

A.I.D. EVALUATION HIGHLIGHTS NO. 20

A.I.D. ASSISTANCE TO THE FAMILY PLANNING PROGRAM IN GHANA

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SUMMARY

For much of the 1968-1991 period, the U.S. Agency for International Development's (A.I.D.) family planning assistance to Ghana faced a daunting environment: frequent changes in Ghana's Government, weak political commitment to the country's well-regarded 1969 population policy, wrenching economic crises, occasional fraying of the U.S.-Ghana relationship, and deep cultural barriers to Ghanaian acceptance of family planning.

During the 23-year period of A.I.D. assistance, the Agency disbursed an estimated \$24.9 million to support population and family planning projects in Ghana. The projects primarily involved training, strengthening certain institutions, and providing and distributing contraceptives.

Given the obstacles faced by USAID/Accra and the upheavals experienced by Ghana itself, one cannot be surprised by the conclusion that the family planning program produced only limited results. The contraceptive prevalence rate—the most reliable program impact measure—increased from 9.5 percent in 1979 to 12.9 percent in 1988. However, most of the increase was in traditional methods. The use of modern methods remained virtually unchanged over the same period: 5.5 percent in 1979 and 5.2 percent in 1988. (More recently, however, the contraceptive prevalence rate for modern methods has increased. Selective survey results show a range of 8 to 10 percent in 1990-1991 for modern methods, while preliminary results from an August 1993 baseline consumer survey indicate a 15 percent prevalence rate for 1993.)

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). Population (70 percent being rural) grew at an increased rate, thanks to a relatively constant fertility rate combined with a lower mortality rate.

However, A.I.D.'s assistance has spurred incremental progress, such as expansion of the family planning distribution system, and the horizon offers much more than a glimmer of hope. A.I.D.-supported efforts to inform and influence political leaders about family planning and its implications seem to be bearing fruit. With A.I.D. now by far Ghana's largest family planning donor, plans for a new Population Council and statements in 1992 by the Head of State stressing the importance of family planning may presage increased political commitment.

BACKGROUND

In 1967, Ghana began to reverse its previous expansionist population policy. The Government formalized that reversal in 1969, when a policy paper recognized family planning as an intrinsic part of economic development because of the severe adverse economic and health effects of large families. Policy objectives to achieve by the year 2000 included reducing to 1.7 percent the nation's annual population growth rate (compared with a projected 3.9 percent without family planning), cutting the fertility rate by about 40 percent to 4, and increasing female contraceptive users to 65 percent of the female population.

Those were the Government's intentions when A.I.D. began its family planning assistance in 1968. Political and economic events, however, soon muffled those intentions and created an inhospitable environment for successful implementation of long-term development activities generally, including family planning. Especially during the late 1970s and early 1980s, a severe economic crisis afflicted Ghana. That was accompanied by deterioration of almost all governmental and private services, including health activities. Doctors and other trained Ghanaians left the country in droves. A.I.D. and other donors curtailed assistance drastically. Responding to deteriorating economic conditions, Ghana embarked on a stringent economic recovery program in 1983, now regarded as a major success although numerous problems persist.

Because of the worsening political relationship between the United States and Ghana, A.I.D. suspended bilateral development assistance in the spring of 1983, not to resume it until more than a year later in 1984. In 1986, interest in population policy and development issues revived and the Government included family planning as part of the mix of primary health care interventions. Previously regarded by the Government's Ministry of Health as a stepchild to other health-related measures, family planning had suffered weak service delivery.

Against that backdrop, a four-person evaluation team from A.I.D.'s Center for Development Information and Evaluation reviewed the Agency's involvement in Ghana's family planning program. The evaluation team, comprising two economists, a demographer, and a specialist in the delivery of family planning services, spent from May 4 to 27, 1992, in Ghana conducting the field study.

The assessment's methodology included a careful review of the literature; briefings from representatives of various institutions in Washington, D.C., who specialized in population policy and family planning; structured discussions in Ghana with private- and public-sector individuals familiar with Ghana's 23-year history of family planning; and site visits to various regions of the country in which family planning programs had been implemented. The evaluation team made an especially strong effort to understand Ghana's family planning experience from the perspectives of a large, diverse range of individuals.

A.I.D.'S ASSISTANCE APPROACH

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 \$0.8 million per year on average. A.I.D. suspended assistance from April 1983 to July 1984. During the 6-year period from 1985 to 1991, A.I.D. provided about \$13.6 million, averaging about \$2.3 million annually. Measured in current dollars, A.I.D. provided, on average, almost three times the level of family planning assistance to Ghana annually after 1985 than before 1983.

