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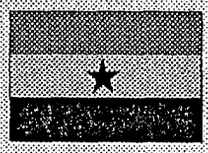

GHANA

USAID

POPULATION SECTOR STRATEGY

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ACRONYMS

ACNM	American College of Nurse Midwives
A.I.D.	Agency for International Development
AID/W	Agency for International Development/Washington
AVSC	Association of Voluntary Surgical Contraception
CBD	Community Based Distribution
DHS	Demographic and Health Surveys
FHI	Family Health International
FPHP	Family Planning and Health Program
FPLM	Family Planning Logistics Management Project
GIMPA	Ghana Institute for Management and Public Administration
GNFPP	Ghana National Family Planning Program
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education and Communication
IUD	Intra-Uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
MCH/FP	Maternal and Child Health/Family Planning
MFEP	Ministry of Finance and Economic Planning
MIS	Management Information Systems
MOH	Ministry of Health
NACP	National AIDS Control Program
NCWD	National Council on Women and Development
NGO	Non-Governmental Organization
NPA	Non-Project Assistance
NPC	National Population Council
OR	Operations Research
PIP	Population Impact Project
PPAG	Planned Parenthood Association of Ghana
PPIAC	Population Policy Implementation Assessment Committee
PVO	Private Voluntary Organization
R&D/POP	Bureau for Research and Development, Office of Population
SCF	Save the Children Fund
SDP	Service Delivery Point
SGMP	Society for General Medical Practitioners
SOMARC	Social Marketing for Change
SSPU	Social Sector Policy Unit
TAC	Technical Advisory Committee
TBA	Traditional Birth Attendant
TOT	Training of Trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VFT	Vaginal Foaming Tablets

POPULATION SECTOR STRATEGY

EXECUTIVE SUMMARY

Ghana's population program has made impressive gains in the last five years as demonstrated by a tripling of the contraceptive prevalence rate, yet much remains to be done to effect a measurable reduction in the total fertility rate. This analysis of Ghana's population sector was undertaken at the request of USAID/Accra in order to assist USAID and the Government of Ghana (GOG) in making strategic choices concerning the magnitude and direction of future activities in population. The purpose of the exercise is to examine the current situation, identify critical issues and gaps in knowledge, and to suggest approaches that can be undertaken in future program activities. Specifically this document seeks to:

- Develop a strategic plan for an expanded country program, including short and long term objectives.

- Build consensus among USAID and Ghanaian policy makers and organizations on critical issues and future directions of the population program.

This document and the recommendations made herein are the result of a variety of activities carried out over a six month period. During February-March 1993, the Population Sector Strategy team convened its first session in Accra in order to develop a preliminary strategic plan. A summary of the draft plan was widely circulated among government officials, private sector service providers and donors for comments and suggestions. During the next six months, several activities were carried out to obtain new information and new estimates of the current population and family planning situation in Ghana. These activities included the Family Planning Situation Analysis, implemented by the Ghana Statistical Service in collaboration with the U.S.-based Population Council, and the Consumer Baseline Survey, carried out under the current Family Planning and Health Project (FPHP). The Strategy team reconvened in August, 1993 to revise the population strategy in light of both the new data, and comments and suggested changes received from the population and family planning community in Ghana.

To facilitate the strategic planning process, the family planning program typology developed by the Family Planning Services Division in A.I.D./Washington's Office of Population (R&D/POP) was used. This approach classifies national family planning programs according to level of use of modern methods of contraception. The FPHP originally was developed to carry Ghana through "launch" -- level 2 of the typology with a modern prevalence of 8 to 15 percent. Thus, for the short-term, the team initially directed its attention to analyzing program needs and suggesting interventions designed to ensure that the target of 15 percent modern method prevalence would be achieved by end of project.

For the longer term, attention was directed towards developing a strategy that would move Ghana's program well into level 3 -- "growth" -- by the year 2000. At this level, modern method prevalence ranges from 16 to 34 percent; demand for services expands among non-urban and non-educated segments of the population, while all

segments of the population are increasingly interested in longer-lasting and permanent methods.

In thinking strategically about both short and the long-term objectives, the team identified six priority areas for which short and long-term interventions are recommended:

PRIORITY 1: Improve the policy environment for population programs through deepening political commitment to the national population policy at the national and local levels; developing support of the national policy among other public and private sector groups; strengthening the coordinating capacity of the National Population Council; and reforming the regulatory environment and customary practices.

PRIORITY 2: Promote public/private sector collaboration in the delivery of family planning/health services.

PRIORITY 3: Intensify support for demand generation and supply for non-clinical methods.

PRIORITY 4: Generate a climate of acceptance and demand for long-term methods, including retraining to improve provider knowledge, acceptance and support for these methods, and targeted IEC to encourage acceptance and trial of these methods by clients.

PRIORITY 5: Increase capacity in both the public and the private sectors to supply long-term and permanent methods of contraception.

PRIORITY 6: Foster technical as well as financial sustainability of population and family planning activities.

I. INTRODUCTION

A. Background

Assistance from the United States Agency for International Development (A.I.D.) to the Government of Ghana's (GOG) health and population sector began in the 1960s. Between 1968 and 1991, an estimated total of $30 million was obligated to support population and family planning activities in Ghana. This support was carried out under eight bilateral and regional projects and 43 centrally funded projects.

In April 1991, A.I.D. and the Government of Ghana signed a new six-year bilateral program, the Ghana Family Planning and Health Program (FPHP), for an additional $30 million, as a direct follow-on to the Contraceptive Supplies Project (1985-1992). A $5 million amendment supports a four-year sub-project for HIV/AIDS activities.

The goal of the FPHP is to lower fertility of the Ghanaian population through maternal and child health interventions, and to reduce the spread of HIV/AIDS. Project purposes are to:

- increase the use of and demand for family planning through expanding the public and private sector capacity for providing family planning, maternal and child health services, and supplies; and,

- assist the Government of Ghana National AIDS Control Program (NACP) increase the effectiveness of its campaign through activities in information dissemination, education and communication, laboratory support, health information system, and cognizance building.

FPHP established targets that addressed the Mission's strategic objective of reducing Ghana's fertility rate, which include lowering the total fertility rate from 6.4 to 6.1 by 1995, and slowing the annual rate of population growth from 3.4 percent to 3.0 percent by 2000. This is to be achieved by increasing contraceptive prevalence of modern methods from 5 to 15 percent by 1995.

The core of the FPHP project component is focussed primarily on expanding the existing private sector Ghana Social Marketing Foundation, under a competitively awarded contract with the Futures Group. In addition to social marketing activities, the Futures Group, as institutional contractor for the project assists in all aspects of family planning and health activities in both the public and private sectors, including technical assistance and training to the Health Education, and Maternal and Child Health/Family Planning Departments of the Ministry of Health (MOH), and other non-governmental organizations.

The American College of Nurse Midwives (ACNM) receives support under the project to help strengthen the Ghana Registered Midwives Association (GRMA) and to provide family planning training to its members. ACNM is also working with the MOH to strengthen its training program in maternal and child health and family planning for traditional birth attendants (TBAs). In addition, the original project design called for buy-

ins from selected centrally-funded projects in A.I.D./Washington's R&D/POP office: support for long-term contraceptive methods from the Association for Voluntary Surgical Contraception (AVSC), and assistance with population policy activities under the OPTIONS II project.

The FPHP project also supports policy dialogue with the GOG through a non-project assistance (NPA) or program component focussed on: fundamental policy and institutional changes to create a sense of national commitment and a supportive policy environment; and regulatory changes to remove constraints on public and private sector health workers and commodity suppliers.

B. Strategic Planning and Purpose of this Analysis

A.I.D./W's Africa Bureau has recently designated Ghana as a focus country, and R&D/POP, with the concurrence of the Mission, now includes Ghana as one of its priority countries. Consequently, the Mission estimates that between now and the year 2000, obligations for population activities may total $6 to 7 million a year through both bilateral assistance and AID/W funded activities. Thus, the Mission and the GOG must assess the current situation and make strategic choices concerning the magnitude and direction of their future joint activities in population. To facilitate this process USAID initiated a Population Sector Strategic Planning Analysis. The first phase of this analysis took place in February and March 1993 when the population sector strategy team convened in Ghana. The primary objectives of the scope of work for the team at that time included:

- identifying critical issues and gaps in knowledge;
- developing a preliminary outline of a strategic plan for an expanded country program; and
- building consensus among USAID and relevant Ghanaian policy makers and organizations on critical issues and future directions of the FPHP program.

During the next six months, a series of studies (listed in the analytical agenda in Appendix A) were implemented to provide additional information needed to revise and sharpen the focus of the draft strategic plan. Two of the studies in particular were of critical importance: the Family Planning Situation Analysis, implemented by the Ghana Statistical Service in collaboration with the U.S. - based Population Council, and the Consumer Baseline Survey, carried out under FPHP. The team reconvened in August 1993 to engage in a process of review and analysis of both the draft strategy and the additional data with key actors in population activities in Ghana in order to achieve consensus and ensure that the proposed future program directions are in line with and support areas and issues identified by the Government of Ghana as critical for the national population program.

The revised strategy contained herein will form the basis for developing the population/family planning component of a follow-on project that will overlap the current FPHP by approximately one year. The new project will build on and complement current

activities, as well as expand the program in new directions, as outlined in this strategy.

C. Methodology

In carrying out its work during phase one (February-March 1993), the sector strategy team reviewed a number of studies and evaluations on key service delivery topics; additional references were consulted during the second phase in August (all references are listed in Appendix B). When the team reconvened in August, they assessed the results of the several studies carried out during April-June 1993 in relation to the findings of February/March 1993 and the draft strategy. During both phases, team members met with policy makers, officials of various governmental and non-governmental groups that carry out population, family planning and health activities in Ghana, and representatives from other donor agencies, as well as with staff of the USAID Mission in Accra. Various team members discussed program activities with providers in Winneba and Cape Coast in Central Region, and in Accra and Dodowa in Greater Accra Region; attended population policy review workshops in Eastern and Central Regions; and participated in the multisectoral Strategic Planning Workshop organized by the National Population Council Secretariat, which was held in Akosombo in August 1993. (Priority activities/programs to come out of the Akosombo workshop are listed in Appendix C). A list of contacts is included in Appendix D.

To facilitate the strategic planning process, the team employed the typology developed by R&D/POP's Family Planning Services Division that classifies national family planning programs according to level of use of modern methods of contraception. A strong association has been found between national family planning policies and program environments and degree of modern contraceptive prevalence, resulting in distinct general patterns of family planning knowledge, supply and method mix at each level. This framework considers five phases through which family planning programs can progress:

. emergent (0 to 7 percent prevalence of modern methods)

. launch (8 to 15 percent)

. growth (16 to 34 percent)

. consolidation (35 to 49 percent)

. mature (50 percent or higher)

Generally, there tend to be direct relationships between modern method prevalence, socioeconomic development and family planning program development and characteristics. These characteristics include the range of sources of services, information and supply; the contraceptive method mix, i.e., short-term, long-term or permanent method; relative roles of public and private sectors in the provision of services.

The following is a brief sketch of the emergent phase (where Ghana was at the time of the last Demographic and Health Survey, 1988), the launch phase, through which the program has moved at an extraordinary pace, and the growth phase which the Ghana

program is about to enter (Appendix E gives a fuller description of all five phases of the framework):

Emergent Phase: During this stage, there is typically a great deal of policy work to build support for family planning programs and to remove legal constraints to the delivery of family planning services. Emphasis on provision of information and counseling is a critical part of service delivery. The method mix is largely composed of non-clinical (supply) methods such as condoms and vaginal foaming tablets. There is substantial financial and technical support from the donor agencies required at this early stage of a family planning program.

Launch Phase: Government and popular support for family planning build. There is usually a wide gap between knowledge and use, requiring a major effort to increase knowledge of specific methods and dispel myths/rumors about side effects and efficacy. National IEC campaigns are often an integral part of the program. Efforts are made to increase demand for more long term methods, and to continue demand generation among new groups for supply methods. Improved commodities logistic and management information systems emerge as necessary components for more effective program decision-making. Finally, the program expands into the private sector (commercial and non-profit).

Growth Phase: During this stage of a country's program, there continues to be an emphasis on the availability of different methods, particularly long term and permanent methods. Services have successfully reached urban and more educated segments of the population; demand generation and service delivery activities are reaching target groups such as adolescents, males, and post-partum women. Contraceptive social marketing and community based distribution play a major role in reaching these special groups. Because of the increasing emphasis and acceptance of clinical methods (injection, surgical contraception, IUDs) quality of care becomes a particularly important aspect of the program. There continues to be expansion of commercial support for family planning programs, and increased attention to the relative roles of government, private voluntary and commercial sectors.

The current FPHP originally was developed to carry Ghana through "launch" -- level 2 of the typology with a modern prevalence of 8 to 15 percent. Challenges at this level include broadening the institutional base and the client population, and providing better information and services. Thus, for the short-term, the team directed its attention to analyzing program needs and suggesting interventions designed to complement current FPHP activities in order both to ensure that the target of 15 percent modern method prevalence would be achieved by 1995, and to set the stage for moving the national program into the initial stages of the next level.

For the longer term, attention was directed towards developing a strategy that would move Ghana's program well into level 3 -- "growth" -- by the year 2000. At that level, modern method prevalence ranges from 16 to 34 percent; demand for services expands among non-urban and non-educated segments of the population, while all segments of the population are increasingly interested in longer-lasting and permanent

methods.

D. **Proposed Priority Areas**

In thinking strategically about both the short and the long-term objectives, the team identified six priority areas for which short and long-term interventions are recommended:

PRIORITY 1: Improve the policy environment for population programs through deepening political commitment to the national population policy at the national and local levels; developing support for the national policy among other public and private sector groups; strengthening the coordinating capacity of the National Population Council; and reforming the regulatory environment and customary practices.

PRIORITY 2: Promote public/private collaboration in the delivery of family planning/health services.

PRIORITY 3: Intensify support for demand generation and supply for non-clinical methods in line with the strategy called for under FPHP.

PRIORITY 4: Generate a climate of acceptance and demand for long-term methods, including retraining to improve provider knowledge, acceptance and support for these methods, and targeted IEC to encourage acceptance and trial of these methods by clients.

PRIORITY 5: Increase capacity in both the public and the private sectors to supply long-term and permanent methods of contraception.

PRIORITY 6: Foster technical as well as financial sustainability of population and family planning activities.

These priorities and proposed interventions are discussed in the following sections.

II. THE POLICY ENVIRONMENT

Strong political support often has been a key issue for development of national family planning programs.

The policy climate in Ghana for population programs has significantly improved over the past five years. Increased awareness of population issues at the highest levels of government and among opinion leaders has led to the creation of a National Population Council and the revision of the 1969 population policy. Continuing improvement in the policy environment, which will greatly facilitate program success, will include a deepening of the political commitment to the population policy objectives (at all levels), strengthening of the capacities of the NPC Secretariat, and some legal and regulatory reform. These processes being undertaken in a rapidly changing political and administrative setting, including a decentralization of authority and resources to the local levels.

The following sections review these changes and the current policy environment in Ghana, and identify constraints or areas requiring attention under USAID's population strategy.

A. The Changing Political/Administrative Setting

Two important political processes are occurring simultaneously in Ghana that will change the policy environment: democratization and decentralization. These processes are taking place during an upturn in the national economy that follows a period of severe structural adjustment during the 1980's. As a result of these dynamics the policy environment in Ghana can be characterized as very fluid.

The move toward a competitive multi-party political system has opened new opportunities for influencing government policies from many directions and is expected to result in more responsive government, while simultaneously creating new roles for various interest groups. This implies an increasing importance for civic education in order to ensure informed political participation.

In line with the democratization process and in an effort to make the government more efficient, the Ghanaian government is undergoing a process of administrative (as well as political) decentralization. Law 207 in 1988 established 110 districts, each with an elected District Assembly which will set and budget programs at the district level. Twenty two central departments and ministries are also being decentralized (a process assisted by a number of donors) and will eventually be responsible for implementing the decisions of the local assemblies. This decentralization process is ongoing and both the formal and de facto relations between the center, the regions, and the districts are still being defined.

Financial decentralization details remain under negotiation, but ultimately, each district is mandated to raise its own revenues, recruit and pay its own staff, and finance its activities with marginal support from the central government. To date, control over provision of services such as health care and education remains vested in the central

ministries which delegate to personnel at the lower levels. Nevertheless, the Ministry of Health seems to be in the vanguard of the decentralization process with the institution of Primary Health Care (PHC) program as the basis for delivery of health services. The MOH was restructured in July 1992 to place responsibility for service delivery at the regional and district levels, retaining policy development and technical assistance functions at the central level. In addition, the MOH has adopted its own plan to build up the capacities at the district level. District Health Management Teams have been established to assume greater district autonomy in setting priorities and delivering services, but the financing of programs has not devolved yet. Budget issues are discussed in more detail in Section IV concerning financial and technical resources.

