



**ASSOCIATES**

**ASSESSMENT**  
**of the**  
**GHANA AIDS AND POPULATION (GHANAPA) PROJECT**

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## ACRONYMS AND ABBREVIATIONS

ARH	Adolescent Reproductive Health
AVSC	Access to Voluntary and Safe Contraception International
BUCEN	U.S. Bureau of the Census
CA	Cooperating agency
CBD	Community-based distributor
CEDPA	The Centre for Development and Population Activities
CHN	Community Health Nurse
CP	Conditions precedent
CPR	Contraceptive prevalence rate
CPT	Contraceptive procurement table
CYP	Couple years of protection
DHS	Demographic and Health Survey
EDLNF	Essential Drugs List and National Formulary
FHI	Family Health International
FMG	Female genital mutilation
FPHP	Family Planning and Health Project
FPLM	Family Planning Logistics Management Project
FP/RH	Family planning/reproductive health
FY	Fiscal year
GAF	Ghana Armed Forces
GDHS	Ghana Demographic and Health Survey
GHANAPA	Ghana AIDS and Population project
GOG	Government of Ghana
G/PHN	USAID Bureau for Global Programs, Center for Population, Health and Nutrition
G/PHN/POP	USAID Bureau for Global Programs, Field Support and Research, Center for Population Health and Nutrition, Office of Population
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
GSS	Government Statistical Service
GUNSA	Ghana United Nations Students Association
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HPN	Health, Population and Nutrition Office
IEC	Information, education and communication
IMPACT	Implementing AIDS Prevention and Care Activities
IR	Intermediate Result
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communications Service
MCH/FP	Maternal and Child Health/Family Planning Unit
MFCS	Muslim Family Counseling Services
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOH/HEU	Ministry of Health/Health Education Unit
MOH/HRDD	Ministry of Health/Human Resources Development Division
MOYS	Ministry of Youth and Sports
NACP	National AIDS Control Program
NGO	Nongovernmental organization
NMC	Nurses and Midwives Council
NPA	Non-project assistance
NPC	National Population Council
NVTI	National Vocational Training Institute
OYB	Operational year budget
PACC	Population and AIDS Coordinating Committee

PHRL	Public Health Reference Laboratory
PIL	Project implementation letter
PIP	Population Impact Project
PPAG	Planned Parenthood Association of Ghana
RAPID–AIM	Resources for the Awareness of Population Impacts on Development—AIDS Impact Model
RDAC	Regional and District AIDS Committees
RH	Reproductive Health
RHESY	Reproductive Health Education and Services for Youth
RPO	Regional Population Office
SMO/DDHS	Senior Medical Officer, Director, District Health Service
SO	Strategic Objective
SOAG	Strategic Objectives Agreement
SOMARC	Contraceptive Social Marketing III Project
SOP	Standard operating procedure
STD	Sexually transmitted disease
TBA	Traditional Birth Attendant
TFR	Total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	U. S. Agency for International Development
VFT	Vaginal foaming tablets

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## **EXECUTIVE SUMMARY**

### **BACKGROUND**

In 1993, U. S. Agency for International Development (USAID)/Ghana's Family Planning and Health Project (FPHP) was still three years from its scheduled completion in 1996. Two studies conducted that year, however, indicated that Ghana was moving more quickly than anticipated toward meeting its fertility targets. Specifically, the 1993 Consumer Baseline Study and the Demographic and Health Survey (DHS) of that year indicated that Ghana's contraceptive prevalence rate (CPR) had already reached somewhere between 14.8 percent (Consumer study) and 10.1 percent (DHS) versus the country's CPR of just 5.2 percent in 1988. Moreover, the DHS showed that fertility—as measured by the total fertility rate (TFR)—had fallen from 6.4 in 1988 to 5.5 in 1993. USAID was convinced by this evidence that an expanded program of assistance could help accelerate the pace of Ghana's transition, that is, from the emergent phase (0–7 percent CPR) through the launch phase (8–15 percent CPR), especially if a new assistance program focused on several continuing constraints to broader and more effective contraceptive use in Ghana. These constraints included inadequate resources from the government of Ghana (GOG) devoted to family planning, health care provider biases, contraceptive pricing, commodity management, client misperceptions about contraceptives, and major gaps in the service delivery system, particularly with regard to clinical methods, men and adolescents.

At about this same time, USAID/Ghana and its partners in the reproductive health sector were becoming increasingly concerned that human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)—while not yet perceived by Ghanaian leadership or citizens as a major health threat—could increase significantly in the years ahead unless immediate steps were taken to change risky sexual behavior and treat sexually transmitted diseases (STDs)

With these factors in mind—the need to build on the considerable success realized to date under FPHP, but in the context of major unresolved challenges for the future—USAID moved quickly to launch an expanded assistance effort—the Ghana AIDS and Population (GHANAPA) project—in September 1994. (The GHANAPA and FPHP projects overlapped until the latter was concluded in 1996).

### **PROJECT DESCRIPTION**

The six-year (fiscal year [FY] 1995–2000) \$45 million GHANAPA project established two overall objectives:

- Increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate from 10 percent to 20 percent and shift the method mix from 20 percent to 40 percent for long-term methods,

and

- Increase awareness and practice of HIV/AIDS risk reduction behavior by increasing the reported use of condoms during the most recent act of sexual intercourse with a nonregular partner to 50 percent and the number of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

The project's assistance mechanisms included a **non-project assistance (NPA) component** (\$14 million) under which annual cash grants would be provided to the GOG upon the latter's satisfaction of certain conditions precedent (CPs); and, **project assistance** (\$31 million) to support GOG efforts to improve and extend its reproductive health service delivery system; to improve diagnosis, treatment and tracking of STDs; to provide contraceptive commodities; and, to fund grants to four organizations (Planned Parenthood Association of Ghana [PPAG], Access to Voluntary and Safe Contraception [AVSC] International, the Ghana Registered Midwives Association [GRMA], and the Ghana Social Marketing Foundation [GSMF]), each of which had an important role to play in the achievement of GHANAPA objectives. In addition, the GHANAPA design called for technical assistance (\$13 million) from USAID/Washington centrally funded contracts and cooperative agreements (subsequently changed to Field-Support-funded technical assistance). Other anticipated funding included \$6.6 million from the GOG and \$4.66 from nongovernmental organization (NGO) grantees, representing a total program cost of approximately \$69.3 million over the six-year period.

