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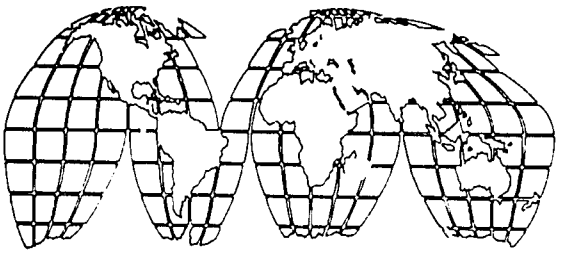

Social Services Programming in Economic Context:

The Case of Ghana

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

SOCIAL SERVICES PROGRAMMING IN ECONOMIC CONTEXT:

THE CASE OF GHANA

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SUMMARY

A.I.D.'s development strategy in Ghana has changed dramatically during the last 30 years: from an early emphasis on infrastructure, institution building, and human resource development; through a late-1960's interlude of policy reform; through a 1970's focus on rural development and poverty alleviation; to a mid-1980's commitment to structural adjustment and privatization. Not surprisingly, A.I.D.'s social services programming has also changed markedly, reflecting these trends. More surprising, perhaps, is the extent to which this social services programming has also reflected a thorough analysis Ghana's changing economic conditions. However, the choice of social services interventions appeared to depend less on economic conditions, as such, than on A.I.D.'s interpretation of these economic conditions in relation to prevailing development ideologies. Thus, in the mid-1970's, given A.I.D.'s emphasis on poverty alleviation and rural development, the "best" response to adverse economic conditions was services that directly alleviated the social and economic constraints facing poor, small farmers. In the mid-1980's, on the other hand, in an era of policy reform and privatization, the "best" response to economic adversity was to de-emphasize social services except for private sector initiatives. During both periods, the specific interventions chosen--primary health care and integrated services in the 1970's versus child survival and contraceptive social marketing in the 1980's--reflected then-current, conventional social services wisdom. In retrospect, A.I.D's mid-1970's social services strategy proved insufficiently responsive to economic conditions; whether A.I.D.'s new strategy will prove more sufficient remains to be seen.

INTRODUCTION

This report is one of six case studies analyzing the responsiveness of A.I.D. social service programs to changing economic conditions in selected countries during the past 25 years. The cases were chosen to cover a range of economic conditions, including countries experiencing continuing rapid economic growth and countries in which early economic growth was followed by economic decline. Each country case study examined social services activities and trends and A.I.D. program and project strategies in relationship to key economic opportunities and constraints. The central question was how, why, and to what extent A.I.D.'s social service programs and projects responded, or failed to respond, to changing macroeconomic conditions.

The studies were based on the analysis of documents available in A.I.D/Washington. Major sources of information included A.I.D. program documents (CDSS's, sector assessments, ABS's, etc.), selected non-A.I.D. reference materials (World Bank reports, economic and social statistics, published papers, etc.), and A.I.D. project documents (project papers, evaluations, special studies, etc.). The studies were conducted within a very restricted time frame (a little over a month), which limited their depth and rigor. However, at least in the case of Ghana, patterns of economic change and program response were quite striking, and findings seem unlikely to be substantially modified through further analysis.

ECONOMIC DEVELOPMENT IN GHANA

Ghana's independence in 1957 marked the beginning of the end of the colonial era in Africa and the start of a seemingly bright future. Already the world's largest producer and exporter of cocoa, Ghana had abundant arable land, extensive natural resources (including gold, diamonds, bauxite, manganese, crude oil, hydroelectric potential, forests, and seashore), and one of the most highly developed economic and social infrastructures in Sub-Saharan Africa. Ghana enjoyed a relatively high standard of living compared with most other West African nations, and was firmly established as, what would now be called, a "middle-income developing country."

Today, after 30 years of "development," Ghana is in many ways worse off than it was at independence. Despite massive government investments in manufacturing and industry, the economy remains based primarily on small-scale agriculture, which accounts for 40% of gross domestic product (GDP) and provides income for 70% of the population. About half of the population continues to live in absolute poverty. Ghana's

basic needs indicators--once the best in Africa--are now no better than other comparable Sub-Saharan countries. Modern health services are available to less than a third of the people, less than half have access to safe water, and fewer than half of the adults have received any formal education (World Bank 1987a:AF.157)

The Ghanaian economy, stagnant throughout most of the 1960's, fell steadily in the mid-1970's, before collapsing near-totally in the early 1980's. Real per capita gross domestic product, which was $512 per year at independence, peaked at $587 in 1974, before falling to $339 per year in 1984 (see Table 1). Between 1970 and 1980, per capita income fell 30% and real wages dropped 80%. (World Bank 1983:ii). By 1982, per capita food availability was 30 percent lower than a decade earlier and domestic cereal production had fallen nearly 40 percent. Production of cocoa, the mainstay of the export economy, which peaked at 538,000 tons annually in the late 1960's, declined to 159,000 tons by 1983 (World Bank 1987b:6). Infrastructure deteriorated badly, roads became unusable, and trucks and trains were abandoned for lack of spare parts.

Inflation, already 80 percent annually by the late 1970's, reached triple digits by 1981. Basic commodities were no longer available, even at black market prices. Economic activities began shifting away from the monetary economy to production for subsistence and personal use (World Bank 1983:2). Between 1970 and 1982, Ghana's imports dropped by two-thirds, export earnings fell 52%, and domestic savings and investment virtually disappeared (World Bank 1983: ii). While the highly controlled economy conferred enormous windfalls to a few priveleged traders, the vast majority faced severe shortages, inequities, and excessively high prices.

> "By 1982, large sections of the Ghanaian economy had virtually ceased to operate. In the urban areas many public utilities were not operating, enterprises were functioning at 20 or 30% capacity, some were shut down, consumer goods were in extremely short supply, unemployment was endemic, money was being replaced by food and other goods as a means of payment and the distribution system was only partially functioning." (A.I.D. 1988:1)

In the World Bank's view, "few developing countries in the world have suffered such rapid economic decline..." (World Bank 1983: 1).

The Causes of Ghana's Economic Decline

Ghana's economic collapse resulted from decades of inappropriate government policies and economic mismanagement. The seeds were sown by government policies of the 1950's,

Table 1
Economic Growth in Ghana

Year	Population	Real GDP (in 1980 Intl. Prices)
1955	5484	511
1956	5748	505
1957	6012	512
1958	6276	476
1959	6540	519
1960	6832	534
1961	7015	549
1962	7203	534
1963	7397	543
1964	7596	527
1965	7799	527
1966	7963	503
1967	8129	505
1968	8299	510
1969	8473	535
1970	8620	568
1971	8860	575
1972	9090	529
1973	9300	558
1974	9690	587
1975	9970	495
1976	10260	463
1977	10560	469
1978	10860	501
1979	11180	442
1980	11500	421
1981	11887	389
1982	12287	371
1983	12700	359
1984	13086	339
1985	13513	349

Source: ESDB

'60's, and '70's (see: A.I.D. 1988: A.1(1)-A.1(3)). While A.I.D., the World Bank, and other donors were well aware of the limitations of these policies, and sought to alter them, their efforts were, for the most part, unsuccessful. It was only after a near complete economic collapse that the government was spurred to drastically alter its development strategy.

Like many other newly independent countries, the Ghanaian government believed that it should play a dominant role in managing economic development and that past colonial dependencies could only be overcome through an emphasis on import substitution and industrial investment. But despite its strong committment to "African socialism," Ghana initially maintained a liberal trade and exchange regime, with virtually no controls. By the late 1950's, however, cocoa prices and earnings were falling, creating a balance of payments crisis in 1961. The government responded by introducing import licenses, higher tariffs, and selected price controls. Over the next few years controls became more complex and arbitrary and the government began assuming an increasingly dominant role in the economy through the creation of numerous state-owned enterprises (SOE's). Soon, inflation and excess demand for imports became the most pressing problems, and by the mid-1960's real per capita GDP had begun to decline. Moreover, the extensive supplier credits provided previously were primarily invested in unsuccessful industrial projects, yielding an increasingly unsupportable level of debt.

In mid-1966, with cocoa prices down and foreign exchange reserves disappearing, Ghana declared a moratoriaum on debt servicing. Also in 1966, with strong support from A.I.D. and other donors, a new Ghanaian government instituted a wide-ranging program of policy reform. This included efforts to reduce price controls, increase exchange rate flexibility, shrink the SOE sector, and encourage private enterprise development. Reforms were intended to improve economic efficiency through greater reliance on market mechanisms and also to increase the utilization of existing economic capacity.

Unfortunately, after a six year struggle (and another political coup), reform efforts were abandoned. By 1972, the government had turned away from private enterprise, taken a majority interest in all large mining and timber companies, and was again withholding payment on foreign debts. Although these debts were finally rescheduled successfully in 1974, by 1975 all foreign enterprises were required to become joint ventures either with private Ghanaians or, more often, the Government. Beginning in 1979, large numbers of small enterprises were simply confiscated. By the early 1980's the government controlled virtually all industrial activity and all of Ghana's major exports were produced and marketed by SOE's, which

totalled more than 235 enterprises employing more than 200,000 people (A.I.D. 1988: 3)).

Although nominal exchange rates remained fixed during the 1970's, large budget deficits, necessitated by artificially low exchange rates, massive subsidies to inefficient public industries, and extensive price controls, produced strong inflationary pressures. Real exchange rates appreciated rapidly (816% between 1973 and 1981), shifting incentives away from exports into import trade. Interest rates were also controlled, with real rates averaging negative 30 percent during the 1970's, and access to credit had to be rationed. Controlled prices further reduced incentives to produce, with real cocoa prices dropping to about 15 percent of their 1963 levels. Falling exports created a perpetual foreign exchange crisis, and increasingly stringent import restrictions.

The government allocated the limited imports and credit that were available primarily to inefficient, but favored, state-owned enterprises. Most of the profits went to traders influential enough to obtain import licences and foreign exchange. Despite the government's committment to rural development and food self-sufficiency, tools, fertilizer, and improved seed were increasingly unavailable to small farmers.

The economy quickly became starved of essential commodities for manufacturing, agricultural, and economic growth. With economic activity declining and the tax base eroding, government operations, maintenance, and capital expenditures were severely cut, further undermining economic infrastructure and social services. The government responded to increasing shortages with ever more stringent controls and rationing, creating a vast parallel black market with related corruption, smuggling, and tax evasion. By the early 1980's, the economy's downward spiral was further acclerated by a series of external shocks: a severe drought, deteriorating terms of trade, and the sudden return of more than a million Ghanaians from Nigeria (World Bank 1987:AF.158).

The Beginning of Recovery

Between 1970 and 1980 Ghana had the most severely distorted economy of any developing country (World Bank 1983:4). By the early 1980's, with production grinding to a halt and international donors withholding further aid, something clearly had to be done:

> "By mid 1983 the Ghanaian economy had been in the process of collapsing into itself for several years. Maintaining the prevailing policies only offered a continuation of the spin into the vortex. Thus the decision to undertake a stabilization program in concert with the IMF and the

> World Bank was not so surprising. ... But the most significant feature was that the government agreed to change its long-standing, fundamental policy of controls and state ownership in favor of a market approach and reduction in the size of the public sector." (A.I.D. 1988: 4)

The Economic Recovery Program (ERP), initiated by the Ghanaian government in April of 1983, represented "an historical decision to change the structure of the economy and the way it would approach economic development" (A.I.D. 1988: i). The core features of the ERP were a much greater reliance on markets to allocate resources, more liberal trade and exchange regimes, increased private sector development, and greater efficiency and cost-recovery in government operations. Most importantly, the ERP represented a decision by the government to "relinquish its role as the dominant economic actor in Ghana's development strategy" A.I.D 1988: i).

Although much remains to be done, "to date the Ghana ERP is among the most successful ever undertaken in sub-Saharan Africa." (AID 1988: 4) During ERP's initial stabilization phase (1983-87), the government of Ghana removed the vast majority of price and distribution controls, promptly adjusted the few remaining controlled prices, dramatically increased agricultural producer prices, adopted a more flexible interest rate policy, and increased public sector wages to restore past erosion. Central to these reforms was the establishment of a more flexible foreign exchange system, including an auction mechanism for most transactions. By late 1987, the offical exchange rate had depreciated 6,000 per cent against the dollar (A.I.D. 1988: 2).