A.I.D.'s investments in family planning 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.

During the 1970s, A.I.D. had been one of the major supporters of the Ghana National Family Planning Program (GNFPP), which proved ineffectual in coordinating national efforts; implementing agencies marched (slowly) to the beat of different donors and drummers. By 1985, after the Agency had resumed assistance to Ghana, GNFPP had become largely nonoperational. A.I.D.'s assistance shifted to the Ministry of Health, which began to offer family planning services in the context of primary health care interventions. An A.I.D.-funded project probably contributed to that decision by the Ministry. The project (Danfa Comprehensive Rural Health and Family Planning Project, 1969-1981) tested various approaches to delivering family planning services and commodities and 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 succeed in the Ghanaian context.

When the Agency renewed its program in 1985, the Mission recognized the need for greater support from the political leadership and targeted assistance to inform and influence policymakers. At the same time, A.I.D. began to support expansion of the distribution system for family planning services and commodities. For example, it introduced the Ghana Social Marketing Program to expand accessibility through commercial channels. The Agency also began supporting distribution of contraceptives through various family planning providers, including the Ministry of Health, the Ghana Registered Midwives Association, and traditional birth attendants. That approach continues today.

From the start, A.I.D.'s assistance approach contended with periods of political and economic instability as well as with other hindrances, such as the following:

- Absence of a consensus among the national leadership and senior decision-makers during the 1968-1991 period that the goals and objectives of family planning are national priorities. This situation prevailed despite the Government's 1969 population policy, which by all accounts provided a clear and comprehensive statement that has stood the test of time.
- Absence of regular and convenient accessibility in rural and urban areas of family

- planning counseling and a wide range of contraceptives from trusted sources that could ensure the privacy and confidentiality of the client. Contraceptive availability per se was not the major issue; the problem centered on convenience, trust, and privacy.
- Presence of cultural attitudes favoring large families, especially among men (who play a dominant role in Ghanaian society), which have tended to undermine the effectiveness of the country's family planning program.

FINDINGS

Summarized below are the evaluation team's findings regarding A.I.D.'s assistance to family planning in Ghana in terms of performance (effectiveness, efficiency, and sustainability) and impact (long-term results).

Effectiveness

When evaluating effectiveness, the evaluation team considered whether family planning services and commodities were used by intended beneficiaries, whether access was equitable, and whether coverage of intended beneficiaries was as planned.

The evaluation team used the 30-item Lapham-Mauldin Family Planning Effort Scale (L-M Scale) to arrive at conclusions concerning effectiveness. The L-M Scale defines "program effort" in terms of four major components: policy- and stage-setting activities, service and service-related activities, record-keeping and evaluation, and availability and accessibility of fertility control methods.

The evaluation team reviewed prior applications of the L-M Scale for the years 1982 and 1989, which indicated that Ghana's family planning program had moved from "very weak" to "moderate" during the period. Although the evaluation team did not assign precise numerical scores to the 30 items because of the subjective nature of the L-M Scale and the small size of the team, it concluded that Ghana's family planning program moved from "very weak" in 1982 to "weak" in 1992 and that the 1989 "moderate" score was too generous.

Most of the improvements in the program's activities occurred after 1987 and in the categories of "service and service-related activities" and "record-keeping and evaluation." Improved least was "availability and accessibility of fertility control methods," with "policy- and stage-setting activities" remaining about the same.

Among the evaluation team's observations regarding effectiveness are the following:

- *Use and coverage of family planning services.* Many maternal and child health and family planning services offered by Ministry of Health clinics are underutilized.

- Although a large proportion of married women in Ghana wanted to delay pregnancy in 1988 (68 percent) and were aware of family planning (77 percent), only a small proportion (13 percent) used any method of family planning.
- *Availability and accessibility of family planning services and commodities.* Although a program for the social marketing of contraceptives in the 1970s failed, it was revived, with support from A.I.D., in 1985 and is successfully marketing contraceptives through an extensive network of commercial outlets in urban and rural areas. However, because providers of family planning services cannot always ensure client confidentiality, many potential users hesitate to go to the providers. An emphasis on provider-to-client delivery would improve accessibility. In general, availability of family planning methods is not as serious a problem in Ghana as is the accessibility of services from trusted, confidential sources that can ensure the privacy of the client.