By the end of the project on September 30, 2000, the project is to have produced the following results:

- Nearly 997,000 Ghanaian women will be using a modern method of contraception (versus 328,000 in 1993);
- Of this number, 361,000 (40 percent) will be using longer term, more effective methods, such as intrauterine devices (IUDs), Norplant, injectables, and voluntary surgical contraception;
- The TFR will be 5, versus nearly 5.5 in 1993;
- The private sector will be providing proportionately more family planning and STD prevention, diagnosis and treatment services through their expanded distribution and information networks; and,
- The public sector will be allocating more resources to family planning and AIDS/STD prevention activities, thereby leading (along with USAID endowments for the GSMF and a population chair at the University of Ghana at Legon) to greater sustainability of Ghana's family planning and National

## AIDS Control Programs (NACPs).

In 1997, USAID/Ghana organized its development assistance program to be in accordance with the Agency's managing for results principles and procedures. GHANAPA was subsequently integrated into the Mission's new Strategic Objective No. 3 (SO3), "Improved Family Health," and was expected to aid in the achievement of Intermediate Result (IR) 3.1—Increased use of reproductive health services, including family planning, safe motherhood and HIV/STD prevention. (A second IR under SO3—IR 3.2—concerns the Mission's relatively new Child Survival program, and was not included under the GHANAPA assessment).

## **PROJECT PERFORMANCE**

GHANAPA has produced some significant accomplishments, even if some fell short of expectations.

- Ghana's modern contraceptive prevalence rate is over 13 percent. This is well short of the 20 percent target called for by the project, but is relatively good when compared with CPRs elsewhere in Sub-Saharan Africa.
- Ghana's policy and regulatory environment for population and family planning is very positive. However, while a National Policy on AIDS will be released in the very near future, few public leaders or prominent figures have expressed support for a more vigorous GOG response to the threat posed by HIV.
- Long-term family planning methods are not yet a significant factor in Ghana's family planning/reproductive health (FP/RH) program—hindered by cultural biases, unresolved client fears and misperceptions, and the lack of any meaningful information, education and communication (IEC) support for long-term methods. Two clinical methods, however—injectables and Norplant—show strong promise for the future.
- Ghana's contraceptive management system is orderly, efficient and effective.
- Oral contraceptives and condoms are being marketed at affordable prices by the Ghana Social Marketing Foundation through more than 3,000 outlets.
- The lessons of a USAID-supported operations research project (Navrongo) have been embraced by the leadership of the Ministry of Health (MOH) as a model of what may become a more efficient, effective health care system that delivers essential FP/RH services to people in their own communities.

- Protocols and guidelines developed for health care providers have the potential to standardize and improve service delivery at all levels of the health care system. Dissemination of the guidelines is proceeding very slowly, however.
- Ghana's total fertility rate of 4.6 is in fact better than the 5.0 target set forth in the GHANAPA design—and even though the project cannot claim full credit for that figure, it is clear that this TFR could not have been attained in the absence of the project.
- Public awareness of HIV/AIDS is high. However, this awareness has not yet been translated into the necessary level of behavior change, and GOG health education efforts have been inadequate.
- The GOG's HIV sentinel surveillance system is in place, and can serve as an accurate early warning system for any upsurge in HIV prevalence. Current national prevalence, as measured by this system, is approximately 4 percent.
- An increasing number of health care practitioners in the public and private sectors have adopted STD-management protocols developed under the project.

The project's shortcomings can be attributed in good part to an overly ambitious set of targets—and timetable to achieve them—in the project design. In hindsight, for example, it was unrealistic to expect the contraceptive method mix to shift from 20 percent long term in 1993 to 40 percent long term in just six years, given the serious cultural and infrastructural impediments to such a dramatic change. Similarly, the project's objective of effectively doubling the overall CPR—from approximately 10 percent in 1993 to 20 percent in 2000—was extremely optimistic. The unmet need for reproductive health services remains high in Ghana, such that a continuing, well-executed assistance program can be expected to produce a steady, if not especially dramatic, increase in prevalence in the years ahead.

The project was also constrained by inadequate levels of support on the part of the GOG for its own RH program—support which was expected as a consequence of USAID's NPA agreement with the GOG. (In fairness to the GOG, USAID/Ghana terminated NPA abruptly in 1997 without prior consultation with the GOG; some resources which the latter had anticipated under the NPA were never provided.)

## **CONCLUSIONS/KEY LESSONS FOR THE FUTURE**

USAID/Ghana and its partners can draw some useful lessons from the GHANAPA project as they plan for a future assistance effort. These lessons suggest, for example, that

- The centerpiece efforts of the USAID assistance program in FP/RH should concentrate on the basics, that is, measures needed to ensure that all sexually active Ghanaians have access to at least three and preferably four FP methods—including, at a minimum, pills and condoms. Special attention should be given to training and service extension efforts, which will expand the availability of injectables and Norplant.
- USAID, in partnership with the POLICY project and the GOG, should re-orient its policy and advocacy investments to focus on efforts to increase public awareness of the threat posed by HIV/AIDS and measures the public can take to avoid infection. This initiative should be concentrated, moreover, on measures needed to communicate with young adults and adolescents, and should include specific information they need to prevent unwanted pregnancy and to avoid transmission of STDs and HIV. Importantly, this communication/advocacy strategy should be complemented by strengthened efforts by the public and private sectors to ensure that young adults and youth have improved access to FP/RH services.
- The Navrongo pilot project shows considerable promise as a model for the delivery of quality health care at the community level in Ghana. USAID support for an expansion effort should avoid cost-and-capital-intensive items, however, which might complicate the wide-scale replicability of the model.
- USAID could realize some cost and managerial efficiencies by concluding and/or re-orienting some of its cooperating agency (CA)–implemented activities, especially those whose mission has changed as a result of new requirements.
- Ghana is currently enjoying some welcome but probably brief isolation from the HIV/AIDS pandemic. USAID and its partners need to address the threat of HIV/AIDS, especially among young adults, while there is still time to forestall an increase in prevalence levels. Program resources currently used to promote a favorable climate for population activities at the regional and district levels should be refocused to address the reproductive health of youth and young adults at those levels.

## **SUMMARY OF KEY RECOMMENDATIONS**

### **IR 3.1.1: Increased Access to Reproductive Health Services**

#### Family Planning

1. As it looks to the future shape of its program assistance, USAID/Ghana should focus

on efforts to expand and improve the availability of basic FP services to ensure that all potential users have access to at least three FP/RH methods, including, at a minimum, pills and condoms. Special efforts should be made to expand the availability of injectables and Norplant. Assistance for other long-term methods (IUD, voluntary sterilization) should concentrate for the midterm (3–4 years) on measures to improve the quality of existing services, thereby enhancing their credibility and acceptability among the general population. USAID should not invest in the expansion of service sites for minilaparotomy and vasectomy at this time.