The results, thus far, have been promising. Ghana's real GDP grew at an average annual rate of 6 percent between 1984 and 1987, and per capita income increased 2.4% per year. Exports grew 20% and imports 14%. Balance of payments improved and loan arrears dropped dramatically. Inflation declined from 122% in 1983 to 10% in 1985 (but rose to 39% in 1987). And the government ran small surpluses in 1986 and 1987. (A.I.D. 1988: 3)

Much of this improved performance, however, reflects favorable weather conditions in 1984 and 1986, and, even at best, "it is sobering that the continued reform scenario succeeds only in restoring many economic indicators to levels that Ghana had attained in the past" (World Bank 1987: 58). Many years of austerity remain, and the ERP's more difficult "structural adjustment" phase--aimed at transferring economic activities from the public to the private sector and shifting resource allocations from controls to markets--is only just beginning. The government's willingness and ability to dramatically reduce

civil service employment and divest itself of state-owned enterprises remains untested. Meanwhile, the welfare of many Ghanaians remains at risk, social services are deteriorating, and past investments in social infrastructure are beginning to evapora

SOCIAL DEVELOPMENT IN GHANA

Like the vast majority of developing countries, Ghana has made substantial progress in improving the human welfare of its citizens and their access to health, education, and population services. In comparison to other middle income developing countries, however, Ghana's progress appears mixed. Social services remain heavily concentrated in urban areas and large differences persist in rural and urban welfare. Moreover, the impact of recent, sharp declines in government social infrastructure investment, and the apparent deterioration of existing social services, is just beginning to have an effect on human welfare.

Social Indicator Trends

Although most of Ghana's basic needs indicators have improved during the past 30 years, they remain relatively low by Western, Latin American, or Asian standards (see Table 2). Life expectancy at birth, for example, increased from 40 years in 1960 to 49 years in 1980. During the same period, population per physician dropped from 21,500 to just under 13,000 and the percentage of children in primary school increased from 38% to 69%. However adult literacy rates remained essentially unchanged and per capita calorie supply has dropped significantly. Population, in particular, has continued to grow rapidly, from just over 7 million inhabitants in 1960 to more than 12 million in 1982. The 1982 crude birth rate of 49/1,000 and the total fertility rate of 7.0 were essentially unchanged from independence, but with mortality declining the rate of population growth has risen substantially, to 3.6% per annum in 1980. At this rate, Ghana's population would reach 24 million by the year 2000 (World Bank 1983: 26).

Overall, Ghana's social indicator trends are rather discouraging, given the relatively high level of past investment and the diminished prospects for further investment in the forseeable future. As the World Bank notes:

> "When compared to other members of the Sub-Saharan Africa group...Ghana lags behind in life expectancy, primary enrollment and adult literacy rate. This has taken place <u>despite</u> a strong initial base ... What is more alarming is that these indicators are likely to worsen over time as

Table 2
Social Indicators Comparisons

Indicator	Ghana		Other Middle incom Oil Importers in S.	
	1960	1980	1960	198
1. Life Expectancy at birth	40	49	40	5
2. Crude Birth Rate (per 1000)	49	49	48	4
3. Population per physician	21,600	12,910	20,971	11,
4. Population per nurse	5,430	1,070	4,321	1,
5. Percent access to safe water	--	35%	--	2
6. Daily per capita calory supply as % requirements	98%	88%	--	9
7. % age group in primary school	38%	69%	51%	9
8. % age group in second. school	5%	36%	4%	1
9. Adult literacy rate	27%	30%	20%	3

Source: World Bank 1983: 28)

> neither new infrastructure such as school and health facilities are being created fast enough to keep up with rapid population growth nor are the existing services and facilities being provided adequate financial, material and manpower resources to maintain the existing standard." (World Bank 1983: 27)

Clearly, the problems of poverty in Ghana remain overwhelming. In 1980, before Ghana's deepest economic decline, at least half of the population still lived at or near the subsistence level. Only a third had access to safe water. At least 50% suffered from preventable parasitic or water-borne diseases. More than 70% lacked access to modern medical care. And infant mortality still averaged 115 per 1,000 live births (A.I.D. 1980: 13-14)

The situation in rural Ghana is even bleaker. Although urban life expectancy averaged 56 years in 1980, rural life expectancy was only 42 years. Althugh rural areas contain 60% of Ghana's population, they have only 29% of the country's health facilities. While infant mortality has declined to 63 per 1000 births in Accra, as many as 234 of every 1000 infants die in the Northern provinces. Rural adults weigh about 20% less than their urban counterparts and growth curves for children are 15-20 percent below norms. Only 6.5% of rural inhabitants have pipe-borne water, compared to 91% in urban eras. And, while more than half of the urban population is literate, less than one-fifth of rural dwellers can read. (A.I.D. 1980: 14-15).

Social Development Strategies

When Ghana achieved independence in 1957, it had a relatively well-educated population and a relatively well-endowed social service infrastructure. For nearly two decades after independence, however, "Ghana's efforts to develop [were] hampered by ... [its] ... inability to evolve a development strategy which would impact successfully upon the majority of Ghanaians producing not only an increase in welfare but also an increase in the equity of the distribution of that welfare" (A.I.D. 1975: 1). While the Ghanaian government expressed a continuing, strong committment to improving human welfare and social services, it rarely was able to follow through. And, the task was made much more difficult by continuing political instability.

Although Ghana's first independent government, under Nkrumah, voiced a strong committment to social equity, its top priorities were government enterprises, economic infrastructure, and industrial development. As economic controls became more intrusive in the early 1960's, rural producers increasingly subsidized urban consumption and

industrial investment. With artificially low prices, food consumption in the cities increased, but little attention was paid to improving social services in the rural areas where the vast majority of Ghana's people lived. Finally, when the economy began declining precipitously, a new government, the National Liberation Council, took power in 1966.

The initial emphasis of the National Liberation Council, and of the Busia government which followed, was on policy reform, market liberalization, and private sector development. While the government was aware that few social services and development resources were reaching the rural poor, and that existing subsidies and controls primarily benefited larger farmers and urban industries, it

> "experienced difficulty in developing an economic strategy that would impact sucessfully upon the low income group that makes up the majority of Ghana's rural population. Under both governments large amounts of money were spend to maintain the established standards of salary and benefits of civil servants and amenities for the urban population...Little effort was made to reach the poor small-holders who make up 82% of the nation's agricultural population..." (A.I.D. 1975: 2)

Towards the end of the Busia government, awareness of Ghana's rural development needs was growing and efforts to expand and decentralize rural social services were initiated (A.I.D. 1969: 40). But the political costs of broader policy reform efforts proved too high, and the government was overthrown in 1972.

The new NRC (Acheampong) government quickly abandoned efforts at market oriented reform and returned to a system of direct controls and government interventions. Soon Ghana was again experiencing the familiar problems of inflation, declining production, and balance of payment shortages. And there seems little doubt that the welfare of Ghana's rural poor declined substantially in the early 1970's (A.I.D. 1975: 5). By 1975, however, the Acheampong government was developing a new five year development plan with a much clearer poverty alievation and rural development orientation. The government, it appeared, would emphasize the expansion of health, population, and education services through a decentralized, integrated rural development strategy.

By 1978, however, after the Acheampong government had been replaced by the Akuffo regime, the picture looked less bright. In A.I.D.'s view, the Acheampong government had "grossly mismanaged the economy for personal and political reasons to such an extent that growth with equity--and, finally, growth itself--was economically precluded" (A.I.D. 1979: 15) "Basically, the causes of these economic crises are rooted in

the [government's] large-scale capital-intensive investment strategy with respect to industry and agriculture." (A.I.D. 1979: 7). Rural development and social services, it would seem, had again received short shrift.

Yet, despite Ghana's growing economic difficulties, A.I.D. did see some social welfare progress:

> "The Acheampong government's policies included: a strong priority for agriculture; a well-articulated plan for reducing population growth; a primary health care system for rural areas ... To partially finance these goals, the Acheampong government typically devoted about 40 per cent of recurrent expenditures and about 20 per cent of capital expenditures to social services - mainly for health, education, and social security. As a result ... [there has been] ... some degree of improvement in the material well-being of the poor..." (A.I.D. 1979: 16)

A.I.D. was more impressed by the "growth with equity" committment of the Akuffo regime, and by its support for better prices for rural agricultural producers. Unfortunately, the Akuffo government was itself overthrown in less than a year by the Armed Forces Revolutionary Council, which reinstituted extensive price controls. A.I.D. was also hopeful about the integrated rural development, food production, and poverty aleviation policies policy of the democratically elected Limann government that replaced the Revolutionary Council later in 1979, and strongly praised the limited program of policy reforms which that government proposed.

Meanwhile the economy continued to disintegrate, and policy reform languished. Finally, on December 31, 1981, the government was again overthrown, and the Provisional National Defense Council took power. Initially, at least, the PNDC government was strongly xenophobic and even more assertive than its predecessors in exerting economic controls. It was also virulently anti-American, and by 1983 the A.I.D. program was reduced to a minimum level.

In 1983, however, the government also made the difficult decision in favor of radical economic reform. Within this framework, government policy has concentrated on economic restructuring and producer price increases, and has sought to maintain public social services while expanding private sector alternatives.

The Impact of Economic Decline

During the past 30 years, social services in Ghana have developed in a context of economic stagnation followed by increasingly rapid economic decline. Indeed, the widening gap

between government expenditures and government revenues during the 1970's was a major contributing factor in Ghana's economic malaise (World Bank 1987: 20). Even so, real public expenditures for basic community, social, and economic services declined substantially during the latter part of the 1970's. Social services were also provided within a larger budgetary context that consistently favored industrial development, state-owned enterprises, and urban consumption. As a result, after expanding significantly in the 1960's and early 1970's, the quantity and quality of social services, particularly in rural areas, has begun to decline at an increasingly rapid pace.

One aspect of this deterioration is reflected in the increasing portion of the government's social services budget allocated to paying recurrent salaries at the expense of investments in facilities and supplies. In 1986, for example, "real expenditure on goods and services per civil service employee was less than 10 percent of the 1975 level. The impact of this decline is evident both in the lack of materials ... and inadequate supplies (essential drugs, dressings, books) for health and education services..." (World Bank 1987: 34). Moreover, given Ghana's overwhelming need for investments in economic infrastructure, only five percent of the government's current (1986-88) Public Investment Program is directed at the social services sectors (World Bank 1987: 37). This is a matter of growing concern to the World Bank, which recognizes that "while most Bank Group lending has focused on financing supporting economic infrastructure and rehabilitation, there is a ... need to support the social sectors. (World Bank 1987: AF.165).

Food and Nutrition:

Although successive Ghanaian governments have remained committed to achieving food self-sufficiency, food production per capita has in fact declined significantly, from an index of 100 in 1969-71 to an index of 82 by 1979-80. Meanwhile, the population per square kilometer of agricultural land has increased dramatically, from 104 in 1960 to 181.6 in the late 1970's, making the achievement of future self-sufficiency extremely difficult. Indeed, World Bank projections show an ever increasing food gap. With its declining economy, Ghana cannot purchase sufficient food and, despite extensive food aid, per capita calory supply has dropped substantially, from 98% of requirements in 1960 to 88% in 1980.

Health:

Although Ghana has made substantial progress since independence in providing health services for its people, it also faces continuing problems. Life expectancy at birth has steadily improved, from 39.7 years in 1960 to about 49 years in 1980 and

infant mortality has declined from 143 per thousand in 1960 to 103 in 1980. Other indices of health care--particularly numbers of medical staff and hospital beds-- have also improved, though rapid population growth has put pressure on limited resources to improve the coverage and quality of these services. Indeed, "although the government has followed a policy of primary health care since 1978, resource and management constraints so far have prevented much progress towards reaching the target of providing it to 80 percent of the population by 1990" (World Bank 1987: 44).

Moreover, the quality and availability of care is markedly poorer in rural as opposed to urban areas, reflecting a maldistribution of services. As A.I.D. noted in 1980, "despite the heavy infusion of resources in the health sector over the past 15 years, there have been noticeable increases in certain communicable diseases and continued high levels of infant and maternal mortality and nutrition problems among the rural and urban poor" (A.I.D. 1980: 33).

The World Bank recently concluded that "significant improvement can be made by reorganizing the content and delivery of health services ...Especially noticeable problems have been overstaffing of rural health facilities with a large number of overly specialized paramedicals, poor logistical support, and the need for a cost recovery mechanism" (World Bank 1983: 31). In fact, by the mid-1980's, the Government of Ghana with A.I.D.'s support, was expanding the utilization of private medical practitioners (particularly indigenous midwives and healers) and increasing the use of fees-for services.

But the World Bank also clearly recognized that "additional financial resources may be needed to enhance the quality and coverage of services in the future" (World Bank 1983: 31). Unfortunately, such resources have become less rather than more available, with government per capita health expenditures delining from $6 in 1972 to $4 in 1979 and less than $1 in 1983. By comparison, average per capita health expenditures for middle-income oil importing countries increased from $9 to $14 during the same period. As a result, "the share of the Ministry of Health's recurrent budget allocated to wages has increased from 44 percent in 1978/79 to 60 percent in 1985 and to 75 percent estimated in 1986" (World Bank 1987: 35). By the mid-1980's, many primary health care facilties in Ghana lacked even the most basic medicines and commodities and the health service infrastructure was deteriorating rapidly.

