPMENT RESULTS: PROGRAM PERFORMANCE

A major purpose of the Ghana field assessment was to examine program performance; that is, the effectiveness, efficiency, and sustainability of A.I.D.'s investments in family planning over the past 23 years.

Effectiveness

CDIE defines effectiveness as whether the services, technical packages, or other products are being used by the intended beneficiaries; whether there is equitable access to these program outputs; and whether the coverage of the intended beneficiaries is as planned.

The Lapham-Mauldin Scale

The field study used the 30 item Lapham-Mauldin Family Planning Program Effort Scale (L-M Scale) to reach conclusions concerning effectiveness (see Appendix D for a detailed discussion of the L-M Scale). Each of the 30 items is scored from zero to four, with four indicating maximum effort. The maximum total program effort score for the 30 items is 120. The L-M Scale defines program effort in terms of four major components: (1) policy and stage-setting activities (8 items); (2) service and service-related activities (13 items); (3) record keeping and evaluation (3 items); and (4) availability and accessibility of fertility control methods (6 items). (Mauldin and Ross 1991).

The 1982 and 1989 Applications of the L-M Scale

The L-M Scale was applied to the Ghana family planning program in 1982 and in 1989. The results, shown in Table 2, are based on the judgment of program staff, donor agency personnel, local observers, and knowledgeable for-

Table 2. Family Planning Program Effort in Ghana Derived From L-M Scale, Numerical Score, 1982 and 1989

L-M Scale Category	1982	1982 as Percent of Maximum	1989	1989 as Percent of Maximum	Percent Changes, 1982-89
	A. POLICY AND STAGE-SETTING ACTIVITIES (32)^a	<u>10.10</u>	32	<u>18.83</u>	59
1. Policy on Fertility Reduction/Family Planning	4.00		4.00		
2. Statements by Leaders	0.00		4.00		
3. Level of Program Leadership	2.00		1.00		
4. Policy on Age at Marriage	0.00		3.00		
5. Import Laws and Legal Regulations	1.00		1.33		
6. Advertising of Contraceptives Allowed	2.00		2.00		
7. Other Ministries/Public Agencies Involved	1.10		3.50		
8. In-Country Funding of Family Planning Budget	0.00		0.00		
B. SERVICE AND SERVICE-RELATED ACTIVITIES (52)^a	<u>7.60</u>	15	<u>31.76</u>	61	318
9. Involvement of Private Sector Agencies	2.10		4.00		
10. Civil Bureaucracy Involved	0.30		0.78		
11. Community-Based Distribution Program	0.00		2.00		
12. Social Marketing Program	0.00		4.00		
13. Social Marketing Program	0.00		1.53		
14. Postpartum Program	0.20		2.22		
15. Home Visiting Workers	0.00		3.50		
16. Administrative Structure	0.00		3.45		
17. Training Program	2.00		3.45		
18. Personnel Carry Out Assigned Tasks	1.50		3.89		
19. Personnel Carry Out Assigned Tasks	0.00		1.89		
20. Logistics and Transport	0.00		1.00		
21. Supervision System	1.00		1.00		
22. Mass Media for IEC of Contraceptives	0.50		3.50		
23. Incentives and Disincentives	0.00		0.00		
C. RECORD KEEPING AND EVALUATION (12)^a	<u>2.10</u>	18	<u>6.83</u>	57	225
22. Record Keeping	1.40		3.00		
23. Evaluation	0.40		1.33		
24. Management Use of Evaluation Findings	0.30		2.50		
D. AVAILABILITY AND ACCESSIBILITY (24)^a	<u>1.50</u>	6	<u>5.05</u>	21	237
25. Abortion	0.30		0.25		
26. Male Sterilization	0.00		0.25		
27. Female Sterilization	0.20		0.50		
28. Pills and Injectables	0.40		1.25		
29. Intrauterine Devices (IUDs)	0.10		0.80		
30. Condoms and Other Conventional Methods	0.50		2.00		
Total Program Effort Score (120)	<u>21.30</u>	18	<u>62.47</u>	52	193

Source: The Population Council.

^a Maximum score for the component.

eigners. The numbers in parentheses indicate the maximum total program effort score for each of the four main categories.

Table 2 shows that Ghana's family planning program, as reflected in the total program effort scores for 1982 and 1989, has improved significantly. In 1982 Ghana's total numerical score was 21.3 (out of a maximum 120); in 1989, it was 62.47. In Table 3 these numerical scores are converted into percentage scores: 17.8 percent (out of a maximum 100 percent) in 1982 and 52 percent in 1989. Thus, Ghana's program moves from the "very weak" category into the "moderate" category.

Table 3. Family Planning Program Effort in Ghana Derived From L-M Scale, Percentage Score, 1982 and 1989

Program Effort Level		Ghana's Score	
		1982	1989
Strong	67+	--	--
Moderate	46-66	--	52
Weak	21-45	--	--
Very Weak or None	0-20	18	--

Source: The Population Council.

Interpretation of the L-M Scale

There are at least two ways to interpret these scores: first, to assess how far Ghana has come during the 1982-1989 period in each of the four main categories (a measure of past progress) and second, to assess how far Ghana has yet to go in each of the categories (a measure of future potential):

The change in the L-M Scale for Ghana from 1982 to 1989 for all four categories combined was about 193 percent: from 21.3 to 62.47 (numerical scores). The most dramatic improvement in program effort was in service and service-related activities (318 percent increase); the least dramatic improvement was in policy and stage-setting activities (86 percent increase). Thus, progress has been impressive, but it has not been evenly distributed (or equally impressive) across all four categories.

In 1989, the program effort score for all four categories combined was 52 percent. The highest level of program effort, 61 percent, was achieved in service and service-related activities; policy and stage-setting activities and record keeping and evaluation also scored relatively high: 59 percent and 57 percent, respectively. In sharp contrast, the lowest level of program effort, 21 percent, was achieved in availability and accessibility. Thus, availability and accessibility are the areas in which the most progress is still needed.

The assessment team made its own estimate of progress for each of the components of the L-M Scale based on key informant interviews, observation, review of documents, and discussion among team members. Because of the subjective nature of the L-M Scale and the small size of the assessment team (four persons), a precise numerical rating of the 30 items was not attempted.

The team's interpretation of the L-M Scale concerning the direction of change was generally consistent with that of the Population Council. However, the actual numerical scores assigned to some measures of program effort seemed to the team to be too high. For example, the team believed that none of the 30 items merited the maximum score (4), with the possible exception of policy on fertility reduction and family planning. The team also believed that administrative structure and items concerning involvement of the public sector did not merit high scores. In view of this, the team concluded that Ghana's family planning program had moved from "very weak" to "weak" and that the 1989 assessment of "moderate" was too generous.

Concerning the category where future potential was greatest (i.e., where the 1989 score as a percentage of the maximum score was the lowest), availability and accessibility of fertility control methods, the team found that availability was generally not as serious a problem as confidential accessibility of fertility control methods. For example, oral contraceptives have generally been available since 1986 at all Ministry of Health MCH/FP outlets, at 47 PPAG clinics, from 238 private sector midwives through the Ghana Registered Midwives Association, (GRMA), and at 3,500 outlets through GSMP. In addition, condoms and vaginal foaming tablets as well as creams and diaphragms are generally available. Abortion and male and female sterilization, however, are less readily available. The problem is that these fertility control methods are not readily accessible from a trusted, confidential source that ensures the privacy of the client (see discussion of "Demand for Family Planning Services" in this section).

Efficiency

In general terms, CDIE defines efficiency as "the results of an intervention in relation to its costs."

Cost-Effectiveness Analysis

CDIE used cost-effectiveness analysis as one means to evaluate the efficiency of A.I.D.'s investments in family planning. Cost-effectiveness analysis is a formal process for organizing information so that the costs of alternative means of reaching a given objective can be compared systematically. The relationship between cost and effectiveness is usually expressed as a ratio. The ratio is calculated by dividing the cost of an alternative, which is usually expressed in monetary terms, by the given level of effectiveness, which is usually expressed in nonmonetary terms.

Although cost-effectiveness analysis is often used to evaluate completed programs, it is used primarily as a decision-making tool to help policymakers and program managers select a *future* course of action. Thus, a *retrospective* cost-effectiveness analysis (e.g., an evaluation of a family planning program that has already been completed) is best used to estimate the cost-effectiveness of carrying out a program using the same, or similar, alternatives in the future.

A common procedure for applying cost-effectiveness analysis to family planning programs is to compute cost per CYP for the entire family planning program over time, either by service and commodity provider (or distribution strategy) or by contraceptive method. However, a cost-effectiveness comparison of specific contraceptive methods alone is not very useful for decision-making. For example, the intrauterine device (IUD) is widely reported as the least expensive method in providing 1 CYP. But, it would be incorrect to conclude that resources should be heavily shifted to providing IUDs, if many women do not choose this method for fear that the method will harm them.

Virtually all family planning programs offer several contraceptive methods to accommodate clients' preferences and medical circumstances. Some women, for example, may be medically advised not to use hormonal methods, such as pills; other women may need to change methods because of complications with a particular method. Perhaps more important, research shows that women tend to switch methods voluntarily more frequently than previously thought (Schwartz and Flieger 1989).

On the other hand, some family planning providers may provide certain contraceptive methods relatively more efficiently than others; therefore, comparing the cost-effectiveness of methods across providers may yield information useful for shifting resources among or providing more resources to service providers.

Constraints to Cost-Effectiveness Analysis in Ghana

Accounting procedures used by both the Government of Ghana and donor organizations did not track expenditures on family planning services and commodities. Ghana is by no means unique in this regard. As is typical in many developing countries, information on costs, or cost-effectiveness, of family planning in Ghana was not found in the literature search conducted before the visit to Ghana or in any program documents. Nor was such information available from key informants in donor organizations, the Government of Ghana, or the private sector. Apparently no one has investigated the cost of supplying contraceptive commodities and family planning services for the overall family planning program in Ghana by donor, by service delivery alternative, or by contraceptive method. This is true because no one has systematically collected economic cost data on family planning services in Ghana since the family planning program began in 1968. The absence of cost and CYP data for a particular provider, strategy, or method seriously restricts analysis because useful comparisons among alternatives cannot be made. Indeed, it effectively precludes a retrospective cost-effectiveness analysis of the Ghana family planning program.

USAID/Accra has been providing a variety of contraceptive commodities (condoms, pills, foaming tablets, IUDs) and supporting the Ministry of Health's family planning program since 1969. In 1985 A.I.D. began supporting the distribution of contraceptive commodities through family planning providers, including the Ministry of Health, commercial outlets, GRMA, and, most recently, traditional birth attendants (TBAs). USAID/Accra is in the process of initiating a 5 year, \$30 million Family Planning and Health Program to continue the current approach to providing family planning services and commodities. Yet, like previous programs, the new effort is progressing at increased funding levels without having first determined the relative economic efficiency of providing contraceptive methods through alternative contraceptive service providers. It should be noted, however, that data will be collected under the new project thereby providing a better basis for assessing alternatives in the future.

The compilation and analysis of actual expenditures for family planning services and the provision of commodities through the Ministry of Health are simply not possible under the current Ministry of Health accounting system.

MCH/FP programs are combined in a single line item of the budget. More problematic is that the 10 Ministry of Health regional health offices have discretion over the regional budgets that allows a shifting of funds among line items, and it appears that regional health offices rarely (if ever) prepare and submit routine reports to the Ministry of Health on actual expenditures. Thus, it is not known how much has been or is being spent on maternal and child health and family planning, much less on family planning alone, by the Government of Ghana.

Cost Analysis

Disentangling family planning expenditures from the Ministry of Health budget will require a detailed family planning program cost study that identifies all direct, indirect, and infrastructure costs attributable to the provision of family planning services and commodities. *Direct costs* are directly attributable to the family planning program. For example, such costs may comprise personnel salaries, volunteer time, contraceptive commodities, training materials, and transportation. *Indirect costs* are the costs of supporting direct services. For example, a family planning program may require a planner in the Ministry of Health for administration of the program or mechanics in the Ministry of Transportation to service the program's vehicles. *Infrastructure costs* are even less directly related to the program. They include the costs of roads, ports, and telephone systems that the program requires.

A further classification of direct, indirect, and infrastructure costs that needs to be made is between capital (or developmental) costs and recurrent (or operating) costs. As a general rule, resources with a life expectancy of 1 year or more are classified as *capital costs* and may include buildings, cars, trucks, beds, and medical equipment. These capital costs need to be depreciated over time. Resources that are purchased and used (or replaced) within 1 year are usually classified as *recurrent costs*. They include such items as personnel salaries, contraceptive commodities, medicine and supplies, gasoline, electricity, and food.

In the absence of cost data, it is not possible to compare the cost-effectiveness (that is, the cost per CYP) of alternative contraceptive methods in terms of alternative family planning service providers in Ghana (Ministry of Health, chemical sellers, and NGOs).

Cost Recovery

In addition to permitting a comprehensive cost-effectiveness analysis of the Ghana family planning program, cost analysis is essential for informed decisions about cost recovery of family planning services and commodities that are currently provided in Ghana. Indeed, it is extremely difficult, if not impossible, to set prices for family planning commodities for cost recovery if the costs of family planning services and commodities are not known.

Since 1986 A.I.D. and other donor organizations have been involved in a series of negotiations with the Ministry of Health to increase contraceptive prices for cost recovery purposes and to move toward free-market pricing in commercial outlets. In January 1992 contraceptive commodity prices were decontrolled. In fact, a condition precedent of the second disbursement of the Family Planning and Health Program was decontrolled contraceptive commodity prices. Yet, there is no information on the costs of various contraceptive commodities nor, to date, on the sensitivity of the demand for contraceptives to price changes.

To shed some light on the issue of prices, the team conducted a minisurvey of 24 chemical sellers (or pharmacists) in four regions of Ghana, most of which (17) were located in the Volta Region. In addition, prices were obtained from Ministry of Health clinics, PPAG clinics, GRMA clinics, and the social marketing wholesaler. Details of this admittedly unscientific survey are given in Appendix B, which tabulates the average reported unit prices as of May 1992 when the foreign exchange rate was approximately \$1 = 425 cedis. The unit price data reveal the following:

- In general, chemical stores charged the highest prices per unit for the three commodities that they sell (pills, condoms, and foaming tablets), although there was considerable variation across stores. Pill prices ranged from 50 to 300 cedis per cycle, condoms ranged from 8 to 25 cedis each, and foaming tablets ranged from 8 to 19 cedis each.
- On average the highest profit margin for chemical stores was for pills; the DANAFCO wholesale price for one cycle was 88 cedis, and the average retail price was 156 cedis. The average profit margin per unit for condoms and foaming tablets was relatively small (4 cedis per condom; 2 cedis per tablet).

- The Ministry of Health charged the lowest prices per unit, with no variation across clinics (although one clinic did report charging 20 cedis per cycle of pills instead of the usual 15 cedis). Ministry of Health TBAs in the Central Region are allowed to sell at twice the Ministry unit price and keep the difference as an incentive.
- The community-based distribution program administered by PPAG sells at PPAG prices, but agents are allowed to keep 40 percent of the price as an incentive.
- GRMA clinics charged the second highest prices. Only three GRMA clinics were sampled, however, and one of these reported charging on a sliding scale.
- The same general price relationships among the sampled suppliers held when unit prices were converted to price per CYP, as shown in Appendix B. That is, chemical stores were most expensive, followed by GRMA, PPAG, and the Ministry of Health. By contraceptive method, the IUD was the least expensive in terms of price per CYP, as is the case in many other countries. At the Ministry of Health, the IUD price per CYP was only 29 cedis. Provera was the second cheapest method in terms of price per CYP at the Ministry of Health but was third cheapest (after the pill) at PPAG.

Contraceptive prices in Ghana, unfortunately, do not accurately reflect costs, because there is no free market for contraceptive services and commodities and because commodities (as well as donor supplied technical assistance, training, and vehicles) are usually supplied free-of-charge to the Ministry of Health, PPAG, and the social marketing commercial distributor. Yet, sound resource allocation decisions should be based on costs (or prices that reflect costs) not on administered prices.

In addition the effect of highly subsidized commodities available from the public sector and donor organizations on the development of the commercial sector is unknown; that is, whether decontrolled prices in the commercial sector will be effectively undermined by less expensive, near-perfect substitutes available from the public sector cannot be determined. Nor is it known whether price deregulation will harm or enhance the public sector cost recovery program. Therefore, in addition to a cost analysis, a price elasticity analysis is needed.

Other Efficiency Issues

As already noted, the relative economic efficiency of the Ministry of Health, the commercial sector, and other providers is unknown. However, it is generally recognized that the Ministry of Health MCH/FP clinics are underutilized, since Ministry staff in these clinics seemed to have few, if any, clients. Nurses in one district-level clinic complained of having to sit around for hours between clients. Such underutilization suggests that activities to create demand should be undertaken or the costs of providing family planning services could be reduced by cutting staff or facilities.