2. GHANAPA's efforts to make quality long-term services available are not yet supported by any meaningful IEC campaign to promote use and overcome obstacles to acceptance. Specific recommendations on IEC and demand generation (see below) underline clients' need to be advised of the availability, utility and safety of these methods, and emphasize that messages should focus directly on clients' fears and misperceptions regarding long-term methods.
3. USAID should direct the Family Planning Logistics Management Project (FPLM) to develop a couple years of protection (CYP) estimation tool—based on contraception consumption and distribution data—which will provide program partners with an accurate, ongoing estimate of CYPs versus program targets.
4. Looking ahead to the possible expansion of the Navrongo model, the MOH might want to consider adopting a different recruitment and assignment practice for community health nurses (CHNs)—notably the recruitment from and placement of CHNs back to their home communities.
5. USAID should allow the current grant to GRMA to expire as scheduled and not execute a follow-on agreement.
6. PPAG should be encouraged to develop a low-cost incentive package to address the high turnover rate of its community-based distributor (CBD) personnel. This package might include bicycles, or in lieu thereof, modest reimbursement to cover transportation costs to villages beyond their home communities.

#### HIV/AIDS/STD Prevention

1. The GSMF condom targeted for family planning (Protector Plus) should be dropped; GSMF should focus on marketing condoms for prevention of STDs and HIV transmission.
2. Considering the importance of condoms to the reproductive health of young adults, the Champion condom should be as aggressively targeted to young adults as is possible.

3. To accurately track GSMF's progress toward self-reliance, the cost of its noncommercial activities, such as collaboration with the MOH and training for NGOs, should be accounted for separately from GSMF's costs for social marketing activities.
4. GSMF should encourage its new sales team to establish sales outlets in bars and hotels and other appropriate environments likely to reach high-risk clients.

### **IR 3.1.2: Improved Quality of Reproductive Health Services**

#### Family Planning

INTRAH/PRIME should work closely with the MOH to expedite dissemination of the policies, standards and protocols to all levels of the health system. USAID, the MOH and INTRAH/PRIME should ensure that all nursing and midwifery schools, medical schools, and other institutions responsible for training health service providers participate in the ongoing effort to disseminate broadly these new guidelines.

#### HIV/AIDS/STD Prevention

1. The NACP should expedite its training in STD management and prevention counseling, with special reference to the five regional training units that have not yet received this training.
2. The Public Health Reference Laboratory (PHRL) should, in consultation with the Institutional Care Division of the Ministry of Health, develop a work plan and budget to complete dissemination of the Standard Operating Procedures within 7–12 months.

### **IR 3.1.3: Increased Demand for Reproductive Health Services**

#### Family Planning

1. Following consultation with the United Nations Population Fund (UNFPA) and the Ministry of Health/Health Education Unit (MOH/HEU) to avoid duplication of effort, USAID should assist the MOH in the development, reproduction and distribution of selected information/education messages (electronic/print/interpersonal) in support of the FP/RH program. Special care should be given to ensure that these messages address specific obstacles to FP/RH acceptance and practice in Ghana, namely fear of contraceptive side effects, misperceptions and rumors, and cultural biases, and that these messages provide practical, easy-to-use information on how and where clients may obtain FP/RH services.

2. Johns Hopkins University/Population Communications Service (JHU/PCS) should develop and submit to USAID/Ghana a multiyear strategy and work plan indicating the rationale, elements, schedule, and estimated cost of the organization's future IEC activities in Ghana. This strategy/work plan should clearly describe how JHU/PCS assistance will address consumer fears and misperceptions related to family planning practice, and how it will effect behavior change among population groups at high risk of contracting HIV/STD infection. Moreover, and in keeping with the project management style of all other cooperating agencies in Ghana, this strategy/work plan should include a schedule for the replacement, within 2–3 years, of the expatriate JHU/PCS adviser with a host country national.
3. To the extent manageable within the strategic and cost parameters of the above work plan, JHU/PCS should assist the MOH, National Population Council (NPC) and PPAG in the development of prototypes of messages to be used in the electronic media. These prototypes would be adapted at the regional level, where attempts should be made to obtain free public services radio air time in local languages. Again, most of these messages should be selected to address obstacles to acceptance of FP/RH services.

#### HIV/AIDS/STD Prevention

1. Recent efforts to target the uniformed forces and travelers at transportation centers should be encouraged. More specifically, USAID should continue to focus its HIV/AIDS/STD prevention efforts on high-risk groups who are most vulnerable to infection, such as truck drivers, miners and sexually active unmarried youth.
2. The MOH sentinel surveillance system is collecting district-level prevalence data on STDs and HIV. NACP, the NPC and the MOH should make these prevalence data, especially data regarding youth, available to region/district-level population and AIDS committees to reinforce the latter's efforts to conduct advocacy work at these levels.

#### **IR 3.1.4: Improved Policies for Reproductive Health Services**

##### Family Planning

1. USAID should work with the NPC Secretariat to explain USAID plans and priorities, underline USAID recognition of NPC's role as an advocate for change within the GOG, and engage the NPC (and NACP) in an effort to forestall the arrival of an HIV epidemic in Ghana.
2. The NPC should develop a mechanism to ensure that adequate GOG funds are made available to its regional- and district-level offices.

### HIV/AIDS/STD Prevention

1. The POLICY project should revise the Resources for the Awareness of Population Impacts on Development–AIDS Impact Model (RAPID–AIM) to incorporate to the fullest extent possible district-level population and HIV–prevalence data.
2. The current structure of the program and its location in the Disease Control Unit should be reviewed in order to give the program the visibility and resources necessary for effective implementation of a national response to the threat posed by HIV/AIDS.

## I. INTRODUCTION

The Ghana Population and AIDS (GHANAPA) project is a six-year (fiscal year [FY] 1995–2000), \$45 million activity designed to increase the use of modern and effective family planning methods and to reduce the rate of increase of HIV prevalence in Ghana.