Education and Human Resources:

Although there has been a steady increase in Ghana's primary school enrollment ratio, from 38 percent in 1960 to 64 percent in 1970 and 69 percent in 1980, growth has slowed substantially

and enrollments remain lower than the average for middle-income countries in Sub-Saharan Africa. Secondary school enrollment, which has grown from 5 percent in 1960 to 36 percent in 1980, is above the average, indicative of Ghana's emphasis on traditional education. Adult literacy in Ghana is about 30 percent, similar to that of other comparable countries in the region. Again, educational levels and access to educational services, are much higher in urban as opposed to rural areas.

"Providing for the education of the rapidly increasing population is going to put serious strain on the resources of Ghana for the coming years" (World Bank 1983: 30). If population continues to grow at the current rate, primary school enrollment would increase by nearly 50% by the year 2020. Meanwhle, government per capita expenditures on education have declined dramatically, from $20 (in 1975 dollars) in 1972 to 10 in 1979 and $1 in 1983. As a result, "the proportion of the education budget allocated to non-salary recurrent items has fallen from 19 percent in 1975 to 15 percent in 1984 and to only an estimated 6 percent in 1986, within a declining total. In the primary school system, wages now account for 97 percent of the recurrent budget..." (World Bank 1987: 34). Spurred by necessity, the government has recently begun emphasizing cost recovery and community involvement as educational policy priorities.

Population:

In 1960, with the publication of "Population Planning for National Progress and Prosperity," Ghana became the first country in Sub-Saharan Africa to embrace a public population policy:

> "The Government of Ghana (GOG) has long been cognizant of the adverse effects of rapid and uncontrolled population growth. Based on analytic work identifying the social and economic consequence of rapid populaton growth, Ghana was among the earliest countries in the continent to undertake formulation of specific policy positions on population matters ... Currently the government perceives the high population growth rate as constraining the development effort by increasing pressure on scarce public resources and social services; worsening the employment situation in a weak economy; and straining the already shrinking food supplies." (World Bank 1983: 26)

Unfortunately, the Ghanaian population program appears to have had little effect in reducing the rate of population growth. Large families remain the desired norm, birth rates and fertility have dropped only slightly, and population growth rates have remained virtually constant since the early 1960's. Historically, the government has distributed contraceptive

devices and family planning information through its public health services. However, public health resources have declined markedly over the past two decades. Recently, with strong A.I.D. support, the government has developed an apparently successful contraceptive social marketing scheme, that utilizes private practitioners, particularly indigeneous healers and mid-wives, in distributing family planning services.

Urban Services:

The percent of Ghana's population living in urban areas increased from 23.3 percent in 1960 to 35.9 percent in 1980 and is projected to surpass 50 percent by the year 2000, substantially higher than the average for Sub-Saharan Africa. This rapid urbanization reflects the "push" of rapid rural population increase and deteriorating rural services, but despite the "pull" of relatively better urban welfare and opportunities, social services in urban areas remain limited. Particularly pressing are the problems of secondary cities and market towns, which not only lack resources, but also the authority to locally generate them (A.I.D. 1988: 19-20)

A.I.D.'S DEVELOPMENT PROGRAM IN GHANA

A.I.D.'s development program in Ghana has changed dramatically over the course of nearly 30 years of foreign assistance. A.I.D.'s initial investments in the early 1960's were aimed at building the basic physcial and institutional infrastructure for economic growth and social development. By the late 1960's, however, Ghana's growing economic crisis required a major infusion of foreign exchange and a shift to program lending in support of broader policy reforms. By the mid-1970's, with policy reforms a political failure, A.I.D. turned to a more direct involvement in rural development, both as a means of poverty alievation and as the primary vehicle for economic growth. By the early 1980's, with economic catastrophe looming, A.I.D. increasingly curtailed and finally abandoned its rural development efforts, recognizing the impossibility of social and economic progress without broader policy reform. By the late 1980's, rural development and poverty alieviation were virtually forgotten, and A.I.D.'s entire program was oriented to supporting the government's broader macro-economic restructuring effort.

Economic conditions in Ghana had at least some bearing on A.I.D.'s changing program strategy. So too did Ghana's varying political relationship with the United States and the declining scale of U.S. assistance--with A.I.D. dropping from the largest donor contributing more than half of total ODA in 1967 (AID 1969, Vol 3: 102) to the ninth largest donor contributing less than 3% of total and 6% of bilateral assistance between 1984

and 1987 (A.I.D. 1988: 21). Also important was the congruence of U.S. and Ghanaian interest during the mid-1970's in directly addressing the problems of rural poverty and rural services. The evolution of A.I.D.'s Ghana program no doubt also reflects the growth of development theory and the lessons from more than 30 years of development experience. At least as significant, however, have been the changes in A.I.D.'s larger development strategy which the Ghana program reflects.

Early Infrastructure and Human Capital Investments (1957-1966)

Ghana's emergence in 1957 as the first newly independent country in Sub-Saharan Africa generated a great deal of attention from the donor community (Price 1988: 2). Although little detailed documentation remains concerning A.I.D.'s earliest development programs in Ghana, the first formal bilateral projects were initiated by the late 1950's. Much of A.I.D.'s initial emphasis was on planning, technical assistance, and training. A.I.D. helped to build basic development institutions, to train managers and technicians, to improve economic infrastructure, and to provide essential development services. A.I.D. completed a series of sector infrastructure appraisals (water resources, transportation, and telecommunications) and contributed substantially to basic industrial investments, such as the $200 million Volta River Dam and Valco Aluminum Smelter project. With Ghana's agrarian economy, agriculture was also an important priority, particularly agricultural research and extension, planning and policy analysis, and the provision of agricultural inputs and services.

Although social services, as such, were not a major emphasis, several projects did provide technical assistance to developing health institutions and long term training for health professionals. This included an initial Study of Health Facilities (#64100015) from 1959 to 1961, a Health and Sanitation project (#64100123) from 1961 to 1967, and a National Water Supply Development project (#64100037) from 1963 to 1968. Another project, aimed at constructing a science center and establishing a medical school at the University of Ghana, was aborted, primarily because of political frictions between the Nkrumah government and the United States. Indeed, continuing political problems resulted in a much diminished A.I.D. program throughout the mid-1960's (Price 1988: 12).

The Policy Reform Transition (1966-1972)

When the National Liberation Council assumed power in 1966, A.I.D. responded quickly by expanding development assistance in support of the government's policy reform program. Most of this assistance took the form of program rather than project aid, since program aid was viewed as "the most appropriate

means of providing additional resources to Ghana." (FY 1970 Program Memorandum) In April 1966, for example, A.I.D. initiated a PL 480 Title I program to meet agricultural commodity shortages following the coup. In succeeding years the program was continued and expanded, providing "the foreign exchange necessary to purchase food supplies ... and basic materials necessary for the fuller utilization of existing industrial capacity." (1971 Country Field Submission: 1). By 1969, PL 480 Title I assistance totalled nearly $18 million (current dollars). A.I.D. provided additional balance of payments assistance to the new government with two Commodity Import Program (CIP) loans in 1967 and 1968 totalling $35 million (current dollars).

In the late 1960's, A.I.D. also continued and expanded its project assistance in Ghana, particularly in agriculture. A.I.D.'s major emphasis was on improving the planning and implementation of Ministry of Agriculture (MOA) "production support programs." This included support for establishing a "Development Coordination Unit" under the National Agricultural Planning project; support for regional and functional area "production advisors" (e.g., seed multiplication, equipment, extension, etc.) through the Agricultural Extension and Production project; assistance to production support (input supply) programs and the Agricultural Development Bank; support for short and long-term participant training; and the provision of expatriate professors for the University of Ghana's Faculty of Agriculture. Additional agricultural development activities were supported through local currency programming. At the same time, A.I.D. expanded its use of PVO's in providing targetted nutrition and maternal/child health services.

By the late 1960's, new projects were also being developed in the social services area. The Family Planning and Demographic Data Development Project (#64100051), for example, was started in 1968 and the first phase of the DANFA Comprehensive Rural Health and Family Planning Project (#6410055) was started in 1969. Both of these projects, initially at least, placed strong emphasis on improved research and analysis, improved management and planning, and especially, training and human resource development. The objective was to create improved institutions to plan, manage, and eventually delivery decentralized health and population services.

From the start, Ghana's mid-1960's policy reform program appears to have been more limited than current restructuring efforts. While the most onerous government controls were removed, trade was liberalized, and private enterprises received some encouragement, the government clearly intended to remain the dominant economic actor and was never willing to rely primarily on market mechanisms to allocate resources and set prices. And, in the late 1960's, A.I.D. appeared to

accept--even encourage--the government's economic management role. Despite occasional pleas for greater liberalization, A.I.D. talked less about making markets free and more about getting prices right; less about privatizing public enterprises and more about improving public sector efficiency and effectiveness.

By the early 1970's, however, the government's already badly frayed liberalization efforts were abruptly ended by another political coup. In 1972 and 1973, with economic controls being reinstituted, state ownership being reasserted, and foreign debt payments being withheld, A.I.D.'s program was put temporarily on hold. By the time debts had been rescheduled in 1974, A.I.D.'s development program turned to an emphasis on project assistance as part of an emerging, rural oriented, poverty alleviation strategy.

Targeting the Rural Poor (1972-1980)

By the mid-1970's A.I.D.'s program, and Ghana's own development policies, had adopted a clear rural poverty focus, with an emphasis on achieving "growth with equity," for the "poor majority." Projects were increasingly oriented to providing better access to resources and services for the vast majority of previously ignored, poor, small farmers. This was not only intended to benefit the rural poor directly, but also to enable them to participate more fully in long term economic growth and social development.

Interestingly enough, this rural development strategy emerged from a careful consideration of Ghana's larger economic situation. A.I.D.'s FY 1976-FY 1980 Development Assistance Program (DAP), completed early in 1975, showed clear awareness of Ghana's growing economic problems and of the policy and management inadequacies--overvalued exchange rates, inefficient state-owned enterprises, intrusive economic controls, subsidized interest rates, and skyrocketing public expenditures--that caused them (see, A.I.D. 1975: 1-28). The DAP also clearly recognized that redistribution alone could not improve the well-being of the rural poor, and that a long-term process of economic growth was essential (A.I.D. 1975: 26-28). While the DAP, in retrospect, may have proven overly optimistic about prospects for eventual policy improvement and may have been more willing than currently fashionable to accept a lead government role in a "mixed" economy, A.I.D.'s rural development strategy was specifically formulated in the context of adverse macroeconomic conditions.

The FY 1976 - FY 1980 DAP (AID 1975: 37-40) spelled out four options for A.I.D. assistance: 1) a "Limited Technical Cooperation Program" based on "the pessimistic view that there is little prospect of Ghana's having the leadership and

stability to tackle the deep-seated and long-range economic and social problems that have plagued the country for so long;" 2) a "Limited Sector Development Option" that would provide selected, but reactive, sector support and which presumed "a somewhat more positive view of Ghana's situation and prospects for achieving some development impact in carefully delineated sectors;" 3) a "Major Sector Development and Support for Growth" strategy "aimed at making a substantial impact on root problems in priority sectors of food and nutrition, health, and population focused on the poorer rural populations," based on the assumption "that Ghana is moving toward a more rational and pragmatic approach to development policy and practice;" and 4) a "Major Growth with Equity" strategy involving a significantly expanded program, substantial resource transfers to boost overall economic growth (similar to the policy reform program of the early 1970's), and "greater attention to key sector developments that emphasizes economic services and amenities to the least developed communities in the country." The DAP specifically noted that any of these options would have to be implemented collaboratively with the government of Ghana and that Ghana both required, and was demanding, greater self-reliance in its development efforts.

Ultimately, the Mission opted for the "Major Sector Development and Support for Growth" strategy. This presumed that the larger macroeconomic and policy environment would remain tolerable, and provided a detailed analysis of the economic potential of small farmers (A.I.D. 1975: 56-72), who despite inadequate resources, a lack of critical inputs, and adverse government policies, were already the most productive component of the agricultural sector. While A.I.D.'s first priority was to increase agricultural production and rural incomes, social services were a major component in most of these rural development efforts. In A.I.D.'s view, the lack of adequate social services--the urban concentration of health and family planning, the rate of population growth, the stresses of malnutrition and disease--not only undermined human welfare, but were also a major constraint to rural economic growth.

The rural development program that emerged from the FY 1976-FY 1980 DAP concentrated in three inter-related sectors: small farmer agriculture and related rural development, health services, and population (A.I.D. 1975: 50). Common themes included 1) the need for an integrated approach to rural development encompassing a broad range of resources, services, and participants; 2) the need for improvements in the planning, management, and operational capabilities of public agencies to expand and decentralize resources and services to rural areas; and 3) the need to "identify strategic points for assistance rather than presume a comprehensive involvment" and to "demonstrate" how a broader range of resources and services could effectively enhance economic growth and well-being in specific "pilot" areas.