Efficiency

The evaluation team used cost-effectiveness analysis to assess A.I.D.'s investments in family planning. However, as is typical in many developing nations, information on costs or cost-effectiveness was not available for Ghana—not from the literature, program documents, donor organizations, the Government, or the private sector. Apparently, no one has ever investigated how much the family planning program costs, either in total or by donor, by government, by service delivery alternative, or by contraceptive method.

USAID/Accra is in the process of initiating a 5-year \$30-million Family Planning and Health Program to continue the current approach to family planning and services. Yet this program (like previous ones) was launched without a clear understanding of the relative economic efficiency of providing various alternative contraceptive methods through alternative contraceptive service providers.

To disentangle family planning expenditures from the rest of the Ministry of Health budget requires a cost study that identifies all direct, indirect, and infrastructure costs attributable to the provision of family planning services and commodities. Those cost categories should, in turn, distinguish between capital (developmental) and recurrent (operating) costs.

In the absence of cost data, the evaluation team could not compare the cost-effectiveness (such as cost per couple-years-of-protection [CYP]) of alternative contraceptive methods in terms of alternative family planning service providers.

Cost analysis is also essential for informed decisions about cost recovery of family planning services and commodities currently offered. Without cost data, one is hard-pressed to set realistic prices for cost recovery. To shed light on the issue of prices, the evaluation team conducted a minisurvey, admittedly unscientific, of many sellers of contraceptives. After converting unit prices to price per CYP, the evaluation team found that chemical stores were the

most expensive sellers, followed by the Ghana Registered Midwives Association, the Planned Parenthood Association of Ghana, and the Ministry of Health. By contraceptive method, the IUD was least expensive in terms of price per CYP; Depo-Provera (injectables) sold by the Ministry of Health was the second cheapest method.

However, because of subsidies, contraceptive prices in Ghana do not reflect costs accurately. Sound resource allocation decisions should be based on costs or on prices that reflect actual costs, not administered prices. To determine whether subsidized contraceptive commodities available from the public sector will undermine those sold at decontrolled prices in the commercial sector or whether price deregulation will harm or enhance a public sector cost-recovery program requires a price elasticity analysis.

Other efficiency issues include the underutilization of Ministry of Health family planning services, which suggests the desirability of initiating demand creation activities or cutting staff and services, or both. Some suggest that low utilization may be due, in part, to inconvenient clinic hours. Others suggest that clinic workers conduct more community outreach activities to increase the use of services and commodities. Both suggestions probably have merit.

Sustainability

Sustainability pertains to the extent to which program benefits and outputs continue after A.I.D.'s involvement ends. However, the benefits derived from A.I.D.'s investments in family planning in Ghana during the 1968-1991 period were limited, at least when measured in terms of changes in the contraceptive prevalence rate and total fertility rate (see section on impact). The issue of sustainability of benefits therefore was not as relevant as understanding why progress in family planning in Ghana has been so disappointing. That understanding is best discussed in terms of institutional sustainability, financial sustainability, and 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. As noted earlier, much of the period during which A.I.D. provided family planning assistance to Ghana was characterized by political instability.

Furthermore, despite Ghana's well-regarded population policy announced in 1969, family planning has not enjoyed a clear national commitment—that is, 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. That lack of overt, continuous political support is a major factor explaining the poor performance of Ghana's family planning program. However, plans for a new Population Council and statements in 1992 by the Head of State stressing the importance of family planning hold hope for the future.

Institutional sustainability also suffered from lack of direction by participating agencies, which was exacerbated by personality conflicts and internal rivalries, ineffective interagency coordination, and poor delineation of responsibility for executing population policy. But that situation may improve with the advent of the planned Population Council, an autonomous unit comprising relevant public and private entities. Conferred with the highest level of official sanction, the Council will plan, coordinate, and monitor the nation'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 only as a health measure but also as part of an interdisciplinary effort to promote overall socioeconomic development.

Of the three main institutional mechanisms for delivering family planning services and supplies in Ghana—the public sector (primarily the Ministry of Health), the nongovernmental organizations, and the commercial sector—the Government supplied 35 percent of users of modern methods of contraception. During most of the 1968-1991 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 a community-based system. The differences between the two delivery systems are striking and may help to explain the low contraceptive prevalence rates during the period:

- Public health clinics are usually urban, whereas community-based systems are usually rural.
- Clients must go to a public clinic for services, whereas services are brought to the client under a community-based system.
- Public health clinics tend to give relatively short shrift to family planning, whereas community-based systems tend to emphasize it.
- Public health clinics are not as careful in protecting the confidentiality of the client as are community-based systems.