The twin dynamics of democratization and decentralization will significantly change the population policy making and implementation environment in Ghana. These processes have the potential to contribute much to strengthening population programs in the country through increased local level participation in planning, implementation and monitoring of programs as well as through improved access to services at the community level. The implications of these dynamics must be considered carefully during this formative period so that population policy and program development both builds on and contributes to them.

B. Political Commitment to Population Policy

1. Background

Population issues have been discussed publicly in Ghana for many years. The population policy adopted by the Government in 1969 included clear fertility reduction goals and the establishment of a national family planning program administration. The Ghana National Family Planning Programme (GNFPP) was established in 1970 to serve as a coordinating department for the family planning programme within the Ministry of Finance & Economic Planning. However little fertility decline occurred for almost two decades. Reasons cited for the "failure" of Ghana's program as identified during a 1989 National Population Conference include: lack of a comprehensive national strategy for policy implementation; poor coordination among agencies; weak political commitment; low public awareness of population pressures and of health risks of high fertility; and the lack of popular involvement in the development of the policy and the related programs.

Despite the problems of the earlier population efforts, over the past five years there has been renewed interest in population issues, particularly fertility reduction. The President and the First Lady are vocal proponents of family planning, and Ghana boasts of a number of internationally known population experts who have also influenced the environment in the country. A series of conferences and workshops dealing with population issues and awareness raising efforts led by the Population Impact Project (PIP) of the University of Ghana (Legon) have contributed to high level political attention to demographic issues. The recent Constitutional clause requiring the establishment of a national population policy is an indication of this increased awareness.

Both the 1986 Legon Conference on Population and National Reconstruction and the 1989 National Population Conference of the University of Ghana (Legon) revitalized the population policy development process by identifying several problems which had hampered the successful implementation of the 1969 policy (as noted above), and by drafting a set of recommendations for a new approach to policy implementation. The "Legon Plan of Action on Population" and the 1989 Conference called for the establishment of a Population Policy Implementation Assessment Committee (PPIAC) to review population activities and to design an institutional structure for policy implementation.[1] In 1991, the PPIAC held a high-level seminar to stimulate debate and begin consensus building for the formation of a National Population Council (NPC). The NPC was established and formally inaugurated in November 1992 by the GOG as "the highest advisory body to Government on all population matters." The Social Sector Policy Unit (SSPU), Ministry of Finance and Economic Planning is currently serving as the interim secretariat for the NPC until a permanent secretariat is created and is leading the policy revision process as well as organizing the plan of implementation that should support the policy. The GNFPP and the district "population" officers who are in the field, will be absorbed into the NPC secretariat structure.

The draft revised national population policy, which is currently being reviewed in a series of regional and national meetings and workshops, contains many of the components of the previous policy, including targets for fertility decline. However, it differs from the previous policy in that it sets up a stronger policy implementation framework to support not only fertility decline but also broader demographic and social objectives.

The Ministry of Health is increasingly committed to family planning programs as indicated by the emphasis on MCH/FP in the recently adopted health policy for the 1990's (MOH, January 1993). The policy's top priority is decentralizing health management to lower levels. Third and fourth listed priorities are to "intensify maternal and child health services and family planning for the maximum reduction of preventable and avoidable maternal and infant morbidity and mortality," and to "support effective implementation of population control strategies within the framework of the National Population Policy."[2]

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[1] During the 1989-91 period, the PPIAC was supported by UNFPA.

[2] It must be pointed out, however, that the ministry budget shows that, unlike other health programs, family planning inputs are largely supported by donors. With the assurance of continued donor support, it is unclear whether (or why) the government will increase its own inputs into the sector. This issue is addressed directly in Section IV.

2. Policy Implementation Structure: The National Population Council and Secretariat

The recently established NPC is mandated to: review, revise and interpret the population policy; guide implementation of the policy; set operational targets for program performance; ensure the full participation of the private sector; coordinate and monitor all population programs and activities; and represent the Government to donors and the international community. The Council is made up of twenty-one persons representing a number of government agencies, institutes of higher education, non-governmental and religious organizations, people serving in their individual capacities and is chaired by Professor Fred Sai, an internationally-known expert in population and family planning.

The Secretariat of the NPC will serve as its executive arm, and will provide technical and administrative support to the Council, guide and coordinate the preparation of plans of action for policy implementation, and establish and operationalize a national system for research, evaluation and monitoring of population programs. In addition, the Secretariat is to: promote the integration of population factors in development planning; maintain a population data bank to promote exchange of information; promote the development of human resources to support policy implementation; liaise with donors and coordinate their resource input; publish a semi-annual newsletter and an annual Population Report; and generally provide national leadership on population issues.

The proposed Secretariat will have the status of a parastatal organization and will have six units and five associated technical advisory committees. The TACs include:

1. Research, Coordination, Monitoring and Evaluation
2. Population Information, Education, and Communication
3. Family Planning Services
4. Training
5. Population Policy and Programs

The sixth unit of the Secretariat is Administration/Personnel. A Technical Coordinating Committee is designed to coordinate the work of the TACs.

In its capacity as interim Secretariat, the SSPU is currently conducting a number of activities. One "stream" of activities is organized around reviewing and revising the population policy, with financial and technical assistance from the UNFPA. Policy revision activities are projected to continue through December 1993 by which time it is expected that the revised policy will have been adopted by Government.

The SSPU is also reviewing a study prepared by the Ghana Institute for Management and Public Administration (GIMPA) which recommends structural and personnel arrangements for the permanent Secretariat. It is expected that a permanent Secretariat will be established by December, 1993. In the meantime, the interim secretariat will carry on the work of recruiting temporary staff and establishing the office protocols and physical premises.

In the area of sectoral coordination, the five Technical Advisory Committees were been inaugurated in July 1993. A planning workshop for line ministries and NGO's was held in August (1993) in Akosombo to set priorities for policy implementation and establish a spirit of collaboration between the agencies. This workshop was the beginning of a series of NPC/Ministry/NGO consultations which will result in developing a population plan of implementation.

3. Regulatory Environment and Customary Practices

In Ghana, as in most countries, increasing attention is being given to the quality of services provided. Nevertheless, certain restrictions designed or intended to ensure high quality have the effect of limiting access to family planning services without necessarily improving quality. Such restrictions have come to be referred to as "medical barriers." These restrictions are imposed on the individual in the name of quality of care, because of a "perceived" medical risk, or more typically because of lack of knowledge about the latest contraceptive technology. These restrictions can appear as inappropriate eligibility criteria, misinterpretation or overstatement of a medical contraindication, restrictions on who can provide certain methods, process hurdles such as repeat medical examinations or laboratory tests, and provider biases to name a few. Taken together, these restrictions can prevent women who choose to plan their families from receiving the care they seek. Currently, there are no regulatory constraints which prohibit dispensing of contraceptives according to age, marital status, or partner's consent. However, clinical guidelines suggest that family planning is for married couples.

In order to achieve the population policy objectives related to fertility decline--increases in contraceptive prevalence through improved, expanded family planning services and IEC--there will need to be a number of legal and regulatory reforms. There are currently restrictions--both legal and normative--on who can provide services and supplies as well as on the availability of methods. These restrictions (both legal and "bureaucratic") must be reviewed and revised in conformity with the population policy goals. Customary practices supporting high fertility must also be assessed and changed where possible. The GOG has already undertaken a number of reforms which should improve supplies of contraceptives in the private sector, including the decontrol of prices. A study to support the reclassification of low-dose oral contraceptives is underway under the policy reform component of the current bilateral USAID project.

4. Current Issues and Constraints

Political Commitment

Although there are clear indications that political support for population programs is improving in Ghana (and there has been little organized opposition), the political commitment must become much deeper throughout all levels of the political system in order to support a strong population and family planning program. Some policy makers, community leaders, and even health service providers are uninformed (or misinformed) about family planning and other broad population issues. Such commitment and

awareness must be increased significantly if expanded population programs are to be successful.

Broadening participation in the policy revision/implementation process will: (1) improve the policy itself by ensuring relevance to concerns beyond the center as well as broad social and cultural acceptance; (2) establish a sense of "ownership" among a wider set of actors (geographic, ethnic and religious groups, districts); and (3) facilitate successful implementation through mobilizing support of the bureaucracy and significant social groups.

Policy Implementation: NPC Institutional Development

Effective policy implementation will require a technically capable NPC Secretariat that can provide leadership for the overall program and facilitate and coordinate program efforts. The NPC Secretariat has been given the mandate to conduct a very ambitious program over the next few years. The Secretariat must: review, revise, and publicize the national population policy; establish networks of expertise in the various program areas (TACs);translate goals into recommendations for resource allocation; develop/deepen political commitment and establish NPC credibility; mobilize social and administrative support for policy/program; legitimize public and private activities; coordinate programs and activities across ministries; and foster linkages with district levels. These activities require a large pool of analytic and technical skills which must be identified or developed as well as sustained technical assistance until this capacity is built.

One key constraint to program coordination and policy implementation is the interim nature of the Secretariat in which SSPU staff are responsible for both NPC activities as well as SSPU duties. This overload of responsibility, as well as insufficient staffing, has resulted in much pressure put on the interim secretariat. The interim Secretariat has good support from the Population Impact Program (PIP) at the University of Ghana (Legon) for many of its activities, but PIP also is understaffed considering its workload. Upon creation of the permanent Secretariat (expected in December, 1993), these staffing issues should be resolved. However, the responsibilities of the Secretariat will be diverse and will require a large pool of analytical, technical and political skills which, as noted, will take some time to create.

A second issue is the need to develop strong, supportive working relationships among the ministries and involved agencies and the NPC/Secretariat. At this time there are, understandably, inconsistent perceptions of the respective roles of the ministries and NPC Secretariat as a coordinating body. It is clear that it would be helpful for some of the major actors involved to visit other countries where an NPC-type agency is performing the functions delegated to Ghana's NPC and to see how such relationships and coordinating mechanisms develop.

Another key issue is that of Secretariat support for policy implementation at the regional and district levels. The Secretariat should, ideally, be able to assist the districts and provide leadership and guidelines for district population coordinating groups. In order to achieve this, NPC itself should have (or have access to) the financial resources and analytical and technical capacity to provide such assistance. In addition, linkages to

the district level from the NPC must be strengthened.

Regulatory Constraints and Customary Practices

To date, some attention has been given to legal and regulatory practices, as well as customs that constrain wider access to services, Nevertheless, additional work is required. Results from the just-completed Family Planning Situation Analysis suggest the presence of provider bias in service delivery in Ghana, a phenomenon whereby practitioners will not provide certain methods at all or not provide them to certain categories of clients because they are misinformed about the safety or efficacy of the method.[3] While taking medical history and blood pressure are certainly in order, urine and blood tests are considered unnecessary prior to providing hormonal methods. Not only does this practice increase the cost of service delivery to both the provider and the client, it creates a process hurdle for the potential client. Table 1 shows the percent of providers interviewed in the Ghana Situation Analysis who reported that they conducted certain tests prior to administering a particular method. Nearly half of all clients wishing to use oral contraceptives or injectables are given blood and/or urine tests. Similarly, pelvic exams, unless warranted by a condition noted in the medical history, should not be required for pill or injectable use.

Table 1: Percent of Staff Conducting Medical Tests by Contraceptive Method Type

TEST	Pill	Injectable	IUD
Medical history	98	98	93
Blood pressure	98	98	94
Weight	90	90	90
Pelvic exam	45	46	89
Breast exam	85	85	93
Urine test	43	44	45
Blood test/hemoglobin	55	56	51
STD screening	26	27	4

Source: Ghana Statistical Service and the Population Council, N.Y., N.Y. Ghana Situation Analysis, 1993

Table 2 shows provider biases regarding eligibility for method use. Nearly 90 percent of the providers interviewed would not provide *any method* to a woman with fewer than three children. Many providers would not provide family planning to unmar-

[3] The Ghana Statistical Service, with technical assistance from the Population Council (a USAID contractor) conducted a Family Planning Situation Analysis in May 1993. Nearly 400 facilities were visited and inventoried, with over 650 interviews with family planning clients, over 1600 interviews with MCH clients, 783 staff interviews, and observations of the client/provider interaction.

ried clients or without the spousal consent of the married clients.

Table 2: Provider Eligibility Restrictions on Method Use by Method and Restriction

METHOD	PARITY[a]	MARITAL STATUS[b]	SPOUSAL CONSENT
Progestin-only pill	85	26	31
Combined pill	87	27	40
Condom	83	5	35
VFTs	86	5	34
IUD	90	44	36
Injectable	88	39	32

Source: Ghana Statistical Service and the Population Council, N.Y., N.Y. Ghana Situation Analysis, 1993

[a] percent of providers who will not provide method to women with fewer than three children
[b] percent of providers who will not provide method to unmarried women.

There are also age restrictions placed on provision of certain methods:

- 10 percent of providers cited 20 as the youngest age they would provide the injectable; another 12 percent said the lowest age would be 25; a further 10 percent reported that the lower age limit was 30
- 25 percent of providers would not provide foaming tablets to clients under 18
- 65 percent of providers would not provide the progestin-only pill to women over 35.

Process hurdles are medical procedures which actually result in denied access or high discontinuation rates. Provision of one cycle of oral contraceptives per visit or requiring a brief medical exam, *even if the client is a continuing user with no adverse side effects or complaints,* can result in a client suspending use of the method. Similarly, restrictions on who can provide certain methods may result in fewer users. For example, the team questioned the restrictions prohibiting trained TBAs, for example, from resupplying pills when women can purchase orals from a chemical seller.

Inappropriate eligibility criteria can also severely restrict clients from obtaining services. It was noted that some providers are more willing to provide services to unmarried clients than to married clients without spousal consent, while other providers were reluctant to provide services to young or unmarried women at all. Some of these

practices relating to eligibility criteria arise from rumors and misconceptions e.g. the delayed return to fertility thought to be associated with injectable use.

These are simply examples of the current restrictions--legal, regulatory or customary--that must be addressed to ensure wider access to services, as well as a broader range of methods.

C. Priorities/Recommended Interventions

PRIORITY 1: Improve the Policy Environment

Proposed Interventions	
Short Term	Long Term
Deepen Political Commitment	
Regional RAPID models	
RAPID activities with target groups.	
Create a population policy support group among parliamentarians	District level workshops/focus groups to guide FP/DEC strategy process
Multi media IEC activities intensified and special targeted campaigns.	Multi-media IEC activities continued
Observational travel for opinion leaders.	
Develop presentation on FP/MCH relationships and workshops for key provider groups	
Strengthen coordinating capacity of NPC	
Observational travel for NPC, policy makers.	RAPID-type presentations in line ministries and NGOs
Increase training of NPC staff	
Strategic Planning workshops with ministries and TACs.	Assessment of alternative center-district linkage mechanisms
Review of the implications of decentralizing for population program implementation	
Transfer MIS developed under FPHP to secretariat	
Secondary analysis of DHS	

Reform of Regulatory Environment and Customary Practices	
Review legal and regulatory constraints to policy implementation and development of reform strategy	
Assess appropriateness of provider certification criteria	
Develop service delivery/training guidelines	
Improve knowledge of providers through in-service training and workshops	Continue training of providers through in-service training and workshops
Conduct contraceptive technology updates for service providers, policy makers and media	Continue to conduct contraception updates
Conduct research to validate safety and efficacy for providers and policy-makers of proposed change in regulations.	

There are a number of ways in which the policy environment for population programs needs to be strengthened at present in Ghana, through the NPC and through activities with key agencies and organizations in both the public and private sectors. Specific areas that the team recommends for attention under this priority include the following:

- deepen political commitment to the national population policy at the national and local levels, and develop support of the national policy among other public and private sector groups;
- strengthen the coordinating capacity of the National Population Council; and
- reform the regulatory environment and customary practices.

Proposed Interventions

Deepen political commitment

It is critical for long range program success that there be broad participation in, and consensus about the revision of the national population policy so that it is not perceived as imposed from above or unrelated to the experience and concerns of people in the districts. The NPC (with UNFPA/USAID support) has held four regional workshops to review the policy and PIP (with OPTIONS II and RAPID IV support) is undertaking a series of awareness-raising activities at the regional/district level. The team recommends that these activities be supplemented (even after the adoption of the revised policy) with additional activities to raise awareness of population issues among the general public and

special target groups (religious groups, parliamentarians, line ministry staff, etc.) in order to strengthen the policy consensus.