### BACKGROUND

Launched in September 1994, GHANAPA overlapped for about a year with the U.S. Agency for International Development's (USAID) predecessor assistance program—the Family Planning and Health Project (FPHP)—which started in 1990 and was originally scheduled to continue until 1996. This earlier activity, comprised of both project and non-project assistance, was designed to assist Ghana in moving its population/family planning program from the emergent phase (0–7 percent contraceptive prevalence rate [CPR]) through the launch phase (8–15 percent CPR) by increasing the modern CPR from 5.2 percent in 1988 to 15 percent by 1996. A Consumer Baseline Study conducted in April 1993 suggested that Ghana had already reached a modern CPR of 14.8 percent among married women. Moreover, while the 1993 Demographic and Health Survey (DHS) showed a more modest rise in the CPR to 10.1 percent, the study also showed a substantial decline in fertility among women—evidenced by a drop in the total fertility rate (TFR) from 6.4 in 1988 to 5.5 in 1993. (The DHS surmised that various factors, such as abortion, periodic abstinence and breastfeeding, might be responsible for a decline in fertility without the concomitant rise in contraceptive prevalence).

By 1993, the FPHP activity was therefore demonstrating real progress, including evidence that Ghana had started on a strong downward trend in fertility. Contraceptive prevalence had risen only slightly, and several constraints still needed to be addressed if Ghana was to move successfully through the launch phase to the next growth phase of population programs: government of Ghana (GOG) resources devoted to family planning and acquired immune deficiency syndrome (AIDS) prevention and control activities were declining, health service provider practices and biases sometimes impeded client access to appropriate information and services, contraceptive pricing impeded prospects for cost recovery and produced distortions in commercial sales of contraceptive products, commodity forecasting and warehousing practices resulted in periodic overstocking and/or stockouts of contraceptive commodities, low levels of public knowledge about contraceptives—and frequent misperceptions about contraceptives—hindered acceptance of family planning practices and resulted in high discontinuation rates among users, and major gaps in the service delivery system existed, particularly with regard to clinical methods, men and adolescents.

Also by 1993, USAID/Ghana noted that—while human immunodeficiency virus (HIV) prevalence in the country was low relative to other African countries, and public knowledge about human immunodeficiency virus/acquired immune deficiency syndrome

(HIV/AIDS) was high—a sharp increase in HIV incidence should be expected in the next five to six years unless quick and effective action were taken to change risky sexual behavior and treat sexually transmitted diseases (STDs), which are co-factors in the heterosexual transmission of HIV. With these factors in mind—the considerable successes realized to date under FPHP, but in the context a major continuing obstacle to further progress in population and reproductive health—USAID/Ghana decided to move quickly into the launch of an expanded assistance effort—GHANAPA—which would build on the previous project’s achievements and address the sector’s still significant challenges.

## **PROGRAM DESCRIPTION**

### **Project Objectives**

In view of the aforementioned factors, GHANAPA was designed to increase the use of modern and effective family planning methods and help stabilize the HIV/AIDS epidemic. (In 1998, child survival was added as a third component of GHANAPA. As a new initiative, however, child survival is not included in the scope of this assessment.) Although the project design included two components—family planning and AIDS/STD control—USAID sought to integrate its assistance efforts to the fullest extent possible, especially since both components were being addressed by many of the same public sector and private nongovernmental organization (NGO) institutions.

The overall objectives for GHANAPA (excepting child survival) are to

- Increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate from 10 percent to 20 percent and shift the method mix from 20 percent to 40 percent for long-term methods, and
- Increase awareness and practice of HIV/AIDS risk reduction behavior by increasing the reported use of condoms during the most recent act of sexual intercourse with a nonregular partner to 50 percent and the number of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

USAID put several support mechanisms in place to help achieve the foregoing objectives. These included non-project assistance (NPA), project assistance, and participation of USAID/Washington centrally funded projects. Other support was to be provided by GOG contributions and some cost-sharing by project grantees.

USAID intended to use NPA—a series of five yearly (1995–99) cash grants totaling \$14 million scheduled to be released to the GOG upon the GOG’s successfully meeting

certain conditions precedent (CPs)—to support critical policy reforms in the population/reproductive health sector. This policy reform agenda called for the GOG to

- Establish a Population and AIDS Coordinating Committee (PACC) to be chaired by the National Population Council (NPC) and comprised of all implementing organizations;
- Make available to the Ministry of Health (MOH) adequate resources to enable the Ministry to meet annual family planning benchmarks for couple years of protection (CYP). These benchmarks, moreover, were to reflect a gradual shift from short- to long-term methods;
- Revise the public sector contraceptive pricing policy;
- Allocate adequate resources [to support] and conduct HIV/AIDS/STD monitoring and prevention and control programs;
- Develop new clinical guidelines for family planning service delivery;
- Revise the Essential Drugs List and National Formulary (EDLNF) to include all contraceptives and additional drugs for the treatment of STDs; and,
- Establish improved contraceptive commodity forecasting and stocking procedures.

GHANAPA's \$31 million in project assistance was intended to support increased demand for family planning services and improvements in family planning service delivery, particularly focusing on long-term methods while continuing to expand the availability of short-term methods; and, to improve diagnosis, treatment and tracking of STDs. Specific activities included

- Expansion of pre-service and in-service provider training;
- Strengthening of the contraceptive logistics system;
- Support for multilevel information, education and communication (IEC) interventions;
- Coordination of public sector with private sector and NGO sector efforts;
- Further strengthening of the institutional capacity of the National Population Council (NPC) and the National AIDS Control Program (NACP);

- Assistance for MOH effort to develop a system of licensing laboratories and laboratory professionals, promote safer sexual behavior through IEC programs, and expand training for health care providers to identify and treat STDs and HIV/AIDS;
- Development of an improved HIV/STD serosurveillance system;
- Provision of contraceptives to the public sector (through the MOH), and to the private and NGO sectors (through the Ghana Social Marketing Foundation [GSMF]); and,
- Improvement of long-term sustainability of the program by increasing the channels through which the GSMF distributes commodities, and by establishing an endowment to ensure continuation of GSMF operations beyond the end of the GHANAPA program.<sup>1</sup>

Technical assistance amounting to \$13 million from the Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition (G/PHN)—funded contracts and cooperative agreements was to be provided in response to requests formulated by USAID/Ghana. (Early in the project, the funding mechanism for these centrally managed projects shifted largely to Field Support, although some USAID/Washington—funded activities—mostly involving research—continue in Ghana.) Other anticipated funding included the equivalent of at least \$6.66 million from the government of Ghana, and \$4.66 from NGO grantees, representing a total program cost of approximately \$69.3 million over the six-year period, FY 1995–2000.