Some have suggested that the low utilization of family planning services may occur in part because clinics are not open after usual working hours on weekdays or on weekends; therefore, accessibility is restricted. Others have suggested that clinic personnel should conduct more community outreach activities to increase the use of services and commodities. Both suggestions probably have merit.

Sustainability

It is important to understand how Ghana's family planning program has been administered over the past 23 years and, in that context, to assess the extent to which A.I.D.'s investments in family planning have been sustained; that is, the extent to which program outputs and benefits continue to be available after A.I.D. funding has terminated.

A.I.D.'s investments in family planning have focused on training a substantial number of nurses and other personnel, strengthening certain institutions charged with coordinating or delivering family planning services and commodities, and providing contraceptives. The benefits derived from these outputs have been limited, at least when measured in terms of changes in the contraceptive prevalence rate and resultant changes in the total fertility rate. The contraceptive prevalence rate had increased to only 13 percent by 1988, and, for modern methods, it was only about 5 percent. Although by 1991 the prevalence rate for modern methods had increased to about 8 percent, by any international

standard, this rate was still low.² The total fertility rate decreased by fewer than 1 child between 1965 and 1988, from 6.8 to 6.4, and because of declining mortality the population growth rate increased from 2.2 percent in 1965-1980 to 3.4 percent in 1980-1990 (Ghana Statistical Service 1989; World Bank 1992).

Given this modest performance, a sustainability analysis is problematic because there have been only limited benefits to sustain. The more relevant question is, Why has progress in family planning in Ghana until recently been so disappointing? As suggested in the following discussion, any development program is less likely to succeed in an environment characterized by political instability, rapid turnover of senior officials, fragmentation of authority and responsibility, and poor leadership. Similarly, where U.S. financial and technical assistance is important to a particular development program, the program is unlikely to succeed when relationships between the recipient government and the United States are strained or suspended. Finally, program success is less likely in a social context characterized by obvious rural/urban and gender inequalities and in an economic climate characterized by negative real growth.

These and related factors can help explain why family planning in Ghana has, until recently, been slow in producing outputs and benefits that could be sustained. They can be conveniently organized in terms of institutional sustainability, financial sustainability, and the demand for family planning services.

Institutional Sustainability

Institutionally, family planning got off to a poor start in Ghana partly because of the adverse political environment in which the program was implemented during much of the 1968-1991 period.

Political Environment. Ghana experienced numerous changes in Government between 1968 and 1991, and the result was political instability. In 1967 Ghana's first independent Government, led by Nkrumah (who advocated a larger population, quickly), was overthrown by the National Liberation Council. The National Liberation Council announced a comprehensive population policy in 1969, but later that year the Busia Government came to power and demonstrated little support for family planning and related social services. In 1972 the Busia

²Preliminary estimates from a recent consumer baseline study suggest a contraceptive prevalence rate of 15 percent for modern methods among married women.

Government was overthrown, and a new political regime led by Colonel Acheampong came to power, during which time GNFPF activities were temporarily suspended. By 1978 the Acheampong Government had been replaced by General Akuffo, but in less than a year the Government of General Akuffo too was overthrown, this time in a coup by the Armed Forces Revolutionary Council led by Flight Lieutenant Jerry Rawlings. The democratically elected Limann Government followed in 1979, but on December 31, 1981, it was overthrown by the military, and the PNDC Government, led by Rawlings, took power. PNDC remains in power in 1992.

In 1967 A.I.D. was the largest donor to Ghana, contributing more than half of total assistance in that year. But in February 1983 the U.S. State Department directed that, for security reasons, the official U.S. presence in Ghana be reduced to the essential minimum. Political tensions continued to rise and by spring the United States had suspended all new starts; U.S. contractors were given early termination notices; and ongoing design activities for all new projects were suspended indefinitely. By midsummer the A.I.D. Mission staff had been reduced from nine to three, the absolute minimum necessary to maintain a presence and a minimum program (Britan 1988 citing USAID/Accra, "FY 1985 Annual Budget Submission").

By July 1984 political relations between the United States and Ghana had begun to improve, and A.I.D. resumed economic assistance after a 15 month freeze (USAID/Accra 1985). By 1987 A.I.D., still rebuilding its program, was only the ninth largest donor to Ghana (behind four bilateral and four multilateral donors), contributing less than 3 percent of total assistance and 6 percent of bilateral assistance. By 1992, however, A.I.D. was one of the largest bilateral donors and was by far the largest donor in the field of family planning, providing three times as much support to family planning as the next largest donor.

Nonetheless, during much of this period, the political environment in which A.I.D. assistance was provided to Ghana was not conducive to long-term development activities, such as family planning. The frequent changes in Government, the military rule during much of the period, and the strained political relationship between the United States and the Government of Ghana help explain why family planning programs produced few sustainable outputs.

National Commitment. Ghana is 1 of only 15 countries in sub-Saharan Africa with a formal population policy and 1 of only 3 countries (together with Kenya and Mauritius) that has had a formal population policy for 15 years or longer (United Nations 1992). Nevertheless, a clear, national commitment to family planning—a consensus among the national leadership, senior decision-makers, and important interest groups that the goals and objectives of family

planning are of national priority—has not been present in Ghana for the past 20 years. And this lack of overt, continuous political support is a major factor explaining the poor performance of Ghana's family planning program.

Although a clear national commitment to family planning is not always a precondition for success, it helps. For example, in the Philippines, the First Lady, Mrs. Marcos, actively encouraged family planning; in Zimbabwe, the sister-in-law of the President was a major promoter of family planning; and in Nigeria, the President has enunciated a policy favoring family planning.

This lukewarm attitude toward family planning in Ghana may be changing, in part as a result of the A.I.D.-supported Population Impact Project, which is specifically designed to inform and influence policymakers. Increased national commitment to family planning is manifested in plans for the creation of a new Population Council and the Head of State has been stressing the importance of family planning more frequently in 1992.

Leadership and Organizational Structure. From 1970 to 1980 all family planning assistance to Ghana was coordinated by and channeled through GNFPP. A.I.D. supported GNFPP during this period, initially with staff support and later with only contraceptive supplies. A.I.D. then began working with and supplying contraceptives directly to the Ministry of Health, which was charged with delivering family planning services and commodities. However, the Ministry of Health traditionally had not been especially committed to implementing family planning programs. Thus, although family planning was envisioned as an important part of Ministry of Health operations, it became a Ministry stepchild and the result was a weak clinic-based system of service delivery.

Although GNFPP continues to exist on paper, it has little power and is not taken seriously. Moreover, GNFPP has become detached from the implementing ministries and is treated as an appendage to the Ministry of Finance and Economic Planning. Consequently, there is a lack of direction among participating agencies, which is exacerbated by personality conflicts and internal rivalries; procedures across agencies are not coordinated effectively; and no clear delineation of responsibility exists to carry out the population policy.

After two decades of poor coordination, poor organizational structure, lack of administrative leadership, and lack of high level governmental commitment, there now appears to be serious change. As previously noted, the Government plans to establish a Population Council, an autonomous unit comprising relevant governmental and nongovernmental entities. The Council will constitute a legally ordained body with the highest level of official sanction to plan, coordinate, and monitor the entire country's family planning program for the

public and private sectors. Family planning will have the prominence and prestige it requires and will be perceived not just as health but as part of a multidisciplinary effort to promote overall socioeconomic development. Regardless of whether the Population Council promotes the best possible family planning strategy, it will at least promote a common, coordinated strategy, one that stresses an integrated approach to the delivery of family planning services. Whether the new body makes any measurable difference remains to be seen.

Delivering Family Planning Services. There are three main institutional mechanisms for delivering family planning services and supplies in Ghana: the public sector, primarily the Ministry of Health; NGOs, primarily PPAG; and the commercial sector, primarily GSMP.

As summarized in Table 4, 35 percent of users of modern methods of contraceptives were supplied by the Government; 18 percent by PPAG; 23 percent by chemical sellers; and the remaining 24 percent by friends and by other organizations. The importance of these providers varies by the type of contraceptive supplied. The public sector is the most important provider of clinical methods (IUDs and voluntary sterilization), supplying 76 percent. The commercial sector is the most important provider of supply methods (oral contraceptives, condoms, injectables, and vaginal methods), supplying 33 percent (Ghana Statistical Service 1989).

Table 4. Users of Modern Methods of Contraceptives in Ghana, by Source of Supply and Method, 1988 (percentage)

Source	Supply Methods	Clinical Methods	Total
Public Sector	19	76	35
PPAG	20	12	18
Commercial Sector	33	0	23
Other	<u>28</u>	<u>12</u>	<u>24</u>
Total	100	100	100

Source: Ghana Demographic and Health Survey (Ghana Statistical Service 1989, 42).

The Ministry of Health, which had only 160 distribution centers in the entire country in 1970, now has 600. PPAG provided clinical services in 46 clinical settings and nonclinical services through 168 community agents in 1989. DANAFCO, which is the main implementing body for GSMP, operates a network of 17 depots and subdepots in the 10 regional capitals, which in turn service 3,000 to 4,000 retailers (chemical sellers). In addition, there are about 2,000 other retail outlets operated by private doctors, the GRMA network, and the National Council on Women and Development, as well as about 3,000 TBAs.

During most of the past 23 years, certainly during the 1968-1982 period, the Government emphasized the public health clinics under the Ministry of Health as the major institutional mechanism for delivering family planning services—rather than, for example, a community-based system. The differences between the two delivery systems are striking and may help explain the low contraceptive prevalence rates during the period:

- Public health clinics are usually urban, whereas community-based systems are usually rural (although this is not a defining characteristic).
- A client must go to a public health clinic for services, whereas services are brought to the client under a community-based system.
- Public health clinics tend to give short shrift to family planning (relative to other services), whereas community-based systems tend to emphasize family planning.
- Public health clinics are not as careful as community-based systems in protecting the confidentiality of the client.

It is not clear which approach is most cost-effective. As suggested later in this section, however, whatever approach is emphasized—a community-based system, a clinic-based system, or another system—it must provide convenient and confidential access to family planning services and supplies. Otherwise, the demand for these services will remain low.

Financial Sustainability

Projects that use resources more efficiently are usually more likely to be financially viable and, therefore, sustained. Efficient resource use requires a strategy of cost containment and cost recovery.

Cost Containment. In order to develop and implement a strategy of cost containment for any program, costs of the elements of the program must be analyzed. As indicated in the prior discussion about constraints to cost-effectiveness analysis, cost data for the family planning program in Ghana are not available and, thus, a cost analysis cannot be carried out. It appears, however, that costs are higher than they need to be as manifest by the unused capacity and underemployed personnel providing family planning services at Ministry of Health clinics. As already noted, this may suggest the need to create additional demand for existing family planning services or to reduce staff and facilities currently providing such services to reduce costs.

Cost Recovery. Financial sustainability can also be achieved by implementing a strategy of cost recovery, which involves charging fees for the commodities provided and the services rendered. Again, however, to set fees, it is necessary to know how much the services cost and how much users are willing and able to pay for them. As indicated in the earlier discussion of cost recovery, no one knows the real costs of the family planning program in Ghana and no one knows the price elasticity of demand for family planning services and commodities—that is, how the demand for services and commodities provided under the program might vary with changes in the prices of these services.

According to USAID/Accra, A.I.D.-funded family planning projects in Ghana have attempted to recover some costs since 1986 (such as distribution and advertising costs of contraceptives sold under the social marketing program). Still, there is a generally held view that the public sector will need to continue to subsidize family planning services for the foreseeable future. Until a certain threshold of acceptance (as distinct from awareness) of family planning is reached, the effective demand for family planning services will be weak. That threshold (sometimes defined as a contraceptive prevalence rate of around 30 percent) has not been reached in Ghana.

A subsidy may nevertheless be justified because programs that confer public benefits (that is, benefits that accrue to society as much as or more than to the individual) will normally need to depend at least in part on public funds. And family planning would be counted among programs conferring public benefits. A separate question is whether a subsidy is politically feasible during times of economic hardship, which have characterized Ghana during much of the past 23 years. A government can choose to allocate budgetary resources to support productive activities that are likely to yield a short-term gain or it can choose to support activities, such as family planning, that are intended to yield long-term savings.

Demand for Family Planning Services

No program will be sustainable if the effective demand for the services and commodities it provides is weak. This appears to be the case with the demand for family planning services in Ghana. Although a large proportion of married women in Ghana in 1988 desired to delay pregnancy (68 percent) and were aware of family planning (77 percent), only a small proportion used contraceptives (13 percent). This large gap can be explained in part by lack of convenient and confidential access to services and supplies and by cultural beliefs and gender concerns.

Lack of Convenient and Confidential Access to Services and Supplies. Although some services and some brands of contraceptives are not always available in some areas (especially in villages), inadequate supply (or stockouts) is not the problem. Instead, the problem concerns the way in which family planning services and supplies are provided, because this determines in large part whether they are used. Too often services and supplies are provided in an environment that does not ensure privacy and confidentiality. And under these circumstances, women, especially single women and teenagers, are often too shy to buy or request the services. According to focus group results reported for three regions, "contraceptives should be dispensed by the person who is able to keep a secret" (see Appendix C). This has generally not been the case in Ghana. Lack of convenient and confidential access to family planning supplies and services that are, in fact, available has been a major problem. For example

- IEC has concentrated on married women, and not on single women and teenage girls, on the grounds that it might encourage promiscuity—despite the fact that teenage pregnancy has been on the rise. As a result, unmarried women do not know how to use family planning methods or where to get information.
- The strategy of integrating the delivery of family planning services with related health and reproductive services did not begin until 1978-1979 and was not operational until about 1985. Before then family planning services and supplies were offered by a separate cadre of Ministry of Health personnel, in a separate facility, and only on selected days of the week. Only the chemical sellers afforded any degree of confidentiality.
- In some cases Ministry of Health nurses who had been trained in family planning were inadequately trained. And in many cases it was the owners of the chemical shops who were trained in family planning not the clerks behind the counter dispensing the contraceptives. As a

result, in one case, saccharine "pills" were sold to clients as oral contraceptives and the family planning program was discredited. In another case, potential clients did not question the benefits of modern contraceptives but questioned their safety, believing such methods were dangerous. In still another case, family planning providers translated the concept of birth spacing into the local language as birth stopping. These factors identified in focus group discussions help to explain the low utilization of modern family planning methods.

- A service delivery strategy with the *sole* emphasis on family planning, or even on maternal and child health and family planning, is unlikely to generate much interest among people living in a village with no school, no water, and no electricity. The Government now accepts this view, partly as a result of the A.I.D.-supported Population Impact Project.

Cultural Beliefs and Gender Concerns. In Ghana there are deeply rooted cultural preferences favoring large families. In addition, Ghanaian women tend to defer to their husbands in many aspects of personal decision-making, even if economic pressures and reproductive aspirations favor fewer children (Ezeh 1992). Cultural beliefs and sexual inequality undermine family planning programs and help explain the low utilization of family planning services. For example

- Ghana's culture is pronatalist: it is not good *not* to want to have children. In addition, there is a belief in Ghana that when a man has had 10 children, "he has made it." These culturally ingrained beliefs are not conducive to increasing the use of family planning.
- The 1988 Ghana Demographic and Health Survey, which included a husbands' questionnaire, found that Ghanaian men on average want two more children than Ghanaian women.
- Marriage and divorce laws in Ghana are not supportive of women who wish to contracept despite their husbands' objections, unless they are willing to sacrifice their economic security. These laws and practices are not likely to change unless female literacy, currently only half that of males, is increased.
- Children are treated as a form of social security in old age, which not only reduces the demand for family planning services but in fact encourages people to have many children. This is likely to continue

until infant and child mortality rates, which were still unacceptably high at 146 per 1,000 in 1989, decline.

- The demographic implications of rapid population growth have simply not been understood in Ghana, by either the policymakers or the beneficiaries. In the early 1970s it was not at all obvious that there was a population explosion in Ghana, at least when compared with Asia where space was (and still is) at a premium. Even today it is difficult to convince Ghanaians that they have a population problem when their country, the same size as England, has a population of about 16 million and England has a population of 60 million.

Table 5 presents results from the 1988 survey that suggest other factors that help explain the large gap between awareness of family planning and desire to delay pregnancy on the one hand, and use of contraceptives on the other. In contrast to the results summarized above, which are based on focus groups (Appendix C) and key informant interviews, the 1988 survey minimizes the importance of access and availability and gender concerns; those were reported as problems by only 2 percent and 4 percent of the respondents, respectively. Fully half of the respondents do not use contraceptives for reasons unrelated to the family planning program; that is, 26 percent do not use contraceptives because they have little need for contraceptives (menopausal/subfecund, postpartum/breast-feeding, or infrequent sex), and 10 percent cited health concerns. Another large group of respondents (24 percent) lacks knowledge of family planning, and 24 percent do not use contraceptives for reasons that are difficult to interpret (other, don't know, or missing).