In particular, as the district assemblies will be more responsible for setting program and budget priorities in the future, local leaders, interest groups, and planners (and the public) must be educated about the importance of population programs so that they can make informed decisions regarding program support and administration. Thus, the team recommends that IEC programs, both general population awareness and for family planning, be developed that are tailored to local conditions (and in local languages) in order to improve their effectiveness. These are but a few examples of the awareness raising activities that the team believes will be needed to ensure program success at the district level.

Deepening the political commitment to population programs will involve a variety of activities in the near term in order to set the stage for future program success. The team, noting that awareness-raising must be intensified at the national and local levels, recommends the following interventions:

- RAPID activities with additional target groups
- Regional RAPID models (and dissemination of model information at the district level)
- Creation of a population policy support group among parliamentarians
- District-level workshops/focus groups to guide appropriate FP/IEC strategies
- Presentations on FP/MCH relationships (focussing on comparative risks) and workshops for key provider groups (esp MOH)
- Intensification of multi-media IEC activities and special targeted campaigns
- Observational travel for key "unconvinced" opinion leaders

Strengthening Leadership and Coordination Capacity of the NPC Secretariat and Institution-Building with Other Organizations

Investment in building a strong institution to advocate for, guide and coordinate population programs will result in substantial returns. A professionally respected, politically influential Secretariat will be able to motivate all other aspects of the program, facilitate the work of the involved ministries and agencies at all levels, and coordinate activities so that efforts achieve synergy. Technical assistance provided from USAID centrally funded projects, and UNFPA, intensive in the early stages, can gradually be phased out as the Secretariat develops capacity--thus achieving a measure of technical sustainability prior to other program components. NPA funding may be able to be used to "leverage" government and other donor inputs into developing program implementation

capacities at the district and subdistrict levels.

Support for institution-building at NPC and other organizations, and for policy implementation should include:

- Structured observational travel for NPC, policy-makers and key opinion leaders
- Increased training of NPC staff
- Strategic planning workshops with ministries and TACs
- Targeted RAPID-type presentations in line ministries and NGOs
- Assessment of alternative center-district linkage mechanisms
- Review of the implications of decentralization for population program implementation (training, finances, monitoring, data needs for planning, MIS, IEC, logistics, role of NGOs and private sector, supervision, evaluation)
- Transfer of Management Information Systems developed under FPHP to Secretariat
- Secondary analysis of DHS to segment target groups for IEC and service delivery activities

Reform of Regulatory Environment and Customary Practices

There is much that can be done to increase access to family planning by removing medical barriers and improving the image of contraception. Examples of these types of impediments occur throughout the family planning services systems in Ghana, as discussed in the previous section. The examples identified may not exist in every region, or at every level of care. Nevertheless, to address the issue of legal and regulatory reform, the team recommends a thorough review of guidelines for the delivery of services, which in turn might form the basis for reconsideration of the material presented in various training curricula.

- Review legal and regulatory constraints to policy implementation and development of a reform strategy
- Assess appropriateness of provider certification criteria
- Improve the knowledge of providers through in-service training and workshops
- Conduct research to validate safety and efficacy for providers and policy-

makers of proposed changes in regulations

- Develop service delivery/training guidelines
- Conduct contraceptive technology updates for service providers, policy makers and the media

PRIORITY 2: Promote Public/Private Sector Collaboration

Proposed Interventions	
Short Term	Long Term
Exchange of workplans between public and private sector organizations	Continue to ensure that activities in the public and private sectors are complementary to one another
Ensure that in-service training is conducted jointly (public/private sectors)	
Develop common service delivering guidelines and protocols	
Address inappropriate regulatory barriers to service delivery in the private sector	

In Ghana, the lines between the public and private sector delivery of family planning products and services are not rigid. Public sector products are purchased at subsidized prices by private sector midwives and resold at those same prices to family planning clients. In some cases, private hospitals take the place of public hospitals in serving remote clients. Private doctors must serve in the public sector before being able to open a private practice. However, though there is mutual support between these two sectors, there is currently limited opportunity for active collaboration and strategic planning which would increase the efficiency of this collaboration.

A more effective public/private sector collaboration is essential to efficiently direct both public and private sector resources to be maximally effective. Efforts have already been initiated in some regions to open discussions between public and private providers. The team recommends that The National Population Council can provide a mechanism to define areas for coordination and collaboration. The NPC is also an appropriate forum for the development of a strategy for NORPLANT introduction and roll-out, for example.

The NPC should take on the task of coordinating many of the initiatives suggested by this strategy including Community Doctors and Midwives Program, insurance schemes, employer financed systems, and other pilot private sector delivery mechanisms. The NPC can then ensure that the new initiatives will complement and not disrupt current effective public delivery systems. For example, the MOH can select target sites and regions for the community doctors/midwives pilot programs which would not conflict with Ministry of

Health programs. NPC could continue to play a coordinating role.

Additionally, the NPC can provide a forum for the Ministry of Health to approve the parameters of private sector initiatives financed under FPHP and the new project, without having to be involved in their day to day management. The NPC can facilitate the development and extension of private delivery systems by ensuring that private doctors and midwives have access to training, equipment and supplies necessary to deliver family planning services in accordance with MOH regulations.

III. SERVICE DELIVERY

A. Current Status

1. Demand for Modern Contraception

In 1988, the Demographic and Health Survey (DHS) found that use of contraceptive methods overall in Ghana was very low at less than 13 percent; use of modern contraceptives was only 5.2 percent. The 1993 FPHP Consumer Baseline Survey (CBS), however, suggests that considerable gains have been made during the past five years. The CBS found current use of modern contraceptives among married women had increased significantly to 14.9 percent. This prevalence was strongly weighted towards temporary methods (Figure 1). Among currently married family planning users 5.9 percent use the condom and 5 percent use the pill. Vaginal foaming tablets are used by only 1.9 percent, injections by 1.8 percent, IUDs by 0.8 percent, and female sterilization by 0.3 percent of married women (Fig 1).

Moreover, the study found that 14 percent of all women were currently using modern contraception and that 12 percent of them had used modern contraceptives for over three months and 9 percent had used them for over a year.

In 1993, somewhat more than one-quarter of currently married women in Ghana do not want more children. Though this is about the same proportion as in 1988, the proportion of married women who report being undecided about whether to have another birth has doubled from 9 percent in 1988 to 19 percent in 1993 (Consumer Baseline Survey). The proportion of women older than 35 who want no more births also increased from 45 to 53 percent. Among women with four or more children, the proportion who do not want more children increased from 45 to 60 percent between 1988 and 1993.

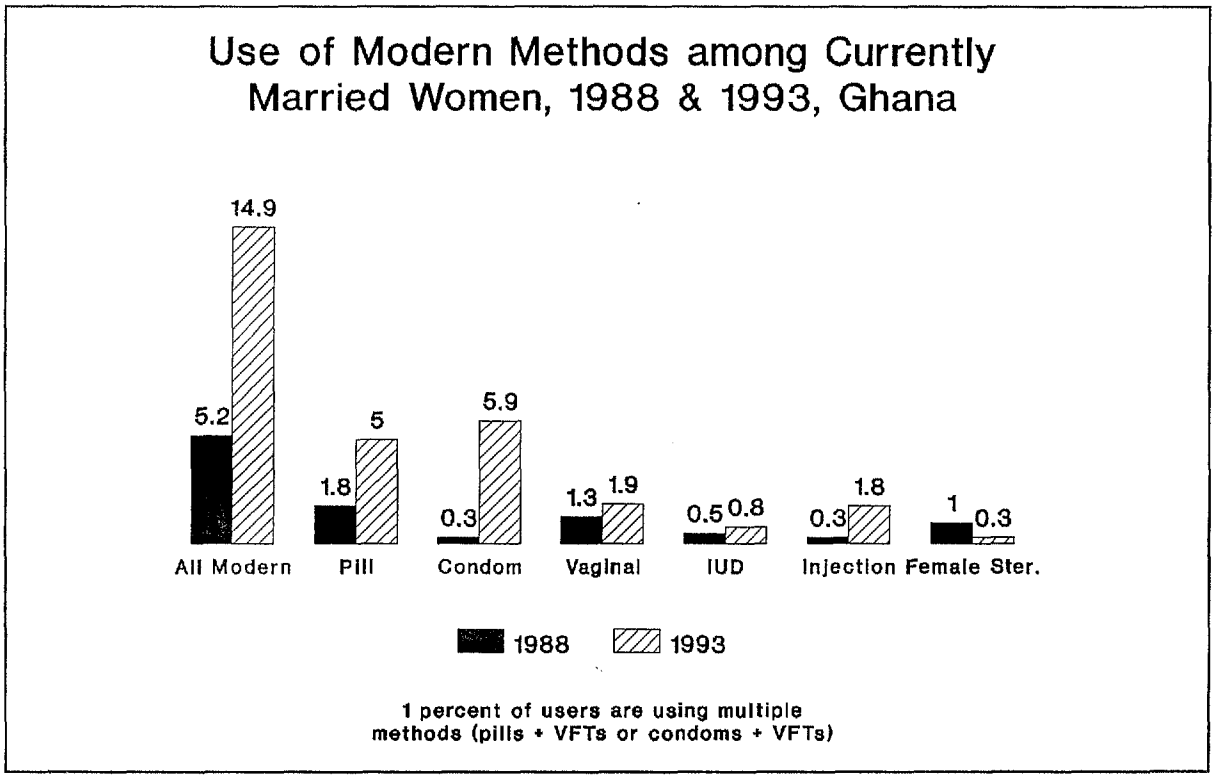

Figure 3

Source: 1988 Demographic and Health Survey, Ghana;Ghana Statistical Services and IRD/Macro Systems. Consumer Baseline Survey, 1993; Futures Group.

In order to increase demand and thus expand the use of effective Contraception, potential users must move along a continuum from awareness and knowledge, through interest/motivation, trial and assessment to retrial/commitment. The data indicate a significant improvement in the pattern of contraceptive use, essentially achieving the FPHP target of 15 percent for married women, as well as a notable shift in attitudes towards further childbearing. Nevertheless, contraceptive prevalence in Ghana remains relatively low, raising the question of how far along this continuum Ghanaian women are willing to move.

Though attitudes toward family planning in Ghana are generally positive, awareness of individual methods among all women as reported in the 1993 baseline remains relatively low (Figure 2) ranging from 10 percent for male sterilization to 34 percent for IUDs, 65 percent for orals, and a high of 70 percent for condoms. Condom awareness has increased to 70 percent from only 49 percent reported in the 1988 DHS (Fig 2).

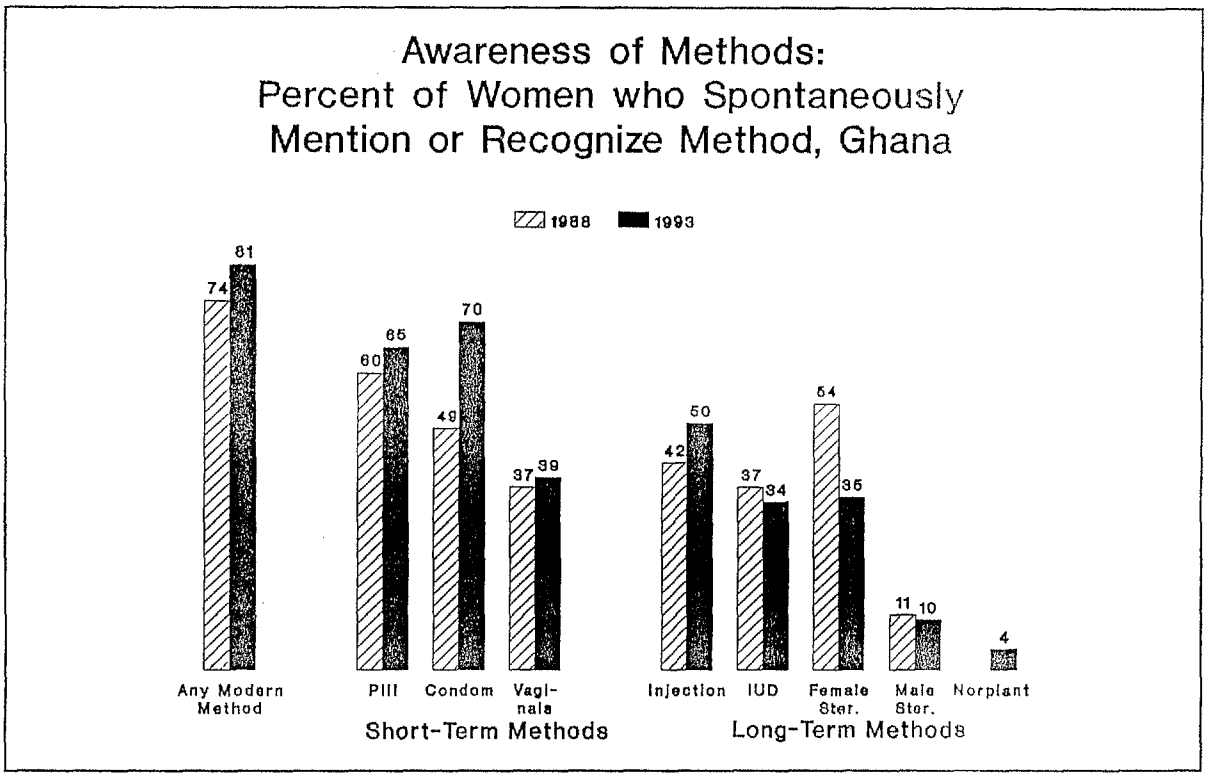

Figure 4

Source: 1988 Demographic and Health Survey, Ghana;Ghana Statistical Services and IRD/Macro Systems. Consumer Baseline Survey, 1993; Futures Group.

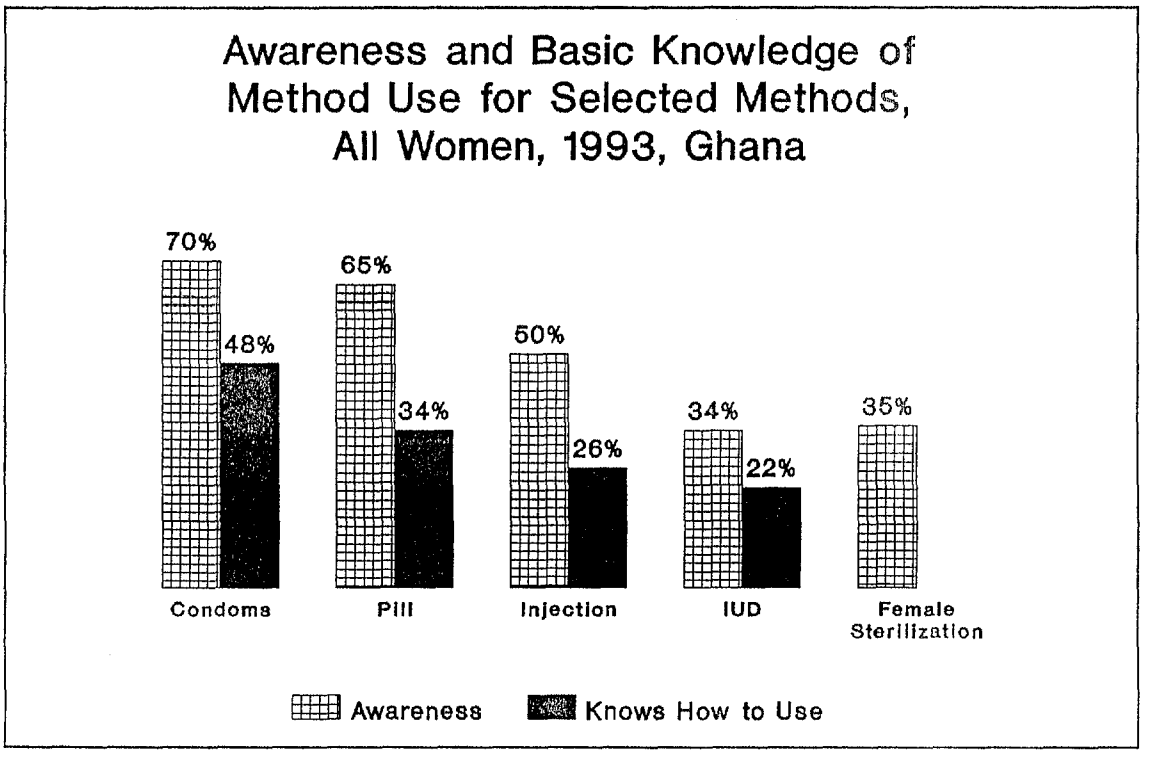

Figure 5

Source: Consumer Baseline Survey, 1993; The Futures Group.