In the health sector, for example, A.I.D. focused "particular attention" on improving "the delivery of health services to the rural populations" through "the development of a planning unit and management system in the Ministry of Health;" "strengthening middle management particularly in regional operations;" "strengthening the logistic support system;" "intensive application of services in a selected region;" and "more intensive applications of the nutrition factor ... particularly with respect to the health of mothers and children in the rural areas." (A.I.D. 1975: 51). In the population sector, A.I.D. expected to continue existing support to the Ghana National Family Planning Program with increased attention to "intensifying the delivery of family planning services through an improved management of MCH and/or 'free standing' clinics and of distribution ... through commercial channels"; "developing an intensive area program in one region"; and "research on the interrelationships of low cost effective rural health/family planning delivery systems." (A.I.D. 1975: 51-52) While most of A.I.D.'s social service and rural development projects included substantial human resource development and training components, because of the "traditional orientation" of Ghana's school system, A.I.D.'s involvement in the education sector was limited to non-formal education and vocational training.

Although A.I.D.'s social services program encompassed PL 480, Title II nutrition and health initiatives, PVO activities, and local currency programming, projects were the primary assistance vehicle. During the mid-1970's, these projects focused particularly on building the national institutional capability to plan and manage social services delivery. They included:

DANFA Comprehensive Rural Health and Family Planning (1969-1981) (#6410055):

The DANFA project evolved into A.I.D.'s primary vehicle for developing, expanding, and demonstrating the feasibility of comprehensive primary health care services in rural areas. This twelve year, $17 million effort provided technical assistance by A.I.D. and UCLA staff, participant training, and commodities to "enable the government of Ghana (GOG) to extend and improve rural health and family planning services in a rational manner" (Abstract/Project Paper). DANFA's four major subprojects involved: 1) "Strengthening the instutional capability at the Ghana Medical School to conduct research and train doctors and other health workers in the delivery of health and family planning services;" 2) Supporting Ministry of Health efforts to gather and evaluate data on "health and family planning behavior in rural Ghanaian communities" to improve health services planning; 3) "demonstrating

several cost-effective health care system models to include family planning as an integrated component" in selected geographic areas; and 4) increasing the "transfer of information derived from project activities to relevant GOG agencies on an ongoing basis."

Management of Rural Health Services (1974-1981): (#6410068):

This $2.2 million project sought to improve the capability of Ghana's Ministry of Health (MOH) to effectively deliver low-cost rural health services. More specifically, the project provided operational support, technical assistance, and training to enable the MOH to develop "suitable organizational arrangements and systems for planning, management, and administration directed toward the achievement of broad low cost and effective rural health services coverage." (Abstract/Project Paper) The project's major outputs included the establishment of a permanent MOH planning unit, the preparation of 5-year sector plans and implementation strategies, and the preparation and presentation of analysis and recommendations for additional external donor assistance. By project completion an effective National Health Planning Unit was established and was utilizing 10 of 13 returned participants. However, the long-term sustainability of the health planning unit, particularly under deteriorating economic conditions, remained unclear.

Population Program Support (1971-1982): (#64010064)

This $2.4 million project created an operational entity to begin implementing Ghana's innovative 1969 population policy. The project established the Ghana National Family Planning Program and provided resources to purchase large amounts of contraceptives, pay operating expenses, purchase vehicles, and provide extensive participant training in the United States. From 1971 to 1974, some of the contraceptive supplies were provided through a separate National Family Planning Program Supplies project (#64100065), which received $67,000 in funding.

The Population Program Support project was managed by the Ministry of Economic Affairs rather than the Ministry of Health, and experienced implementation problems nearly from the start. Commercial distribution of contraceptives, for example, was placed in the hands of the Ghana National Trading Corps (GNTC), a parastatal. Because the government allowed only a small profit margin (even at subsidized prices), and withheld approval for over-the-counter distribution of birth control pills, the

GNTC lacked much incentive to market or distribute contraceptives, and commodities piled up in government warehouses. Ultimately, the project had little, in any, effect on contraceptive prevalence (Price 1988: 27-29).

Programs in Population Dynamics (1977-1982): (#6410087)

This $877,000 project continued earlier efforts, begun in 1972 under A.I.D.'s centrally funded "University Teaching of Population Dynamics" project (#69811570-360), "to develop the capacity of the University of Ghana's Population Dynamics Program (PDP) to conduct training and research in population dynamics for Ghana and other African countries" (Abstract/Project Paper) The Population Dynamics Project was supposed to provide 33 student fellowships; develop new population-related courses; finance library acquisitions; and support a variety of population research projects, conferences, and publications. From 1973 to 1979, further support was provided through a $3 million centrally funded project to develop Family Planning Curricula at African Health Training Institutions (AHTIP).

Unfortunately, the Population Dynamics project achieved few of its targets: only one of two planned international symposia took place, only four of six planned research projects were conducted, only one of eight publications were completed, and few of the long-term participant trainees returned to Ghana. The reputation of the Population Dynamics Program at the University of Ghana was little enhanced, research efforts remained individual academic exercises of little public value, and the government never actively utilize research findings (Final Report 1983).

By the late 1970's, A.I.D.'s rural development projects were becoming more directly involved in improving the quantity and quality of social services actually delivered in Ghana's rural areas. In addition to ongoing projects, this included several new health and non-formal education initiatives and a greater incorporation of social service components in broader rural development efforts:

Community Health Team Support Project (CHETS) (1979-1984): (#64010088)

This $790,000 project provided a grant for training, equipment, and technical assistance to "institutionalize the capability within the University of Ghana to train physcicians at the postgraduate level in public health" (Abstract/Project Paper). One of the major key objectives

of the project was the development of a four year public health training program that would qualify physicians as District Public Health Officers, a key role in the Primary Health Care Plan developed under A.I.D.'s earlier Management of Health Services Project. The CHETS project was also expected to develop shorter-term courses to upgrade the public health capabilities of other medical personnel. It soon became apparent, however, that few physicians were willing to undertake four years of postgraduate training as preparation for rural public health care posts.

Community Development Staff Training (1978-1981) (#6410095)

This $457,000 project provided an operational program grant to World Education, Inc. to assist the Department of Social Welfare and Community Development (DSWCD) in delivering "integrated nonformal education (NFE) services to adults living in rural areas" (abstract/project paper). More specifically, the project provided training and technical assistance to DSWCD headquarters, regional, district, and local staff, volunteers, and other personnel in designing, implementing, and evaluating the Family Life Education Project (FLEP), a comprehensive nonformal education effort including basic literacy, community development, and self-help activities.

By 1979, the project was already experiencing implementation difficulties, "meeting only a third of its original objectives, reaching only 100 of 1,100 targeted rural adults, and establishing only 12 of 25 planned Family Learning Programs (Special Evaluation 10/79). This poor performance was "due mainly to the severe economic problems facing Ghana" (Special Evaluation 9/80). Indeed, "the project, which was overambitious to begin with, should have been redesigned as soon as the effect of Ghana's crippling economic problems on project resources (staff, money, vehicles, fuel) became apparent."

Africa Regional Accelerated Impact Program (#6980410) Subproject 15: Village Development Through Nonformal Education:

This project assisted the People's Education Association's village improvement activities in Eastern Ghana by providing support and training for village leaders through nonformal education approaches developed in collaboration with the University of Massachusett's Center for International Education. The project achieved its basic objective, implementing a variety of community development initiatives (installing a village piped water system,

establishing a rural health clinic, etc.) in addition to more usual adult education and literacy activities (Final Report 3/83). However, implementation was increasingly impeded by deteriorating economic conditions, inadequate staffing, and the loss of volunteer community facilitators, many of whom were teachers who left Ghana for employment in neighboring countries. (Price 1988)

Opportunities Industrialization Centers (1977-1985): (#6410063, 6410101, & 6410108)

The Opportunities Industrialization Centers project established community-based, nonformal vocational training programs for middle school leavers in Ghana, particularly unemployed, out-of-school urban youth (and adults) who lacked skills for other training opportunities. The initial project established training centers in one region. Follow-on projects expanded coverage to additional regions and sought to institutionalize the centers and ensure their continued financial viability.

Other Rural Development/Social Services Initiatives:

Several of the broader rural and agricultural development projects initiated during the late-1970's also included substantial social services components. For example, District Planning and Rural Development--Phases 1 & 2 (#6410073; $464,000; 1977-1982), which supported a "decentralized approach to integrated rural development" in the Brong Ahafo Region, included "pilot activities" to develop a maternal child health center and a rural health clinic. Similarly, the Agricultural Rehabilitation/Health Promotion project (#6410074; $205,000; 1976-1979) sought to improve nutrition, health, and agricultural productivity in the sub-Sahel region, providing vehicles, medical equipment, and vaccines; supporting a mass-vaccination program; providing partial operating costs for the Bawku Nutrition Center; and providing training for health and agricultural workers. Likewise, the Rural Reconstruction Movement (a subproject of the centrally funded Accelerated Rural Learning Project (#698038703; $171,000; 1976-1979) sought to improve nutrition, health and agricultural productivity in the Sub-Sahelian "Mampong Valley Social Laboratory." The project trained nutrition workers, established a nutrition rehabilitation program, purchased health supplies and vaccines, and expanded immunization efforts in the region.

Unfortunately, most of these efforts proved difficult to implement and even more difficult to sustain. In part, this reflected the unwillingness of the government to decentralize power and the difficulty of attracting

qualified staff to work in rural areas. Although many of the local health facilities were intended to become self-supporting, village and district councils generally lacked the authority to generate local revenues or charge fees (Price 1988: 35-40.). Of course, by the early 1980's, "the deteriorating and chaotic economic conditions of the country ... cause one to wonder if any project can succeed..." (Project Evaluation 1980)

Other Centrally Funded Projects:

During the mid- and late-1970's, Ghana also participated in several vertically integrated programs aimed at addressing specific health problems. This included the multi-donor Sahel Regional Onchocerciasis Control Program (Phases I, II, & III) and a program for Yellow Fever/Yaws control (Subproject 25 of the Africa Regional Accelerated Impact Program.) Both of these regional, problem focused efforts were continued through the 1980's.

Poverty Alieviation in Transition (1979-83)

During the late 1970's and early 1980's, A.I.D.'s Ghana program remained strongly focused on rural development and poverty allieviation. From 1979 (FY 1981) through 1983 (FY 1985), each CDSS included a detailed analysis of the causes and conditions of rural poverty and how A.I.D.'s program addressed them. However, as economic conditions continued to deteriorate and project implementation became more difficult, the program also became more focused: "concentrating development activities in the Brong-Ahafo region," "reducing project proliferation by developing sector support projects," "replicating or expanding successful projects," "enhancing the use of intermediaries such as PVO's," and "using selectively A.I.D. centrally funded resources particularly in Health and Population." (1983 CDSS: 1)

Some of the rural development projects that A.I.D. initiated during the late 1970's and early 1980's were specifically designed to cope with Ghana's adverse economic conditions. The Farmers Associations and Agribusiness Development Project (#6410072; $10.8 million; 1977-1982), for example, was developed precisely because "government programs for rural populations have too little staff [and] too little money to provide information, inputs, and services." As an alternative, the FAAD project supported efforts by seven PVO's "to achieve wide-scale rural improvement through farmer associations and rural-based business enterprises." (Abstract/Project Paper) However, while the PVO's "generally performed well" (Special Evaluation 1980), there were continuing delays caused by the lack of key commodities. While "some activities had good results on a localized basis," "all activities met with some degree of failure due to the complete deterioration of the Ghanaian economy" (Final Report 2/83).

By the early 1980's, it was becoming increasingly apparent that little development progress was possible without deep-seated economic reforms. Indeed, as early as 1979, A.I.D. recognized that "stabilization is a key factor affecting our ability to deliver effective assistance." (1980 CDSS: 20). But in 1979 and 1980 A.I.D. remained hopeful that new governments were finally committed to fundamental change. At the same time, A.I.D. was also beginning to hedge its bets: ready to support a stabilization program with expanded assistance, but also indentifying "a core of activities ... that can have a strong impact despite chaotic economic conditions ... with or without a stablization effort." (1982 CDSS).