### **Implementation Arrangements**

As noted, GHANAPA was to provide \$14 million in NPA to the GOG in five yearly installments subject to the government’s satisfaction of key CPs related to the project’s policy reform agenda. It was further expected, but not explicitly agreed to, that the contribution of these NPA funds would encourage the GOG to increase funding for the family planning and AIDS control activities of the Health Education Unit (HEU), the Maternal and Child Health/Family Planning Unit (MCH/FP), the Human Resources Development Division (HRDD), and the National AIDS Control Program (NACP) of the Ministry of Health (MOH); and, the National Population Council, which had been established further to a condition precedent of the NPA under the predecessor FPHP.

The \$31 million in project assistance was to include a \$6 million bilateral grant to the

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<sup>1</sup> GHANAPA also called for the endowment of an autonomous chair in population studies at the University of Ghana at Legon. This initiative was later rejected by the Academic Committee of the University, largely on the grounds that the university already had an unusually large number of autonomous units. Because the proposition never progressed beyond the discussion stage, it is not reviewed in this assessment.

GOG for analytical and operational research on population and AIDS topics, equipment and materials, participant training, and project support, evaluations and audits. USAID was to utilize \$14 million of project assistance funds for grants to support activities of the GSMF, the Ghana Registered Midwives Association (GRMA), and the Planned Parenthood Association of Ghana (PPAG); a cooperative agreement with Access to Voluntary and Safe Contraception (AVSC) International to promote long-term methods; and, grants for endowments for GSMF and for a chair in the autonomous Center for Population and Development at the University of Ghana at Legon. Contraceptives were to be procured via an operational year budget (OYB) transfer of \$11 million to the USAID Bureau for Global Programs, Field Support and Research, Center for Population Health and Nutrition, Office for Population (G/PHN/POP) Contraceptive Procurement Project.

### **End of Project Status**

The project is scheduled to end September 30, 2000. The project design anticipated that by that date

- Nearly 997,000 Ghanaian women will be using a modern method of contraception (versus 328,000 in 1993);
- Of this number, 361,000 (40 percent) will be using longer term, more effective methods, such as intrauterine devices (IUDs), Norplant, injectables and voluntary surgical contraception;
- The TFR will be 5, versus nearly 5.5 in 1993;
- The private sector will be providing proportionately more family planning and STD prevention, diagnosis and treatment services through its expanded distribution and information networks; and,
- The public sector will be allocating more resources to family planning and AIDS/STD prevention activities, thereby leading (along with the GSMF and University of Ghana at Legon endowments) to greater sustainability of Ghana's family planning and National AIDS Control Programs.

### **Subsequent Changes and Developments**

#### Management by Strategic Objectives (SOs) and Results

Strategic Objective 3 (SO3): During 1997, USAID/Ghana organized its development assistance program to be in accordance with the Agency's managing for results principles and procedures. Drawing on consultations with its key partners in the health sector, USAID established a new SO3—Improved Family Health—which is expected to signal a

more strategic approach to the implementation of USAID–assisted activities in the health sector. In September 1998, USAID/Ghana formally added child survival to its bilateral grant agreement, and in December 1998, revised its results framework to encourage integration and more fully support the maternal and child health care programs of the Ministry of Health. Two intermediate results (IRs) under SO3 were defined: IR 3.1, Increased use of reproductive health services, including family planning, safe motherhood and HIV/STD prevention; and IR3.2, Increased use of selected child survival services, including immunization, oral rehydration, integrated care of the sick child and improved nutrition. (As noted earlier, this evaluation focuses on IR 3.1 only).

In February 1999, USAID/Ghana and the GOG executed a Strategic Objective Agreement (SOAG) which formalized the parties’ agreement to collaborate in accordance with the new results framework.

Termination of the non-project assistance component: In 1999, USAID and the GOG signed a project implementation letter (PIL) terminating the NPA component of the GHANAPA agreement after an extended Congressional hold and ultimate loss of funds for that component.

### **Measuring Performance**

USAID measures changes in the SO—Improved Family Health—by monitoring three SO–level indicators, two of which relate to IR 3.1: the contraceptive prevalence rate (CPR) is used as a proxy for the total fertility rate (TFR), and HIV/STD–prevention performance is measured by changes in the HIV–prevalence rate. Key data sources include the Ghana Demographic and Health Surveys (GDHS) conducted every five years (1988, 1993, 1998), HIV–prevalence data from sentinel sites, and routine service statistics provided by partner organizations. Earlier in the project, USAID also used consumer surveys—scheduled to take place every two years after a 1993 baseline study, but subsequently downplayed because results were costly and not comparable with the GDHS, and situation analyses conducted in 1993 and 1996.

Preliminary results from the 1998 GDHS were made available in May 1999. Some key findings are shown below, along with comparable data from the 1993 GDHS:

<b>Indicator</b>	<b>1993</b>	<b>1998</b>	<b>Target for 2000</b>
Total Fertility Rate	5.5	4.6	5.0
CPR	10.1%	13.4%	20%
CYP (000)	483 (1997)	596	955
HIV Prevalence	2–5%	4%	<1%/year gain
Condom Sales (millions)	7.8 (1997)	10.2	18.3

These GDHS results indicate that fertility in Ghana has declined rapidly over the last

decade—from over 6 births per woman in the mid-1980's to 4.6 births per woman during the last five years. Fertility has fallen in every age group, and especially in the youngest age group (15–29). Differences by place of residence are marked, with rural women having two and a half more children than urban women. Fertility is highest in the Northern Region (7.0 births per woman) and lowest in the Greater Accra Region (2.7 births per woman).

Overall, 22 percent of currently married women report using a family planning method at the time of the survey, with approximately 13 percent reporting the use of a modern method. This 3–point increase in the modern CPR—from about 10 percent in 1993 to 13 percent in 1998—cannot fully account for the dramatic decline in the TFR of one child per woman over the last five years. Other proximate determinates of fertility are evidently influencing this change and should be the subject of further research, including secondary analysis of GDHS data.

The GDHS findings present clear challenges to family planning program planners—especially the study's findings indicating that both knowledge of and ever-use of family planning are high in Ghana, current use of contraception is low, and there is still a significant unmet need for family planning in the country.