As shown in Figure 3, basic knowledge of individual methods lags even further behind awareness. Though 70 percent of all women are aware of condoms, only 48 percent know how to use them. Similarly, knowledge of use of pills is only 34 percent, of injections 26 percent, and of IUDs 22 percent.

Lack of awareness and knowledge of individual methods continue to be major barriers to use. Thirty-five percent of never users state that they are not using contraceptives due to lack of knowledge; 14 percent cited fear of side effects as a reason for non-use (Fig 4).

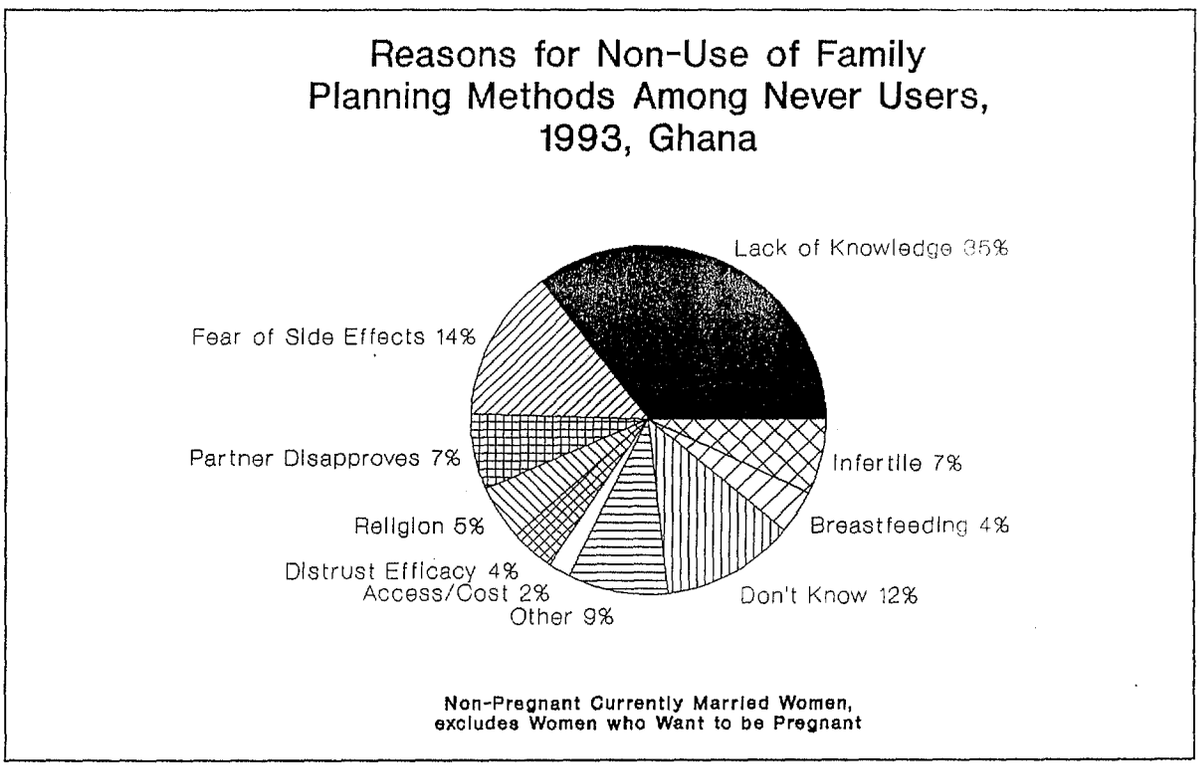

Figure 6

Source: Consumer Baseline Survey, 1993, The Futures Group.

Another factor that is particularly important in Ghana is the extent to which husbands or partners are knowledgeable about, or approve of the use of contraception. There is general consensus in Ghana that, to date, men have not been adequately involved in the family planning program, with the exception of the promotion of condom use. Figure 4 shows that 7 percent of married women who have never used a method report partner disapproval as the reason. Data from the Situation Analysis show that 16 percent of MCH clients do not know whether their partner approves or disapproves of family planning, suggesting it has not even been discussed.

In addition to inadequate information about specific methods, there is also a lack of knowledge of sources for contraceptives. Only 47 percent of all women know that condoms can be obtained from pharmacies; only 28 percent know that pills can be obtained there. Similarly, only 32 percent mention MOH clinics as a source of condoms and 33 percent of women mention MOH as a source of pills.

Once women have a positive attitude toward family planning, and are aware and knowledgeable about methods and their sources, they can proceed to try the methods, evaluate that trial, and, if the trial is successful, continue to use the method. This process is greatly facilitated by the involvement and approval of their partners. In Ghana, as a result of the low levels of awareness and knowledge, trial of modern methods (ever use) has been limited. As shown in Figure 5, for all women, trial of any modern method is 32 percent, ranging from 1 percent for IUD, and 3 percent for injection to 5 percent for vaginal foaming tablets, 12 percent for the pill and 18 percent for condoms. Current use ranges from 6 percent for the condom and 4 percent for the pill to 2 percent for vaginals and 1 percent for the IUD (Fig 5).

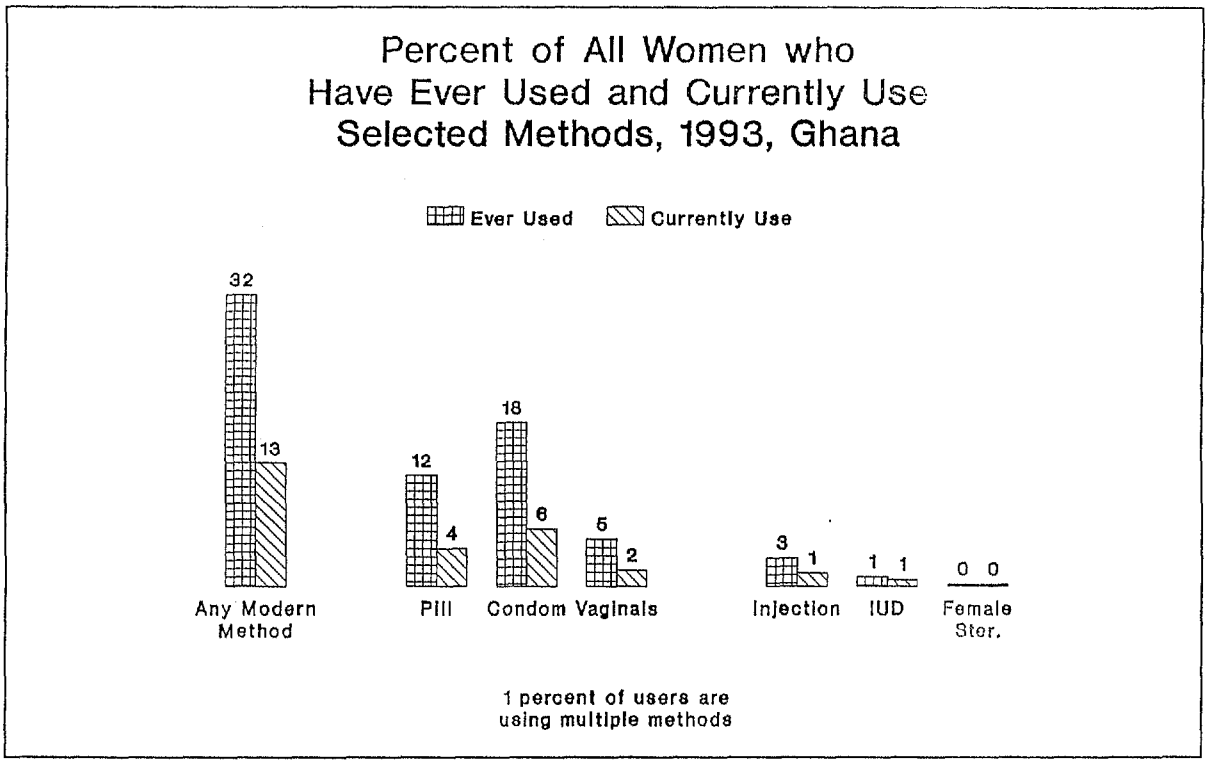

Figure 7

Source: Consumer Baseline Survey, 1993, The Futures Group.

2. Supply of Methods and Services and Quality of Care

Demand for contraceptives is only half of the equation, of course. Consistent use of family planning also depends on the supply of methods, including both commodities and the availability of trained providers. Availability of a wide range of methods is a key aspect of quality of care. This can be hampered by provider biases or other regulatory or customary factors (discussed in Section II) of by the lack of supplies or trained personnel to provide specific methods. Expanded availability of methods means that appropriate methods are available for couples at every stage of their reproductive lives. From a programmatic standpoint, the methods available and the mix of methods used by couples also have implications for program costs and for impact on fertility.

While the tripling of modern method contraceptive prevalence that Ghana has recently experienced is an outstanding achievement, without a concomitant change in method mix, there will not be a corresponding decline in total fertility rate nor a slowing of the population growth rate. The method mix in 1988 (DHS) and 1993 (Consumer Baseline Survey) are shown below:

	1988 %	1993 %
Condoms	0.3	5.9
Injectables	0.3	1.8
IUD	0.5	0.8
Oral Contraceptives	1.8	5.0
Vaginal Foaming Tablets	1.0	1.0
Other vaginal methods	0.3	--
NORPLANT	--	--
Female Sterilization	1.0	0.3
TOTAL	**5.2**	**14.8**

As can be seen there has been a twenty-fold increase in condom use, a six-fold increase in injectable use and a three-fold increase in oral contraceptive use. The clinical methods such as IUDs, NORPLANT and female sterilization have remained essentially the same. In the public sector at present, motivation for family planning counselling and contraceptive methods are available at all MCH/FP service delivery points (SDPs). However, surgical contraception is available only at seven regional hospitals, while NORPLANT can be obtained only at two sites.

Further information on availability of methods and method choice is found in the results of the Situation Analysis:

- 21 percent of new clients indicated a method preference; 26 percent of new clients were asked by the provider if they had method preference

- 33 percent of new clients reported that they did not receive the method that they preferred; 28 percent of these clients reported that they were disappointed

- 17 percent of new clients reported that the method they received was the only method that was discussed with them during the consultation

At present, there are over 6,000 service delivery points in Ghana, and an additional 12,000 individuals such as traditional birth attendants, outreach workers and community based distributors who provide family planning services and commodities. Under FPHP, the number of service delivery points covered by the Ghana Social Marketing Foundation (GSMF) has risen substantially from 3,000 in 1992 to 5,000 in 1993 with an expected increase of 2,000 per year.

With respect to deployment of staff, MCH/FP manpower policy has not been successful. Despite decentralization efforts, as of 1992 Greater Accra had 70 MCH/FP

professionals above that required to meet the national average staff to population ratio of 1:41,348. Similarly, disparity in the distribution of Community Health Nurse Midwives persisted, with disproportionate concentrations in Eastern, Greater Accra and Volta regions.

The 1992 Annual Report of the MCH/FP unit reports that, despite increases in the number of SDPs there continue to be problems with poor continuity and underutilization of services. A major factor is the quality of care. Factors such as availability of services, provider attitudes, and lack of skill may play a role in mitigating the significant improvements in family planning service coverage that have been achieved in Ghana.

Many quality of care issues that affect access and utilization of services can be examined using data from the Situation Analysis. Selected findings are presented below:

Counselling skills:

- 33 percent of new clients report that they were not given information about side effects of the method accepted
- 39 percent of clients report that they were not told about switching to another method if they had problems
- 23 percent of new clients report that they were not told how to manage side effects of the method accepted
- 26 percent of new clients were asked whether they had a method preference
- 44 percent of providers were not willing to provide information and counseling on AIDS to family planning clients

Technical competence:

- 11 percent of providers indicated that they knew of no major problems associated with pill use requiring return to the clinic; 13 percent reported no such medical problems associated with IUD use or injectable use
- in 33 percent of pelvic examinations, the provider did not wash hands before the examination

Acceptability of services:

- the average visit was 17 minutes long
- other family health issues (including AIDS) were discussed in fewer than 13 percent of the client/provider interactions
- 25 percent of providers did not mention condoms as a way to avoid AIDS

However, over 90 percent of the clients felt that they received the information and services that they wanted, felt that the time spent with the provider was sufficient, and

found that the provider had answered all questions about family planning to their satisfaction.

Mechanisms to encourage continuity:

- 19 percent of continuing pill clients coming for *resupply* and given pills during the visit were given only one cycle; 14 percent were given two cycles; 61 percent were given three cycles

- 33 percent of facilities providing the progestin-only pill had a stockout in the past six months; this figure was 18 percent for facilities providing VFTs and 11 percent for facilities providing condoms; 8 percent for both combined pills and IUDs; and 4 percent for injectables

Recommendations:

In a short five years, the family planning program in Ghana has moved from the "emergent" level, in which modern method prevalence is 0-7 percent to the launch phase (modern method prevalence 8-15 percent) and over the course of the next five years will be well into the "growth" phase. The "launch" phase of a family planning program is one in which political and popular support for family planning grows while customary practices which impede service delivery are changed. Method choice expands to include longer acting and permanent methods of contraception, but this must be done carefully in conjunction with IEC efforts to address consumer attitudes and knowledge about these methods. At that level, the private sector takes on an increasingly important role in complementing the services already available in the public sector.

A program in the "growth" phase, which will be the target of the follow-on project, concentrates on expansion of services and quality of care, while integrating these services into already existing programs. The push is toward a method mix with a greater proportion of more effective methods (IUDs, injectables, NORPLANT and surgical contraception) and expanding the availability of non-clinical methods to low income consumers and hard to reach clients in the rural areas.

To accomplish this, the team is proposing a method mix which emphasizes the more effective, long term and permanent methods of contraception. The target is to have these methods comprise 40 percent of the method mix. The following shows the projected method mix for the year 2000.

Condoms	6.75 %
Injectables	6.25
IUD	2.25
Oral Contraceptives	6.75
Vaginal Foaming Tablets	1.5
NORPLANT	0.25
Female Sterilization	1.25
TOTAL	**25.0**

Details of the TARGET MODEL which was run to arrive at these figures are given in Appendix F.

B. Constraints/Issues

Overall, the team identified several service delivery gaps in the current program which would benefit from additional resources. The first is a program for adolescents which would provide *services* in addition to information and counseling. These services should be provided in a setting which is outside the usual MCH/FP context, providing maximum privacy to the teen. As a first step, the team recommends that a small study be undertaken which examines adolescents attitudes, needs and desires concerning family planning services.

Post-abortion/post-partum services receive little emphasis at present. There are many missed opportunities to educate women about family planning during this period. The situation analysis found that 47 percent of family planning clients have had an unwanted pregnancy and 50 percent of these women have had an abortion. Of 1,397 women visiting MCH facilities and interviewed, 62 percent have never used a family planning method. Of those who are currently using a method, many were not aware that family planning was available in *the same service delivery site that they were in for MCH services.* Elsewhere in this report, it is recommended that training for post-partum IUDs be added to the clinical training received by nurse midwives and private physicians.

Third, the rural areas are somewhat underserved. Programs which will attract providers to these rural areas and the use of CBD workers (TBAs or others) are recommended. Programs should look at the best candidate in a community to be the CBD (not necessarily the TBA). The market women programs currently in urban areas should be enhanced as another way of reaching those living in rural areas.

In assessing the current demand and supply for modern contraceptives in Ghana, it is necessary to consider clinical (surgical contraception, IUDs, injectables and NORPLANT) and non-clinical (pills, condoms, VFTs) methods separately. Demand and supply for contraceptives obviously have to be built in a coordinated fashion. However, the level of demand and the supply infrastructure vary for the different types of methods. For example, the distribution systems are more developed for non-clinical methods than for clinical methods because the previous USAID family planning project--the Contraceptive Supplies Project-- focused on building demand and delivery mechanisms for non-clinical (supply) methods.

1. Non-Clinical Methods

a. Constraints to Demand for Non-Clinical Methods

Lack of information on temporary methods is a major constraint to trial and use. In more urban settings, especially in the south, where women are more educated and there is greater acceptance of modern contraceptives, evidence suggests that improving knowledge of products and increasing awareness of sources has a positive impact on prevalence. Service statistics in districts that had information campaigns indicate an increase in awareness and trial of modern contraceptives as a result of the campaign.