Table 5. Main Reason Cited for Not Using Contraceptives, by Age, 1988

Reason for Nonuse	Age		Total (%)
	Younger Than 30 (%)	30 and Older (%)	
Lack of Knowledge	29.0	18.3	23.7
Opposed to Family Planning	3.9	3.2	3.6
Husband Disapproves	2.8	4.7	3.8
Others Disapprove	0.7	0.6	0.7
Health Concerns	7.1	11.9	9.5
Access/Availability	2.2	1.5	1.9
Costs too Much	1.9	2.3	2.1
Inconvenient to Use	2.2	0.9	1.6
Infrequent Sex	12.7	7.2	10.0
Fatalistic	0.2	0.8	0.5
Religion	2.4	4.2	3.3
Postpartum/Breast-feeding	8.2	5.9	7.1
Menopausal/Subfecund	0.2	18.0	9.0
Other	12.2	13.8	13.0
Don't Know	13.1	6.6	9.9
Missing	<u>0.9</u>	<u>0.2</u>	<u>0.6</u>
Total	99.7	100.1	100.3
Number of Women	534	529	1,063

Source: Ghana Demographic and Health Survey (Ghana Statistical Service 1989, 44).

Note: Distribution is for nonpregnant women who are sexually active, who are not using any contraceptive method, and who would be unhappy if they became pregnant. Women who have never had sexual intercourse and women who have not resumed sexual relations since the last birth are excluded.

5. DEVELOPMENT RESULTS: IMPACT

The longer term effects or impact of Ghana's family planning program can be assessed in terms of demographic impact, health impact through the reduction of high risk births, and economic and social impact.

Demographic Impact

The demographic impact of any family planning program is a function of several key variables, including population growth, fertility, contraceptive prevalence, other major proximate determinants, and desired family size. Normally, one would expect progress indicators to be reflected first in measures such as couple years of protection and contraceptive prevalence rates, next in fertility rates, and ultimately in population growth rates. The analysis below begins with the longer term indicators and moves to the intermediate and short-term indicators.

Population Growth

Ghana's population grew from 4.1 million in 1948 to 6.5 million in 1960. By 1970 it had increased to 8.6 million, and by 1984 it had risen to 12.2 million. By mid-1992 Ghana's population was approximately 16 million. The average annual rate of growth of population from 1965-1980 was 2.2 percent; from 1980-1990, it was 3.4 percent (World Bank 1992). At the 1990 population growth rate of 3.4 percent, the Ghanaian population is expected to double in fewer than 21 years.

Estimates of the population growth rate range from 2.6 percent to 3.4 percent. The Ghana Statistical Service (1992) uses an official population growth rate of 2.6 percent, which is the 1973-1983 intercensal growth rate. This intercensal period included a severe drought and the economic crisis of the early 1980s. USAID/Accra believes that the figure of 3.4 percent, which is a point

estimate derived from the 1988 Ghana Demographic and Health Survey, represents the best estimate of current population growth.

The 1969 population policy set a specific demographic target of reducing the rate of population growth from the projected 3.9 percent by the year 2000 (the expected level in the absence of a family planning program) to 1.7 percent by the year 2000. Although there is no clear consensus in Ghana on the exact levels of current fertility and mortality rates, it is clear that the family planning program and other elements of the population policy have not yet begun to yield results in reducing the rate of population growth.

Fertility

The 1988 Ghana Demographic and Health Survey reports that for 1985-1988 the total fertility rate for women aged 15-49 was 6.4, and for the period 1982-1984, it was 6.6. The 1979-1980 Ghana Fertility Survey reports that the total fertility rate for the period 1975-1979 was 6.5. The 1968-1969 National Demographic Sample Survey recorded a fertility rate of 6.9, while the 1971 Supplemental Enquiry recorded a rate of 5.9. It is apparent from these data that little change has occurred in the total fertility rate during the last 20 years. It is also clear that Ghana has not reached the fertility reduction targets established in the 1969 population policy. That policy had set as an objective a 50 percent reduction in completed family size by the year 2000 by lowering the total fertility rate from about 7 in 1970 to 5 by 1985 and to 4 by the year 2000.

Age-specific fertility rates (as well as total fertility rates) from the 1971 Supplemental Enquiry, the 1979 Ghana Fertility Survey, and the 1988 Ghana Demographic and Health Survey are compared in Table 6. The table shows that there have been at most only minor shifts in age patterns of fertility.

Contraceptive Prevalence

The most reliable measure of the impact of a family planning program is the contraceptive prevalence rate. Early surveys showed very low prevalence. For example, the 1968-1969 National Demographic Sample Survey (Gaisie and David 1974) reported a prevalence rate of only 2.6 percent, of which 76 percent were using rhythm, followed by pills and then foam and foaming tablets; there were very few users of other methods. The two most recent sources of published survey data on contraceptive prevalence were the 1979 Ghana Fertility Survey and the 1988 Ghana Demographic and Health Survey. Table 7 compares contraceptive prevalence in 1979 and 1988 using these two sources. The

proportion of currently married women using any contraceptive method increased from 9.5 percent in 1979 to 12.9 percent in 1988. However, the use of modern methods remained virtually unchanged: 5.5 percent in 1979 and 5.2 percent in 1988. In contrast, there was a substantial increase in the use of traditional methods from 4.0 percent to 7.7 percent. The increase in traditional methods rather than modern methods is understandable given the political and economic crises of the early 1980s.

Table 6. Age-Specific Fertility Rates in Ghana, 1971, 1979, and 1988

Age Group	Supplemental Enquiry 1971 ^a	Ghana Fertility Survey 1979 ^b	Ghana Demographic and Health Survey 1988 ^c	Difference (1979-1988)
15-19	0.110	0.137	0.124	- 0.013
20-24	0.259	0.258	0.258	0.000
25-29	0.266	0.275	0.278	+ 0.003
30-34	0.236	0.249	0.248	- 0.001
35-39	0.176	0.184	0.195	+ 0.011
40-44	0.097	0.133	0.117	- 0.016
45-49	0.041	0.061	0.060	- 0.001
Total Fertility Rate	5.92	6.49	6.4	- 0.09

^a Average number of births during the 12 months preceding the 1971 Supplemental Enquiry, as reported in the 1979-1980 Ghana Fertility Survey, First Report, Table 5.4 (Ghana Statistical Service 1983).

^b Average number of births during the 5 years preceding the 1979-1980 Ghana Fertility Survey (Singh and Shah 1985, 54).

^c Average number of births during the 5 years preceding the 1988 Ghana Demographic and Health Survey (Ghana Statistical Service 1989).

Table 7. Currently Married Women Using Contraception, by Method, 1979 and 1988

Method	Ghana Fertility Survey 1979	Ghana Demographic and Health Survey 1988	Difference (1979-1988)	
All Methods	9.5	12.9	+	3.4
Modern Methods	5.5	5.2	-	0.3
Pill	2.4	1.8	-	0.6
Injectable	0.1	0.3	+	0.2
IUD	0.3	0.5	+	0.2
Condom	0.6	0.3	-	0.3
Female Sterilization	0.5	1.0	+	0.5
Vaginal Methods	1.6	1.3	-	0.3
Traditional Methods	4.0	7.7	+	3.7
Withdrawal	0.2	0.9	+	0.7
Abstinence	3.8	6.2	+	2.4
Other	0.0	0.6	+	0.6

Source: For 1979, Ghana Fertility Survey (Appiah 1985); for 1988, Ghana Demographic and Health Survey (Ghana Statistical Service 1989, 37).

Note: More recent surveys indicate contraceptive prevalence rates for modern methods increased to an estimated 8-10 percent in 1990-1991, and preliminary results of a 1993 consumer baseline survey show 15 percent.

In 1979 and 1988 abstinence was the contraceptive method used most often, with the proportion almost doubling from 3.8 percent in 1979 to 6.2 percent in 1988. It should be noted that, for 1979, prevalence rates for prolonged abstinence and periodic abstinence (rhythm) have been added together and recorded as "abstinence," even though they were recorded separately in the 1979 Ghana Fertility Survey. This was necessary for purposes of comparison because the 1988 Ghana Demographic and Health Survey did not record prevalence rates specifically for prolonged abstinence; however, the results of the 1988 survey suggest that women using prolonged abstinence to avoid pregnancy generally were recorded as using periodic abstinence.

Among modern methods the pill was the most frequently used method in 1979 and 1988; however, the proportion of women using the pill declined from 2.4 percent in 1979 to 1.8 percent in 1988. There were also slight increases in the use of injectables, IUDs, and female sterilization.

Couple Years of Protection

Service statistics compiled by USAID/Accra from the three major providers of contraceptives (Ministry of Health, PPAG, and GSMP) have been used to calculate CYP for more recent years. Table 8 shows CYP from 1987-1991 by modern method. Although the absolute number of CYP is small, the magnitude of the change in CYP is dramatic. In 4 years the CYP nearly tripled from about 75,000 in 1987 to almost 223,000 in 1991. There was an especially high rate of growth in CYP attributable to the use of injectables (510 percent), IUDs (466 percent) and surgical contraception (387 percent). This compares with an overall rate of growth in CYP of 195 percent.

Table 8. Couple Years of Protection,
by Modern Method, Ghana, 1987-1991

Method	1987	1988	1989	1990	1991
Orals	37,378	49,508	56,099	70,800	82,296
Condoms	19,559	25,392	25,225	29,868	34,542
Foaming Tablets	4,968	9,215	8,496	16,230	19,118
Injectables	5,620	9,780	11,953	17,030	34,300
IUDs	7,470	11,774	25,589	36,055	42,299
Surgical Contraception	<u>696</u>	<u>916</u>	<u>1,256</u>	<u>2,308</u>	<u>3,392</u>
Total CYP	75,691	106,585	128,618	172,291	222,947

Note: USAID/Accra used the CYP "standards" listed below to calculate CYP. In the case of surgical contraception, the standard is based on a formula of 42 minus the mean age of women receiving the procedure, rather than the commonly used 12.5 years. As the mean age of women undergoing the procedure drops, the standard would rise.

Oral Contraceptives:	15	cycles
Condoms:	150	units
Foaming Tablets:	150	tablets
Injectables:	4	injections
IUDs:	3.5	years per IUD
Surgical Contraception:	4	years per procedure

Source: USAID/Accra.

Table 9 shows CYP from 1987-1990 by provider. CYP provided by the Ministry of Health clinics increased most dramatically, from providing the least CYP (relative to GSMP and PPAG) in 1987 (about 14,000) to providing the most CYP in 1991 (over 101,000), nearly a sevenfold increase.

Table 9. Couple Years of Protection,
by Provider of Modern Methods, Ghana, 1987-1991

Provider	1987	1988	1989	1990	1991
GSMP	39,416	50,811	55,013	64,664	67,987
Ministry of Health	14,574	26,734	63,978	90,458	101,592
PPAG	<u>21,701</u>	<u>29,040</u>	<u>9,627</u>	<u>17,169</u>	<u>53,368</u>
Total CYP	75,691	106,585	128,618	172,291	222,947

Source: USAID/Accra.

These data for this more recent period from 1987 to 1991 are consistent with the increase of the contraceptive prevalence rate for modern methods from about 5 percent to about 8 percent.

Among the many factors affecting the level of contraceptive use, two seem to have the strongest explanatory power: urban versus rural residence and level of female education. The 1988 Ghana Demographic and Health Survey shows that contraceptive prevalence among urban women was 19.6 percent (8.1 percent modern) and prevalence among rural women was only 9.9 percent (3.9 percent modern). Table 10 shows the relationship between contraceptive use and female education. Contraceptive use rises progressively from 8.5 percent among women with no education to 28.7 percent among those with higher education. The most dramatic increase occurs for women who have gone beyond middle level education, which appears to be a threshold level. Similar differentials exist for both modern and traditional methods.

Table 10. Currently Married Ghanaian Women Using Contraceptive Methods, by Educational Level, 1988

Educational Level	Percentage of Women Using		
	Any Method	Modern Method	Traditional Method
No Education	8.5	3.2	5.3
Primary	12.1	6.1	6.1
Middle	16.8	6.7	10.1
Higher	28.7	10.1	18.5

Source: 1988 Ghana Demographic and Health Survey (Ghana Statistical Service 1989, 39).

Proximate Determinants

It is not possible to attribute changes in fertility solely to changes in contraceptive prevalence. In fact, fertility levels are governed by the interaction of five major proximate determinants: the proportion of women aged 15-49 in union, the mean duration of postpartum amenorrhea due to breast-feeding, the proportion of women protected by contraception, the incidence of abortion, and the incidence of sterility.

For example, Ghana's total fertility rate of 6.4 is below the rate of other countries, such as Kenya, which have higher contraceptive prevalence rates, and it is well below the maximum natural fertility rate or total fecundity. This difference between maximum natural fertility and observed fertility is explained by the combined effects of the proximate determinants, particularly marriage patterns and breast-feeding patterns.

The Regional Institute for Population Studies (University of Ghana 1983) calculated the relative effect of the proximate determinants in accounting for the difference between maximum natural fertility and observed fertility using data from the 1979 Ghana Fertility Survey. As shown in Table 11, the level of maximum natural fertility implied by the model was 14.9 children per woman.

The total fertility rate (model estimate), however, was only 6.4 children per woman. The difference, 8.5 children per woman, is accounted for by the proximate determinants.

Table 11 shows that 31.3 percent of the difference is due to the proportion of women who are married (or in union); 64.0 percent is due to postpartum infecundability; and only 4.7 percent of the difference is due to contraceptive use. A similar analysis could be done using 1988 Ghana Demographic and Health Survey data to show changes in the relative importance of the proximate determinants over time. However, given the low level of contraceptive prevalence of modern methods in 1988, it is doubtful there will have been much change in the relative impact of the proximate determinants. This type of analysis is important in understanding the fertility impact of intermediate variables, such as education. While the effect of contraception may increase over time with higher levels of contraceptive prevalence, shortened periods of breast-feeding may reduce the fertility-inhibiting effects of breast-feeding. Because of the importance of postpartum infecundability in explaining the difference between total fecundity and observed fertility, programs that promote breast-feeding should have a significant role in family planning.

Desired Family Size and Unmet Need

As was noted there is a large gap between the number of women who state they would like to delay their next pregnancy and the number of women who are using some form of contraception. The 1988 Ghana Demographic and Health Survey reported that 23 percent of currently married women claimed they did not want any more children or were already sterilized, and another 45 percent said they wanted to postpone the next birth by at least 2 years; that is, 68 percent wanted to limit the number of children or space births. However, only about 13 percent of the women were practicing some form of family planning. The gap between the 68 percent who want to space births or limit children and the 13 percent who are using family planning does not define unmet need. However, some portion of the women who comprise that gap (the 55 percent who want to space or limit births but are *not* using family planning) has unmet need.

Table 11. Indexes of Fertility and of Proximate Determinants of Fertility and Their Impact on Fertility in Ghana, 1979-1980

Index of Fertility	Value
Total Fecundity or Maximum Natural Fertility (implied)	14.9
Total Fertility rate (model estimate)	6.4
Total Fertility Rate (observed)	6.2
Total Natural Marital Fertility Rate	8.5
Total Marital Fertility Rate	8.2
C(m) (index of marriage)	0.76
C(i) (index of postpartum infecundability)	0.57
C(c) (index of contraception)	0.96

Proximate Determinant of Fertility	Percentage Reduction
Proportion of Women Married C(m)	31.3
Postpartum Infecundability C(i)	64.0
Contraceptive Use C(c)	4.7
Total	100.0

Source: University of Ghana, Regional Institute for Population Studies, "Household Fertility and Contraception in Mpraeso," 1983.

A more precise definition of unmet need has been developed by Westoff and Ochoa (1991). One first identifies the number of women currently married or in union and from this group selects women who are not using a contraceptive. These women are then divided into two groups as shown in Table 12: women who are *not* pregnant or amenorrheic (47.1 percent) and women who *are* pregnant or amenorrheic (40.1 percent). Women in the first group who are infecund (12.3 percent) are excluded because they do not have unmet need for contraception. Of the remainder (34.8 percent), women with unmet need are defined as women who want no more children (7.0 percent) or who want to postpone their next pregnancy by at least 2 years (15.6 percent).

Table 12. Reproductive and Contraceptive Use Status
and Fertility Intentions among Currently
Married Women in Ghana, 1988

	Percentage of Currently Married Women
NOT PREGNANT OR NOT AMENORRHEIC WOMEN	47.1
Infecund Women	(12.3)
Fecund Women	(34.8)
Want no more children (limiting)	(7.0) ^a
Want child later (spacing)	(15.6) ^a
Want child soon	(12.2)
PREGNANT OR AMENORRHEIC WOMEN	40.1
Unwanted pregnancy (limiting)	(2.0) ^a
Mistimed pregnancy (spacing)	(10.7) ^a
Intended pregnancy	(27.4)
CURRENT USERS OF CONTRACEPTION	<u>12.9</u>
Total	100.1

^a Denotes categories that comprise unmet need.

Source: 1988 Ghana Demographic and Health Survey.