By 1981, these "high" and "low" program options were at the core of A.I.D.'s development strategy:

> If such an agreement [a stabilization program] is not reached with the IMF, or if Ghana fails to adopt stringent measures on its own, the Ghanaian economy will probably continue to deteriorate. Under these circumstances, our aid program in Ghana should be minimal--enough to demonstrate our concern for Ghanaian democracy. This is the "low track" option described below. On the other hand, if the Government has the determination to make the necessary reform, A.I.D. should be prepared to increase its assistance and make a more meaningful contribution to Ghana's economic development--the "high track" option." (1983 CDSS: 25)

Although it remained on hold, hostage to Ghana's growing economic collapse, the high option program involved a continued rural development focus, with an emphasis on improved social and economic services and increased agricultural production for poor, small farmers. (1983 CDSS: 4-5)

By early 1983, A.I.D.'s previous optimism finally gave way to pessimism. The economy was in virtual free-fall and the new Provisional National Defense Council government that took power late in 1981 was increasingly recalcitrant and anti-American. With the government bankrupt, and with even essential commodities unavailable, projects were falling further and further behind schedule. A.I.D. therefore revised its strategy, eliminating the "high track" option and elaborating the "low track"--the minimal maintenance program--that it expected to implement. Funding for major agriculture and social services initiatives was dramatically reduced. Based on an intensive review during FY 1982 and FY 1983, for example, the Managed Input Delivery of Agricultural Services (MIDAS II) project was redesigned from a "multi-faceded, coordinated, integrated, agricultural development project" to a narrowly focused effort to improve the efficiency and effectiveness of the Ghana Seed Company parastatal (FY 1983 CDSS: 3).

But even A.I.D.'s "low-track" option proved overly optimistic. In February of 1983, "in reaction to sporadic but increasingly virulent attacks in the Government-owned and controlled media" ..."the U.S. State Department directed that for security reasons the official U.S. presence in Ghana continue to be reduced to the essential minimum." (1985 ABS: 1). By spring, with Ghana's economy continuing to decline and political tensions continuing to rise, the U.S. suspended consideration of additional assistance requests from Ghana and began reviewing ongoing activities. All new starts in participant training and all commodity procurements for ongoing projects were suspended; U.S. contractors were given early termination notices; and ongoing design activities for new projects were suspended indefinitely. By midsummer, the A.I.D. mission had been reduced from 9 to 3 staff--"the absolute minimum necessary to maintain a presence and a minimum program"--and there was little hope that the program would be increased substantially, even if an expected political rapprochment between the U.S. and Ghana occurred (1985 ABS: 2-3).

Economic Stabilization and Structural Adjustment (1983 - present)

In April 1983, the Ghanaian government initiated its Economic Recovery Program--one of the most austere reform programs in Africa--and A.I.D.'s strategy had to be rethought again. In July of 1984, with reforms continuing and political relations improving, A.I.D. ended a 15 month freeze and resumed normal assistance to Ghana. But, in the interim, A.I.D.'s development strategy had shifted dramatically, from an an emphasis on project assistance aimed at poverty alleviation and rural development to an emphasis on program lending and economic reform.

By 1988, support for economic restructuring was clearly the paramount element in A.I.D.'s program planning. As the current Ghana strategy emphasizes, "the main thrust of the USAID program over the next three years will be to support Ghana's Economic Recovery Program (ERP)" (1990 Concept Paper: ii) and "to contribute to an increase in Ghanaian per capita income growth" particularly by addressing "the perceived lag in employment growth in the economic restructuring process" (1990 Concept Paper: 9-10). More specifically, A.I.D. expects to contribute to "the creation of productive employment in the private sector with an emphasis on agriculture;" to "finance some of the costs of the structural adjustment program, particularly the costs of redeploying government employees and costs associated with divestitute of SOE's;" to "improve management of population pressures at the national and family levels;" and to "increase the Mission's knoweldge and understanding of the private sector and of aspects of the ERP" (FY 1990 Concept Paper: 10).

During the mid-1980's, A.I.D. implemented this strategy primarily through fast-disbursing program assistance from an "Agriculture-related Commodity Import Program" and the PL-480, Title I program. Initially, A.I.D. expected to use some of the local currencies generated to fund specific agricultural and social service activities. By 1988, however, most local currency funds were being directed at broader investment programs: providing credit for private firms through the commercial banking system, supporting the government's Public Investment Program (which included some social services investments), repaying SOE debt to the financial system, paying the redeployment costs of redundant civil servants and SOE personnel, and supporting other elements of the government's "Program of Actions to Mitigate the Social Costs of Adjustment" (FY 1990 Concept Paper: 11).

Social services were far less central to A.I.D.'s mid-1980's strategy than to previous rural development efforts. Most of the Mission's limited financial and staff resources were allocated to priority economic reform efforts. While A.I.D. reaffirmed its support for "the provision of primary health care to all Ghanaians" (FY 1989 ABS: 3), the emphasis was on "expanding the private sector's role," and the only major vehicle was the Contraceptive Supplies Project. A.I.D. also continued to provide PL-480, Title II food aid and initiated short-term, private sector oriented, training through the Africa Bureau's Human Resources Development Project.

As with previous efforts, the Contraceptive Supplies Project (#6410109; 1985-89; $7,000,000) sought "to reduce the rate of population growth and improve maternal and child health in Ghana" by increasing "the voluntary use of safe, effective, and appropriate contractive methods." (Abstract/Project Paper). The project focused on providing contraceptive commodities and, at least initially, on improving the capabilities of the Ministry of Health (MOH) in managing and distributing them. This included training/retraining for at least 50% of the service providers at MOH clinics, courses for more than 100 gynecologists and nurse-midwives, and U.S. Master of Public Health degrees for 3 regional health administrators. The Contraceptive Supplies Project was supplemented by the centrally funded Ghana Family Health Initiatives (#6980662; 1980-1989; $22.5 million) which provided "a continuous and adequate supply of contraceptives and family planning services" to Ghana's Ministry of Health while the Ghana program was frozen (Abstract/Project Paper).

From the beginning, the Contraceptive Supplies project also included a more innovative component aimed at improving contraceptive distribution through the use of modern marketing techniques and commercial intermediaries. This involved assisting the MOH in developing "a culturally sensitive, multmedia information, education, and communication (IE&C)

strategy," involving a "Ghanaian distribution company" in "an A.I.D.-supplied CSM [contraceptive social marketing] program," and "a CSM training program to inform retailers of project requirements and to add some 3,000 new outlets." (Project Paper).

By the late-1980's, the CSM program and efforts to involve the private sector in contraceptive distribution appeared to be bearing fruit. The USAID program had "developed a self-sustaining nationwide contraceptive social marketing program," "trained 2,700 pharmacists and chemical sellers in modern contraceptive technology," "developed a program for commercial advertizing of contraceptives nationwide," "developed a comprehensive and innovative research program," and "developed a program [through the centrally funded Africa Family Health Initiatives II project] for providing family planning training to 200 private midwives" (FY 1990 Concept Paper: A.3(2)). By 1988, A.I.D. estimated that "already half of the contraceptives being distributed in Ghana move through the CSM program, while the private sector in general (including NGO's) accounts for over 3/4 of all the family planning services" (FY 1990 Concept Paper: A.3(3)).

However, while noting that "overall the CSM project in Ghana is in very good shape" (ISTI 1988, Vol. 2, Ghana Case Study: 73), a recent assessment of A.I.D.'s contraceptive social marketing programs puts the project's performance in clearer perspective. Thus far, Ghana's CSM efforts have focused solely on urban areas and the goal--to "increase contraceptive prevalence in urban areas from 7 to 10 percent"--remains relatively modest. Even so, a variety of problems and constraints remain, including government restrictions (and an only recently lifted ban) on mass media advertizing, delays in needed market research and analysis, government price-setting that has kept profit margins too low, and continued diversion of public sector commodities to the commercial marketplace (ISTI 1988, Vol. 2, Ghana Case Study: v). In addition, "the quality of information given to customers about contraception is generally poor" (pg viii), "the numbers of trained vendors is small ... and the pace of training is slow" (pg 71). Total CSM program costs were estimated at more than $20 per couple-year of protection and it is unclear whether the commercial distributor will ever be able to cover operating costs, even with subsidized commodities (pg. 72).

Based on the perceived success of the contraceptive social marketing effort, A.I.D. hopes to further expand the role of the private sector in health care delivery. The Mission, for example, "is currently developing a program for training 6,000 traditional birth attendants (TBAs) to deliver PHC [primary health care] services, including family planning, to the 70% of the population residing in rural areas." This is seen as "a

direct private sector extension of the public sector health system" with "the TBAs who are private practitioners, [receiving] training and their supplies of contraceptives through the public health system." (FY 1990 Concept Paper: A.3(3)). The Mission also forsees a further expansion of private sector involvement in child survival services, HIV/AIDS prevention, and other health care areas. Already, for example, "through negotiations with UNICEF, the MOH, a private pharmaceutical firm, and using only centrally funded resources, USAID has developed a local production and commercial distribution facility for oral rehydration salts (ORS), which will increase the availability of ORS by up to 1000% within a year through the retail network already developed for the CSM program." (FY 1990 Concept Paper: A.3(4))

A.I.D., moreover, expects to accomplish all this while further reducing its direct involvement in social services activities: "with the exception of only three activities (private midwives, ORT, and family planning IEC) all [of the USAID's current population and health program activities] will cease with the bilateral project in 1989." "At this juncture, the foundations for a sustainable and comprehensive program will be set, and the management burden which was assumed by the Mission in the development of the current program will be substantially reduced" (FY 1990 Concept Paper: A.3(4)).

By 1989, in other words, A.I.D.'s social services "strategy" will focused nearly entirely on privatization" and will be limited to providing commodities, mobilizing indigeneous medical practitioners, and supporting PVO feeding and nutrition initiatives. Yet, despite A.I.D.'s laudable achievements in expanding private sector health and population services, no country--certainly not a struggling developing country--can meet all its social service needs through private providers. One of the key recommendations of the recent worldwide CSM study, for example, was that A.I.D. needed to assume a more more active role in increasing "the capability of the government to assume responsibility for overall coordination of the public and private sector components of the program" (ISTI 1988, Vol. 2, Ghana Case Study: vi). While A.I.D. recognizes that "private sector" social service providers will require continuing public sector inputs and support, A.I.D.'s role in mobilizing such support and achieving an appropriate and sustainable mixture of public and private services remains curiously undefined.

THE RESPONSIVENESS OF SOCIAL SERVICES PROGRAMMING TO ECONOMIC CONDITIONS

A.I.D.'s development strategy in Ghana has changed dramatically during the last 30 years: from an early emphasis on

infrastructure, institution building, and human resource development; through a late-1960's interlude of policy reform; through a 1970's focus on rural development and poverty alleviation; to a mid-1980's committment to structural adjustment and privatization. Not surprisingly, A.I.D.'s social services programming has also changed markedly to reflect these differing strategies. More surprising, perhaps, is the extent to which this social services programming has also reflected a thorough analysis Ghana's changing economic conditions. The issue, then, is not merely whether A.I.D. took economic conditions into account, but why it responded to these conditions the way it did and whether its response was appropriate.

At the level of the individual social services project, the answer seems fairly straightforward. Every project must cope with numerous unexpected problems--equipment that fails to arrive, spare parts that are unavailable, counterpart contributions that lag, costs that are too high--many of which reflect broader economic conditions. The primary factor in responding successfully to such constraints is the quality of project management. Well managed projects adjust flexibly, on the spot, with immediate solutions and minor redesigns; poorly managed projects fail to adjust and, ultimately, fail to perform.

However, even well managed projects respond to opportunities and constraints within the framework of original project designs and strategies. A primary health care project (like CHETs), that is unable to attract physicians for training, might settle for less qualified paramedics, but is unlikely to shift to an entirely new service delivery system. A nonformal education project (like OIC), that cannot find employment for its graduates, may refocus its training, but is unlikely to abandon vocational training all together. Only when constraints become so severe that normal project implementation becomes impossible are more basic changes considered.

This, in fact, is what occured in Ghana. By the early 1980's, equipment, supplies, and counterpart resources became so scarce that project implementation ground to a halt. Under these circumstance, the mission responded by sharply curtailing project activities, by deobligating and reprogramming funds, and by redesigning existing projects (such as MIDAS II) so that they might still make a difference.

At the program level--where broader social services strategies are defined and project portfolios are selected--the situation is more complicated. On the one hand, the Mission self-consciously analyses broader economic conditions in developing its social services program. On the other hand, how the Mission responds to these economic conditions--what social

services strategy it choses and which projects it selects--is greatly influenced by other factors, including foreign policy consideration and, in particular, A.I.D.'s broader development ideology.

During the mid-1970's, for example, A.I.D. was well aware of Ghana's deteriorating economic performance and of the policy inadequacies that produced it. Within this economic framework, the Mission chose to respond--and felt that it could make the most significant contribution--by directly improving the social and economic conditions of rural farmers. While the specific interventions chosen--primary health care, integrated services, institutional development--reflected then current social services wisdom, the decision to focus on poverty alleviation and rural development, and the belief that this represented an appropriate (albeit, partial) response to economic conditions, reflected A.I.D.'s broader development policy.