Thus, it is important to provide proactive outreach, where women are sought out to be given information, support and access rather than waiting for women to seek out the information, products and services.

The difference found in the baseline between trial and current use also indicates that there is substantial discontinuation. Former users report that they are not contracepting because of lack of knowledge, as well as because of fear of side effects and partner disapproval (Fig 6).

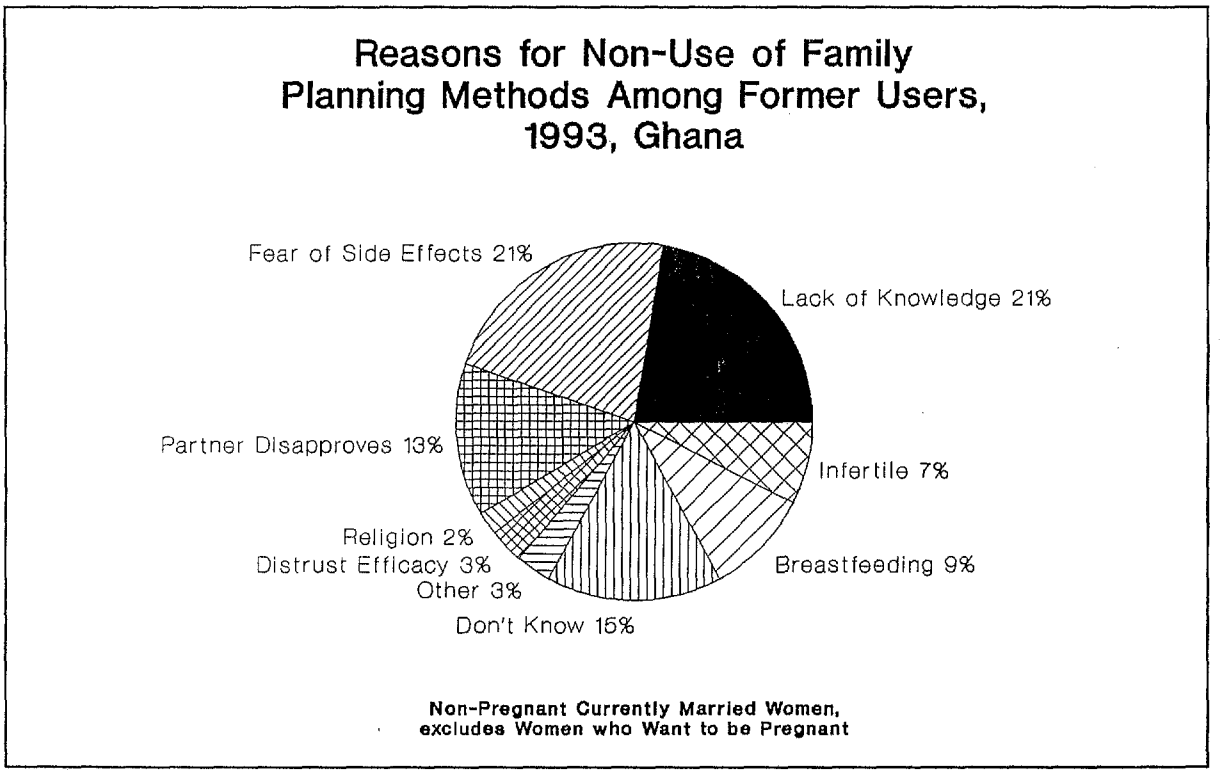

Figure 8

Source: Consumer Baseline Survey, 1993; The Futures Group.

This finding underscores the need for more information and support for women to increase their knowledge about specific methods and reduce their health concerns as well as a need to educate men about the benefits of contraception in order to foster greater levels of continuation.

The strategy for the communication campaigns under FPHP is to specifically address the low level of knowledge of all the methods. IEC efforts focus on community mobilization and interpersonal communication supported by public relations and media campaigns. Public sector IEC campaigns providing method specific information will be supported by brand specific campaigns addressing the benefits of the social marketing products. The team recommends that given current low levels of awareness, knowledge, trial and use, these communication and social marketing efforts should be continued and extended in the follow-on project.

In order to support this information base and encourage successful trial, the FPHP

is also continuing to train health personnel about the methods and their contraindications as well as in family planning counseling techniques. Through this training, health personnel are encouraged to realize that their responsibilities include the creation and support of demand, as well as the delivery of services, and they are trained in outreach and interpersonal communication techniques. The team recommends that this training in counseling be continued and extended in the future and that a permanent capacity to provide and maintain this training be established.

FPHP is also working with NGOs to develop information and distribution systems since they can provide excellent networks to reach women with information, support and products. However, these networks will take time to develop before they can effectively and efficiently reach the target audiences for demand generation. Therefore, the team recommends that these NGO networks should continue to receive support in the follow-on project. Once they can demonstrate the effectiveness of their efforts, the NGO network should be expanded even further to target rural audiences and other key groups such as youth and men.

At present the FPHP does not include a well-developed system of CBD workers who could provide information and thus expand the demand for Contraceptives. Through the American College of Nurse Midwives (ACNM), FPHP currently supports MCH training for Traditional Birth Attendants (TBAs) that includes family planning. This training is intended to enable TBAs to provide information and serve as CBDs. Educating TBAs about family planning can provide important access, especially to more rural women. It is unclear whether TBAs are the most appropriate group as a whole to serve as CBD workers, although individual TBAs may serve successfully in this role. The team suggests that the current study by Family Health International (FHI) on the impact of TBAs will include attention to the attitudes of communities and the TBAs themselves towards their involvement in family planning service delivery in order to determine their future role as family planning agents.

There are additional "message and product deliverers" who are not currently included in the FPHP that can extend the reach of family planning efforts. Networks such as those provided by agricultural extension agents and teachers provide highly respected sources of information and could potentially provide supplies as well. The NPC workshop held in Akosombo in August 1993 specifically identified these agents as a necessary target of future family planning projects. These networks will be added as appropriate to the follow-on project.

b. Constraints and Recommended Interventions for the Supply and Delivery of Non-Clinical Methods

Public Sector: In the past the public sector has experienced considerable disruption in the supply of non-clinical contraceptives. Stock outages have occurred for almost all the methods at different times due to problems with ordering, shipment, clearance and inventory levels. A recent (February 1993) Family Planning Logistics Management (FPLM) assessment reported improved stock management in the public sector. However, the 1993 Situation Analysis indicated that there continue to be moderate levels of stock outs. Thirty-three percent of service delivery points providing the progestin-only pill reported a stockout in the past six months. This figure is 18 percent for VFTs, 11 percent for condoms, 8 percent for combined oral contraceptive, 8 percent for IUDs and 4 percent

for injectables.

To the extent that there is a continuing need to support the public sector logistics system, FPHP has the mandate and resources to provide limited technical assistance to the Ministry of Health logistics system. However, to ensure that this system performs consistently and reliably, the team recommends periodic assistance from the FPLM project.

NGO Sector: Several NGOs are currently providing contraceptives, particularly non-clinical methods, through their networks. Planned Parenthood of Ghana (PPAG) provides these methods through their clinics and through their Community Based Distribution program. The Situation Analysis indicates that PPAG has by far the highest number of new clients per year per facility, with an average of 881 compared to hospitals with 173 and MOH clinics and health posts with 93, as shown in Figure 7.

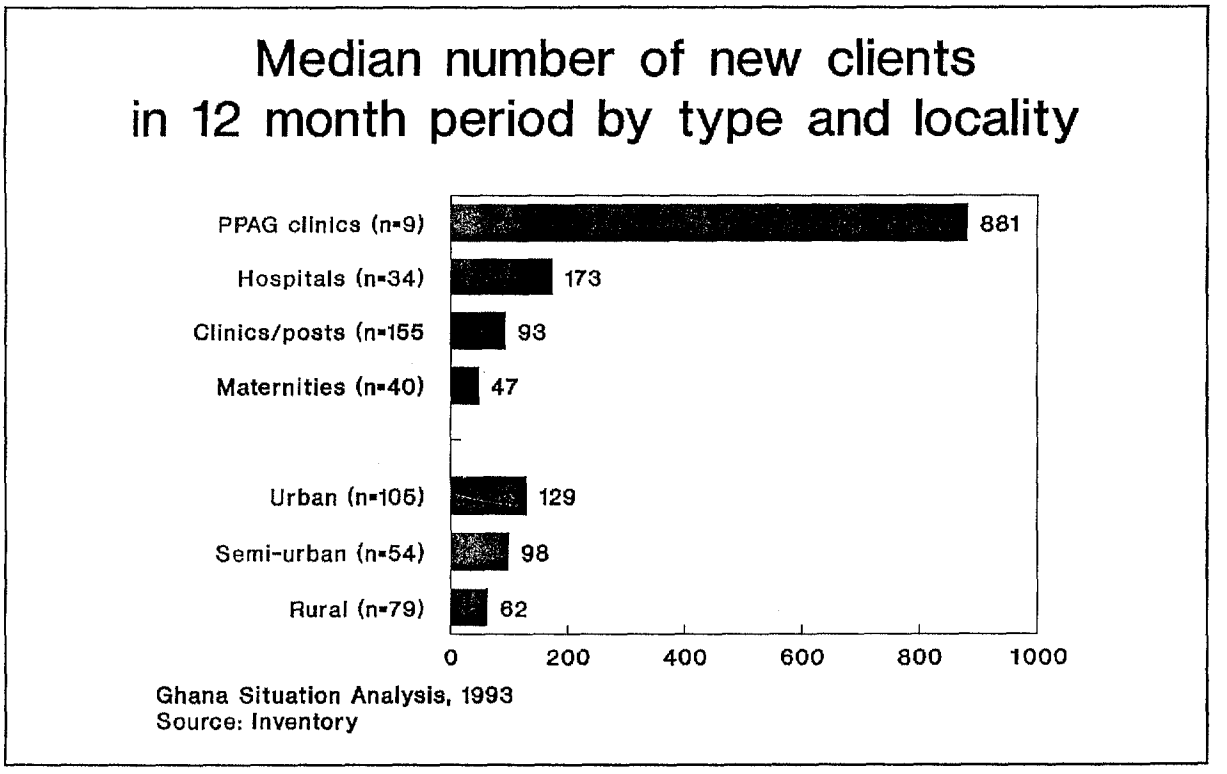

Figure 9

Source: Ghana Situation Analysis, Ghana Statistical Service, 1993.

Thus, they are an effective provider of services whose role should be expanded in the future. The team recommends that support for PPAG be explored when the new program is designed.

Members of the Ghana Registered Nurse Midwives Association (GRMA) provide contraceptives through their private maternities, which serve an average of 47 new clients per year per maternity. As noted, ACNM also supports a program for training TBAs in family planning and encourages them to sell condoms and vaginal foaming tablets.

The National Council of Women in Development (NCWD), though a government

organization, coordinates a large number of local NGOs that address women's concerns (119 organizations in the Accra region alone). In the past, they have developed and supported a network of market women who sold condoms and vaginal tablets in the markets. This network has been absorbed by the GSMF. The team recommends that community based networks be supported where there is an indication of the need for expanded delivery of condoms and vaginals, especially in more rural areas through women's organizations.

Thus, NGOs not only can play an important role in creating a supportive environment for the use of family planning by providing a forum for reaching women and men to increase knowledge and trial, they can also provide a network for distribution of non-clinical family planning methods. Currently, FPHP is responsible for working with 15 NGOs which can provide networks for information, support and non-clinical products. These NGOs will be selected to provide support and distribution to areas of low prevalence that are unserved by either the public or the commercial sectors, or where more intensive proactive support is required. However, one major constraint to the development of this alternative delivery network is the lack of funds to support NGO activities. No resources are included in FPHP to provide direct support to NGO collaborating institutions. Though the FPHP can offer training to NGOs, the reality is that the participation of these organizations requires financial and logistical support. Therefore, the team recommends that funds be provided to support NGOs and community based distribution in the subsequent project.

Private Sector: Both the NGO and private sector have played a significant role in the supply of non-clinical methods in Ghana. Distribution of non-clinical methods in the private sector through the GSMF in the past, however, has been limited by the capacity of the single distributor that serviced the pharmacies and chemical sellers. Since condoms and VFTs have much wider distribution potential, their distribution can be extended to lower level retailers. By doing so, distribution can also extend to a greater geographical area. To extend both the breadth and depth of the social marketing distribution, under FPHP the GSMF has added two distributors (one pharmaceutical, one non-pharmaceutical), which will vastly increase the GSMF distribution capacity from over 3,000 outlets to 10,000 outlets.

Employers also provide a source of support for family planning activities. Either employer-based or employer-financed schemes can ensure that private resources are directed to supporting family planing activities. Once established these employer systems will be able to provide access to both non-clinical and clinical methods. FPHP will establish five employer based systems over the next three years, and is already supplying the Trust Hospital in Accra with contraceptives.

PRIORITY 3: Intensify support for demand generation and supply for non-clinical methods

Proposed Interventions	
Short Term	Long Term
Provide support and TA to the public sector logistics system	Provide added emphasis on rural areas and target audiences such as youth and men.
IEC campaigns to build knowledge	Continue IEC campaigns to build knowledge of individual methods
Family planning counseling training	Expand work with NGOs on distribution and education in target areas
Work with NGOs on distribution and education	Continue family planning counseling training
Employer based services	Expand employer based services
Assistance to GRMA	Create distribution for private providers
Training of TBAs	Provide assistance to extend network of GRMA and PPAG
	Create a sustainable training capacity (including pre-service training)
	Extend family planning network to other message deliverers and distributors such as agricultural extension agents, teachers, and others.

Figure 8 is a schematic representation of supply and demand factors for non-clinical and clinical methods that displays short and long term interventions that the team believes should be addressed under FPHP and the follow-on project. In the short term (next three years) FPHP will address most of the major constraints to the provision of non-clinical methods. The shaded areas in Figure 8 indicate initiatives that will be undertaken by FPHP.

FIGURE 8

	NON-CLINICAL METHODS						CLINICAL METHODS					
	DEMAND			SUPPLY			DEMAND			SUPPLY		
	KNOWLEDGE	TRIAL	EVALUATION	PUBLIC	NGO	PRIVATE	KNOW	TRIAL	EVAL	PUBLIC	NGO	PRIVATE
SHORT TERM	FPHP Campaign	Counseling Training NGOs TBAs	Consistent Stock Consumer studies Ability to Pay Study	Improve Logistics/ MIS	Distribution through NGOs Midwives	Extend Commercial Distribution Employer-based Launch Minipill	Targeted Campaigns Referral Systems Satisfied Users NORPLANT Strategy			Increase Capacity-training including counseling Greater increase in capacity Inventory of current trained personnel		Employer financed Initiate targeted capacity building - pilot program Develop Insurance schemes Training of private midwives
LONG TERM	⇓ Added emphasis on rural	⇓	⇓	Sustainable Training Capacity Pre-service Training	⇓	⇓	Roll out campaigns Interpersonal Counseling referral			⇓ Pre-service training Post-partum IUD	⇓ Support additional PPAG clinics	⇓ Social Marketing of Long term methods Private provider networks Insurance schemes Employer financed

Essentially FPHP covers Short Term
Extend activities in Long Term

Develop capacity in Short Term-- targeted demand activities
Extend demand generation, public/private capacity and initiate social marketing of long term methods

FPHP will go a long way in addressing constraints to use of non-clinical methods both on the demand and supply side and in addressing knowledge constraints to use of clinical methods. Since the FPHP baseline found 14.9 percent prevalence of modern contraceptive use, the project will undoubtedly exceed its current target of 15 percent modern method prevalence. However, FPHP will not be able to completely eradicate demand and supply constraints in the next two years. Therefore, to continue to increase knowledge and improve supply of temporary non-clinical methods, extending prevalence and reducing fertility, for the long term the team recommends that the FPHP initiatives should continue to receive support. The possible exception is the refinement of the public sector logistics system, which may be accomplished within the time span of the current FPHP project.

As the program moves from the "launch" phase into "growth", follow-on activities will need to place greater emphasis on reaching rural areas and in establishing a sustainable training capacity and in-service training of family planning providers in all sectors.

2. Constraints to Demand for Long-Term Methods

Demand is even lower and the supply infrastructure is much less developed for the long-term clinical than for the non-clinical methods. The development of demand and supply for these methods must be approached in a coordinated manner. For example, it is difficult to train providers in sterilization or IUD techniques without an adequate number of clients. Similarly, once trained, health workers must have adequate opportunity to practice the techniques to maintain their skills. On the other hand, programs must be careful not to develop demand ahead of the capacity to service it, or potential clients may be frustrated.