Financial Sustainability

The chances of projects achieving financial viability, and thus sustainability, improve when they use resources efficiently. Efficient use of resources requires a strategy of cost containment and cost recovery. As noted earlier, however, cost data are not available.

Nonetheless, given the unused capacity and underemployed personnel providing family planning services at Ministry of Health clinics, one can infer that program costs were higher than necessary. Such a situation suggests the need for creating additional demand or cutting staff and facilities to reduce costs.

Cost recovery has been attempted since 1986 (such as costs of distribution and advertising of contraceptives sold under the social marketing program). Still, the generally held view maintains that the public sector will need to continue subsidizing family planning services for the foreseeable future.

Demand for Family Planning Services

No program is sustainable if the demand for its services and commodities is weak, the apparent situation in Ghana. One factor that dampens demand in Ghana for family planning services and supplies is how they are provided. As noted earlier, failure to assure clients of privacy and confidentiality has been a major drawback. Under those circumstances women, especially single women and teenage girls, are often too shy to buy or request family planning services.

Also, information, education, and communication efforts focus on married women, not on single women and teenage girls, despite a heightened teenage pregnancy rate. Thus, unmarried women do not know how to use family planning methods or where to get the information. Furthermore, a service delivery strategy with sole emphasis on family planning, or even when combined with maternal and child health care, is unlikely to generate much interest in smaller families or demand for contraceptives among people living in extreme poverty.

Cultural beliefs and sexual inequality also undermine family planning programs and help explain the low demand for family planning services. Ghana's culture is pronatalist: failure to have children is not good. Parents treat children as a form of social security in old age, which encourages people to have more children, not fewer. That is likely to continue until infant and child mortality rates decline further.

According to the 1988 Ghana Demographic and Health Survey data, Ghanaian men, on average, want two more children than do women. Husbands discourage family planning because they believe it gives wives a chance to have sexual relations with other men. Furthermore, marriage and divorce laws in Ghana are not supportive of women who wish to use contraception over their husbands' objections, unless they are willing to sacrifice their economic security. That situation is not likely to change unless female literacy, currently half that of males, is increased.

Impact

The assessment of longer term effects or impact of A.I.D.'s support of Ghana's family planning program includes three components: demographic impact, health impact through 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.

Estimates of Ghana's *population* for 1970, 1984, and mid-1992 are, respectively, 8.6 million, 12.4 million, and 16 million. From 1965 to 1980 the average annual population growth rate was 2.2 percent; from 1980 to 1990, 3.4 percent. The 1969 population policy set a specific demographic target of reducing the population growth rate to 1.7 percent by the year 2000, in contrast to the projected rate of 3.9 percent without family planning. Clearly, the family planning program and other elements of population policy have not yet begun to reduce the population growth rate.

Total *fertility rates* for 1968-1969, 1979-1980, and 1988 are, respectively, 6.9, 6.5, and 6.4—very little change during the 20-year period. Equally clear is that Ghana has not reached its fertility reduction objectives as spelled out in its 1969 population policy: an average of 5 births per woman of reproductive age by 1985 and 4 by 2000.

The most reliable measure of the impact of a family planning program is the *contraceptive prevalence rate*. 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 was almost unchanged: 5.5 percent in 1979 and 5.2 percent in 1988. Use of traditional methods increased from 4 percent to 7.7 percent during the period. (In 1991, the contraceptive prevalence rate for modern methods may have increased to as high as 8 to 10 percent based on selective survey results, and preliminary results of a consumer-based survey suggest a 15 percent rate in 1993).

Statistics compiled by USAID/Accra from the three major providers of contraceptives—Ministry of Health, Planned Parenthood Association of Ghana, and Ghana Social Marketing Program—indicate that although the absolute number of CYP afforded by various modern contraceptive methods is small for the 1987-1991 period, the magnitude of change is dramatic (see Figures 1 and 2). In 4 years, CYP almost tripled. Moreover, of the three providers, Ministry of Health clinics registered the most dramatic increase in CYP, from the fewest CYP in 1987 to the greatest number in 1991.

Among the many factors affecting 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 (8.1 percent using modern) in 1988, while prevalence among rural women was only 9.9 percent (3.9 percent using modern). 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 for women who have gone beyond middle-level education.

The interaction of five major proximate determinants govern changes in fertility: the proportion of women ages 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.