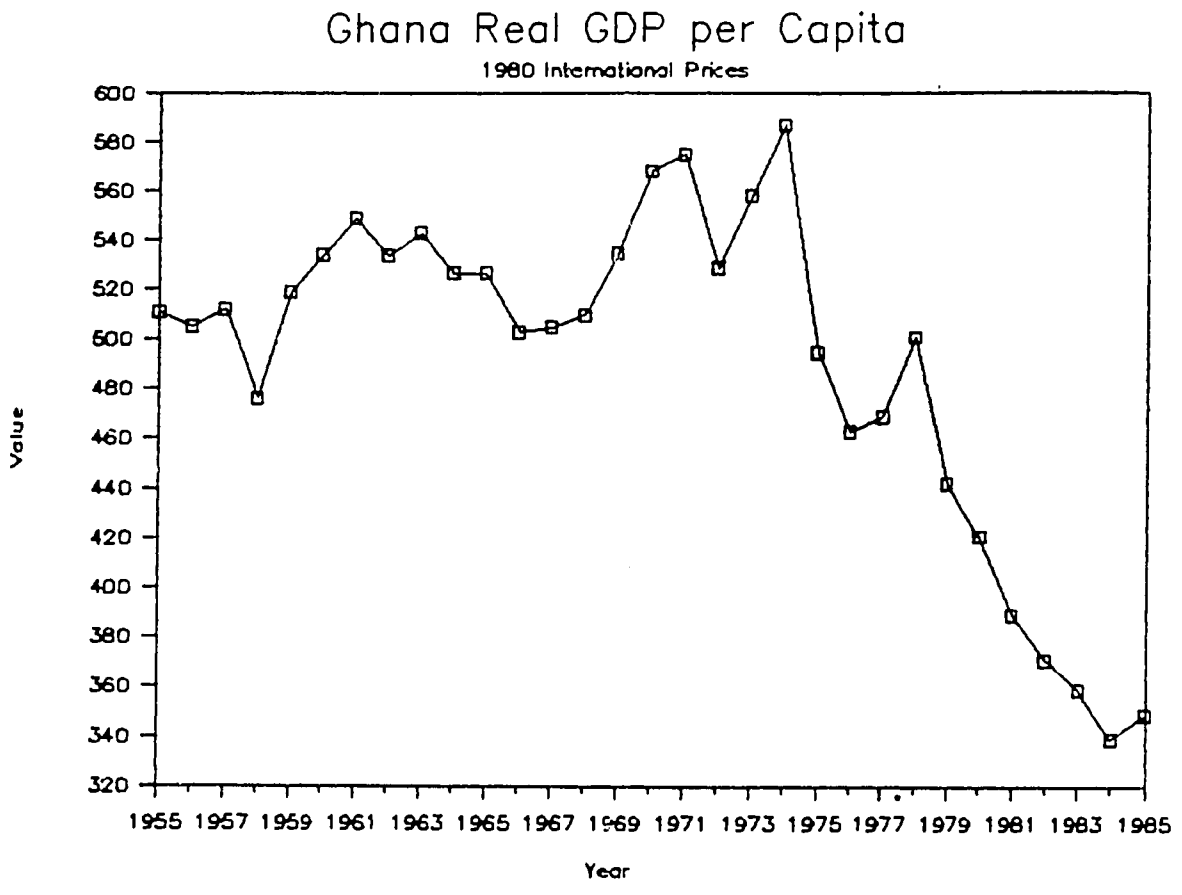
Similarly, since the mid-1980's A.I.D has been well aware that Ghana's social services infrastructure were deteriorating rapidly, that the government could not afford to maintain even the minimum essential social services, that A.I.D.'s past investments in institutional and human resource development were evaporating, and that human welfare was on the edge of a potentially preciptious decline. Moreover, while Ghana might not be able to afford the level of social services to which it had previously aspired, A.I.D. also recognized that public institutions had a continuing and central role to play in a more sustainable public and private social services system. Still, A.I.D. chose to "respond" to Ghana's adverse economic conditions, and felt that it could make the most significant contribution, with a social services strategy almost exclusively oriented to expanding private sector health and population services. While the specific interventions chosen--contraceptive social marketing, oral rehydration therapy, and child survival--again reflected contemporary social services wisdom, the decision to focus on economic reform and privatization, and the belief that this represented an appropriate (albeit, partial) response to economic conditions, reflected A.I.D.'s broader development policy.

In retrospect, A.I.D.'s social services program of the mid-1970's proved inappropriate to the economic conditions that emerged in the late 1970's and early 1980's. A.I.D.'s optimism about host government policy change proved unfounded and the economy deteriorated so rapidly that no rural development investment could have made a difference. It is still too early to tell whether A.I.D.'s current social services strategy will prove to be an appropriate response to economic conditions in Ghana during the mid-1980's. However, without a more detailed assessment of the role of private and public institutions in the emergence of a more effective and sustainable "mixed"social

services system, it is even less clear whether A.I.D.'s current program is an appropriate response to Ghana's social service needs and opportunities.

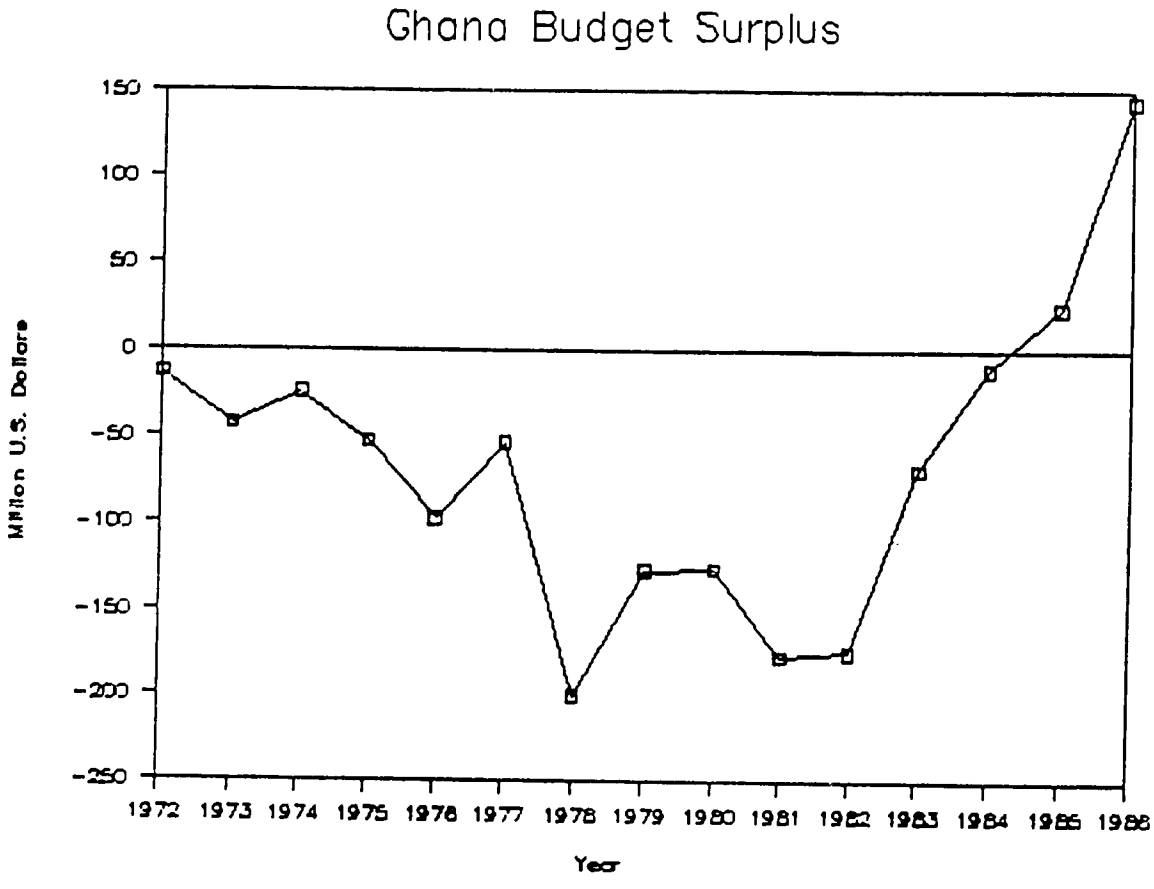
STATISTICAL ANNEX

Note: The tables and graphs in this annex were derived from various A.I.D., World Bank, and other sources. A list of sources is attached.

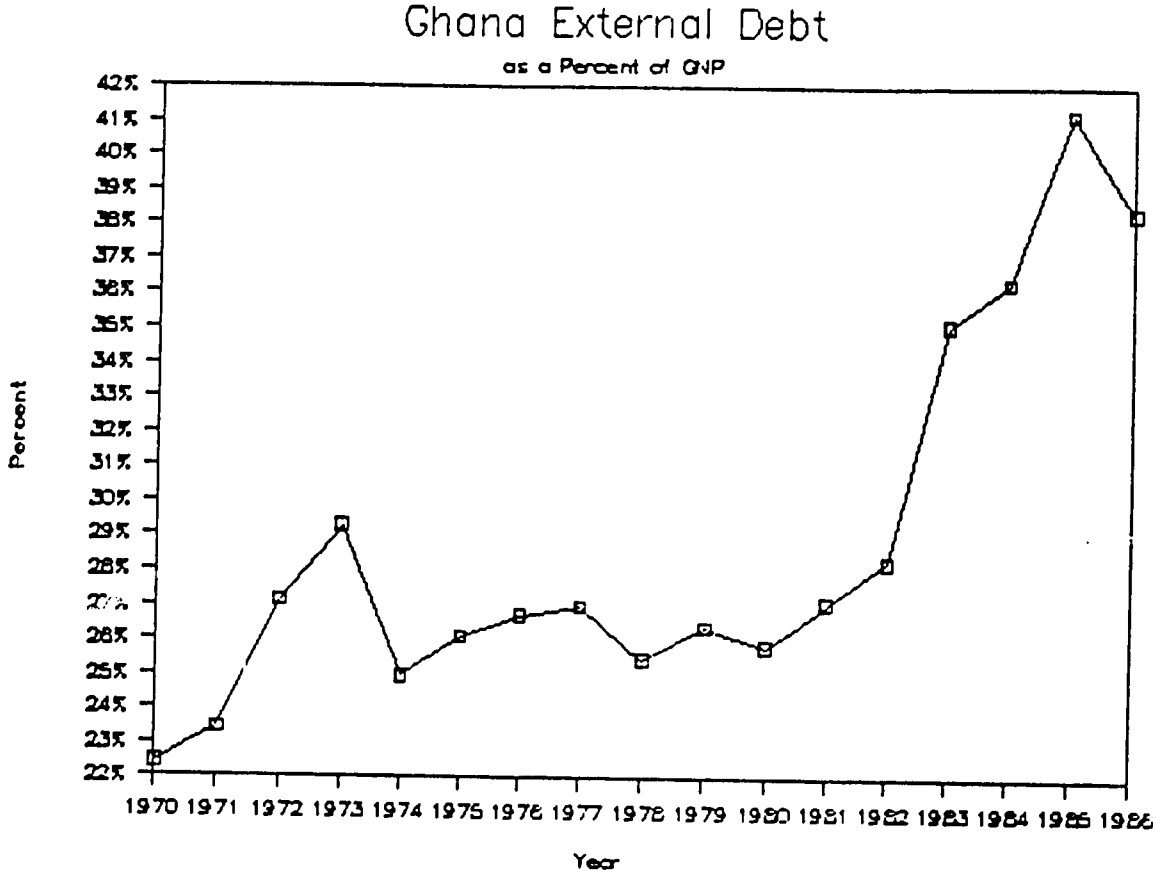


Year	RGDP per capita	Percent Change
1955	511	
1956	505	-1.2%
1957	512	1.4%
1958	476	-7.0%
1959	519	9.0%
1960	534	2.9%
1961	549	2.8%
1962	534	-2.7%
1963	543	1.7%
1964	527	-2.9%
1965	527	0.0%
1966	503	-4.6%
1967	505	0.4%
1968	510	1.0%
1969	535	4.9%