The 1993 FPHP baseline clearly demonstrates the demand situation: among all women, awareness of injectables was 50 percent, IUDs was only 34 percent, female sterilization was 35 percent, and male sterilization was only 10 percent. Moreover, only 23 percent of women were aware of that MOH clinics were a source for IUDs; only 5 percent were aware that PPAG was a potential source.

Very few women possess basic knowledge about long-term methods. Only 26 percent of women know how to use injectables; and only 22 percent of women have a basic knowledge about IUDs. No data were available about knowledge of sterilization or NORPLANT.

Trial lags even further behind with only 3 percent who ever used injectables; 2 percent who have tried IUDs, and .3 percent who have been sterilized. Current use of injections was 2 percent and IUDs was only 1 percent. Additionally, private providers who were previously trained in IUD insertion report lack of demand for their services and many public clinical programs are under-utilized.

The environment of acceptance is even lower for clinical than non-clinical methods. Numerous myths exist about IUDs and there is little acceptance of even the concept of sterilization among either males or females. Therefore, demand generation activities must allay misplaced fears and improve acceptance of methods. Acceptance of sterilization, especially in a culture that reveres fertility, is a long term effort, requiring gradual shifts in attitudes with increased exposure from as many sources as possible and an emphasis on interpersonal and community based communication efforts.

Thus, the team recommends that a major emphasis for future programming must be the development of demand for these methods. This demand generation must be coordinated with and targeted to the development of the delivery infrastructure. Once an area has a critical mass of providers who are trained in the techniques and who have the time and access to the facility to perform them, specific demand generation activities can be targeted to that area. Women must be given specific information about the methods and the sources for obtaining them.

The development of referral systems will also be important to stimulate demand and trial of clinical methods. Because there will be far fewer potential service sites for long term methods, community outreach, CBD, pharmacists, and others will have to be trained to refer potential clients to an appropriate source.

Finally, in the short term, there needs to be a strategy for the continued provision of NORPLANT. This strategy must consider whether NORPLANT will be maintained in the public sector or private sector and whether there is donor support for the purchase of the sets. Additionally, it should also explore if and how the product can be marketed in the private sector. There has been social marketing of NORPLANT in Mexico, where the product is brought in through the FPA at donor prices, but marketed through the private sector. However, even these prices are vastly outside the grasp of most consumers in Ghana, and would have to be subsidized.

In the longer term, training will need to continue and with the development of the infrastructure, demand generation activities can be rolled out nationally. In the long term, demand will continue to need to be supported with interpersonal counseling and referral systems including referral from the entire range of health providers.

PRIORITY 4: Constraints to Demand for Long-Term Methods

Proposed Interventions	
Short Term	Long Term
Increase awareness and knowledge about benefits of long-term methods. Focus IEC efforts on interpersonal communication and community mobilization.	Actively promote injectables, as an appropriate and easily accessible method for long-term or temporary use. Develop targeted demand generation activities for IUD and sterilization for specific audiences built around the delivery infrastructure.
Develop a comprehensive NORPLANT strategy	Establish and maintain adequate counseling systems
Draw on satisfied users to promote an environment of acceptance.	Develop referral systems for clinical services.
	Promote and market NORPLANT as appropriate.

3. Constraints to Supply and Service Delivery of Long-Term Methods

The service delivery capacity for provision of clinical contraceptive methods is not well developed in either the public, NGO or private sectors. To date the major emphasis of the work of JHPIEGO and AVSC has been the training of the public sector to deliver these services, although both organizations have provided limited private sector training.

Those who have been trained have the capacity for far more procedures than they currently perform, since many have other duties and access to clinical facilities may be limited. Therefore, the actual capacity is reduced. Additionally, the coverage of the training has been very limited. Many areas have no capacity to provide any of the clinical methods to potentially interested women. Thus, the team recommends the continuation of training in long term methods in all sectors.

The training that has been done has also not been well orchestrated and documented. Some providers have been trained in general family planning, others in IUD insertion, others in sterilization. Though AVSC has a clear understanding of the sterilization capabilities at the major centers with which they have worked, there is no clear record of IUD trainees, where they are, whether they are currently practicing and so forth. Since future efforts require the development of demand concurrently with the development of a service delivery capacity, it is critical to be able to identify and locate past and present trainees.

Public Sector

In the short term, the lack of an adequate service delivery infrastructure for clinical methods remains a major constraint to meeting prevalence targets. The IUD has the greatest acceptance and the greatest potential for increasing prevalence but the number of trained service providers is very limited. Therefore, the team recommends that the clinical training capacity be expanded as much as feasible in the short term and that it be fully developed in the long term.

The development of a training capacity is a lengthy process. There is a current proposal by JHPIEGO to develop Regional Training Centers which the team recommends should be implemented. It is currently unclear how much additional resources can expedite the development of the centers. However, training should be expedited to the extent possible and reasonable in order to increase the service delivery capacity.

In the long term, the training capacity should be shifted to pre-service training to ensure that new doctors are trained in the full range of contraceptive techniques. Additionally, training can be provided in post-partum and post-abortion IUD insertion.

NGO's

The network of service providers can be extended by working with PPAG. Currently, PPAG staff are providing family planning services at several MOH clinics, as well as their own clinics. PPAG's current program calls for them to shift these clinics to the MOH once they have the capacity to run them. PPAG staff will then be able to provide services in other areas not reached by MOH clinics.

The extension of the network for clinical methods, especially IUDs, will be critical in increasing the prevalence of these highly effective methods. PPAG should be assisted to extend their current delivery network to the extent that such expansion is consonant with their strategic plan and their management capabilities. Expansion to include voluntary surgical contraception and necessary training has already begun.

Private Sector

The private sector clinical service delivery infrastructure is the most underdeveloped of all the sectors. Only 64 private physicians (out of only 300) have been trained in IUD insertion techniques. However, there are several promising ways to stimulate private delivery of clinical methods.

In the short term, employer provided and financed schemes, such as that currently underway at the Trust Hospital, should be explored. Employer based programs should certainly include clinical methods in order to provide the greatest choice and effectiveness. The team recommends that additional employers should be recruited for the next project if the pilot effort is successful.

The team also recommends exploration or pilot testing of a program where employer based or financed programs pay for NORPLANT for their employees. Over the five year period, the cost of NORPLANT at public sector prices is not significantly more than the cost for pills and effective use is much higher. Therefore, employers and employer-funded HMOs, like the Trust Hospital, should be interested in financing this product for their employees.

The Society for General Medical Practitioners, which represents private medical practitioners, has developed a fee schedule for their members. They would be interested in negotiating accessible rates for clinical contraceptive services in return for training of their members. However, it is not currently clear what prices are appropriate for these services and whether there would be enough demand to warrant the training. Therefore, a pilot program should be launched to test private service provision, evaluating pricing and marketing strategies.

The Society is also currently in the process of developing a health insurance scheme in Ghana for the first time. The initial plan is for curative services only. However, the insurance will cover Ob/Gyn and family planning services as an option for their clients. (Once established the Society should be encouraged to provide family planning as part of the general services.) The development of the private insurance system, will make the private providers more accessible to the general public and will consequently, make them a more important part of the service delivery mix.

Private midwives provide an excellent network to promote and support family planning services. With support from USAID to the GRMA, two hundred and fifty (250) midwives have been trained in family planning and 45 private midwives have been trained in IUD insertion. These midwives, with their private maternities, are an excellent network for clinical methods. The GRMA has a current list of midwives who have requested the training. However, they do not have a current list of all their members (90 are no longer reporting) or whether all who have been trained to provide family planning services are currently practicing. Assistance to help them with this task could be provided from FPHP or from the Initiatives Project, and the team recommends that both options be explored. In the

past, midwives received training in business skills along with their family planning training from the Enterprise Project. This initiative was very helpful for their ability to run a profitable business and should be repeated. Here, again, the team recommends that assistance from the Initiatives Project should be investigated.

In the longer term, the team recommends that the private sector play an even greater role in the provision of family planning services. The GSMF currently is investigating the addition of injectables in its product line. Distribution would be through the network of midwives and doctors. Private practitioners currently have no formal distribution network which services them with either non-clinical or clinical methods. The team recommends that the social marketing project be expanded to include long term methods and that a formal distribution network be established with private providers. Success of this private distribution would require that the MOH restrict the sales of subsidized products to private maternities and doctors.

After the initial test of the private provision of family planning services, a more extensive social marketing of long term methods should be initiated. In this scheme private providers can be trained in a range of family planning methods in return for an agreement on the price of services (including product in the case of the IUD). Private providers can receive their products from the GSMF and their network can be advertised, creating a higher level image than the MOH facilities. Providers can be trained in the Marketing of Services course being developed by SOMARC which will help them to be more consumer driven and improve their quality of care, as well as to promote their services. Extensive support for longer term methods and private providers can be provided by public relations activities and referral networks. Private practitioners are also hampered from promoting increased contraceptive use because they themselves do not have the time to counsel patients and their nurses are not trained in family planning counselling. Family planning counseling training should be expanded to include the staff of private providers.

Finally, the community doctors (and midwives) approach can stimulate the development of private practices in undeserved areas. This initiative would provide investment funds for private providers to open clinics and maternities providing a range of family planning services to under-served areas. Establishment of clinics is capital intensive, which prevents many practitioners from entering the private sector. For those who do have the capital to invest, they need to charge much higher prices to get an adequate return. By providing financial resources to those willing to open clinics in under-served areas, the private sector can extend the reach of their network and can provide services at a reasonable rate (established as part of the agreement).

PRIORITY 5: Increase capacity in both the public and private sectors to supply long-term and permanent methods of contraception

Proposed Interventions	
Short Term	Long Term
PUBLIC SECTOR	
Inventory the status of previously trained personnel.	Complete the training of service providers
Extend current training capacity in order to provide training to public, NGO and private sectors.	Institutionalize the training capacity
Develop a critical mass of trained providers.	Provide capacity in post-partum and post-abortion IUD insertion
	Ensure that family planning counseling and clinical method service delivery are established in all pre-service training facilities
NGO	
	Support PPAG increased capacity to deliver long-term methods
PRIVATE SECTOR	
Develop a pilot program for provision of clinical methods in the private sector as a precursor to social marketing of long term methods.	Initiate social marketing of long term methods and private provider networks.
Assist the development of health insurance systems	Develop a community doctors and mid-wives programs.
Increase the training of private midwives	Extend the coverage of insurance schemes
Initiate employer-based and employer-financed private delivery systems	Continue to encourage employer-based and financed delivery systems

IV. FINANCIAL AND TECHNICAL RESOURCES

PRIORITY 6: Foster Technical as well as Financial Sustainability of Population and Family Planning Activities.

The issue of program sustainability has received increasing attention from A.I.D. and other international donors in recent years. As discussed here, a fully sustainable program or project is one that generates sufficient revenue to cover its recurrent costs. In the area of family planning, the success of programs has resulted in dramatic increases in the demand for contraceptives. Even if global resources from donors and host country governments increase, however, they will not rise fast enough to cover this rising demand. It has been estimated that resources may fall short by as much as $1.4 billion by the year 2000 (USAID, 1989). Thus, generating more-sustainable programs has been identified as a way to stretch scarce dollars.[4]

Despite recent improvements in the economy, it seems unlikely that family planning service delivery in Ghana--in the public or the private sector--will become fully sustainable in the near future. Experience in successful programs (e.g., Thailand) has shown that given prolonged low contraceptive prevalence levels, subsidy is necessary for a period of time.

Strategies directed towards building long-term financial sustainability in family planning or in other sectors typically focus on two potential national sources of funds to sustain activities: budgetary support from the government at various levels; and cost recovery mechanisms, which require beneficiaries to pay for services.

Current Budgetary Support

Between 1988 and 1993, gross budget allocations by the GOG to the Ministry of Health rose dramatically, but the MOH share of total budget resources has been maintained at about 6 percent of total government allocations. Nevertheless, persistent, rapid inflation has reduced the value of allocations with the result that there has been little or no increase in funds available to the MOH. About 90 percent of the 1993 capital budget will be financed by GOG and 10 percent by donors. Compared to other West African countries, the contribution by donors to Ghana's capital health budget is quite low which might suggest sustainability in the long-run. However, the percent of the capital budget devoted to MCH/FP is negligible. The total estimated 1993 recurrent budget for the MOH as a whole is 46.7 billion cedis ($70.2 million at $1 = 665 cedis), representing 11 percent of the total GOG recurrent budget.

According to Save the Children Fund (UK), donor contributions currently represent 15 percent of the total MOH budget (recurrent plus capital costs). From 1984 to 1991, over $85 million was committed by donors for Ghana's health care system, including family planning. For the 1991-1996 period, external assistance is estimated at $162.8 million. As shown in Table 3, during this period the African Development Bank (23 percent of total), USAID (21 percent) and the World Bank (16 percent) will be taking the lead in health sector financing; USAID will continue to take the lead in the financing of family planning activities:

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[4]As discussed here, we are concerned with financial sustainability in the absence of external donor resources; that is, the sustainability is a characteristic of the program itself.

Table 3: External Assistance 1991-1996 in Health/FP

(in $ Million)

DONOR	TOTAL FOR HEALTH	PERCENT	AMOUNT FOR FAMILY PLANNING	PERCENT
World Bank	27.0	16	4.7	10
UNFPA	4.6	3	4.6	10
UNICEF	10.0	6	0	0
ODA	1.6	1	1.6	3
USAID	35.0	21	34.8	77
WHO	2.7	2	0	0
SCF	0.5	0	0	0
DANIDA	22.0	14	0	0
GTZ	1.7	1	0	0
EEC	10.7	7	0	0
ADB	38.0	23	0	0
Saudi Fund	9.0	6	0	0
TOTAL	**162.8**	**100**	**45.7**	**100**

With respect to family planning and maternal and child health alone, the Ministry of Health has examined the issue of sustainability by developing estimates of the resources required to attain all MCH/FP targets concerning safe motherhood, family planning and child survival in relation to an annual average of donor support, the GOG share of the recurrent budget, and rough estimates of maximum community contributions through hypothetical "user fees". The results suggest that in 1992 the MCH/FP program operated with only 37 percent of their required budget needs being met of which 8 percent was provided by the GOG, 24 percent by donors, and a potential maximum of 5 percent from user fees.

The budgetary situation is even bleaker at the regional and district levels. In 1992, the Ministry of Health was restructured to make services more effective and efficient. This new structure assigns to the central level the role of policy formation, technical guidance and central procurement, while direct responsibility for management of health services is to devolve to the regions. In line with overall GOG policy on decentralization, the Regional Medical Directors in turn are to delegate increasing responsibility for service delivery to the District Health Management Teams. Nevertheless, while efforts are ongoing to strengthen the management capacity at regional and district levels, the MOH budget process does not currently allow resources to reach these levels. For example, the draft of a 1993 study by Save the Children (U.K.) shows that other than salaries and supplies, only about 5 percent of

the MOH budget is allocated to the district level and 0 percent to the level B or sub-district level, the majority of the budget being reserved for the central level and teaching hospitals (about 50 percent). Level B facilities are apparently operating exclusively from funds generated from the sales of drugs and collection of service fees.

The lack of budgetary resources overall, as well as the unavailability of resources at the district and sub-district levels provide serious constraints to efforts to expand family planning service delivery through the public sector. The present situation also suggests that, in the absence of change, sustainability of program activities through budgetary means will meet with little success.

Cost Recovery

The other potential avenue for achieving financial sustainability for programs is through cost recovery. With respect to health services in general, there is evidence to suggest that Ghanaians can pay for services, or least for some portion of services. The GOG was able to surpass a 15 percent recurrent cost recovery target within 2 years of implementation of cost recovery measures in pilot areas (beginning in 1985, and attaining 20 percent by 1987). Due to salary increases (nearly two-fold) and a rise in the cost of drugs and medical equipment, however, the rate has dropped to between 5 and 10 percent over the past two years. Also, an experiment with a health insurance scheme in the Nkoranza District achieved its goals and showed that 87 percent of in-patient costs (excluding health staff salaries and facility costs) at the pilot hospital could be recovered, with 31 percent of the population buying into the scheme (GOG, District MOH, 1992). Further evaluation needs to be done to assess overall costs related to health care delivery. Nonetheless, the already strong commitment of the MOH to design a national health insurance plan has been reinforced by the success of these early trials.

On the other hand, a study conducted in the Ashanti-Akim District raises questions about equity under cost recovery schemes (Waddington and Enyimayew, 1989). Introduction of cost recovery led to substantial declines in utilization levels, although urban sites gradually regained pre-cost recovery utilization rates and eventually surpassed them. There were also significant decreases in the proportion of females using both the rural and the urban health centers.