Some women in the second group, currently pregnant or amenorrheic, may have unmet need. They are defined as women who became pregnant against their wishes and most likely would not have become pregnant if they had been using a modern contraceptive (2.0 percent) and women who became pregnant earlier than they had intended (10.7 percent). In both cases, the women were in need of contraception.

Thus, the four categories that together constitute unmet need (want no more children, want child later, unwanted pregnancy, and mistimed pregnancy) total 35.3 percent of currently married women. In addition, 12.9 percent of women are current users of contraception. Thus, the total need for contraception (both unmet need and met need) represents 48.2 percent of all currently married women. This indicates that family planning services in 1988 were meeting only

27 percent of the total need; that is, 12.9 percent of met need out of 48.2 percent of total need.

It appears that this level of total need has remained fairly constant over the past decade. The 1979 Ghana Fertility Survey reports that 39 percent of currently married fecund women did not want the next child soon and 12 percent wanted to stop childbearing, for a total of 51 percent.

Women with unmet need (the 35.3 percent as defined above) can be further identified as women who want to limit the number of children and women who want to space births. This distinction has important programmatic implications, as some contraceptive methods are better suited for limiting, whereas others are more appropriate for spacing. Of the total unmet need, 75 percent was for spacing births and 25 percent was for limiting the number of children.

Health Impact

One of the explicit goals of GNFP is to improve maternal and child health. However, given the program's lack of progress in reducing fertility and increasing contraceptive prevalence, it is unlikely to have contributed substantially to any improvements in health. Mortality rates for children under age 5 remain very high at 146 per 1,000 (although this represents a reduction of about 17 percent from the mid to late 1970s). The major causes of child mortality are measles, malaria, pneumonia, anemia, and diarrhea (about 34 percent of Ghanaian children have episodes of severe diarrhea each year). These diseases are all linked; for example, the diarrhea-dehydration-pneumonia complex is a well-known phenomenon throughout the developing world. According to the joint Government of Ghana/UNICEF study on "The Status of Children and Women in Ghana," maternal mortality remains high at 10 maternal deaths per 1,000 births.

Table 13 shows there is a clear and direct relationship between infant and child mortality and high risk fertility. High risk fertility refers to the proportion of recent births that occur among women who are too young (18 or under), too old (35 or older), at high parity (4 or more children), and who space their births too closely (fewer than 2 years apart). The proper spacing of births is of particular importance for child survival. For example, Table 13 shows that, on average, almost twice as many children born sooner than 2 years after their next oldest sibling die during their first year (about 115) compared with children born 2 or 3 years after their next oldest sibling (about 68). This conclusion is substantiated by other recent survey data (Maine and McNamara 1985).

Table 13. Infant and Child Mortality Rates in Ghana, by Demographic Characteristics, 1978-1987

Demographic Characteristic	Infant Mortality Rate 1978-1987	Child Mortality Rate 1978-1987	Both 1978-1987
MOTHER'S AGE AT CHILD'S BIRTH			
Younger Than 20	97.0	94.5	182.3
20-29	73.1	80.1	147.3
30-39	82.8	65.7	143.0
40-49	118.6	89.2	197.2
BIRTH ORDER			
1st	86.3	81.8	161.1
2nd-3rd	67.9	84.7	146.8
4th-6th	82.6	79.8	155.9
7th +	101.8	57.9	153.8
PREVIOUS BIRTH INTERVAL			
Fewer Than 2 years	114.6	87.2	191.7
2-3 years	67.7	79.7	141.9
4 years or more	51.5	58.9	107.4

Source: 1988 Ghana Demographic and Health Survey (Ghana Statistical Service 1989, 66).

Note: Mortality rates are defined as the number of deaths per 1,000 live births.

The age-specific fertility rates shown in Table 6 indicate no decline in fertility between 1971 and 1988 for women in the 15-19 age group or for women over age 35. No data were available to monitor trends in the proportion of births by parity or by birth interval. However, the MCH/FP program of the Ministry of Health has begun to monitor these trends under its management information system. The problem is that the system is limited to observations based on deliveries assisted by trained personnel, which amounted to only 29 percent of births in 1990. The system will also monitor the proportion of births under 2.5 kilograms, an indicator that remained constant at 5 to 6 percent between 1987 and 1990.

Economic and Social Impact

There is a fairly well-established conceptual linkage between family planning programs and economic growth. The reasoning is straightforward (Schwartz and Bender 1992):

- Family planning programs can serve to increase contraceptive acceptance rates and prevalence, thereby contributing to decreases in fertility.
- Fertility decline can contribute to economic growth through a number of direct and indirect pathways, including maternal and child health, education, women's labor force participation, and the savings rate.
- Economic growth itself can contribute to fertility decline; in fact, some argue that economic growth is a necessary condition for fertility decline, although there are exceptions to this rule.

Conclusions reached in recent analyses by Kelley (1988) and Schultz (1988), presented at a seminar sponsored by A.I.D. in 1991 on "Demographic Change and Economic Growth," suggest a broader interpretation of the effect of population growth on economic development. Specifically

- Reduction of population growth alone will not solve severe fundamental economic problems.
- Reduction of population growth can buy time and flexibility, however, and may release some resources.
- Justification of strong family planning programs is based less on economic development grounds than on family welfare grounds.
- Success of family planning depends heavily on the underlying changes in the economic and social environment that motivate couples to demand fewer births, a lesson learned over the last two decades by family planning managers in different countries.

During the late 1970s and early 1980s, Ghana experienced a severe economic crisis accompanied by a deterioration of almost all governmental and private services, including health services. There was a mass exodus of trained Ghanaians, including doctors. In addition, donor assistance, which is almost always essential during the formative stages of a family planning program, was drastically curtailed until the start of the economic recovery program in 1983.

Despite substantial gains since the introduction of the recovery program, Ghana's relatively high population growth rate has meant that increases in real income have been modest. Over the 1985-1989 period, Ghana's GDP grew by about 6 percent per year. Population growth cut this to 2.6 percent per capita per year. In 1990, when the GDP growth rate slowed to 3.1 percent, per capita GDP actually declined. Population growth has also put a heavy stress on food supplies, energy resources, the environment, and the labor market.

Therefore, although Ghana was among the leaders in sub-Saharan Africa to recognize the severe economic and health effects of large families, the economic environment of the period severely hampered the effectiveness of programs designed to reduce fertility. A constant fertility rate combined with a declining mortality rate led to even more rapid population growth.

The Family Planning Program Evaluation, Planning and Financial Analysis (FamPlan) model is designed to illustrate how births averted as a result of family planning programs result in lower governmental expenditures for education, health, and other social services. The basic approach of the model is to compare two scenarios: one scenario reflects the actual family planning program (including the number of acceptors and users), and the other scenario reflects no family planning program at all. The FamPlan model then calculates the impact of contraceptive use on fertility, comparing the number of births under each scenario. In calculating the number of births averted because of family planning, the model incorporates the effects of the other proximate determinants of fertility (marriage, postpartum infecundability, abortion, and sterility), but these other determinants are the same for both scenarios, with and without a family planning program.

As indicated above, there has been little change in age-specific and total fertility rates in Ghana (Table 6). Moreover, only a very small proportion of the difference between total fecundity and observed fertility can be attributed to contraceptive use (Table 11). Given the low levels of modern contraceptive prevalence during the period (probably falling to 2 percent or less during the worst years of economic difficulties in the early 1980s), the small observed changes in fertility are likely to be related to changes in the other proximate determinants. Therefore, because there have been few births averted that can be clearly attributed to the family planning program, the FamPlan model is not an appropriate tool for evaluating the effects of the program.

6. CONCLUSIONS

General Conclusions

1. The most reliable measure of the impact of any family planning program is the contraceptive prevalence rate, which, in Ghana, increased from 2.6 percent in 1969, to 9.5 percent in 1979 (Ghana Fertility Survey), to 12.9 percent in 1988 (Ghana Demographic and Health Survey). However, the use of modern methods remained virtually unchanged from 1979 to 1988: 5.5 percent and 5.2 percent, respectively. In contrast, there was a substantial increase in the use of traditional methods from 4.0 percent to 7.7 percent. On average, Ghanaian women were having almost as many children in 1988 (6.4) as they were in 1965 (6.8). *Thus, the results of Ghana's family planning program during much of the 1968-1988 period were meager and disappointing.*

2. More recently, however, since A.I.D. resumed its family planning assistance to Ghana, the contraceptive prevalence rate for modern methods increased to about 8 percent in 1991; preliminary results of a consumer-based survey suggest a 15 percent rate in 1993. In addition, data compiled by USAID/Accra show that CYP almost tripled between 1987 and 1991 from about 75,000 to almost 223,000. *Because A.I.D. is the predominant donor agency in the area of family planning, much of this recent improvement may be directly attributable to A.I.D.*

3. *Among the many factors affecting the level of contraceptive use in Ghana, two seem to be particularly important: urban/rural residence and level of female education.* Contraceptive prevalence among urban women was 19.6 percent in 1988, while prevalence among rural women was only 9.9 percent. Contraceptive use rises progressively from 8.5 percent among women with no education to 28.7 percent among those with higher education, with the most dramatic increase among women who have gone beyond middle level education.

4. For the period from 1968 to 1988, the demand for contraceptives in Ghana was weak—in spite of a reasonably high and growing level of awareness;

and the supply of contraceptives was limited primarily to urban areas, which comprise only about 30 percent of the population, and supplies even in urban areas were scarce in the early 1980s as donor support ceased. Under these circumstances, any family planning program in any country is unlikely to succeed.

5. *During the 1968-1991 period, A.I.D. disbursed an estimated \$24.9 million to support 8 bilateral and 43 centrally funded population and family planning projects in Ghana. Measured in current dollars, A.I.D. provided almost three times the level of family planning assistance after 1985 (\$2.3 million per year, on average) as before 1983 (\$0.8 million per year, on average).*

6. Among the more important outputs of A.I.D.'s investments are (1) a substantial number of individuals trained in providing family planning services and in understanding the importance of population variables in economic planning and (2) the introduction of a social marketing program for distributing contraceptives in the commercial sector.

Political and Economic Environment

7. *The political and economic environment in which A.I.D. assistance was provided to Ghana during most of the period was not conducive to the successful implementation of long-term development activities, such as family planning. Especially during the late 1970s and early 1980s, Ghana experienced a severe economic crisis accompanied by a deterioration of almost all governmental and private services, including health services. There was a mass exodus of trained Ghanaians, including doctors. In addition, donor assistance, which is almost always essential during the formative stages of a family planning program, was drastically curtailed.*

8. In addition, a consensus among the national leadership and senior decision-makers that the goals and objectives of family planning are of national priority has not been present in Ghana for the past 20 years, and this *lack of strong, overt, and continuous political commitment is a major factor explaining why progress has been limited.*

9. This lack of political commitment occurred despite the Government's development in 1969 of a clear and comprehensive national population policy. However, the policy has never been implemented, partly because the implementers and beneficiaries of the policy were not sufficiently involved in its develop-

ment, partly because the governmental agency charged with coordinating the program became detached from the implementing agencies, and partly because leadership responsibilities and lines of authority were not clearly established.

10. The A.I.D.-funded Population Impact Project, which began in 1986 and is designed to inform and influence policymakers, has heightened the Government's awareness of family planning and the key role it must play in encouraging implementation of the population policy.

Implementation Considerations

11. IEC efforts have had an important impact on improving awareness of family planning but have not been successful in explaining *how* to avoid pregnancy. Although 77 percent of Ghanaian women were aware of a modern family planning method in 1988, "lack of knowledge of contraception" was still cited as the main reason for nonuse of contraceptives.

12. *The wide gap between the proportion of women who in 1988 wanted to delay or avoid their next pregnancy (68 percent) and those who were using some form of contraception (only 12.9 percent) can be explained, in part, by the fact that family planning counseling and a wide range of contraceptive methods were not regularly accessible in both urban and rural areas from a convenient and trusted source that ensured privacy for the client.*

13. Family planning services were meeting only about 27 percent of total need for contraception in 1988. Of the unmet need, 75 percent was for spacing births and 25 percent was for limiting births. This distinction has important programmatic implications because some contraceptive methods are better suited for limiting, whereas others are more appropriate for spacing.

14. The A.I.D.-funded Danfa Comprehensive Rural Health and Family Planning Project, which tested various approaches to delivering family planning services and commodities, helped substantiate the conclusion that family planning programs must be integrated with maternal and child health and primary health care systems if they are to be successful in the Ghanaian context. Eventually, family planning services were integrated with other maternal and child health services in order to increase the number of women requesting services from the MCH/FP clinics.

15. *Cultural attitudes favoring large families, together with the dominant role of men in Ghana, has limited the effectiveness of the country's family planning program.*

Cost Considerations

16. *Ghana's family planning program is not financially self-sustainable. The public sector will need to continue to provide family planning services and contraceptive supplies at highly subsidized prices, especially in rural areas.*

17. *The real costs of the family planning program in Ghana are unknown, largely because annual data on expenditures and costs are not routinely collected by either the Government or donor agencies. In the absence of these data, a cost-effectiveness analysis of the Ghana family planning program cannot be undertaken, and decision-makers cannot allocate family planning resources efficiently among alternative contraceptive methods, geographic locations, providers of services and supplies, and specific groups of users.*

18. *The effect of price changes on the demand for contraceptives is unknown again because there has been no systematic data collection and analysis.*

Recent Developments

19. From 1987 to 1990 the number of family planning service delivery points expanded substantially, from an estimated 87 public health clinics to 584 public health clinics, 238 private sector midwives, 46 PPAG outlets, and almost 3,000 TBAs.

20. The A.I.D.-supported GSMP has made a significant contribution in expanding the number of delivery points for contraceptives.

21. Improvements in the Ministry of Health management information system have contributed to timely reporting from nearly all of the clinics, districts, and regions using the simplified forms developed with A.I.D. assistance.

APPENDIX A

EVALUATION METHODOLOGY

The assessment of Agency for International Development (A.I.D.) assistance to family planning in Ghana was undertaken by a four person team from May 4-27, 1992. The team included two A.I.D./Washington direct hire employees and two contract personnel from Research Triangle Institute in North Carolina. It was comprised of two economists (including one population economist), a demographer, and a population advisor. Two team members had previous experience working in Ghana.

Before departing for Ghana the team met in Washington, D.C. for a 3 day team planning meeting (April 20-22, 1992). During that period, the team was briefed by Center for Development Information and Evaluation (CDIE) personnel on the purpose of the assessment and its audience, the assessment design and conceptual framework, data collection and analysis techniques, and economic dimensions of the assessment. The team also met with persons in Washington knowledgeable about family planning in Ghana (including representatives from the World Bank, The Futures Group, and A.I.D./Washington). Finally, the team developed the evaluation methodology described here as well as a tentative work plan (with individual writing assignments) and a tentative schedule for carrying out the various elements of the assessment.

The evaluation methodology was relatively straightforward. It included reviewing the literature, conducting key informant interviews, and undertaking a field trip to four of the nine regions in Ghana outside Greater Accra.

A vast amount of material has been written about Ghana's population policy (one of the first in sub-Saharan Africa) and about how its family planning program has been implemented over the past two decades. Research Triangle Institute had summarized much of this literature and analysis in the form of an annotated bibliography which the team was able to review before departing the United States. Selected publications consulted by the team are listed in the bibliography.

The team interviewed representatives of the Government of Ghana (both current and former representatives), nongovernmental organizations (NGOs), the donor community, the commercial sector, the university community, and persons who might be characterized as the architects of Ghana's population policy and family planning program. Rarely did all four members of the team participate in any particular interview. As a result, the team, collectively, was able to interview over 60 individuals in Accra alone as well as another 50 individuals during the field trip. In order to assure comparability the team followed a standard format that included nine key questions asked of each key informant; Exhibit A-1 lists these questions.

During May 17-20, 1992, the team visited four of the nine regions outside Greater Accra (Volta, Eastern, Central, and Western Regions) in order to gain a field perspective of Ghana's family planning program. Four criteria were used to select specific places to visit: they should cover a diverse area; they should include rural villages as well as towns; they should include all of the various providers of family planning services and commodities (including Ministry of Health public health clinics, NGOs, chemical-sellers, and maternity homes); and they should not be "showcase" examples of family planning delivery but, rather, "representative" examples.

The team divided into two, two person groups; one group traveled to Volta and Eastern Regions, and the other group traveled to Central and Western Regions. Again, to assure comparability, the team identified particular institutions and officials that each group would be expected to interview and specified key questions to guide each interview; Exhibit A-2 lists the institutions and officials interviewed, and Exhibit A-3 lists the key questions. One of the groups commissioned a research assistant to interview chemical-sellers in Volta Region both in the town of Ho and in villages surrounding Ho; the research assistant asked the same key questions as in Exhibit A-3. Appendix B summarizes the results of the field trip.