A study by the University of Ghana, which used 1979 data, explained the difference between maximum natural fertility (14.9 children per woman) and observed fertility (6.4 children per woman) for the nation (8.5) as follows: 31.3 percent of the difference was due to the proportion of women who were married or in union, 64.0 percent was due to postpartum infecundability due to breast-feeding, and only 4.7 percent of the difference was due to contraceptive use. Because of the importance of the fertility-inhibiting effects of breast-feeding in explaining the difference between total fecundity and observed fertility, programs that promote breast-feeding should have a significant role in family planning.

Regarding *desired family size*, the following categories of women constitute unmet need for contraception: (1) fecund women who are neither pregnant nor amenorrheic (postpartum infertility caused by breast-feeding) and who (a) want no more children or (b) want children later, and (2) pregnant or amenorrheic women who (a) had an unwanted pregnancy or (b) had a mistimed pregnancy. These categories totaled 35.3 percent of all married Ghanaian women in 1988. (Note that this more refined measure of unmet need is lower than the crude measure of 55 percent used in the focus group studies [see box, The Beneficiary's Perspective].) In addition, 12.9 percent of married women were current users of contraception. Thus, the total need in 1988 for contraception was 48.2 percent of married women. That indicates that family planning services were meeting 27 percent of the total need (12.9 percent of met need out of 48.2 percent of total need). The 48.2 percent level of total need appears to have remained fairly stable during the 1980s.

Of the total unmet need (the 35.3 percent), 75 percent is for spacing births and 25 percent is for limiting the number of children. That distinction has important implications, for some contraceptive methods are better suited for limiting births and others for spacing them.

Health Impact

An explicit goal of Ghana's national family planning program is to improve maternal and child health. That goal is not likely to have been achieved, given the lack of progress in reducing fertility and the modest increase in contraceptive prevalence. Mortality rates for children under age 5, though 17 percent lower than in the late 1970s, remain very high at 146 per 1,000 live births.

A direct relationship exists between infant and child mortality and high-risk fertility. High-risk fertility refers to the proportion of recent births occurring among women who are too young, too old, at high parity, or who space their births too closely. Spacing of births is of particular importance for child survival.

Economic and Social Impact

The conceptual linkage between family planning programs and economic growth is fairly well established. For example, family planning programs can lead to a fertility decline, which can contribute to economic growth through a number of direct and indirect pathways, including improved maternal and child health, improved education, increased women's participation in the labor force, and higher savings rate. At the same time, the success of family planning depends heavily on the underlying changes in the economic and social environment that motivate couples to demand fewer births.

In Ghana, a relatively constant fertility rate combined with a declining mortality rate led to rapid population growth. That trend, in turn, has resulted in only modest increases in real per capita income and heavy pressure on food supplies, energy resources, the environment, and the labor market. Thus, 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.

CONCLUSIONS

- The results of Ghana's family planning program during much of the 1968-1988 period have been limited in terms of both the contraceptive prevalence rate and the fertility rate.
- Much of the more than threefold increase in the CYP between 1987 and 1991 may be directly attributable to A.I.D. inasmuch as the Agency is the predominant donor in the area of family planning.
- Two of the many factors affecting the frequency of contraceptive use in Ghana seem to be particularly important: urban versus rural residence and level of female education.
- Information, education, and communication in Ghana focus on married women, not on unmarried women and teenage girls even though teenage pregnancy is on the rise. As a result unmarried women do not know how to use family planning methods or where to get the information. Moreover, a narrow focus on married women ignores the importance of educating men in a male-dominated culture that favors large families.
- Breast-feeding has had significant influence in controlling fertility and should be promoted.
- The absence of strong, overt, and continuous political commitment is a major factor in explaining why progress in family planning has been limited in Ghana.
- A partial explanation for the wide gap between the proportion of women who want to delay or avoid their next pregnancy and those who are using some form of contraception is that family planning counseling and a wide range of contraceptive methods are not regularly accessible in urban and rural areas from a convenient and trusted source that can ensure clients' privacy.

- Ghana's family planning program is not financially self-sustainable; therefore, the public sector must continue to provide family planning services and supplies at highly subsidized prices, especially in rural areas.
- The real costs of the family planning program in Ghana, as well as the effect of price changes on the demand for contraceptives, are unknown, largely because of the absence of systematic collection and analysis of data on program expenditures and costs.

This Evaluation Highlights summarizes the findings of the report Evaluation of A.I.D. Family Planning Programs: The Ghana Case Study, Technical Report No. 13. Technical Reports can be ordered from the DISC, 1611 North Kent Street, Suite 200, Arlington, VA 22209-2111, telephone: (703) 351-4006, fax: (703) 351-4039.