Although not uniformly positive, the limited studies to date suggest that some cost recovery in the health sector might be possible. However, at present, MCH/FP services, which are targeted to the most vulnerable segments of the population, are to be provided free of charge. Nevertheless, even if the cash and carry system were to be implemented for family planning commodities, the MCH/FP Division estimates that the maximum potential contribution from family planning user fees in 1992 would have totaled less than 5.5 percent of the cost of commodities distributed (Ministry of Health, 1992).

Typically, countries with family planning programs at the launch stage of the family planning typology (A.I.D., 1990) such as Ghana initiate social marketing of contraceptives to upper income groups in urban areas to begin some effort at cost recovery. Under both the previous Contraceptive Supplies Project and the current FPHP, USAID has supported social marketing activities. Nevertheless, economic factors have dictated that prices be kept affordable that there is no prospect of recovering more than a limited portion of recurrent costs in the near future.

Technical Sustainability

Attention to the financing of programs alone is not sufficient to ensure sustainability; it is critically important to also focus on transferring technical skills. A recent analysis of several health and population projects suggests that the prospects for sustainability were stronger in projects that included a strong training component (Bossert, T., 1990). Such training may encompass long term professional training, often at overseas institutions, as well as in-country training for professionals and para-professionals, both in-service and pre-service, and long and short-term.

Investment in training can contribute to long-term sustainability through several avenues. For example, training of trainers creates a technical capacity that can continue to advance the goals of the program as these trainers use their skills to develop additional human resources. Once trainers are in place and curriculum developed, costs to the government of continuing with training are limited. Further, the trainers and their trainees--service providers and policy makers, for example--can form a constituency for continuation of program activities in the long run.

In the case of Ghana, the training required is not just that for service providers. There is also an acute shortage in both the public and private sector of individuals with the requisite managerial and financial skills to manage increasingly complex family planning and health programs.

INTERVENTIONS

Financial Sustainability

To address the budgetary constraints and thus begin to take the steps necessary to achieve financial sustainability in the long run, the team notes that Non-Project Assistance (NPA) may be a particularly useful strategy. The team recommends that NPA under the follow-on project include conditions precedent directed towards increasing the Government of Ghana's contribution to recurrent costs for family planning/maternal and child health activities. Further, the team also recommends that other conditions precedent be considered that would facilitate the flow of resources to the regional and district levels through the budget process.

A major emphasis in the strategy followed by USAID in Ghana has been to encourage activities in the private sector, most notably through the Ghana Social Marketing Foundation, and the Ghana Registered Nurse Midwives Association. It is clear that while the Government of Ghana has a commitment to providing health and family planning services to all citizens, the public sector resources to do so are lacking. Thus, it is in the Government's interest to foster the development of a favorable environment for private sector service delivery, as part of a long term approach to developing a sustainable national family planning effort. Future efforts should include support, for example, to the Planned Parenthood Association of Ghana.

An early section of the strategy highlights collaboration between the public and private sector as a priority area for attention, and lists specific interventions. Similarly, many of the interventions recommended with respect to Priority 5 (increasing the capacity to

supply long-term and permanent methods of contraception) speak directly to the issue of financial sustainability, for example, expansion of social marketing to include long term methods, establishing private provider networks, developing a community doctors program, extending insurance coverage to include family planning, and encouraging the development of employer-based and financed delivery systems. The team recommends the use of Operations Research to test these approaches, including the commercial feasibility of setting up private practices in rural and under-served areas. Also recommended are studies on the ability of clients to pay for services, with attention to pricing of commodities and services.

To facilitate these initiatives, the team recommends that the OR include cost effectiveness and cost efficiency studies of various service delivery approaches. Further, cost-analyses directed at comparing the costs of hospital stay for delivery or for treatment for abortion complications with family planning costs, and examining the opportunity costs of the social sectors (e.g., health and education) to show the potential impact of family planning (cost-benefits) on reducing public expenditures in these sectors are recommended.

Technical Sustainability

Human resource constraints in Ghana encompass both the lack of skilled personnel, and the inadequate deployment of those who are trained. As noted, there is a continuing need for training service providers, especially those who can provide long-term and permanent methods. With respect to deployment, the team recommends that an assessment be undertaken of the underlying reasons for the inequitable distribution of staff. Based on this assessment, if appropriate, it is recommended that consideration be given to experimentation with an incentive package to encourage service providers (in the public sector as well as the private sector) to locate in the under-served regions.

For the public sector, the team recommends a human resources needs assessment is required to form the basis for a training plan that will include short and long term training, as well as technical assistance. If appropriate, the team recommends support for a long-term technical advisor, if it is coupled with the necessary training and skills transfer to make the advisor's role unnecessary. Other recommended training includes management and financial skills training for relevant staff at regional and district levels. In addition, it is recommended that members of the GRMA, along with other private providers, receive training in business skills, to facilitate their setting up and operating private maternities and clinics.

PRIORITY 6: Place increased emphasis on technical as well as financial sustainability of population and family planning activities.

Short term	Long term
Use NPA to encourage service provision to low-income and indigent groups	Cost effectiveness and cost efficiency studies
Use of NPA to encourage additional allocation to MCH/FP	Explore alternative financing strategies
	Financial incentive schemes in the private sector to serve rural and under-served areas

V. NON-PROJECT ASSISTANCE

The team recommends that the follow-on project include an NPA component. The NPA should be a cash transfer program to the GOG to be used for structural adjustment support for family planning and AIDS activities. It could be provided in yearly tranches based on the GOG budget calendar. Policy issues and constraints to the efficient and effective provision of family planning and AIDS programs have been identified in consultation with the GOG. Conditions Precedent (CPs) will be negotiated with the GOG to identify benchmarks for the removal of these constraints. Each CP will be negotiated with the GOG to ensure that it is both feasible and will positively affect the constraint or issue.

Major constraints and suggested interventions

1. **The majority of public sector population financing is through extrabudgetary donor funds.** Due to budgetary and disbursement constraints from the GOG, most recurrent and capital funding for population activities come directly from international donors. NPA funds could be used to identify and remove disbursement constraints and provide a large percentage of the funds for the government of Ghana to finance family planning activities through the normal MOH budget. By funneling international resources for population activities through an improved budgetary process, the GOG can help ensure the survival of these programs as donor support declines, while maintaining clearer administrative control, eliminating duplication of budgets from various sources.

2. **Although the National Population Council has been formed, and is charged with advising the GOG on population matters, it relies largely on donor funding, making it vulnerable once donor support is withdrawn.** The NPC has a very important role to play in continuing to guide GOG policy and coordination. Without commitment and budgetary support from the GOG, the NPC may not be sustainable. The nature of the CP would be to have the GOG establish a budget line item for the NPC and its secretariat from general funds.

3. **Family planning commodities are currently provided exclusively by donors.** Although there is a commodities fund established from receipts of sold commodities, the GOG has not contributed directly to the procurement of contraceptives from its own

resources. The CP may specify a negotiated amount, or percentage of the MOH budget, to be used for the direct procurement of contraceptives. Technical assistance may be provided from the follow-on project to assist the MOH in improving its capacity to program and order contraceptives through its regular pharmaceutical procurement system, if required.

4. **The lack of official MOH guidelines for appropriate family planning services result in "medical barriers" to these services because potential clients may be discouraged from obtaining the services they want and need.** Well developed, accurate guidelines would complement training provided by the Program to reduce these barriers and increase contraceptive prevalence. Technical assistance could also be provided in developing these guidelines, as requested. The use of NPA will be developed more explicitly during the design of the new project.

APPENDIX A: ANALYTICAL AGENDA

1. RETAIL AUDIT (TFG): JANUARY - JUNE, 1993

Analysis of unit sales and correct inventory levels of GSMF products as well as other major contraceptives and MCH products in retail outlets; determine penetration levels of GSMF products in retailer networks as well as serve as a monitoring system to track the efficiency and effectiveness of distribution of GSMF products.

2. CONTRACEPTIVE ADVERTISING SURVEY (TFG): MARCH - JUNE, 1993

Focus Group Discussions for Advertising Materials.- This is to solicit views of the target audience on various advertising messages as well as for the new logo for the GSMF. The study is a pre-test of advertising materials to ensure that the intended informational message is communicated to the target audience.

3. CONTRACEPTIVE BASELINE SURVEY (TFG): JANUARY - JUNE, 1993

This study establishes a baseline of levels of contraceptives, ORS, anti-malarial and AIDS prevention knowledge, attitudes and practices and to define target populations for these services. The study will form the basis for evaluating the impact of the project interventions.

4. PRIVATE PROVIDER KAPB STUDY (TFG): JANUARY - JUNE, 1993

This Private Service Provider Contraceptive KAPB Study determines the knowledge levels and correct use as well as relevant image of contraceptives among the private sector physicians, midwives and retailers (chemical sellers and pharmacists). The study provides inputs into the development of training materials for retailers and other private sector service providers.

5. LOGISTICS SITUATION ANALYSIS (FPLM): FEBRUARY, 1993

A two person team will be working with the Ministry of Health and other donor representatives involved in procurement and distribution to review the existing GOG contraceptives logistics.

6. REPRODUCTIVE HEALTH TRAINING ANALYSIS (JHPIEGO): FEBRUARY, 1993

Programming of follow-on Reproductive Health training for nurses, development of curriculum for medical interns and establishment of decentralized continuing education. Completing of evaluation of training activities and trainee tracking system.

7. PRIVATE SECTOR HEALTH FINANCING: FEBRUARY, 1993

This is an exploratory visit by a three person team from the Private Sector Family Health Initiatives that will assess the potential for implementing and testing private sector approaches that can provide sustainable preventive and primary as well as curative care to Peri-Urban residents.

8. VITAMIN A EXPLORATORY TEAM (VITAL): MARCH, 1993.

Assist the GOG to plan strategies for the design and development of program options to resolve vitamin A related problems identified by the VAST study in Northern Ghana.

9. RAPID MODEL (RAPID II): APRIL - MAY, 1993.

Develop this Model to show graphically the impact of rapid population growth on the socio-economic development of the Country. This will be used in raising the level of awareness and commitment of high level decision makers.

10. NON-CLINICAL CONTRACEPTIVE DISTRIBUTION SAFETY STUDY (NPC SUBCONTRACT): MARCH - DECEMBER, 1993.

Examine the safety of using distribution systems other than pharmacies/chemical sellers for provision of oral contraceptives. It is intended to provide information necessary to making a national decision as to whether the distribution of oral contraceptives can be deregulated.

11. DEMOGRAPHIC AND HEALTH SURVEY (MACRO): JANUARY - DECEMBER, 1993.

The Ghana Statistical Service (GSS) is in the process of conducting a Demographic and Health Survey II with technical support from Macro International.

12. TRADITIONAL BIRTH ATTENDANTS (TBA) CLINICAL IMPACT STUDY (FHI): FEBRUARY - DECEMBER, 1993.

Assessment of the clinical impact of the TBA training program on Maternal and infant morbidity and mortality rates. It is expected to answer the question as to whether TBA training actually affects mortality and morbidity of mothers and children.

13. SITUATIONAL ANALYSIS (POPULATION COUNCIL): MARCH - AUGUST, 1993.

This operational research project examines availability and quality of family planning services in all parts of the country to identify areas requiring attention in future projects.

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APPENDIX C: PRIORITY ACTIVITIES/PROGRAMS DEVELOPED AT AKOSOMBO WORKSHOP

August 15 - 18, 1993, Akosombo

During the Akosombo workshop there was a great deal of discussion and interest in the design of population activities to achieve the objectives. An intersectoral group exercise generated extensive lists of population activities to address each of fourteen population policy objectives. These activity lists formed the basis for the ministry/agency planning sessions. In the course of these planning sessions, priority activities/programs were identified along with some initial ideas for program implementation. The complete activity lists include the specific tasks, time frames, resources, collaborators, etc., but some highlights emerged from the presentations and general discussions. The key findings were organized around the five Technical Advisory Committee (TAC) topics (IEC, Service Delivery, Policy, Research and Evaluation and Training) and are presented below.

Information, Education, and Communication (IEC)

There is considerable involvement in IEC for family planning by agencies outside the MOH and PPAG, and significant potential for duplication of efforts in this area. There was consensus that IEC efforts should be intensified through a multi-media, multi-sectoral IEC campaign to raise awareness and generate demand for family planning services. The following stipulations for this campaign were identified:

1. IEC messages must be consistent and culturally relevant, therefore there is great need for role definition and coordination of the IEC component of the family planning program. This coordinating role should be played by the NPC Secretariat, guided by its Technical Advisory Committee on IEC.

2. Particular emphasis should be placed on the design of IEC messages to target men, rural women, women seeking ante and post natal care, and in school and out-of-school youth.

3. The network of IEC message deliverers should be expanded to include those who have greater access to the targeted groups, including the Ministry of Food and Agriculture (MOFA) extension officers, Guinea Worm Volunteers, Community Development Workers, Teachers, and Literacy Facilitators.

4. While mass media has a significant role to play, it was recognized that attention should be paid to cost-effectiveness in choosing the means of communicating family planning messages.

5. While IEC directed at national level policy makers should be continued and intensified, the decentralization process currently underway in Ghana increases the need to sensitize leaders at the district and sub-district level.

6. Raising awareness of the relationship between infertility and STDs should be a component of all health and family planning education efforts.

Service Delivery

The need to expand family planning services and improve the quality and variety of services were seen as instrumental to increasing access and contraceptive prevalence. The Ministry of Health should be responsible for service delivery in both the public and private sectors, directing the participation of NGOs and private organizations. The following specific recommendations were made:

1. The number and variety of service delivery points should be increased by: providing integrated services in all health facilities, providing non-clinical services at youth and community centers, increasing the number and type of vendors, and expansion into under-served rural areas via mobile clinics and community based distribution.

2. Sufficient supplies are critical to satisfying demand for services and attention must be paid to avoiding stock outs. The development of an integrated reporting system and improved commodity tracking is required.

3. Special attention should be paid to providing services to under served target groups such as out of school youth, rural women, the disabled, and men.

4. Family planning counselling and services should be provided as a regular component of ante and post natal care.

5. Improving quality of care will involve increasing the choice of family planning methods available, greater attention to counselling, and more convenient clinic hours.

6. Family planning delivery sites must be more responsive and hospitable to adolescence and men.

Policy

Participants in the workshop widely recognized that successful population programs require that the policy environment be conducive to population program implementation, and that leadership and coordination are necessary to ensure a supportive policy environment. The following specific recommendations were made:

1. The leadership and coordination of population programs should be the responsibility of the NPC, which requires strengthening the NPC Secretariat structure and capabilities.

2. Awareness raising at all levels (from community leaders to national policy makers and parliamentarians) is required to increase political commitment to, and support for, population programs.

3. All ministries and agencies should incorporate the objectives of the population policy into their program planning.

4. The legal and regulatory environment must be reviewed and revised as necessary to ensure that this environment is conducive to effective program implementation.

5. Customary practices must be reviewed to ensure that they complement the population program. This review should be the responsibility of the House of Chiefs, and should promote positive practices as well as discourage negative ones.

6. The involvement of the private sector in family planning service delivery should be promoted. This will involve attention to the provision of supplies, possible modification of service regulations, and training of service providers.

Research and Evaluation

The importance of conducting research and on-going evaluation, and modifying or implementing programs in light of the resulting data, was widely recognized. The following specific recommendations and needs were identified:

1. Surveys of attitudes and knowledge of providers, teachers, school authorities etc. should be used for the design of in-service training programs and curriculum revisions.

2. Census and survey data must be organized in useful ways and disseminated widely to all involved and interested institutions and agencies.

3. A monitoring and evaluation system should be developed for the Family Life Education program (in and out of school).

4. Sentinel sites should be established for rapid assessment of program effectiveness.

5. A pilot birth-based monitoring system and coordination with EPI should be developed.

6. Regional and district level data should be collected for the purposes of raising awareness at the local level, and for program planning.

7. All sectors are in need of better monitoring and evaluation for feedback into program planning.

Training

Training is a cross cutting activity that is implied in all other activities from the functions of the NPC to TBA service delivery. Therefore the following recommendations should not be taken in isolation.

1. Family planning information must be included in the curriculum of teacher training colleges and in all medical schools.

2. In-service training and awareness raising should be provided to service providers who lack familiarity with the most up-to-date contraceptive technology.

3. All new service providers (including those from the private sector) should receive information in family planning methods, as well as training in counselling and IEC message delivery.