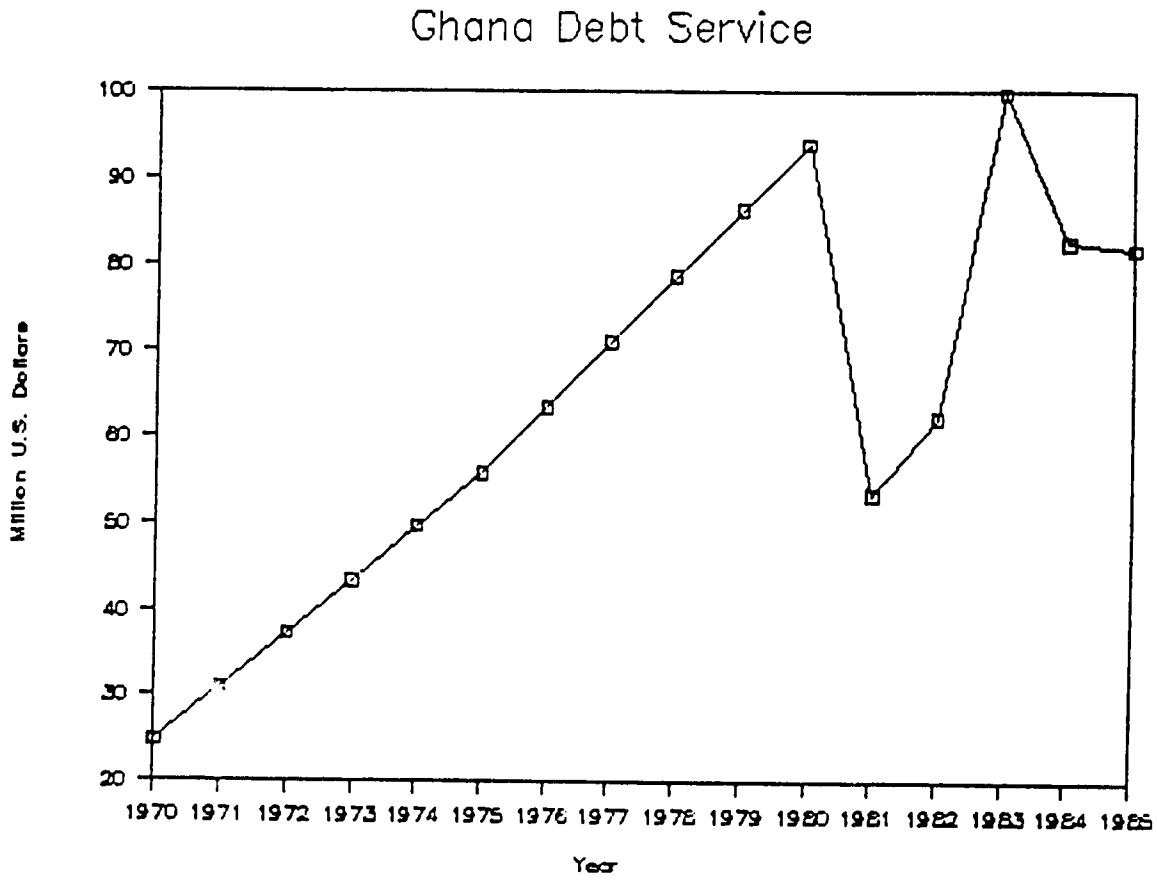
Year	RGDP per capita	Percent Change
1970	568	6.2%
1971	575	1.2%
1972	529	-8.0%
1973	558	5.5%
1974	587	5.2%
1975	495	-15.7%
1976	463	-6.5%
1977	469	1.3%
1978	501	6.8%
1979	442	-11.8%
1980	421	-4.8%
1981	389	-7.6%
1982	371	-4.6%
1983	359	-3.2%
1984	339	-5.6%
1985	349	2.9%



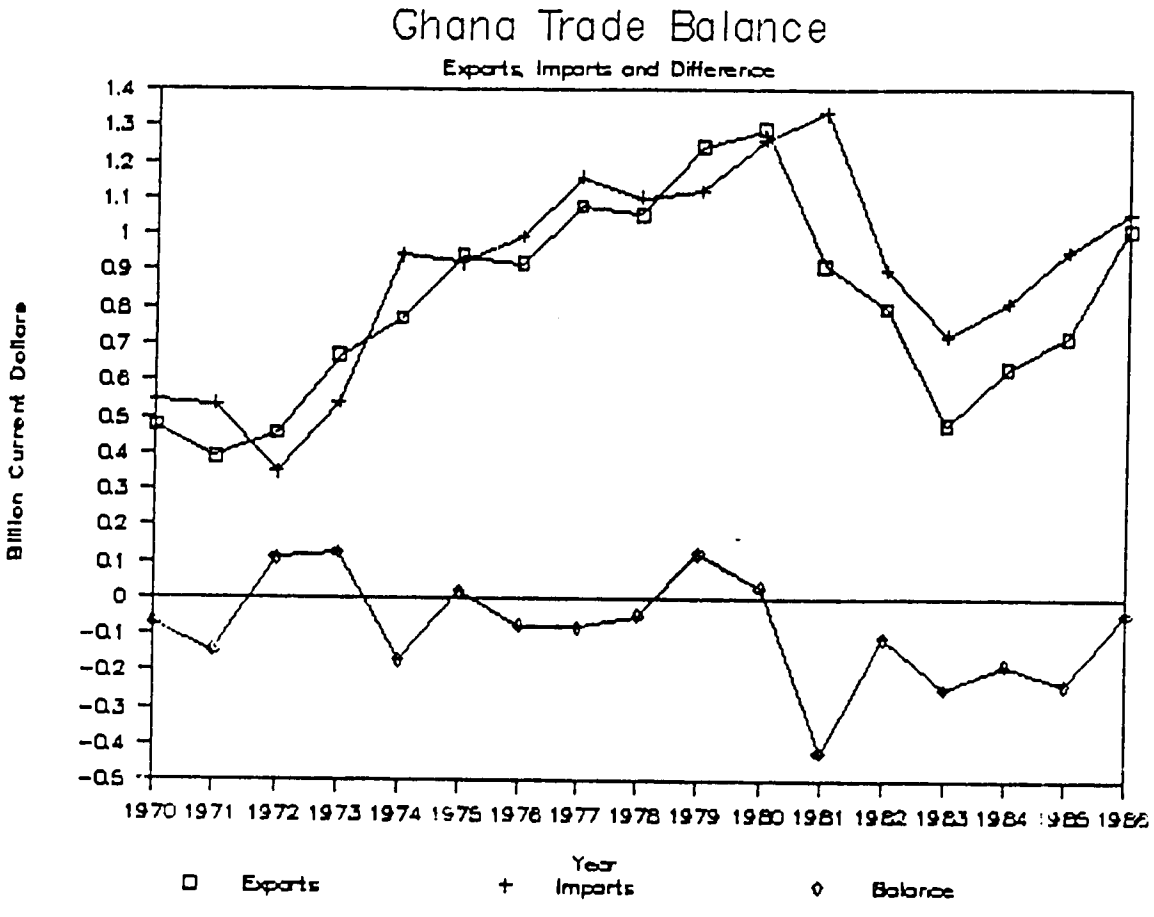
Year	Budget Deficit
1972	-13.6
1973	-43.0
1974	-24.8
1975	-53.2
1976	-98.3
1977	-54.3
1978	-200.3
1979	-128.2
1980	-127.4
1981	-177.4
1982	-174.9
1983	-69.6
1984	-11.2
1985	24.3
1986	143.3



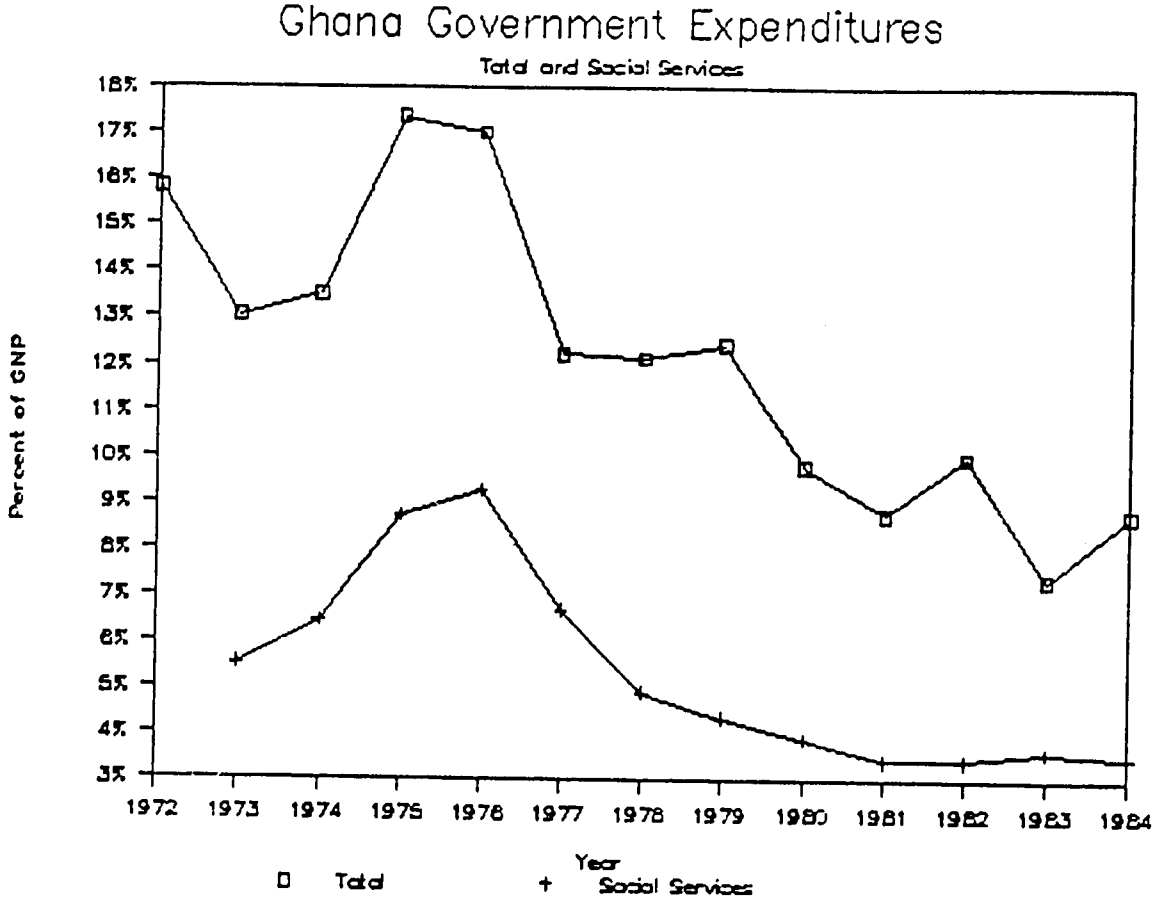
Year	Debt as % of GNP
1970	22.43%
1971	23.43%
1972	27.12%
1973	29.27%
1974	24.96%
1975	26.08%
1976	26.68%
1977	26.98%
1978	25.45%
1979	26.36%
1980	25.81%
1981	27.07%
1982	28.27%
1983	35.12%
1984	36.33%
1985	41.20%
1986	38.35%



Year	Debt Service
1970	24.8
1971	30.98
1972	37.16
1973	43.34
1974	49.52
1975	55.7
1976	63.34
1977	70.98
1978	78.62
1979	86.26
1980	93.9
1981	53.2
1982	62.1
1983	99.7
1984	82.5
1985	81.8

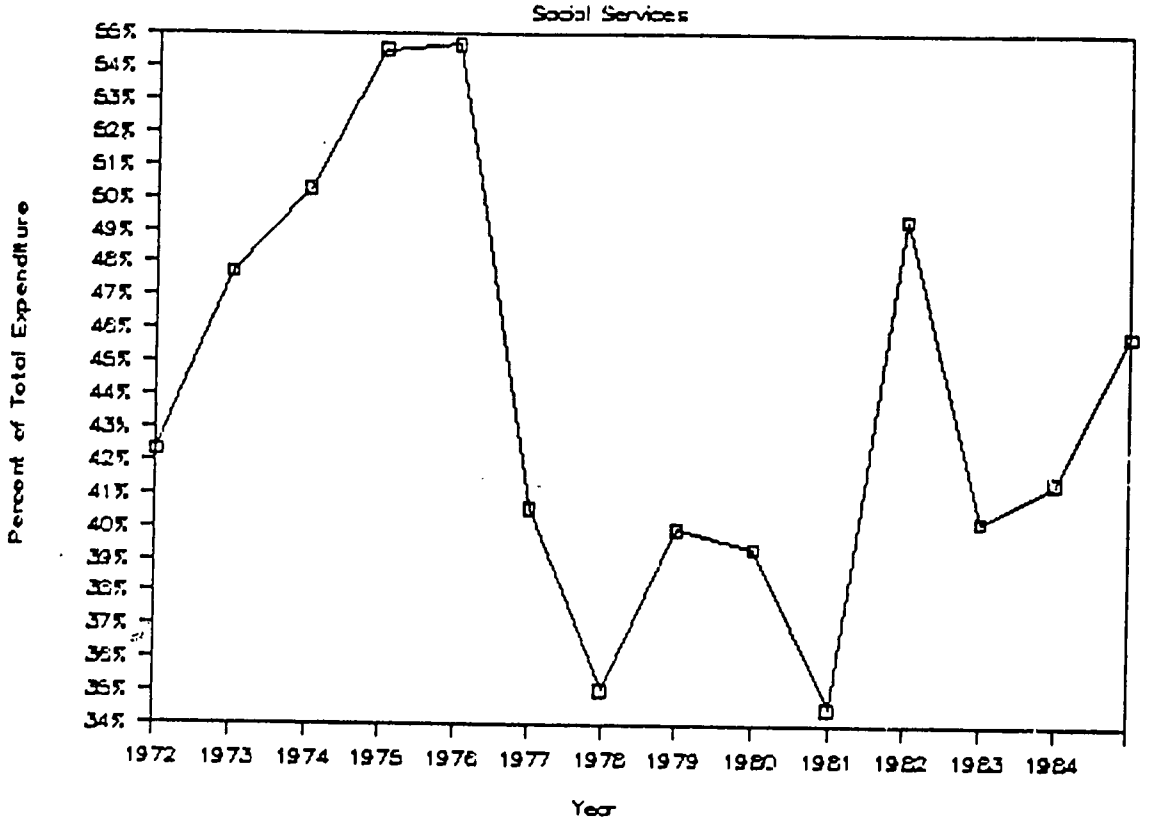


Year	Exports	Imports	Export/Im Balance	Percent Change
1970	474.8	542.5	-67.7	
1971	389.6	535.4	-145.8	-115.4%
1972	456.1	347.9	108.2	174.2%
1973	666.3	539.6	126.7	17.1%
1974	770.7	942.1	-171.4	-235.3%
1975	939.9	922.4	17.5	110.2%
1976	920.6	994.8	-74.2	-524.0%
1977	1078.9	1158.7	-79.8	-7.5%
1978	1055.7	1101.6	-45.9	42.5%
1979	1243.4	1121.4	122	365.8%
1980	1292.7	1263.5	29.2	-76.1%
1981	914.8	1335.6	-420.8	-1541.1%
1982	796.4	905	-108.6	74.2%
1983	478	724.1	-246.1	-126.6%
1984	633	812.8	-179.8	26.9%
1985	718.1	952.3	-234.2	-30.3%
1986	1013.1	1056.1	-43	81.6%