The team had intended to retain facilitators to lead focus groups comprised of the beneficiaries of family planning programs. However, focus group discussions had very recently been completed in a total of 25 villages in 3 other regions of Ghana, 2 of which were not visited by the team (Upper East and Brong Ahafo regions), thereby obviating the need for the team to duplicate this effort. Appendix C summarizes the results of these focus group discussions.

EXHIBIT A-1

Interview Guide

A. Introduction

A.I.D./CDIE is conducting an assessment/evaluation of A.I.D. family planning investments over the past 20 years. Key issues to be studied include the effectiveness, efficiency, sustainability, and impact of family planning programs.

B. Goals for the Interview

1. Collect information on the interviewee's program and particularly any data on family planning.
2. Get suggestions on other sources of information.
3. Get suggestions on other contacts.
4. Get opinions on several key questions.

C. Key Questions

1. Please give your general assessment of the Ghana family planning program from 1969 until the present.
2. There seems to have been very little change in the use of family planning in Ghana. Why do you think this is?
3. What was the single most important constraint to expanded family planning?

4. Which aspects of the family planning program were effective? Why?
5. Which aspects of the family planning program were not effective? Why?
6. In the 1988 Ghana Demographic and Health Survey, 68 percent of currently married women said they wanted to delay their next pregnancy by at least 2 years or they wanted no more children. But only 13 percent said they were using family planning. How do you explain the 55 percent who don't want to become pregnant but are not using family planning? (Note that in the same 1988 survey, 77 percent of women said they knew of a method of family planning.)
7. There seems to have been some progress with the family planning program during the past 2 or 3 years, including some increase in contraceptive prevalence. Do you agree with this, and why do you think this is happening?
8. What do you think is the most important thing to do now to increase family planning?
9. Do you think the appropriate institutions are in place to do this?

EXHIBIT A-2

**Institutions and Officials
Interviewed on Field Trip
May 17-20, 1992**

A. Regional Officials

Purpose: Courtesy call to inform regional officials of the purpose of the visit and to ask briefly about the range of family planning services available in the region, including family planning providers not listed below, such as the Christian Hospital Association for Ghana and mission hospitals.

Note: It is not necessary to visit all of the organizations listed below, only those where someone is readily available for a brief discussion.

1. **Ministry of Health:** **Regional medical officer
Regional Ministry of Health family
planning coordinator**

2. **Ghana National
Family Planning
Program:** **Regional coordinator**

3. **Planned Parenthood
Association of Ghana:** **Regional director**

4. **Ghana Registered
Midwives Association:** **Regional chairperson**

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B. Ministry of Health Clinics

1. Regional or district hospital: Maternal Child Health/Family Planning clinic
2. Rural Ministry of Health clinic
3. Ask about community-based distribution activities
4. Ask about traditional birth attendants activities

C. Planned Parenthood Association of Ghana Clinics

1. Clinic in major city
2. Clinic in one other town
3. Ask about community-based distribution activities

D. Ghana Registered Midwives Association Maternity Homes***E. Chemical-Sellers and Pharmacies***

1. Ghana Social Market Program (GSMP) and non-GSMP retailers
2. Ask about other social marketing outlets (markets, etc.)

Exhibit A-3

**Key Questions Asked on Field Trip
May 17-20, 1992**

Institution Name: _____

1. Do they have data on number of clients by method?

Collect data for last month, last 12 months, or whatever is available.

2. What methods and brands do they provide?
3. What do they charge for each method and for each brand?
4. Do they have supplies now? Do they have any problems with supplies?
5. Why don't more women use contraception?
6. Do they have any difficulties in providing family planning services along with their other duties? (Are there any problems with integration?)

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APPENDIX B

SUMMARY OF FIELD TRIP

The team conducted site visits to Central, Western, Eastern, and Volta Regions during May 17-20, 1992. The primary purpose of the visits was to verify information learned from key informant interviews conducted in Accra. In addition, data on availability, quantity, and price of contraceptive methods were collected from a sample of the principal providers (chemical stores, Ministry of Health, Planned Parenthood Association of Ghana [PPAG], and Ghana Registered Midwives Association [GRMA]). The following is a summary of findings from the admittedly unscientifically based sample of providers.

Supply of Contraceptive Commodities

- **There was a concern that processing the Ministry of Health contraceptive supplies through customs was sometimes delayed and, as a result, they arrived at the regional or district headquarters with only 6 months or less until expiry.**
- **There was also some concern about the Ministry of Health stockouts of various contraceptives at different times, which limited the choices available to clients and may have led to higher discontinuation rates. At the time of the field trip, Ovrette was in particularly short supply, as were Neo-Sampoon vaginal foaming tablets. There was a general feeling that logistics management was primarily a problem at the national level and that the regional and district systems were working adequately.**
- **The majority of chemical-sellers surveyed carry Ghana Social Marketing Program (GSMP) products (condoms, pills, vaginal foaming tablets), and they appear to be located even in the smallest towns. They also seem to be open for long hours (many were open on Sunday), which is especially important in the case of condoms. Profit margins for contraceptives appear to be sufficient for chemists to stock contraceptive supplies.**

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- One of the major objectives of GSMP is to make orals more accessible, so that women will not have to travel to an MCH/FP clinic just for resupply. However, the brand of orals supplied by A.I.D. to GSMP (Norminest/Secure) is different from the brands supplied by A.I.D. to the Ministry of Health (Lo-Femenol, Ovrette) and from the brands supplied by PPAG. Although an important element of GSMP is to segment the market for contraceptives, focus group research has pointed out the problems caused by having to switch brands, and this may make it difficult for some clients to use GSMP for resupply.
- While chemical-sellers were generally satisfied with supply logistics (either Danish African Company Inc. [DANAFCO] delivered the supplies, or sellers went to a local depot, another chemical-seller, or to DANAFCO in Accra), there were current shortages of Kamal vaginal foaming tablets, and some found it difficult to get supplies of Neo-Sampoon vaginal foaming tablets.
- PPAG had been affected by periodic shortages of contraceptives. These shortages together with limited staff resources may have led to fluctuations in couple years of protection (CYP) during 1987-1992.

Provision of Family Planning Services

- Family planning services seemed to be fully integrated with maternal and child health services at all Ministry of Health facilities, and there seemed to be few restrictions on the time when family planning services were available. However, within the Ministry of Health, everyone pointed to the community health nurses and nurse-midwives as the staff who provided family planning services. One important aspect of integration is to ensure that all cadres of Ministry of Health staff receive the appropriate level of training in family planning and receive encouragement to provide whatever family planning services they are equipped to handle.
- Family planning service providers appear to be extremely conservative in their practice, as indicated by their requiring a physical exam before prescribing pills, dispensing only three cycles of pills at a time, and inserting intrauterine devices (IUDs) only during menstrual cycles.
- Most chemical-sellers and pharmacists involved in GSMP (which includes the vast majority of chemical-sellers) have received training provided by the project or by the Pharmacy Board. However, in

many cases this training was provided to the owners of the shops rather than to the store clerks who deal directly with clients. This may affect the quality of advice provided to the clients.

- The major concern of the Ministry of Health staff about GSMP is that first time users of oral contraceptives will not be screened for possible contraindications nor directed to an MCH/FP clinic or private physician for an exam prior to using the orals. If these women then have side effects, this could lead to a bad reputation for orals and have an adverse impact on long term prevalence.
- Another concern of the Ministry of Health staff is that GSMP condoms are not properly stored. In some cases, strips of condoms are displayed in a glass case in the front of the store, where they are exposed to light and heat. This can lead to deterioration of the product with an increased likelihood of breakage.
- The Ministry of Health staff also expressed concern that chemical-sellers do not pay proper attention to expiry dates for the contraceptives. Because of the profit motive and insufficient training, they may sell contraceptives beyond the expiry date.
- PPAG provides high quality family planning services through its network of regional and district clinics. These services are supplemented by a community-based distribution program involving mature, carefully selected agents (former school teachers and nurses).
- The coverage provided by PPAG is constrained by available resources. For example, in Volta Region there are no PPAG clinics at all. In Eastern Region, the staff was reduced in 1990 and 1991, three of the six clinics could be operated only 1 day per week, and two other clinics, only 1 day every other week.
- There appears to be competition developing among midwives, traditional birth attendants (TBAs), and Ministry of Health nurses for infant delivery and family planning services. One woman of GRMA complained that the TBAs were taking all her clients away.

Demand for Services and Commodities

- Low demand for services and commodities is probably the primary cause for low contraceptive prevalence rates.
- The two most common reasons given for why the contraceptive prevalence rate is low were (1) the practice of husbands not allowing their wives to use contraception (because they think it leads to promiscuity) and (2) the existence of misinformation about harmful side effects of some methods, especially IUDs.
- The role of husbands in restricting contraceptive use was particularly emphasized in the field visits and suggests that information, education, and communication for males may yield significant gains.
- Although "husband's attitudes" was universally regarded as a major constraint, and has been so regarded for some time, only PPAG had mounted an active campaign for educating and counseling men.
- Underutilization and underemployment of MCH/FP staff at the Ministry of Health and GRMA clinics is common in all regions surveyed. In contrast, PPAG appears to have stimulated increasing demand in Western and Central Regions.

Availability and Quality of Data

- Data on new acceptors, continuing users, and quantity of contraceptive commodities distributed were generally available from all providers, with the exception of chemical stores. One reason the chemical-sellers have difficulty reporting data is that they tend to think in terms of boxes of commodities. Yet not one of the GSMP products has the number of units inside the box clearly marked on the outside of the box.
- The "Maternal and Child Health/Family Planning 1991 Annual Report" for Volta Region is an excellent example of the use of trend data, spatial analysis, population/service ratios, and risk analysis for monitoring the progress of family planning in the region. The principal nursing officer (public health) and the United Nations Population Fund (UNFPA)-provided administrative assistant were jointly responsible for this report. GSMP data, however, were missing and would have been useful in understanding the proportion

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of contraceptives supplied by each major source, as well as in calculating an overall prevalence rate.

- Although all regions and districts seem to be monitoring family planning use and contraceptive prevalence, the recent increases reported in contraceptive prevalence may be overstated. This is so because the clinics record the number of new acceptors and the number of continuing users, but in each case these acceptors and users may visit only once during the year and may not be users throughout the year. This is especially the case with condoms and foaming tablets. For January-March 1992 in Volta Region, new acceptors and continuing users totaled 3,903 but, CYP totaled only 1,779.

Contraceptive Prices

- In general, chemical stores charged the highest prices per unit for the three commodities that they sell (pills, condoms, and vaginal foaming tablets), although there was considerable variation across stores. Pill prices ranged from 50 to 300 cedis per cycle, condoms ranged from 8 to 25 cedis each, and foaming tablets ranged from 8 to 19 cedis each.
- On average, the highest profit margin for chemical stores was for pills; the DANAFCO wholesale price for one cycle was 88 cedis, and the average retail price was 156 cedis. The average profit margins per unit for condoms and vaginal foaming tablets were relatively small (4 cedis per condom; 2 cedis per tablet).
- The Ministry of Health charged the lowest prices per unit, with no variation across clinics (although one clinic did report charging 20 cedis per cycle of pills instead of the usual 15 cedis). The Ministry of Health TBAs in Central Region are allowed to sell at twice the Ministry of Health unit price and keep the difference as an incentive.
- The community-based distribution program administered by PPAG sells at PPAG prices, but agents are allowed to keep 40 percent of the price as an incentive.
- GRMA clinics charged prices second only to the chemical stores. Only three GRMAs were sampled, however, and one of these reported charging on a sliding scale.

- These same general price relationships among the sampled suppliers held when unit prices were converted to price/CYP. That is, chemical stores were most expensive, followed by GRMA, PPAG, and the Ministry of Health. By contraceptive method, the IUD was the least expensive in terms of price/CYP, as is the case in many other countries. At the Ministry of Health, the IUD price/CYP was only 29 cedis. Depo-Provera was the second cheapest method in terms of price/CYP at the Ministry of Health but was third cheapest (after the pill) at PPAG.

Table B-1 summarizes the number and type of institutions visited in each region. Table B-2 shows unit price data summarized by supplier and method. Table B-3 shows the same price data converted to price/CYP using USAID/Accra conversion factors. Price data are in cedis as of May 1992 when the foreign exchange rate was approximately \$1.00 = 425 cedis.

Table B-1. Number and Type of Institutions
Visited on Field Trip, by Region

Institution	Eastern	Central	Western	Volta	Total
Chemical Stores	3	2	2	17	24
Ministry of Health Clinics	4	1	2	2	9
PPAG Clinics	1	1	1	--	3
GRMA Clinics	1	1	1	1	4
DANAFCO Supply Depot	1	--	1	--	2
Ministry of Health Regional Office	1	1	1	1	4
PPAG Regional Office	1	1	1	=	3
Total	12	7	9	21	49

Source: Field Trip, May 17-20, 1992, Ghana.

Table B-2. Average Unit Prices, by Method and Source (Cedis)

Source	Pill (Cycle)	Condom (Each)	Vaginal Foaming Tablet (Tablet)	IUD (Insert)	Depo- Provera	Mini-Lap
Chemist Range	156 (50-300)	18 (8-25)	13 (8-19)	n/a	n/a	n/a
Ministry of Health	15	2	2	100	40	4,500
PPAG	20	10	5	200	150	n/a
GRMA	67	11	10	400	367	n/a
Wholesale: DANAFCO	88	14	11	n/a	n/a	n/a

Source: Field Trip, May 17-20, 1992, Ghana.

Table B-3. Average Price per CYP, by Method and Source (Cedis)

Source	Pill	Condom	Vaginal Foaming Tablet	IUD	Depo- Provera	Mini-Lap
Chemist	2,340	2,700	1,950	n/a	n/a	n/a
Ministry of Health	225	300	300	29	160	1,125
PPAG	300	1,500	750	57	600	n/a
GRMA	1,005	1,650	1,500	114	1,468	n/a

Note: CYP conversion factors are defined as follows:

- Pill: 15 cycles/year
- Condom: 150/year
- Vaginal Foaming Tablet: 150/year
- IUD: 3.5/years
- Depo-Provera: 4/year
- Mini-Lap: 4/years; see Note to Table 8 of main report.

Source: Field Trip, May 17-20, 1992, Ghana.

APPENDIX C

FAMILY PLANNING: THE BENEFICIARY'S PERSPECTIVE

Background

There is a desire among Ghanaian women to space or limit future births. Nationwide it is estimated that 55 percent of currently married women have an "unmet need" for contraception. Yet only about 5 percent of married women are currently using modern contraceptive methods (1988 Ghana Demographic and Health Survey). Therefore it is important to understand why many women have knowledge of family planning, yet few use modern family planning methods.

The Health Research Unit of the Ministry of Health conducted a series of focus group studies over the course of about 7 months in 1991. The research unit selected one district in each of three regions with contrasting social and economic settings and conducted focus groups in eight or nine villages in each of the selected districts. These studies gathered information about the Ghanaian family planning program from the beneficiary's perspective. Although the focus groups took only about 2 weeks in each of the districts, preparing for the focus groups, informing the district and village leaders, training the focus group facilitators and reporters, selecting the participants, and, finally, analyzing the data and writing up the results took several months. Funding for these studies was provided by the Overseas Development Authority, the United Nations Population Fund, and the Ministry of Health.

The objectives of the focus group discussions in each district were the same:

- To consult the communities in the district on why many people express the need for family planning but so few are currently using it
- To assess the attitudes of the communities and health staff toward selection and training of community members as family planning providers

- To assess the potential for developing a community-based family planning strategy and to make recommendations regarding appropriate followup

Results

The results of the focus group studies, summarized below, are published in the following reports:

- Ministry of Health, Health Research Unit. 1991. *The Ability to Keep Secrets: An Appraisal of Community Potential to Support Family Planning Services in Dangme West District.* March.
- Ministry of Health, Health Research Unit. 1991. *First Make Sure Our Children Won't Die: An Appraisal of Community Potential to Support Family Planning Services in Bolgatanga District.* September.
- Ministry of Health, Health Research Unit. 1991. *Won't It Cause Infertility: An Appraisal of Community Potential to Support Family Planning Services in Berekum District.* September.

Dangme West District Study

The study was implemented in January 1991 in nine communities in Dangme West District of Greater Accra Region. The focus groups in each community included women over 35 with five children or more (potential "stoppers"), women under 35 with fewer than three children (potential "spacers"), girls between 15 and 20, and male opinion leaders between 25 and 45 years old.

The study found that the term: "family planning" was well known. It is associated with child spacing, which is traditionally practiced in all communities. Advantages of child spacing were clearly recognized by the respondents, especially for improved health of the mother and child. Child spacing was also seen to ensure a sound financial situation, especially of the mother who cares for the children, and to prevent teenage pregnancy.

The focus groups identified many constraints to the use of family planning, of which inadequate availability and accessibility of family planning methods were typically mentioned first.

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A lack of adequate information was also identified as a major constraint. Awareness of the existence of family planning methods is high, but detailed knowledge is low. Many stories and rumors circulate in the communities on the effects and side effects of some methods. Although side effects certainly exist, stories go so far as to relate family planning to AIDS and death. People have many questions, but there is nobody knowledgeable enough in the communities to provide the answers.