With regard to HIV/AIDS/STD prevention, the GDHS found that public knowledge about AIDS is broad, but not deep: over 97 percent of men and women have heard of AIDS, but 14 percent of women and 9 percent of men stated that they did not know if AIDS is avoidable; and, 1 in 5 women and 1 in 10 men did not know of any way to avoid contracting AIDS. More problematically, 54 percent of women and 58 percent of men believe that they have no chance of contracting HIV/AIDS. Condoms play an important role in preventing the transmission of HIV/AIDS, but only 7 percent of men (and 3 percent of women) report having used condoms during their most recent sexual encounter for the prevention of HIV/AIDS.

### **Structure of the Assessment**

As noted previously, GHANAPA is composed of two major components—Family Planning and HIV/AIDS/STD Prevention and Control. The original GHANAPA Project Paper presented these two components as follows:

#### Family Planning Component

- |                               |                                                          |
|-------------------------------|----------------------------------------------------------|
| <u>Goal:</u>                  | Reduce Ghana's fertility rate.                           |
| <u>Performance Indicator:</u> | Reduce the TFR from 5.5 to 5.0 by the year 2000.         |
| <u>Purpose:</u>               | Increase the use of modern and effective family planning |

methods as measured by an increase from 10 percent to 20 percent in the modern contraceptive prevalence rate (CPR) and a shift in long-term methods from 20 percent to 40 percent of the overall method mix.

- Program Elements:
1. Improved Policy Environment
  2. Increased Demand for Family Planning Services
  3. Expanded Provision of Family Planning Services
  4. Greater Sustainability

### HIV/AIDS/STD Prevention and Control Component

Goal: Help reduce the rate of increase of HIV prevalence in Ghana.

Performance Indicator: Maintain the average annual rate of [increased] HIV incidence at no more than 1 percent among the adult population (1994 HIV prevalence was estimated to be 3.36 percent).

Purpose: Increase awareness and practice of risk reduction behaviors, as measured by increasing the proportion of respondents who report using a condom during the most recent act of sexual intercourse with a nonregular partner to 50 percent, and increasing the proportion of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

- Program Elements:
1. Improved Policy Environment
  2. Promotion of Safe Sexual Behavior
  3. Increased Diagnosis and Effective Treatment of Sexually Transmitted Diseases
  4. Improved HIV/AIDS/STD Serosurveillance Systems and Laboratory Capability

Also as noted above, USAID/Ghana and the GOG executed a Strategic Objectives Agreement (SOAG) in February 1999, which brings GHANAPA into accordance with USAID's managing for results principles. Specifically, USAID's new Results Framework established IR 3.1, Increased use of reproductive health services, including family planning, safe motherhood and HIV/STD prevention, as the overall framework for both FP and HIV/AIDS/STD prevention components of the project, and further grouped both components under four sub-IRs. These include

IR 3.1.1: Increased Access to Reproductive Health Services,

IR 3.1.2: Improved Quality of Reproductive Health Services,

IR 3.1.3: Increased Demand for Reproductive Health Services, and

IR 3.1.4: Improved Policies for Reproductive Health Services.

For the purposes of this assessment, the key activities implemented under GHANAPA were reviewed in the context of these four sub-IRs. It is hoped that this approach will help reinforce the dialogue between USAID and its partners along the strategic lines defined in the February SOAG, and facilitate Mission reporting further to its results framework.

A 4-person team comprised of two expatriates and two Ghanaians conducted the assessment. Prior to initiating the assessment in Ghana, team members reviewed project documents provided by USAID/Ghana; two team members consulted by phone and directly with representatives of selected U.S. cooperating agencies and with current and former USAID staff familiar with the GHANAPA project.

After the team assembled in Accra, assessment team members met with USAID/Ghana staff and personnel of the several public and private sector organizations and NGOs participating in the GHANAPA project, as well as with representatives of other donor agencies involved in the reproductive health sector in Ghana. Team members made field trips to Kumasi and Koforidua in Eastern and Central regions, respectively, to observe project operations in those areas.

During the team's final week in Ghana, two members presented the assessment team's overall findings, conclusions and recommendations at a meeting attended by representatives of USAID/Ghana, cooperating agencies, and the several Ghanaian organizations engaged in the GHANAPA project. Suggestions and comments provided at that meeting are reflected in this report.

## II. PERFORMANCE ASSESSMENT: FAMILY PLANNING

### IR 3.1.1: INCREASED ACCESS TO REPRODUCTIVE HEALTH SERVICES

#### Program Strategy

A major emphasis of the GHANAPA program is to assure the supply of short-term methods and gradually increase the private sector's share of providing these methods, thereby reducing the financial burden on the public sector. Specifically, GHANAPA calls for a shift in the contraceptive method mix from 80 percent short-term/20 percent long-term in 1993, to 60 percent short-term/40 percent long-term by the year 2000. The design also calls for an expanded role for the private sector in delivering these methods—increasing its market share of short-term methods from 65 percent in 1993 to 75 percent in 2000, and increasing its share of long-term methods from 15 percent in 1993 to 25 percent in 2000. These are shares, moreover, of overall contraceptive prevalence that was projected to increase from 10 percent in 1993 to 20 percent by 2000. In order to attain this increase in the CPR, GHANAPA was designed to address several service delivery gaps in the then-current program—gaps which were constraining the program's ability to make FP services more accessible and more available to a wider group of people desiring these services (e.g., adolescents, post-abortion/post-partum patients, MCH clients, males, and rural clients). GHANAPA calls for the expansion and improvement of service delivery systems for nonclinical methods through the public sector and through a variety of private sector/NGO channels, including GSMF, GRMA, and PPAG. The effort to promote a shift to long-term methods (i.e., to increase the number of users of long-term methods from 59,000 in 1993 to 361,000 by 2000) was to be accomplished by significantly increasing the number of service delivery points for long-term methods, as well as the number of personnel trained in counseling and performing these procedures. USAID looked primarily to AVSC and Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) to support this effort and to help ensure a high level of quality of care at the clinical practice sites.

#### Performance: Project Activities

##### Expanded Provision of Nonclinical (Short-term) Family Planning Methods through the Private Sector

###### Ghana Social Marketing Foundation (GSMF)

GSMF is the largest supplier of all short-term contraceptives in Ghana and holds 60 percent of the market share in the private sector. Over the last six years, CYP almost doubled from 100,493 to 193,987, largely due to GSMF's efforts. There is evidence that awareness of modern contraception has grown as a result of GSMF marketing, particularly through its use of television and radio advertising.

GSMF has been a cooperative partner to its GHANAPA partners and joined in campaigns, such as the long-term methods campaign, took the lead in developing research and interventions for youth, and has recently developed strategies for responding to the needs of travelers using transportation hubs. As previously mentioned, GSMF has succeeded in training and motivating pharmacists and chemical sellers.