APPENDIX D: PERSONS CONTACTED

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APPENDIX E: FPSD'S PRINCIPLES AS APPLIED TYPOLOGY

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Quality of Care	Small programs able to meet quality needs of early adopters.	As clientele increases, new programs open and new types of programs launched (urban and pilot rural CBD); quality needs become more systematic.	Quality services needed in general basic supply methods, clinical method provision, multi-method promotion and for quality services by rural promoters and private sector providers.		
Client Populations	Urban early acceptors High parity women.	Urban and peri-urban early and educated acceptors. Rural pilot projects.	Urban and peri-urban early and educated acceptors, initiate broad rural programs.	All urban populations, emphasis on rural acceptors.	All populations, focus on hare-to-reach groups, e.g. adolescents, men.
Method Mix by Stage	Transition from traditional methods to supply methods. Maintain effective breastfeeding.		Encourage method switch from less to more effective.	Climate of acceptability and availability lets choice prevail.	Variety of methods, each adds to prevalence.
Types of Methods	Pills, condoms Female VSC Encourage effective breastfeeding (all ages)	Pills, IUDs, Norplant (when approved) injectables, condoms Female VSC	Pills, IUDs, Norplant, injectables, condoms. Female VSC increasing rapidly.	Pills, IUDs, Norplant, injectables, condoms, female VSC.	Female VSC is most popular method. Pills, condoms, IUDs Norplant, injectables, vasectomy should be promoted.

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Sector Involvement	Limited system of fixed government and private facilities serving urban early adopters. Private voluntary organizations play a key demonstration role.	Government/private association. System expanding but additional private facilities needed. CBD in cities, rural pilot projects.	Private sector becoming major supplier of pills. CSM directed at meeting specific consumer needs. Demand for VSC growing and facilities to provide clinical methods coming on line (increase in government participation). Rural facilities and mobile teams needed.	Private sector strong in delivery of temporary methods. Public sector strengthening delivery of clinical methods since demand for more effective methods increasing.	Public sector system well developed to provide clinical methods. Private sector potential is large and realized in LAC, increasing in Asia.
Sustainability	Cost recovery systems needed for services to urban early adopters for clinical and temporary methods.	Marketing to A&D (upper income) consumers/cost recovery for services to urban groups which can afford to pay.	Social marketing to C&D (lower income) consumers.		Cost recovery/social marketing systems sustained. Market segmentation of consumers/pricing structure well delineated.
				Cost participation for low income consumers of services for voluntarism, compliance and appreciation of services	
Comparative Advantage	Public sector: Integrating FP in MOH clinics. Private sector: Linking FP programs to modern and indigenous social groups, e.g. worker based programs, market women, etc. Commercial sector: supply methods to pharmacists/physicians.		Emphasize sector with biggest payoff for increased prevalence.	Equalize competency levels among sectors/agencies and reduce overlap.	All sectors involved and roles well understood.

APPENDIX F: REVISED TARGET MODEL

METHOD MIX

	1993 %	1994 %	1995 %	1996 %
Condoms	39.9	38.5	37.1	34.4
Female VSC	2.0	2.0	2.0	2.6
Injectable	12.2	14.0	15.9	17.7
IUD	5.4	5.9	6.4	7.6
Norplant	0.0	0.1	0.3	0.4
Orals	33.8	32.8	31.9	30.9
Vag. Tablets	6.3	6.6	6.5	6.4

	1997 %	1998 %	1999 %	2000 %
Condoms	32.5	30.7	28.8	27.0
Female VSC	3.2	3.8	4.4	5.0
Injectable	19.5	21.3	23.2	25.0
IUD	8.0	8.3	8.7	9.0
Norplant	0.6	0.7	0.9	1.0
Orals	29.9	28.9	28.0	27.0
Vag. Tablets	6.7	6.2	6.1	6.0

PROXIMATE DETERMINANTS OF FERTILITY

	1993	1994	1995	1996
Number of WRA	3,543,571	3,684,489	3,825,408	3,966,326
% WRA Married	68.1%	67.7%	67.3%	66.9%
Post Partum	13.1 mths	12.9 mths	12.7 mths	12.5 mths
Total Abortion Rate	0.0	0.0	0.0	0.0
Sterility	3.0%	3.0%	3.0%	3.0%
TFR	6.0	5.9	5.8	5.7
Prevalence	14.8%	16.3%	17.7%	19.2%

	1997	1998	1999	2000
Number of WRA	4,107,245	4,248,163	4,389,082	4,530,000
% WRA Married	66.1%	66.7%	65.3%	65.9%
Post Partum	12.4 mths	12.2 mths	12.0 mths	11.8 mths
Total Abortion Rate	0.0	0.0	0.0	0.0
Sterility	3.0%	3.0%	3.0%	3.0%
TFR	5.6	5.5	5.4	5.3
Prevalence	20.6%	22.1%	23.5%	25.0%

APPENDIX G: DONOR AGENCY ACTIVITY

The World Bank

The First Health and Population Project ($15M, 1986-1988) provided equipment, materials and supplies for rural health facilities, support for improved service delivery and training. The second Health and Population Project ($27M, 1990-1995) comprises 6 components: a) drug and vaccine supply ($6M) and drug infrastructure rehabilitation ($2.6M); b) MOH institution building ($0.7M); c) supply, repair and maintenance of district hospital equipment ($5M); d) population and family planning ($4.7M); e) district level primary health care ($6.7M); and, f) a prizes fund to promote improved performance ($0.9M).

United Nations Fund for Population Activities (UNFPA)

During the period 1984-1990, a US$3M grant has financed MCH/FP activities and the collection and analysis of the 1984 census data. The current program ($4.6M, 1990-1995) finances training activities ($0.7M), administrative support and equipment to regions and headquarters ($0.8M), contraceptives ($0.7M), technical assistance and evaluation ($0.6M).

United Nations Childrens Fund (UNICEF)

The 1986-1990 program ($6.5M) main focus was on immunization and diarrheal disease control. Another focus the development of comprehensive community-based PHC systems in selected districts à la Bamako Initiative. UNICEF's new program ($10M, 1991-1995) is devoted to 4 main projects: a) iodine deficiency ($0.7M); b) EPI/ORT ($4.4M); c) district PHC development ($3.8M); d) food and nutrition policy development ($0.06M); and, e) safe motherhood ($0.8M).

Overseas Development Assistance (ODA)

ODA supports technical assistance, health education, training fellowships and supply of medical equipment. A $1.4M budget will be devoted to contraceptive supply (funds to be channelled through UNFPA).

The World Health Organization (WHO)

WHO supports a wide range of disease control program. During the 1993-1995 period, WHO plans to support: a) health situation and trend assessments ($0.2M); b) PHC ($0.5); c) development of human resources for health ($0.67M); d) promotion of oral health ($0.55); e) mental and neurological disorders ($0.037M); f) malaria prevention and control activities ($0.27M); g) tuberculosis and leprosy prevention and control activities ($0.03M); h) other communicable disease prevention and control activities ($0.2M); and, i) the global program on HIV/AIDS ($0.3M).

Save the Children Fund (SCF)

The SCF program for the 1992-1993 period is estimated at $0.5M and is targeted towards: a) the development of the MOH transport system ($0.2M); b) the strengthening of district and sub-district health management teams in Eastern Region ($0.04M); c) capacity building of Eastern Region and MOH national level staff ($0.06M); d) research and information systems of the Eastern Region ($0.03M); e) HIV/AIDS control in the Eastern Region (0.02M); f) direct support to the Eastern Regional Health Administration ($0.03M); and, g) technical assistance to the Eastern Region ($0.07M).

Danish International Development Agency (DANIDA)

Danida's five-year Health Sector Support Program ($22.1M, 1993-1998) will support the strengthening of PHC in the Upper West Region ($10.5M), the strengthening of PHC Training Institutions ($7.5M), and the prevention and control of tuberculosis ($4.1M).

Canadian International Development Agency (CIDA)

From 1984-1990, CIDA provided $3.9M through UNICEF in support of the EPI program. In addition, $2.5M was provided to strengthen the health and hygiene education activities linked to the Eastern Region Water Supply Program.

Germany's Gesellshaft fur Techische Zusammernarbeit (GTZ)

GTZ's interventions have involved a small community-based program and the supply of drugs in the Northern Region. Beginning in 1992, GTZ has supported health systems development on a region-wide scale (over 3 years, DM 3M or $1.7M @ $1=DM1.7). GTZ has also financed a unit in Western Regional Hospital to screen blood for HIV and to treat sexually transmitted diseases.

European Economic Community (EEC)

In the period 1984-1990, $0.6M was spent on the provision of essential drugs and in the rehabilitation of Western Region Hospital. In 1992 cedis 300M were provided (around $0.5M) as balance of payment support to policy conditionality in the health sector. A cedis 6 billion ($10.2M) as MOH recurrent budget support will be provided in 1993.

African Development Bank (ADB)

The ADB assisted in the financing of feasibility studies for 5 district hospitals, 1 regional hospital and 2 teaching hospitals for an amount of $1.8M. A loan of $18M, 1989-1994 was made available for the rehabilitation of Komfo Anokye and Korle-Bu Teaching Hospitals. An agreement for Hospital Rehabilitation Project II ($20M) was recently signed.

Saudi Fund for Development

A loan of $9M for the construction of 40 new health centers nation-wide (scheduled for 1989-1993) is still under negotiation.

Government of Japan

Japan supplies, annually, vehicles ($2.3M) and $1.5M budget to the Noguchi Memorial Institute for tropical disease, and grants for the purchase of X-ray equipment.

APPENDIX H: LIST OF PRIORITIES AND PROPOSED INTERVENTIONS

PRIORITY 1: Improve the policy environment for population programs

Proposed Interventions	
Short Term	Long Term
Deepen Political Commitment	
Regional RAPID models	
RAPID activities with target groups.	
Create a population policy support group among parliamentarians	District level workshops/focus groups to guide FP/DEC strategy process
Multi media IE&C activities intensified and special targeted campaigns observational travel for opinion leaders.	Multi-media DEC activities continued
Develop presentation on FP/MCH relationships and workshops for key provider groups	
Strengthen coordinating capacity of NPC	
Observational travel for NPC, policy makers.	RAPID-type presentations in line, ministries and NGOs
Increase training of NPC staff	
Strategic Planning workshops with ministers	Assessment of alternative center-district linkage mechanisms
Review of the implications of decentralizing for population program implementation	
Transfer MIS developed under FPHP to secretariat	
Secondary analysis of DHS	

Reform of Regulatory Environment and Customary Practices	
Review legal and regulatory constraints to policy implementation and development of reform strategy	
Assess appropriateness of provider certification criteria	
Develop service delivery/training guidelines	
Improve knowledge of providers through in-service training and workshops	Continue training of providers through in-service training and workshops
Conduct contraceptive technology updates for service providers, policy makers and media	Continue to conduct contraception updates
Conduct research to validate safety and efficacy for providers and policy-makers of proposed change in regulations.	

PRIORITY 2: Promote Public/Private Collaboration

Proposed Interventions	
Short Term	Long Term
Exchange of workplans between public and private sector organizations	Continue to exchange workplans
Ensure that in-service training is conducted jointly	
Develop common service delivering guidelines and protocols	
Address in appropriate regulatory barriers to service delivery in the private sector	

PRIORITY 3: Intensify support for demand generation and supply for non-clinical methods

Proposed Interventions	
Short Term	Long Term
Provide support and TA to the public sector logistics system	Provide added emphasis on rural areas and target audiences such as youth and men.
IEC campaigns to build knowledge	Continue IEC campaigns to build knowledge of individual methods
Family planning counseling training	Expand work with NGOs on distribution and education in target areas
Work with NGOs on distribution and education	Continue family planning counseling training
Employer based services	Expand employer based services
Assistance to GRMA	Create distribution for private providers
Training of TBAs	Provide assistance to extend network of GRMA and PPAG
	Create a sustainable training capacity (including pre-service training)
	Extend family planning network to other message deliverers and distributors such as agricultural extension agents, teachers, and others.

PRIORITY 4: Constraints to Demand for Long-Term Methods

Proposed Interventions	
Short Term	Long Term
Increase awareness and knowledge about benefits of long-term methods. Focus IEC efforts on interpersonal communication and community mobilization.	Actively promote injectables, as an appropriate and easily accessible method for long-term or temporary use. ——— Develop targeted demand generation activities for IUD and sterilization for specific audiences built around the delivery infrastructure.
Develop a comprehensive NORPLANT strategy	Establish and maintain adequate counseling systems
Draw on satisfied users to promote an environment of acceptance.	Develop referral systems for clinical services.
	Promote and market NORPLANT as appropriate.

PRIORITY 5: Increase capacity in both the public and private sectors to supply long-term and permanent methods of contraception

Proposed Interventions	
Short Term	Long Term
PUBLIC SECTOR	
Inventory the status of previously trained personnel.	Complete the training of service providers
Extend current training capacity in order to provide training to public, NGO and private sectors.	Institutionalize the training capacity
Develop a critical mass of trained providers.	Provide capacity in post-partum and post-abortion IUD insertion
	Ensure that family planning counseling and clinical method service delivery are established in all pre-service training facilities
NGO	Support PPAG increased capacity to deliver long-term methods
PRIVATE SECTOR	
Develop a pilot program for provision of clinical methods in the private sector as a precursor to social marketing of long term methods.	Initiate social marketing of long term methods and private provider networks.
Assist the development of health insurance systems	Develop a community doctors and midwives programs.
Increase the training of private midwives	Extend the coverage of insurance schemes
Initiate employer-based and employer-financed private delivery systems	Continue to encourage employer-based and financed delivery systems

PRIORITY 6: Foster technical as well as financial sustainability of population and family planning activities

Proposed Intervention	
Short term	Long term
Use NPA to encourage service provision to low-income and indigent groups	Cost effectiveness and cost efficiency studies
Use of NPA to encourage additional allocation to MCH/FP	Explore alternative financing strategies
	Financial incentive schemes in the private sector to serve rural and under-served areas

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APPENDIX I: SHORT TERM ACTION PLAN

Intervention	Mechanism	Possible Counterpart Organization
PRIORITY 1 **Deepen political commitment**		
Observational Travel	OPTIONS Buy-in (reprogram)	NPC, PIP, Secretariat
Strategic planning workshops	OPTIONS Buy-in (reprogram)	NPC, Secretariat
New RAPID development; targeted presentations	RAPID (RD/POP) OPTIONS Buy-in (reprogram)	NPC and line ministries; PIP
Regional RAPID model development and presentations; dissemination of model information to districts	RAPID (RD/POP); NPA funds to PIP	PIP; Regional policy makers; community leaders
Review implications of decentralization	OPTIONS (RD/POP) (reprogram)	NPC
Develop presentations on MCH/FP comparative risks for providers and MOH	FHI (buy-in) OPTIONS (reprogram)	MOH - MCH/FP
PRIORITY 2 **Continue and intensify support for non-clinical methods**		
Logistics management support	FPLM (RD/POP)	Ministry of Health
Pilot study of teachers as CBDs	Operations Research (Africa OR/TA)	MOH, Ministry of Education
PRIORITY 3 **Generate a climate of acceptance and demand for long-term methods**		
Targeted campaigns to increase demand	PCS Buy-in or RD/POP	MOH, GSMF
Use of satisfied users for motivator	PCS Buy-in or RD/POP	MOH, GSMF
Develop and test referral systems for clinical services	Operations Research	
Develop comprehensive NORPLANT strategy	AVSC/FHI	

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Intervention	Mechanism	Possible Counterpart Organization
Training to improve provider acceptance of long-term methods (contraceptive technology updates)	FHI	
PRIORITY 4 **Increase capacity to deliver long-term methods**		
Expand capacity through training (in-service)	AVSC (RD/POP, Buy-in, coop.agr., NPA) JHPIEGO (Buy-in)	MOH, Private providers, GRMA
Pilot program for provision of clinical methods to precede social marketing (full service center)	SOMARC	GSMF
Post-partum, -abortion Program (IUDS)	AVSC	MOH
Increase service delivery sites	AVSC (NPA)	
PRIORITY 5 **Increase emphasis on technical and financial sustainability**		
Business skills to private providers and GRMA	INITIATIVES (RD/H)	GRMA; private providers
Financial assistance for nurse midwives and private providers to set up in undeserved areas	INITIATIVES (RD/H) Buy-in	
Additional studies for strategy development **1. Adolescent F.P.** **2. Cost/Pricing studies** **3. Acceptability of sterilization, L.T. methods**		