A number of sociocultural constraints were identified. Secrecy in relation to the use of family planning is of prime importance. Openly admitting to its use is seen as socially undesirable behavior for several reasons: family planning is associated with abortion, its use is known to lead to infertility, and users are thought to become promiscuous and flirts. Further, men perceive family planning methods as a threat. Women are often maintained by men because of their ability to produce children, and use of family planning means potential disloyalty and may lead to social repercussions.

In order to improve family planning service provision (including provision of adequate information), the training of certain community members was accepted and welcomed by all the communities studied. Most communities were able to identify potential providers in the communities within 1 day.

The possibility of training specific groups in society, such as pastors, district assembly representatives, traditional healers, teachers, traditional birth attendants, community clinic attendants, shopkeepers, or 31st December Women's Group members was rejected in the focus group discussions. This is so because communities selected potential providers on the basis of personal qualities rather than social position and made it clear that careful selection of the provider is of utmost importance.

The ideal profile of a provider includes first and foremost "no slippery mouth"; that is, the ability to keep secrets. Other personal qualities, such as patience and respectfulness, are also important. In most cases women were preferred. The educational level of the potential provider was highly valued, and the age of the provider should be close to the client's age. Thorough training in family planning service provision is seen by the community as essential for the execution of her tasks.

Bolgatanga District Study

The focus group discussions were done in eight different villages in Bolgatanga District of Upper East Region. Through these discussions, women

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from monogamous marriages (25-35 years), women from polygamous marriages (25-35 years), opinion leaders (40-50 years), and husbands (30-40 years) gave their opinions on constraints related to family planning service delivery and possible training of community based service providers.

The study found that child spacing is a strong concept within these communities and is mainly practiced through sexual abstinence for 3 to 4 years. Not spacing births is seen as having a hazardous effect on the children's health. Sexual abstinence is regarded as a burden for men and women, but not spacing children adequately is embarrassing and a reason to be ridiculed.

Other methods of birth control are therefore (theoretically) welcome. Modern family planning methods are, however, hardly used. Family planning service provision is first and foremost hindered by a lack of information. Most people have heard about family planning but have the impression that it is a governmental directive to have no more than two or three children. Family planning is related to sterilization and "to stop giving birth"; that is, having "your womb turned" in the hospital. These ideas are reinforced by the local translation of the term for family planning, "adomake," which means stop giving birth after you have enough. Accurate knowledge of family planning methods is generally very low.

Children are highly valued and symbolize prestige and wealth, and although infant mortality is decreasing in the district, killer diseases are still feared: "If the Government wants us to practice family planning, they should make sure our children won't die."

Apart from the above-mentioned misconceptions, family planning service delivery is hindered by some other major factors: availability of services is very low, and family planning devices cannot be obtained in the rural areas. A flow of information on family planning is hindered by the general reluctance to discuss matters related to sex and reproduction: "Sex is like stealing because no one tells even his friend when he has sex with his wife."

The communities recognize that the lack of appropriate information hinders them in using family planning methods and that family planning service providers in the community might improve their state of knowledge.

A community-based service provider should, according to the informants, have specific personal characteristics, a major one being the ability to keep secrets. The preference is often for young and educated people, male providers

for men and females for women. Female providers should have had the experience of childbirth. Most focus groups were able to identify such a person in the community within 1 day but were reluctant to mention names without first consulting their leaders.

Berekum Health District Study

The focus group discussions were done in eight different villages in Berekum Health District of Brong Ahafo Region. Through these discussions, opinion leaders (50-60 years), married women (25-35 years), married men (30-40 years), and girls (15-20 years) gave their opinions on constraints related to family planning service delivery and possible training of community based service providers.

Although there is the desire to have a large number of children (especially important to support the family later), the study found that people recognize the need for limiting the number of births because of financial problems and lack of land in the area. Delivery of family planning services, however, is hindered by several factors. One overall constraint concerns the secrecy surrounding matters related to sex and reproduction, thus hindering a flow of information or open discussion.

Other major factors are a lack of family planning service provision in the area and/or inaccessibility of these services; the well-known, often exaggerated side effects of family planning methods; and a lack of understanding of the effects of family planning methods, including the widespread view that they will cause permanent infertility.

The communities recognize that the lack of appropriate information hinders them in using family planning methods and that family planning service providers in the community might improve their state of knowledge.

A service provider should have specific personal characteristics, a major one being the ability to keep secrets. The preference is often for an educated female between the ages of 25 and 35 years. Most focus groups were able to identify such a person in the community within 1 day.

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Recommendations

A package of five strategies was proposed to improve family planning service provision in both Bolgatanga District and Berekum Health District:

- **Develop appropriate information, education, and communication (IEC) messages**
- **Ensure a full range of clinical family planning methods at the health center level**
- **Introduce and support comprehensive services at 12 outreach points per health center**
- **Ensure privacy at all service delivery points**
- **Extend IEC and service delivery through community-based agents**

The first four strategies are meant to create an environment in which the community-based agents can adequately function by ensuring the availability of adequate information, sufficient referral points, and curative services (which are seen as having priority by the communities).

APPENDIX D

LAPHAM-MAULDIN SCALE

This appendix discusses the rationale for the conclusions regarding each of the 30 items in the Lapham-Mauldin Program Effort Scale (L-M Scale) summarized in the main text of this report. It also provides an overview of Ghana's health care system in recent years.

Policy and Stage-Setting Activities

1. Policy on Fertility Reduction and Family Planning

Ghana was among the leaders in sub-Saharan Africa to recognize the severe economic and health effects of large families. A broad population policy that identified family planning as an integral part of social and economic development was promulgated in 1969. The objectives of the implementation plan, which included specific targets, were to

- Reduce the rate of population growth from a projected level of 3.9 percent to 1.7 percent by the year 2000
- Achieve a 50 percent reduction in completed family size by the year 2000 by lowering the total fertility rate from a range of 7 to 8 in 1970 to 5 by 1985 and to 4 by the year 2000
- Recruit as contraceptive users 40 percent of the entire female population by 1990 and 65 percent by the year 2000

It is unlikely that the demographic targets of this policy will be achieved by the year 2000. The growth of the program since 1970 can best be characterized as glacial. However, since about 1986 there seems to have been some revitalization. The 1988 Ghana Demographic and Health Survey estimated the population growth rate at 3.4 percent, the total fertility rate at 6.4, and the contraceptive prevalence rate for modern methods at 5.2 percent; since then, the contraceptive prevalence rate may have increased to 8 percent.

In June 1989 a National Population Conference was held to commemorate the 20th anniversary of Ghana's population policy. The conference was conducted under the auspices of the Ministry of Finance and Economic Planning (Social Sector Policy Unit, Policy Analysis Division). The purpose of the conference was to review specific achievements and shortcomings in the implementation of the national population policy. It was agreed that the basic tenets of the policy remained valid but that several issues of the 1990s needed to be recognized, such as the environment, the aged, AIDS, and the role of the newly established district assemblies. Specific recommendations encompassing 11 themes were included in a plan of action for consideration by the Government: implementation of the national population policy; family planning/maternal child health; socioeconomic components of the policy; gender issues; data collection; research, monitoring, and evaluation; population information, education, and communication (IEC); population and law; funding agencies; manpower development and utilization; and institutional arrangements. The conference recommended the establishment of the National Population and Human Resources Board to coordinate all population-related activities.

Conclusion. The population policy, written in 1969 and reviewed in 1989, remains a valid document in 1992. The national policy has recently been incorporated as a "directive principle" in the new constitution of Ghana, with a provision that the Government will pursue the population policy and report to Parliament annually on progress.

2. *Statements by Leaders*

The Head of State and other senior leaders have never overtly opposed family planning, and official statements of various governmental ministries have from time to time suggested broad support. For example, a 1984 press release by the Secretary of Agriculture identified control of population growth as one of the four essential components of food security. In a 1985 bulletin, the director of medical services gave prominent attention to family planning as a part of maternal and child health. On the other hand, an A.I.D. evaluation reported that during 1985-1988 there were no positive statements on family planning in the media by governmental officials (A.I.D. 1988).

During the past 2 to 3 years, leaders have increasingly spoken out in support of family planning. At the same time, they often stress the importance of giving greater emphasis to the non-family planning components of the population policy (including health, education, women's roles, and population-related research). Although these social factors have a considerable impact on the use of family planning and on the other proximate determinants of fertility, an

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increased emphasis on them may detract from the attention given to family planning.

There are a number of daily and weekly newspapers in Ghana, most of which have covered family planning topics about every week or 2 weeks during the past several years. Although the emphasis has been on the economic benefits to the nation of slowing population growth, more recent articles have focused on the health benefits to the individual of child spacing. For example, an article entitled "Population Growth and Health Services" in the *Daily Graphic* on May 13, 1992, captured a whole page of print. Recently, the family planning message that is routinely included in public pronouncements by Chairman Rawlings and other high-level officials has focused on family finance; that is, do not have more children than you can support.

Conclusion. Lack of overt support from the Government of Ghana early in the program slowed the pace of implementation and failed to legitimize the concept for policymakers, implementers, and the general public. More recently this situation appears to be improving.

3. Level of Program Leadership

After the promulgation of the population policy in 1969, the Ghana National Family Planning Program (GNFPP) was established in 1970. It was placed at the cabinet level in the Ministry of Finance and Economic Planning, which was seen as a mechanism to ensure governmental and interministerial support and attention. GNFPP was charged with coordinating family planning-related activities of both governmental ministries and nongovernmental agencies, but unlike the Ministry of Health, it had no real authority for implementation. As a result, there was confusion over the role of GNFPP. The Ministry of Health, on the other hand, was lukewarm to implementing family planning activities under the direction of GNFPP.

One of the recommendations of the 1989 National Population Conference was to establish the National Population and Human Resources Board, which would be responsible for coordinating and directing all population and human resources activities in the country. It was envisioned that the Board would reinforce the institutional arrangements for more effective and efficient implementation of the policy. To date it has not been decided where the Board will be placed in the Government or how it will relate to GNFPP.

Conclusion. GNFPP, although highly placed in Government, has been ineffectual. Factors contributing to its lackluster performance since its inception

are lack of an implementation strategy, personal and institutional rivalries, lack of overt support from the Government, and lack of guidelines on the roles and responsibilities of the public sector, the commercial sector, and nongovernmental organizations.

4. Policy on Age at Marriage

Ghanaian law recognizes marriage according to customary law, Islamic law, and the provisions of the Marriage Ordinance. Ordinance marriages require that both parties be over the age of 21 unless they are widowed or have parental consent. Neither Islamic law nor customary law marriages specify a minimum age. The median age at marriage is 18. According to the 1988 Ghana Demographic and Health Survey, entry into a formal or informal marriage before age 15 is not rare but is less common than previously. There is only a 6 month age difference between rural and urban dwellers on age at first union.

Conclusion. The Marriage Ordinance in Ghana, which requires both individuals to be over the age of 21, appears to have had little effect on age at marriage.

5. Import Laws and Legal Regulations

The legality of contraceptive use is inferred from the 1969 national population policy and from reference to contraceptives in the Pharmacy and Drug Act of 1961. Under the 1961 Act, drugs are classified as "exempted" or "restricted." Restricted drugs are further categorized as Class A (dangerous), Class B (narcotic), or Class C (other).

In January 1992 oral contraceptives were classified as Class C (other) drugs by the Pharmacy Board, partly because of USAID/Accra's policy initiatives; previously, they had been classified as Class A (dangerous) drugs. Furthermore, their distribution was changed from Class D (specialty center) to Class A (community health worker). The Pharmacy Board also considers vaginal foaming tablets Class C (other) drugs. Condoms are not considered drugs and are treated instead as unrestricted contraceptive devices. Intrauterine devices (IUDs) are also considered contraceptive devices, but they are treated as if they were Class A (dangerous) drugs. By and large the Pharmacy Board leaves regulation of IUDs to the Maternal and Child Health/Family Planning Division of the Ministry of Health. Drugs administered intravenously or intramuscularly, including injectables such as Net-90 and Provera, are considered Class A (dangerous) drugs.

All contraceptives imported by Ghana are donated by A.I.D. and other international donors. Although a 10 percent duty is imposed on some of these goods, the Customs and Excise Protection Service has recognized a blanket exemption that the Ministry of Health has received from the Internal Revenue Service.

Conclusion. Import barriers and regulations affecting the expanded family planning functions of health care providers have decreased access to family planning services from what it might otherwise have been. Until it was changed in 1992, the classification of oral contraceptives as dangerous drugs, which cannot be supported by epidemiologic data, posed a barrier to sound public health and family planning practice.

6. Advertising of Contraceptives Allowed

Since the early 1970s, social marketing of condoms and vaginal foams has been supported by a successful series of advertising campaigns, except for the period between June 1986 and July 1987 when an advertising ban stalled the marketing component of the program. After the ban was lifted, radio advertising of contraceptives was voluntarily limited to airing after 9 p.m., and particular attention was given to community standards in developing advertising materials.

Conclusion. Advertising of contraceptives has been allowed and practiced in Ghana since the 1970s (except for about 1 year in the early 1980s), and this appears to have increased the awareness of family planning methods. It is not clear that advertising has been effective in increasing demand.

7. Other Ministries and Public Agencies Involved

Various ministries have been involved in population and related activities. For example, the Ministry of Education has made considerable progress in incorporating family life education into the school system, and a nucleus of teachers has been trained and equipped with manuals and source materials. In addition, information programs are administered by the Ministry of Information, the Ministry of Labor, and the Departments of Social Welfare and Community Development, with contributions from the Ministry of Agriculture. The Ministry of Health is now the main provider of family planning services.

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Conclusion. Although various ministries and public agencies have been involved in family planning, lack of GNFPF coordination among sectors and ministries reduced the opportunities for leveraging family planning program inputs and capitalizing on synergistic effects.

8. In-country Funding of Family Planning Budget

The majority of funds for family planning in Ghana are provided by external sources. The Ministry of Health has a budget line item for Maternal and Child Health/Family Planning but no records of actual expenditures for family planning are available. (Note that the L-M Scale scoring system requires a top score [four] if in-country sources provide 85 percent or more of the budget and no score [zero] if these sources provide less than 50 percent of the budget.)

Conclusion. The Government's historical record of financial commitment to family planning is impossible to determine because no expenditure records for family planning in the Ministry of Health exist. What is certain is that the majority of family planning funding has been from external sources, especially from A.I.D.

Service and Service-Related Activities

During the last decade there has been considerable interest in identifying the critical features that make family planning services effective. Quality of services is an important determinant of acceptance and continuation rates and, therefore, is a major contributor to the level of contraceptive prevalence. A framework for assessing quality from the client's perspective has been developed which includes the following six elements: choice of methods, information given to users, technical competence, interpersonal relations, followup or continuity mechanisms, and appropriate constellation of services (Bruce and Jain 1990). The effectiveness of family planning services was assessed on the basis of quality as well as on the L-M factors below.

9. Involvement of Private Sector Agencies

The Planned Parenthood Association of Ghana (PPAG) and the Christian Council of Ghana have been the principal nongovernmental providers of family planning services and education since the inception of the program. Other private

sector agencies that offer family planning education and services are the Christian Hospital Association of Ghana, Ghana Registered Midwives Association (GRMA), the Danish African Company Inc. (DANAFCO) through the Ghana Social Marketing Program, private medical practitioners, and the Market Women Association.

Conclusion. Private sector agencies were pioneers in launching family planning services in Ghana and continue to play an important role.

10. Civil Bureaucracy Involved

The Government of Ghana recently embarked on a decentralization program that resulted in increasing the number of districts from 68 to 110. Each district has an assembly responsible for allocating governmental resources. At a meeting on the African Agenda for Population (a World Bank-funded initiative) in a district in Central Region, it was decided to include a line item for population in the annual budget. Although it is too early to report any results, this indicates that population is becoming a topic of concern at the lower levels of government.

Conclusion. A.I.D.-supported activities designed to inform policymakers and decision-makers on the effects of population growth have been an important and influential, though relatively recent, input to the revitalization of the program.

11. Community-Based Distribution Program

The Ministry of Health has been interested in community-based programs since the early 1970s, with the beginning of the Danfa project, but no community-based distribution program was implemented until 1988, when A.I.D. authorized a traditional birth attendant (TBA) component of the Contraceptives Supply Project. With technical assistance provided by the American College of Nurse-Midwives, the Ministry of Health has trained almost 3,000 TBAs in five regions of the country as well as 63 master trainers and 307 Level B supervisors and trainers of TBAs. The TBA program is expanding to the other four regions of the country with the support of UNICEF. TBAs have been trained to provide and sell, for a profit, nonclinical family planning methods. PPAG not only provides services through its 46 clinics but also enlists the assistance of 168 community-based distributors. In 1989, the community-based distributors provided nonclinical services to 42,000 people.