The GHANAPA goal of diversifying the type and doubling the number of sales outlets has been underachieved by GSMF. The 4,000 sales outlets that existed in 1995 appear to have decreased rather than increased in number. Hairdressers were willing to provide population education but not to sell contraceptives. GSMF was successful in getting condoms sold in 24-hour convenience shops located at garages.

There were a number of handicaps to expanding the outlets. One was the overestimation of the number of pharmacies and chemical shops that existed in the country. Also, the three commercial distributors focused on their own products, were often late in settling payments and only distributed to pharmacies and chemical shops. The recommendation of the recent evaluation of GSMF that GSMF establish its own sales and distribution network is supported by the findings of this assessment. A wider variety of sales outlets and a more dedicated sales and distribution operation can be expected to increase sales.

One of GHANAPA's objectives was to help GSMF move towards a greater degree of financial self-sufficiency, such that by the end of the project, GSMF would recover just over half of its costs. (By the end of 1998, GSMF had reached a cost-recovery level of 35 percent.) To this end, the GHANAPA project called for, and successfully executed, a \$5 million endowment that was invested in a managed investment portfolio of equities and bonds. Completion of the endowment, however, occurred two years later than originally planned, and deposits into the investment portfolio were made in two annual tranches—events which resulted in a financial return to the investment portfolio below the 7 percent annual return anticipated in the GHANAPA Project Paper. The endowment is not likely, therefore, to produce the hoped for level of GSMF self-sufficiency by the time GSMF can access the endowment's income stream in 2001.

#### Ghana Registered Midwives Association (GRMA)

GRMA accounts for a very small percentage of family planning services in Ghana. This is due partly, of course, to the relatively small membership of the organization. But even that number of service providers is shrinking. GRMA midwives report that they are having difficulty competing successfully with virtually free GOG health services, few new members are being recruited, and many of the current members are approaching retirement age.

It is difficult to judge overall performance of the GRMA, as only about 64 percent of GRMA's members regularly submit family planning/reproductive health (FP/RH)

activity reports. GRMA service statistics for the period January–June 1999, show quantities of commodities distributed as follows: oral pills–24,102, IUDs–2,431, condoms–70,586, injectables–18,054, and, vaginal foaming tablets (VFT)–38,281. (GRMA’s quarterly reports to MCH/FP and USAID combine contraceptive distribution data from midwives and midwife assistance in the case of pills, condoms and VFT.) On average, each midwife sees 13 clients a month.

Midwives’ assistants who have been trained as community-based distributor (CBD) agents are providing condoms, pills and VFT to FP clients. The agents are easily identified in the communities by their distinctive T-shirts, badges and CBD bags. Many of these midwives’ assistants display considerable enthusiasm for their work and derive personal satisfaction from their community outreach activities. Others complain about their very modest remuneration, the occasionally hostile reception they encounter in some households and the lack of encouragement by their midwife-supervisors to undertake outreach visits. An unreported number of these less satisfied assistants are vacating maternity homes to practice as traditional birth attendants (TBAs).

#### Planned Parenthood Association of Ghana (PPAG)

The GHANAPA program provided a grant to PPAG to expand and improve on innovative FP services appropriate to the needs of males, adolescents and clients who can best be reached by community-based services; hence, the implementation of its three projects: Reproductive Health Education and Services for Youth (RHESY), Male Involvement in Family Planning, and Community-Based Distribution Services (CBD).

The RHESY project supports youth centers in eight regions (except Upper East/West) and teenage centers in two regions (Eastern and Western). The main strategy is to educate and counsel the youth in sexual/reproductive health issues and provide service to sexually active young persons.

PPAG implements the male involvement project among daddies’ clubs, drivers’ unions, garage associations, industrial centers, young men’s clubs, National Vocational Training Institutes (NVTI), selected hotels and restaurants, and functional literacy groups.

Of PPAG’s 923 CBD agents, 300 were trained under GHANAPA (compared with the target of 385 by September 2000). Currently, 792 CBDs are active (Ashanti–165, Brong Ahafo–124, Central–114, Eastern–136, Greater Accra–50, Northern–75, and Western–128). The Volta region has 125 peer educators.

PPAG’s CBD services are supported by 10 full-time and 48 part-time supervisors (some of whom are MOH nurses). One full-time supervisor works with 30 CBD agents while a part-time supervisor works with 10 agents (though the program is aiming at 5 or 6). Attrition is quite high among part-time supervisors and CBD agents. Unfortunately, not all of the CBD agents have bicycles so many are not able to conduct outreach to the

extent desired. Resource persons who give lectures under the CBD program and the staff who works late during community rallies report that they would welcome some modest per diem as an incentive. For effective monitoring and implementation of the CBD program, regional coordinators have been recruited in all the regions of operation. To ensure full impact of the CBD services and effectively measure success, one district in each region has been selected for concentration of project activities (Ashanti–Atwima, Brong Ahafo–Wenchi, Central–Lower Denkyira, Eastern–Kwahu South, Greater Accra–Dangbe East, Volta–North/South Tongu and Western Ahanta West). By the end of the first quarter of 1999, FP acceptors for the three projects are as follows:

	<b>New Acceptors</b>	<b>Old Acceptors</b>	<b>Total</b>
Male Clinic	467	2,736	3,203
Youth Centers	65	684	749
CBDs	8,569	20,165	28,734

Note: Data were obtained from the PPAG Quarterly Report to USAID (January–March 1999).

#### The Centre for Development and Population Activities (CEDPA)

CEDPA supported four pilot projects through three religious organizations (YMCA, YWCA and Muslim Family Counseling Services [MFCS]) and one youth organization (Ghana United Nations Students Association [GUNSA]) to help meet the demand for family planning services. All four projects used a peer education approach in which 170 peer educators were trained to contact peers and inform and counsel them about FP and STD/AIDS. Through these programs, a total of 3,536 clients were served with condoms and pills, while 193 were referred for clinical methods. This yielded a total CYP of 1,380 during 1997–98 (73 percent from condoms, 23 percent from pills and 2 percent from foaming tablets). Community mobilization for reproductive health and development was another important activity in the projects of the three religious organizations. A total of 1,807 community leaders, parents and youth were trained on adolescent reproductive health (ARH) issues and 59,300 were reached through various IEC activities in four regions (Ashanti, Brong Ahafo, Greater Accra, and Volta). These four regions currently operate under CEDPA’s new ENABLE project, which has a broad mandate to support integrated FP, maternal health, child survival, and STD/AIDS prevention programs.