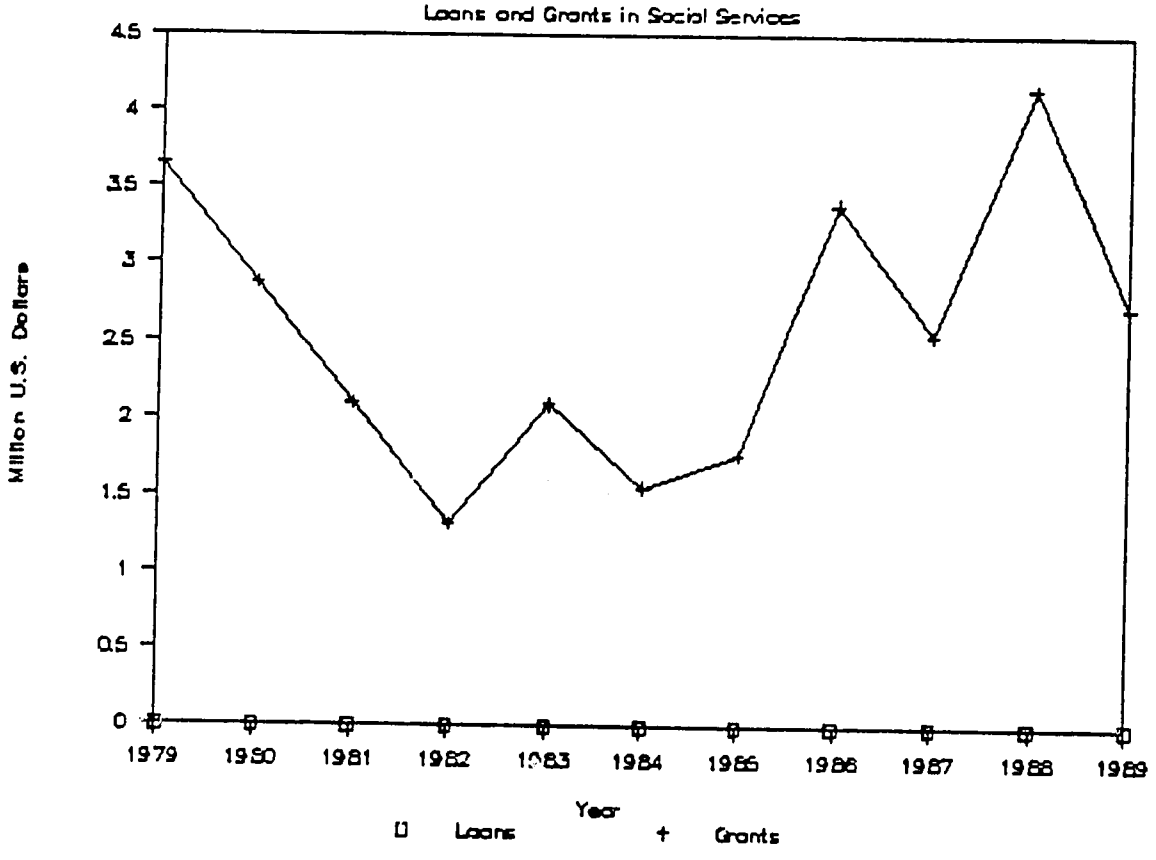
Year	Govt Exp. as % of GNP	Soc Services as % of GNP
1972	15.83%	0.00%
1973	13.05%	5.52%
1974	13.50%	6.44%
1975	17.37%	8.73%
1976	17.01%	9.27%
1977	12.24%	6.69%
1978	12.13%	4.92%
1979	12.45%	4.37%
1980	9.79%	3.91%
1981	8.74%	3.44%
1982	9.98%	3.45%
1983	7.35%	3.63%
1984	8.74%	3.51%
1985	11.37%	4.71%
1986	12.09%	5.55%

Ghana Government Expenditures



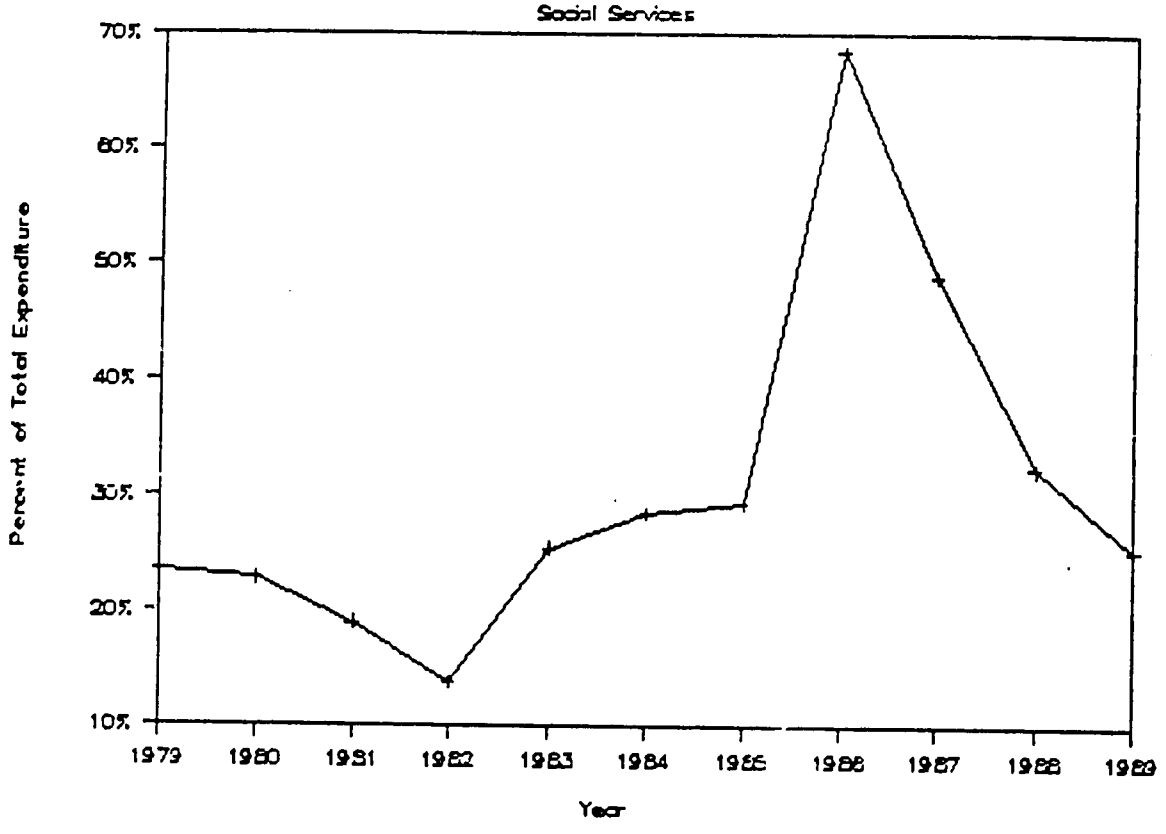
Year	Soc Services as % of Total
1972	0.00%
1973	42.32%
1974	47.73%
1975	50.24%
1976	54.49%
1977	54.67%
1978	40.57%
1979	35.09%
1980	39.96%
1981	39.38%
1982	34.55%
1983	49.37%
1984	40.21%
1985	41.40%
1986	45.87%

Ghana A.I.D. Expenditures



Year	Soc Serv Loans	Soc Serv Grants
1979	0	3.655
1980	0	2.875
1981	0	2.094
1982	0	1.314
1983	0	2.091
1984	0	1.556
1985	0	1.766
1986	0	3.398
1987	0	2.543
1988	0	4.150
1989	0	2.719

Ghana A.I.D. Expenditures



Year	Soc Serv as % Expend
1979	23.65%
1980	22.86%
1981	18.98%
1982	13.79%
1983	25.44%
1984	28.47%
1985	29.28%
1986	68.44%
1987	49.00%
1988	32.30%
1989	25.37%

Official Assistance By Donor

Year	F.R.G.	Canada	Sov Bloc	China	Other
1976	5.9	12.2	0	0	10.3
1977	9.6	13.5	1	0	19.6
1978	13.8	15.56	0	0	42.63
1979	18.6	15.5	0	0	39.9
1980	31	14.1	0	0	50.0
1981	37.8	8	0	0	27
1982	32.4	8.6	10	0	23
1983	25.4	6.2	0	0	29.5
1984			20		

RGDP Per Capita:	World Bank On Line Data Base
Export Import Balance:	World Bank World Tables
External Debt over GNP:	World Bank World Tables
Budget Deficit:	World Bank World Tables
Gov't Social Service Spending over GNP:	World Bank World Tables Gov't Finance Statistics Yearbook
A.I.D. Social Service Spending over Total Expenditures:	A.I.D. Congressional Presentation World Bank World Tables
A.I.D. Loans and Grants:	A.I.D. Congressional Presentation
Gov't Social Service Spending over Total Expenditures:	World Bank World Tables Gov't Finance Statistics Yearbook
Total Debt Service:	World Bank World Debt Tables
Official Donors:	A.I.D. Congressional Presentation

NOTES: World Bank World Tables 1987 Fourth Edition
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(6410055)

DIS Abstract (Source: PD-AAT-603)
1975 Special Evaluation (PD-AAA-561-A1)
1979 Special Evaluation (PD-AAG-356-A1)

Management of Rural Health Services
(6410068)

Non-capital Asst Project Proposal (PD-AAB-823-B1)
Project Paper (PD-AAB-824-A1)
Project Appraisal Report (PD-AAB-825-A1)
Audit Report (PD-AAA-564-A1)
Final Report (PD-AAC-713-A1)
Final Report of the Contractor (PD-AAC-712-A1)
Project Evaluation Summary (PD-AAP-304)

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(6410088)

Project Paper (PD-AAG-683-A1)

Accelerated Impact, Subproject 25: Yellow Fever/Yaws Control
(6980410)

Grant Agreement (PD-BAD-478)
Project Evaluation Summary (PD-AAL-910)

Family Health Initiatives, Subproject 41: Nurse/Midwife Training
(6980462)

AID Contract/Grant (PD-BBI-065)

Family Health Initiatives, Subproject 12: Ghana Family Health
(6980662)

Project Paper (PD-JAA-062)

Program in Population Dynamics
(6410087)

Project Paper (PD-AAV-671)
Final Report (PD-AAM-901)

Contraceptive Supplies
(6410109)

Project Paper (PD-AAR-948)

Farmer Associations & Agribusiness Development
(6410072)

Project Paper (PD AAF-344-B1, PD-AAF-345-A1)
Special Evaluation (PD-AAG-107-C1)
Project Evaluation Summary (PD-AAG-107-B1)
Final Report (PD-AAM-545)
Special Evaluation (PD-AAW-936)

Community Development Staff Training
(6410095)

A.I.D. Contract/Grant (PD-AAJ-949)
Special Evaluation (PD-AAQ-026)
Special Evaluation (PD-AAQ-083)

Opportunities Industrialization Centers
(6410108)

Project Paper (PD-AAT-254)
Special Evaluation (PD-AAU-290)

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Final Report (PD-AAM-743)