The Health Research Unit, Department of Community Medicine, has been charged by the Ministry of Health to recommend a strategy for extending and supporting community-based family planning services. In 1991, the research unit conducted 25 focus groups in three districts, one from each of three regions. The focus groups identified the type of person best able to meet the community's expectations of a community-based distributor as well as key concerns the community holds with regard to family planning. The recommendations from this research have not been implemented to date.

Conclusion. Community-based distribution has only recently begun in Ghana and is still in its infancy.

12. Social Marketing Program

Conclusion. An attempt to introduce social marketing of contraceptives in the 1970s failed, in part because the incentive structure was not sufficient to generate the active support of the retail outlets. This activity was revived in 1985 through an A.I.D.-supported project with DANAFCO. Although the project still has some important pricing issues to resolve, it has successfully marketed condoms, orals, and vaginal foaming tablets through an extensive network of chemical sellers and pharmacies in urban and rural areas. It includes an effective training component, and its sales are increasing rapidly.

13. Postpartum Program

There is no emphasis on postpartum programs in Ghana. Women are likely to avail themselves of family planning services, including sterilization services, if they are provided immediately postpartum, as well as 6 weeks postpartum when (and if) the infant is taken to a well-baby clinic. This opportunity to provide services has not received attention.

Conclusion. There has been no emphasis on postpartum family planning.

14. Home Visiting Workers

From 1967-1979, 90 TBAs and 20 village health workers were trained under the Danfa Comprehensive Rural and Health Family Planning Project in an effort to extend primary health care and family planning to the rural population in the study area. A 1979 project evaluation recommended extension of the

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community-based models employed by the project. Under a more recent plan, not yet implemented, the Ministry of Health would surround each maternal and child health and family planning health center with 12 outreach points. A third proposal for reaching the rural population is a carefully planned and orchestrated rural family planning program. An effective rural outreach program would require improved systems for the distribution of supplies, record keeping, support, and follow through.

Although scheduled appointments and home visits are not a regular service of the Ghana family planning program, the 268 midwives offering family planning services are reaching women not served through other channels; 79 percent of their clients had never used a family planning method. The midwives have also been successful in increasing the percentage of their clients who use a modern method in comparison to the general population surveyed by the 1988 Ghana Demographic and Health Survey.

Conclusion. Though conceived of and partially implemented (through training) under the Danfa project, the provision of family planning services to rural areas through outreach activities of village health workers did not occur.

15. Administrative Structure

At the national level, the Maternal and Child Health and Family Planning (MCH/FP) Division of the Ministry of Health (which was the Maternal and Child Health Division prior to 1977) is headed by a physician. At the regional level, a public health nurse, under the supervision of the regional medical officer, is usually responsible for the MCH/FP program. At the district level, the district health management teams function as front line managers of primary health care, with the public health nurse taking primary responsibility for maternal and child health and family planning. The health management teams were formed in 1986 to strengthen the administrative structure, and the results are only beginning to be perceptible.

The administrative structure still suffers from neglect brought on by deteriorating economic conditions, maldistribution of personnel skewed to the urban areas, a mass exodus of professionals beginning in the 1970s, and a low level of resources available to the Ministry of Health. A large proportion of the available health resources support curative rather than preventive services. Management decisions often cannot be implemented because of poor communication and transport systems and crumbling infrastructure. In addition, primary health care programs are funded as separate activities, largely through

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donor contributions; this adversely affects the overall administration of the program and hinders the health management teams in carrying out their action plans coherently.

Administrative restructuring is not required. Rather, transport, equipment, and improved systems are needed to carry out the work more effectively within the existing administrative structure, but guided by a strategic implementation plan and with more attention paid to coordinating donor support.

Conclusion. The Ministry of Health administrative structure for family planning still suffers from neglect brought on by deteriorating economic conditions, maldistribution of personnel skewed to the urban areas, a mass exodus of professionals beginning in the 1970s, and a low level of resources allocated to the Ministry of Health, a large proportion of which is devoted to curative care.

16. Training Program

During 1972-1982 A.I.D. supported a wide array of training programs both in the United States and Ghana. Training of trainers programs were offered and more than 4,000 graduate nurses and nearly 1,000 other individuals were trained in family planning. A.I.D. also supported a seminar for nursing officers on integrating maternal and child health and family planning into the primary health care system and a comprehensive program on information, education, and communication (IEC).

During 1983-1985, when A.I.D. reduced its operations in Ghana, participant training was continued. From 1986-1988 A.I.D. sponsored training programs for district health management teams from 29 districts. Evaluation reports concluded that the teams generally performed well and were prepared to train health-center and health-post personnel.

During 1987-1991, 170 personnel were trained abroad in service delivery and IEC. Since 1988, 63 master trainers and 307 other individuals have been trained as supervisors or as trainers of TBAs, and this resulted in the training of 3,000 TBAs in 5 regions of the country. In addition, 435 public sector midwives and 268 private sector midwives have been trained in family planning skills; 20 physicians and 50 interns, in mini-lap; 50 physicians, in IUD insertion and removal techniques; 689 personnel, in logistics; and 5,154 level-B providers, in family planning IEC. The Population Impact Project has reached large numbers of policymakers and decision-makers. Most chemical sellers and pharmacists involved in GSMP have received training provided by the project or by the

Pharmacy Board. (However, this training was often provided to the owners of the shops rather than to the store clerks who deal directly with clients, and this has affected the quality of the advice provided to clients.)

A.I.D. has also supported the integration of family planning in the preservice educational programs for nurses and midwives. Because there is such a small volume of clients, it is difficult for trainees to gain minimal competency in the clinical aspects of family planning. As a result, almost all training in family planning clinical skills in Ghana lacks practical experience, and this affects the quality of care, diminishes access to long term clinical methods, and affects couple years of protection (CYP).

The impact of the training will be maximized if it is complemented by other service inputs such as IEC, equipment, and contraceptive supplies. The sustainability of the training will be maximized by including family planning in the preservice education programs of health and medical personnel, treating in-service training as a continuing process, and implementing a continuing education program.

Conclusion. Ghana has benefitted from much A.I.D.-supported training covering different aspects of family planning, including clinical skills and management. Personnel have been trained at almost all levels of the system.

17. Personnel Carry Out Assigned Tasks

The personnel trained in family planning carry out assigned tasks within the constraints described above. This usually requires the client to come to the provider. Accessibility would be improved with an increase in provider to client delivery.

Conclusion. With few exceptions, the personnel responsible for providing family planning services do so. Unfortunately, the client is almost always required to come to the provider, and this has restricted accessibility to family planning services and commodities.

18. Logistics and Transport

With rare exceptions, all the contraceptive supplies entering Ghana are procured and funded by donor agencies. The International Planned Parenthood Federation (IPPF) supplies a full range of contraceptives to PPAG, the United Nations Population Fund (UNFPA) supplies Depo-Provera, and A.I.D. supplies

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all other commodities. The process of clearing commodities through the port is cumbersome and has been the cause of delays and artificial stockouts. A.I.D.'s new grant agreement includes conditions for reform of the port clearance procedures.

Another problem area is the distribution of commodities from the national level to the regional and district levels. The general practice is for health personnel to collect supplies and commodities from the regional stores, rather than for the regional stores to distribute supplies to the delivery points. Frequently, transport is not available to collect the commodities. Because service delivery points cannot depend on a consistent flow of supplies, both the public and private sector agencies frequently trade their extra stock to compensate for shortages. As a result, clients must sometimes switch formulations (in the case of oral contraceptives) or change methods altogether.

Also the perception by family planning personnel of shortages of supplies sometimes causes hoarding when in fact supplies exist but are not being delivered efficiently. As a result, insufficient supplies may be dispensed to clients, and in some cases the client will need to return to the clinic or service delivery point for resupply sooner than would otherwise be required. The Ministry of Health is well aware of the weaknesses in the logistics and transport systems and is taking measures to make improvements.

Conclusion. The process of clearing contraceptive commodities through the port-of-entry is cumbersome and has contributed to delays and stockouts. The Ministry of Health logistics and transport system that distributes commodities to the regions and districts has been weak, at best. Commodities sometimes have arrived at clinics shortly before their expiration date. Storage facilities in rural clinics have been and continue to be inadequate, especially for heat-sensitive commodities.

19. Supervision System

All the Ministry of Health health and family planning workers in Ghana have an assigned supervisor. However, as a result of decentralization of primary health care, supervisors and employees are often based at different sites and the supervisor may encounter transport or other problems in visiting the employees. Thus, opportunities are missed in giving on-the-job technical assistance, training, and immediate feedback on performance. As Ghana implements a rural-based program, mechanisms should be developed to ensure frequent and supportive supervision of fieldworkers.

Conclusion. All the Ministry of Health health and family planning workers in Ghana have an assigned supervisor, but recent decentralization has caused some supervisors to be based at locations different from their employees.

20. Mass Media for IEC of Contraceptives

IEC efforts in Ghana were begun by GNFPP, and they remain the strongest component of the entire program. The IEC effort has benefitted from the involvement of the Ministries of Information, Education, Agriculture, and Health and the Departments of Social Welfare and Community Development. Nongovernment organizations (NGOs) and GSMP have also been active in IEC efforts. IEC efforts have helped improve awareness of family planning, but they have not been successful in explaining how to avoid pregnancy. The 1988 Ghana Demographic and Health Survey found that 77 percent of Ghanaian women knew of a modern family planning method but "lack of knowledge of contraception" was still cited as the main reason for nonuse of contraceptives.

An integral part of the public sector component of the A.I.D.-supported Contraceptive Supply Project is an IEC subproject entitled Ghana Health and Family Planning Information which was initiated in 1985. Johns Hopkins University/Population Communication Services assisted the Ministry of Health, Health Education Division in implementing this subproject, which trained service providers in counseling and interpersonal communication, developed and produced audiovisual materials to support client education, and conducted mass information campaigns to attract clients to service delivery points. Family planning workers were given a lapel button that read "We Care," and billboards carried the same message. The results of the campaign were evaluated through household surveys, special studies, and analysis of clinic statistics. Over 90 percent of the men and women in the three campaign regions were exposed to messages through at least one medium, and in the first year of the campaign CYP in the three regions increased by nearly 90 percent.

IEC efforts in Ghana are becoming more sophisticated as a result of research on the selection of the message and the media for delivering the message to the specific groups most in need of family planning services. However, interpersonal relations are often lacking for some subgroups, particularly adolescents. Several informants reported clinic workers taking unmarried clients aside to reprimand them and, in one instance, to pray for a change in their behavior. Family planning workers appear, in some instances, to be insensitive to the privacy concerns of clients.

Conclusion. IEC efforts in Ghana have been a relatively strong component of the program since the mid-1980s. The technical capability for IEC has been institutionalized, but it will likely require sustained financial support.

21. *Incentives and Disincentives*

There are no monetary or other incentives for the adoption of family planning in Ghana. The Industrial Relations Act of 1965 (Act 299, Sec. 10) and the Labor Decree of 1967 (NLCD 157) introduced into Ghana the concept of maternity leave. Under these decrees, each woman is entitled to 6 weeks leave at half pay just prior to giving birth and an additional 6 weeks following the birth. The postpartum leave is extended to 8 weeks if twins are born or if there were complications during labor or delivery. The employer must also allow the woman to use accumulated annual leave, if any. According to the national population policy, which favors smaller families, there is a limit of three paid maternity leaves per woman; however, that limit is not enacted into law and is widely ignored in practice.

Conclusion. By law or practice there are no incentives or disincentives for the adoption of family planning in Ghana.

Record Keeping and Evaluation

22. *Record Keeping*

Until 1987, record keeping was unreliable. Now each MCH/FP service site keeps records on the number of new acceptors and continuing users by method and the type and amount of commodities dispensed to the client. Steps are being taken to refine the record keeping and data collection process. The next step will be to standardize data collection procedures for use by all agencies.

Conclusion. It is difficult to measure family planning outputs in Ghana because there is no standardized system of record keeping, data collection, or central reporting practiced by the agencies providing services.

23. *Evaluation*

Most evaluation efforts have been project specific, but increasingly an institutional capability is being created with A.I.D. assistance in the universities

and the Ministry of Health's Health Research Unit, Department of Community Medicine. The research unit, for example, tested the training strategies for TBAs that are now incorporated into national guidelines for the TBA program. It also worked with the Ghana Registered Midwives Association (GRMA) in obtaining a profile of client characteristics and in developing a client record form. In 1991, 25 focus groups were conducted in 3 different regions with a view toward developing a strategy for community-based distribution programs. Under the present structure of the family planning program, the special needs of significant subgroups as defined by age, gender, marital status, lactation status, location, and health profile are not recognized.

Conclusion. An institutional capacity for research is being developed.

24. Management Use of Evaluation Findings

Although the institutional capacity for undertaking research and evaluation has improved, there is often a lag in the application of evaluation findings. For example, a major conclusion of the Danfa project concerned the integration of family planning and maternal and child health activities; yet this conclusion was not implemented until years after the end of the project. Also, application of evaluation findings often depends on donor assistance and support. Some regions, on the other hand, are very proactive in analyzing their data. The Volta Region, for example, has instituted a system for tracking family planning data, including contraceptive prevalence rates, over time.

Conclusion. The Ghana family planning program has been somewhat responsive to evaluation findings and has been taking measures to improve program performance and effectiveness since the period of revitalization beginning in 1986.

Availability and Accessibility of Fertility Control Methods

25. Abortion

The Criminal Code, Amendment No. 102 (February 22, 1985) states that abortion is legal in Ghana if it is done by a medical professional and (1) the pregnancy is the result of rape or incest, (2) there is serious risk of significant disease or disability in the resulting child, or (3) continuing the pregnancy would involve risk of injury to the woman's physical or mental health. The 1987 law on abortion promulgated by the Provisional National Defense Council is fairly flexible, with physicians allowed to exercise their judgement on whether an

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abortion is necessary for "health" reasons. However, this liberal legal framework does not appear to be widely discussed or understood by the medical establishment.

Studies at Korle Bu hospital and elsewhere show fairly high proportions of women with at least one child having reported a previous abortion (over 20 percent). The World Bank (1989) found that many public service physicians were augmenting their incomes by providing abortion services, usually upon request, with little or no restriction. Ministry of Health statistics garnered from midwives indicate a decrease in reported abortions during 1980-1986, as shown in Table D-1, but it is likely that many abortions go unreported unless there are complications and the woman requires medical attention.

Table D-1. Number of Reported Abortions in Ghana, 1980-1986

	1980	1981	1982	1983	1984	1985	1986
Reported Abortions	4,002	4,054	3,714	2,255	1,892	2,082	1,856

Source: Ministry of Health.

Traditional methods for inducing abortion, herbal drinks and douches, as well as more modern concoctions thought to induce abortion, such as strong sweetened coffee, are still used.

Conclusion. Abortion is legal in Ghana if it is done by a medical professional and (1) the pregnancy is the result of rape or incest, (2) there is serious risk of significant disease or disability in the resulting child, or (3) continuing the pregnancy would involve risk of injury to the woman's physical or mental health.

26. Male Sterilization

There are no reported cases of male sterilization in Ghana. Research should be conducted on how to motivate men to accept male sterilization.

Conclusion. Male sterilization is restricted to a few locations where there are trained personnel. It is not promoted actively and is not a widely chosen option.

27. Female Sterilization

According to the 1988 Ghana Demographic and Health Survey, nearly one in every four women (23 percent) desires to limit childbearing. Slightly less than 20 percent of husbands want no more children. For only 12 percent of couples do both spouses want no more children. The medical profession imposes limitations on the use of female sterilization. A woman seeking sterilization services typically must be at least 30 years old and have four living children. After counseling she will be asked to consider the matter for a month at which time she can return to the service with her spouse, who must consent to the procedure.

A few Ministry of Health facilities and some private medical practitioners provide female sterilization services. According to the 1991 Annual Report of the MCH/FP Division, there were no acceptors of female sterilization in 1988; 146 (less than 1 percent) in 1989; and 523 (less than 1 percent) in 1990. There is an urgent need to make female sterilization available and accessible in public and private health facilities in urban and rural areas. As a first priority, postpartum tubal ligations should be available at every hospital where obstetric services are available.

Conclusion. There are limitations on the use of female sterilization, and postpartum tubal ligations are not available at all hospitals where obstetric services are available.

28. Pills and Injectables

A.I.D. has been supplying oral contraceptives to Ghana through the Ministry of Health and GSMP since the family planning program was launched; IPPF supplies oral contraceptives to PPAG, and UNFPA supplies Depo-Provera. Although there have been stockouts and shortages, these have been associated with port clearance and distribution rather than inadequate procurement. Since 1986 oral contraceptives have generally been available at all Ministry of Health MCH/FP outlets; 47 PPAG clinics; 238 private sector midwives through the GRMA project; and 3,500 outlets through GSMP.

A problem imposed by medical conservatism is that health workers will frequently dispense only three cycles at a time, even though the client knows how to take the pill and does not report any side effects. She may be required to return for supplies frequently so the provider can check to see if the instructions are being followed. One of the major objectives of GSMP is to make orals more accessible so that women will not have to travel to an MCH/FP clinic just for resupply. However, the brand of orals supplied by A.I.D. to GSMP (Norminest/Secure) is different from the brands supplied by A.I.D. to the Ministry of Health (Lo-Femenol, Ovrette) and the brands supplied by PPAG. Although an important element of GSMP is to segment the market for contraceptives, focus group research has pointed out the problems caused by having to switch brands, and this may make it difficult for some clients to use GSMP for resupply. Marketing research should be carried out to examine the seriousness of this problem.

For many years, only physicians were allowed to prescribe oral contraceptives, and only pharmacists were allowed to dispense them. Beginning in 1986, about 3,000 chemical sellers were authorized to distribute orals under an A.I.D.-sponsored pilot distribution program. As a result of this experience, a new policy, enacted in early 1992, was codified to permit oral contraceptives to be provided by anyone who has received appropriate training and to be dispensed by both chemical-sellers and community health workers.

Improvement in the accessibility and availability of oral contraceptives and injectables hinges on several factors, including continuing procurement of supplies by donors, increasing the number of outlets in both the public and private (commercial) sectors, improving the supply and distribution system, breaking medically imposed barriers, and strengthening IEC which promotes a positive image and dispels rumors and myths.

Conclusion. Oral contraceptives are generally available from Ministry of Health MCH/FP clinics, PPAG clinics, private sector midwives, and commercial outlets. Health workers dispense only three cycles at a time, however, even to clients who know how to take the pill and report no side effects. Stockouts occur but have been less frequent in recent years.

29. IUDs

A.I.D. supplies the CuT.380, and over 50 physicians and 538 nurses and nurse-midwives have been trained in insertion and removal. However, only 5 percent of acceptors used the IUD in 1990. A study should be conducted to investigate why the number of acceptors is so low and to determine how many

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of the trained personnel are actually applying their skills and, for those who are not, why. The medical policies and protocols for IUDs should be reviewed and updated in terms of contraindications and to ensure that there are no medical barriers to access.

Conclusion. A large number of health personnel have been trained in IUD insertion and removal techniques; however, only a small fraction of acceptors choose IUDs.

30. Condoms and Other Conventional Methods

A.I.D. has supplied condoms and vaginal foaming tablets since the family planning program was launched. IPPF supplies condoms and vaginal foam, creams, and tablets, as well as diaphragms to PPAG, and the market offers women foam and condoms. Condoms and foaming tablets are available at all the service delivery points mentioned above and, recently, 3,000 TBAs have been trained to supply and sell condoms and tablets. The Catholic Secretariat, through the Christian Hospital Association of Ghana, offers only natural family planning methods.

The duration of breast-feeding in Ghana is fairly long. Nine out of 10 women with births 2-3 months before the 1988 Demographic and Health Survey were still breast-feeding, and more than half (57 percent) of the women still breast-fed for the period 20-21 months after delivery. This natural method of family planning needs to be reinforced, and health workers need to be updated on the Lactational Amenorrhea Method, which will become increasingly important as the rural population migrates to the periurban and urban areas.

Conclusion. Condoms have become generally available from a variety of sources, especially since the commercial sector has become involved through GSMP. Conventional and traditional methods have been, and continue to be, relied upon.

Overview of Ghana's Health Care System

This section describes Ghana's health care system in recent years (1990-1991). It provides a quantitative overview of physical facilities and MCH/FP service delivery points, of human resources, and of the utilization of maternal and child health and family planning services.

Physical Facilities and Maternal and Child Health/Family Planning Service Delivery Points

In 1990 the public sector supported 49 general hospitals (including two teaching hospitals, 8 regional hospitals, and 39 district hospitals) plus about a dozen specialized hospitals. There were about 10 urban and 300 rural health centers and health posts and about 170 separate maternal and child health centers. The parastatals operated a dozen hospitals; the armed forces and police operated another 10 hospitals; and missions operated 41 hospitals and 64 clinics. The private sector operated some 400 clinics and 300 maternity homes. Since 1985 total bed capacity has remained constant at 18,300 (one bed for 819 people), with 13,400 beds in the public sector and 4,900 beds in mission facilities. Since 1981 almost no new Ministry of Health health centers and only five new Ministry of Health health posts have opened each year, on average. In 1988 there were 359 registered private pharmacies; 60 percent were in the Greater Accra Region, and 24 percent were in Ashanti Region. There were 3,077 chemical-sellers. Virtually all the facilities are in need of extensive rehabilitation, both the basic infrastructure and medical equipment (World Bank 1990).

There were 4,060 public and private delivery points for maternal and child health/family planning services in 1991. These services were provided by GSMP (2,968 outlets); Ministry of Health (584); GRMA (238); PPAG (24); the Christian Council of Ghana (8); and the Christian Hospital Association of Ghana combined with private medical practitioners (238). Not included in this total are the 3,000 TBAs who recently completed training in dispensing condoms and foam.

Human Resources

Currently about 966 doctors work in Ghana. Of these, 611 are in the public sector, 300 are in the private sector, and 55 are in mission facilities. Of the 611 public sector doctors, 227 are in the teaching hospital in Accra. In addition to the 55 physicians in mission facilities, there are 25 expatriate physicians. The Ministry of Health employs 10,000 nurses, 80 percent of whom are clinical. There are about 4,000 primary health care personnel at the health center/health post level, and about another 3,000 at the village level. The 1990 MCH/FP Division Annual Report shows that the number of community nurse-midwives (CNM) increased from a ratio of 1 CNM to 28,494 population in 1989 to 1 CNM to 25,193 population in 1990.

Utilization of Maternal and Child Health/Family Planning Services

Many maternal and child health and family planning services are underutilized. Outpatient attendance fell from 11 to 10 million in 1973 to only 4 million in 1985 and it appears to have stagnated at 5 million from 1987-1990. This is due primarily to declining health standards and shortages of drugs. The modern health system reaches around 65 percent of the population. Table D-2 shows the trends in maternal and child health and family planning service coverage from 1987-1990. Although the percentage of the population covered is slowly increasing, family planning coverage is disappointingly low at only 7 percent in 1990.

Table D-2. Maternal and Child Health/Family Planning Service Coverage in Ghana, 1987-1990 (percentage of population)

Service	1987	1988	1989	1990
Antenatal Care	56	65	85	91
Postnatal Care	20	41	50	49
Delivery	18	19	27	29
Child Welfare	16	16	12	23
School Health		8	6	14
Family Planning	4	4	6	7

Source: Ministry of Health, MCH/FP Division, 1991 Annual Report.

Table D-3 shows the trends in the average number of visits per client by type of service during 1987-1990. The number of visits has been static or declining, which signals concern about the quality of health care.

Table D-3. Average Number of Visits per Client, by Maternal and Child Health/Family Planning Service in Ghana, 1987-1990

Service	1987	1988	1989	1990
Antenatal Care	2.4	2.9	2.0	2.1
Child Welfare	4.7	4.0	4.0	3.5
Family Planning	3.4	3.0	2.7	3.0

Source: Ministry of Health, MCH/FP Division, 1991 Annual Report.

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APPENDIX E

SUMMARY OF A.I.D. INPUTS

A.I.D. disbursed an estimated \$24.9 million to support population and family planning projects in Ghana during 1968-1991. These activities included 8 bilateral and regional projects and 43 centrally funded projects. This appendix briefly describes each project. Depending on data availability, it also reports the project number, dates of implementation, and total project expenditures. Some centrally funded projects were partially funded by Mission buy-ins, estimated at one-half of total funding; in these cases, Mission buy-in expenditures are included under the bilateral projects, not the centrally funded projects.

Bilateral/Regional Projects

- *Family Planning and Demographic Data Development.* (641-0051; 1968-1972; \$244,000.) This was the first of a series of projects designed to develop demographic research and training capacity in the universities in Ghana. It included funding for the 1968-1969 National Demographic Sample Survey.
- *Danfa Comprehensive Rural Health and Family Planning.* (641-0055; 1969-1981; \$602,000, 10 percent of total project funding, which was estimated by USAID/Accra as the portion used to support family planning.) This was a research and demonstration project designed to develop methods for delivering primary health care and family planning services in rural areas. During Phase I (1970-1975) a quasi-experimental design was implemented to evaluate the benefits of providing family planning within a comprehensive health care setting. Phase II continued activities in research, training, health care demonstration, and information sharing. The University of California at Los Angeles and the University of Ghana Medical School implemented the project.

- *Population Program Support.* (641-0064; 1971-1982; \$2,433,000.) The purpose of this project was to develop the basic systems of a national family planning program. The objectives of Phase I (1971-1975) were to train a wide range of governmental and nongovernmental organization (NGO) personnel and to provide contraceptives to the Ghana National Family Planning Program. Additional funding was provided in Phase II (1976-1982) to establish integrated health and family planning community-based programs administered by NGOs in two regions, implement a commercial sales program in two rural regions, and support operations research and further in-service family planning training for supervisory and paramedical personnel.
- *University Teaching of Population Dynamics.* (698-1157-0360; 1972-1977; \$112,000.) This regional project established the Population Dynamics Program at the University of Ghana under a contract with the University of North Carolina.
- *Programs in Population Dynamics.* (641-0087; 1977-1982; \$526,000.) This project provided bilateral funding for a population research and training program at the Institute of Social, Statistical and Economic Research of the University of Ghana under the Population Dynamics Program.
- *Family Health Initiatives.* (698-0462; 1982-1987; \$500,000.) At least 12 subprojects in Ghana have been funded under this regional project. For instance, a 1983-1984 subproject provided contraceptive supplies for use by service delivery systems supported by the Ministry of Health, the Christian Council of Ghana, and the YMCA.
- *Contraceptive Supplies Project.* (641-0109; 1985-1992; \$7,000,000.) The purpose of the project was to increase contraceptive use by making contraceptives available through both Ministry of Health service delivery networks and a contraceptive social marketing program. Bilateral funding (\$7 million) was to be supplemented by \$4 million from central and regional funds. The project was designed to have five mutually reinforcing elements: (1) supplying contraceptives (including pills, condoms, vaginal foaming tablets, and intrauterine devices) for distribution through Ministry of Health service sites and expanding capabilities for performing female sterilization; (2) improving the distribution of contraceptives based on reports on the number of clients served,

contraceptives dispensed, and inventory levels at each level of the distribution system; (3) training or retraining of at least half of the Ministry of Health service providers; (4) implementing a multimedia, culturally sensitive, multilingual information, education, and communication (IEC) campaign on the benefits of child spacing and the availability of services; and (5) providing technical assistance, training, and supplies to support a contraceptive social marketing program implemented by the Danish African Company Inc. (DANAFCO).

- *Family Health Initiatives II.* (698-0662; 1987-1991; \$950,000.) Under Phase II of this regional project, additional subprojects were funded. For instance, beginning in 1987 the American College of Nurse-Midwives implemented two projects to increase family planning and health care services, one through the Ghana Registered Midwives Association and the other by training traditional birth attendants.

Centrally Funded Projects

- *Expansion of Postpartum Family Planning Program.* (1969-1972; \$150,000.) This program supported three hospitals in Ghana in conjunction with the Program Grant to the Population Council.
- *Participant Training for Population and Family Planning-Related Activities.* (1969-1978; no funding data available.) This program trained 166 Ghanaians abroad.
- *Family Planning International Assistance.* This program funded the Christian Council of Ghana (1973-1977, \$237,800); the YMCA (1979, \$29,400); and the Association of People for Practical Life Education (1980, \$30,100).
- *African Health Training Institutes Project.* (932-0359; 1973-1978; \$338,000, one-sixth of total project funding, which was estimated as the portion used to support family planning.) Ghana was a major participant in this project implemented by the University of North Carolina and designed to improve the family health content in curricula of medical, nursing, midwifery, and allied health training institutions.

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- *Program Grant to the Population Council.* (1973-1980; \$61,800.) This program supported research and teaching activities at Ghanaian universities.
- *Family Planning Assistance Through Home Economics.* (1973-1980; \$19,600.) This activity supported the Ghana Home Science Association.
- *Family Planning Education Through Adult Literacy Programs.* (1974-1980; \$398,200.) This program provided grants through World Education.
- *International Development of Qualified Social Work Manpower for Population/Family Planning Activities.* (1976; no funding data available.) This program provided grants to the International Association of Schools of Social Welfare.
- *Training for Family Planning Managers.* (1976-1979; no funding data available.) This activity supported training at the Center for Population Activities in Washington, D.C.
- *Contraceptive Retail Sales.* (1976-1980; no funding data available.) This program funded a contract with Westinghouse Health Systems (with subcontracts to local firms, Lintas, and DANAFCO for advertising, packing, and delivery) to promote retail sales of contraceptives.
- *United Nations Population Fund (UNFPA).* (1977-1979; about 27 percent of A.I.D. contributions to UNFPA, or approximately \$61,000, funded Ghana projects.)
- *Physicians Postgraduate Training in Reproductive Health.* (1977-1980; \$118,000.) This project funded training at Johns Hopkins University and Washington University Medical Schools; it included a special program in surgical contraception.
- *University Teaching of Population Dynamics II.* (1978-1979; no funding data available.) This project provided follow-on support for the Population Dynamics Program at the University of Ghana.
- *Ghana Fertility Survey, 1979.* (1979; \$218,181.)

- *Program for Voluntary Sterilization.* (1979; no funding data available.) This activity supported several training programs.
- *Family Planning Services (The Pathfinder Fund).* (1980; no funding data available.) This project funded various training activities.
- *Strengthening International Population Communication and Training.* (1980; no funding data available.) This program supported a July 1980 seminar administered by the University of Chicago.
- *Grant to the International Planned Parenthood Federation (IPPF).* (No funding data available.) This activity provided support to the Planned Parenthood Association of Ghana.
- *Population Information Program.* (No funding data available.) This program, implemented by Johns Hopkins University, supported the dissemination of population materials in Ghana.
- *Program for International Training in Health.* (936-3031; 1984-1986; \$5,000.)
- *Demographic and Health Surveys.* (936-3023; 1984-1989; \$93,000.)
- *Family Planning Services (The Pathfinder Fund).* (936-3042; 1988; \$11,000.)
- *RAPID II.* (936-3017; 1988; \$4,000.)
- *Program in Voluntary Sterilization.* (932-0968; 1988-1989; \$105,000.)
- *Population Communication Services.* (936-3004; 1988-1989; \$330,000.)
- *Contraceptive Social Marketing I.* (936-3028; 1988-1989; \$296,000.)
- *Family Planning Logistics Management (Centers for Disease Control Participating Agency Service Agreement).* (936-3038; 1988-1989; \$101,000.)
- *Family Planning Management Training.* (936-3039; 1988-1989; \$81,000.)

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- *Population Program Development and Support.* (932-0502; 1988-1990; \$121,000.)
- *Family Planning International Assistance.* (932-0955; 1988-1990; \$132,000.)
- *Central Contraceptive Procurement.* (936-3018; 1988-1990; \$32,000.) In addition to contraceptives provided under the bilateral Contraceptive Supplies Project, central contraceptive procurement was funded under this project.
- *Africa Operations Research Regional: Strategies for Improving Service Delivery.* (936-3030; 1988-1991; \$848,000.)
- *Population Information Program.* (936-3032; 1988-1991; \$264,000.)
- *Family Planning Enterprise Program.* (936-3034; 1988-1991; \$286,000.)
- *Population Policy Initiatives.* (936-3035; 1988-1991; \$637,000.)
- *Family Health International.* 936-3041; 1988-1991; \$119,000.)
- *Training in Reproductive Health (Johns Hopkins Program of International Education in Gynecology and Obstetrics).* (936-3045; 1988-1991; \$394,000.)
- *RAPID III.* (936-3046; 1988-1991; \$162,000.)
- *Association for Voluntary Surgical Contraception.* (936-3049; 1989-1991; \$300,000.)
- *Contraceptive Social Marketing II.* (936-3051; 1989-1991; \$447,000.)
- *Population Services Internship Program.* (936-3033; 1991; \$45,000.)
- *Extending Family Planning Services Through Women Managers.* (936-3037; 1991; \$10,000.)
- *Population Communication Services II.* (936-3052; 1991; \$58,000.)
- *Central Contraceptive Procurement.* (936-3057; 1991; \$2,340,000.) This project funded contraceptives in 1991 under the

bilateral Contraceptive Supplies Project; the \$2.34 million expenditure is included under the Contraceptives Supplies Project, not under this project.

Future A.I.D. Family Planning Assistance

The next phase of A.I.D. population assistance to Ghana is the 5 year, \$30 million Family Planning and Health Program under which expenditures began July 1, 1991, and which is currently scheduled to continue through 1996. The purpose of the program is to increase the use of and demand for family planning through expanding the public and private sector capacity for providing maternal and child health and family planning services, supplies, and information. The program provides both project assistance (\$17 million) and program assistance (\$13 million).

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