Even though the 1998–99 reporting year focused on institutional strengthening, a concerted effort was made to expand provision of short-term FP methods. As part of the activities geared towards increased utilization of a broad range of high quality reproductive health services, 12 workshops for 290 peer educators and CBD agents were conducted and these reached 20,262 youths and adults. In terms of service provision, 44,702 condoms, 1,046 VFTs and 290 cycles of pills were sold to both youth and adults. In addition, effective linkages were established with private medical practitioners and three government clinics for STD referral for youth. Among CEDPA’s accomplishments is the establishment of centers/clinics that are appealing to youth in four regions (Ashanti,

Easter, Greater Accra, and Volta), where 470 peer educators/adult educators are trained for outreach services in counseling and commodity distribution. On the average, 30,000 condoms are sold monthly and 6,000 youth and adults are reached monthly with behavior change communication and community participation/advocacy. CEDPA has also built coalitions with other professional, social and religious groups (especially Muslim community leaders and Islamic scholars).

#### Expanded Provision of Clinical (Long-term) Family Planning Methods

In February 1999, AVSC conducted an indepth evaluation of its AVSC-supported activities in Ghana. That report is generally available to the partners involved in GHANAPA, so with few exceptions, its findings and conclusions will not be repeated here. The following discussion reinforces only those findings—and additional observations made during this assessment—that have particular relevance to future programming decisions by USAID/Ghana.

##### Increased training in long-term methods

AVSC training activities have been significantly helpful in increasing access to permanent and long-term contraceptive services in all regions of the country. Over 1,000 providers have been trained in long-term services, including counseling and infection prevention procedures. Of this total, approximately 150 doctor/nurse teams have been trained in minilaparotomy using local anesthesia (USAID cooperative agreement target: 340 teams); 160 doctors and nurse/midwives in Norplant insertion/removal (target: 40 doctors, 200 nurse/midwives); 6 doctors in vasectomy (target: 5 doctor/nurse teams); 830 nurses in counseling (target: 600); and, 47 providers in infection prevention approaches.

The cooperative agreement also called on AVSC to work closely with JHPIEGO in monitoring the quality of IUD services provided by JHPIEGO-trained service providers. AVSC reports that this task was never addressed because JHPIEGO's assistance in IUD insertion (JHPIEGO's in-service training program) ended before AVSC could build an effective medical monitoring system, and subsequent collaboration with JHPIEGO was constrained by the lack of an in-country JHPIEGO representative.

AVSC also played a role in support of MOH and INTRAH efforts to develop the policies, protocols and standards materials. To date, however, AVSC has not been invited by the MOH to participate in any training programs for personnel responsible for second- and third-tier dissemination of the guidelines. This is a potentially serious omission, given AVSC's important ongoing role in supporting service provider training (in service delivery and counseling) at approximately 100 health care facilities and its concomitant role in helping to ensure high quality care at these facilities.

### Extension of service delivery sites

At the start of GHANAPA, the USAID Mission estimated that there were 15 sites for delivery of surgical/clinical long-term methods in Ghana—clearly inadequate to achieve the population and geographic coverage requirements of the program. The GHANAPA Project Paper notes that an analysis of training requirements to perform the number of procedures anticipated under the project indicated that a total of 100 additional doctor/nurse teams were needed for sterilization and subdermal implant insertion procedures, approximately 600 trained and practicing nurse/midwives for IUD insertion, and a minimum of 125 personnel for counseling and referral. In 1993, AVSC conducted an assessment of 100 additional (beyond the existing 15) service delivery points to determine their suitability as sites where long-term clinical methods could be offered. These sites consisted of university teaching hospitals and regional, district, military and missionary hospitals, as well as polyclinics, NGO clinics and private physician facilities. The assessment included an analysis of services offered, space requirements, equipment and supplies, and training needs. On the basis of that assessment, AVSC concluded that 35 sites required major renovation, and 20 required minor renovation. The remaining 45 sites required equipment only, no assistance, or renovation was not possible because the space was rented.

Of the 115 delivery sites planned under the USAID cooperative agreement with AVSC, about 100—in all regions of the country—are now capable of providing long-term family planning methods. The availability of vasectomy services is more limited—the method is currently available only at Komfo Anokye Teaching Hospital, Korle Bu Teaching Hospital, Odoi-Agyarko clinic in Bolgatanga, Volta River Authority Hospital in Akosombo, and the PPAG Link Road Clinic in Accra. Given the very low demand for this service, AVSC does not plan to introduce it into any additional sites in the foreseeable future. AVSC's plan to establish 10 regional training centers—one in each regional capital—has fallen behind schedule, largely because AVSC determined that several of the hospitals initially identified as candidate sites could not meet essential training criteria—most notably, a client caseload large enough to sustain a training program. The five functioning training sites include Korle-Bu Teaching Hospital, Komfo Anokye Teaching Hospital, Cape Coast, Koforidua Central Hospital, and Sunyani Hospital.

AVSC estimates that its assistance efforts have resulted in the provision of long-term family planning methods to approximately 17,800 clients as of June 30, 1999. This is not on track toward serving the 52,000 clients expected per the cooperative agreement. But in view of the constraints it has faced thus far, this performance is probably as good as might have been anticipated. Some of these constraints included:

- **Lack of expected financial support under the NPA component of GHANAPA:** As discussed above, AVSC (and the MOH) had conducted a site

assessment early in the project period. This assessment identified sites which would need renovations to effectively provide long-term services. Funding for these renovations—specifically for 50 of the sites—was supposed to be provided by the Ministry of Finance. Only 11 of these sites ever received renovation assistance, significantly slowing the pace at which AVSC could strengthen the service delivery system.

- **Lack of IEC support:** AVSC had expected that the HEU was going to undertake an extensive IEC campaign in support of long-term methods. Such a campaign was necessary, notes AVSC, in the first months of the project in order to generate a caseload for training and to educate the public about these methods, which were relatively new to Ghana. With the exception of some activity early in the launch phase of the program, very little IEC support was ever provided—due again, according to observers—to the non-transfer of NPA funds from the Ministry of Finance (MOF) to the MOH, and then to the HEU. AVSC compensated for this deficiency to a modest extent by launching some small-scale IEC efforts itself (including its Satisfied Customer initiative). AVSC and Johns Hopkins University/Population Communications Service (JHU/PCS) attempted to address the IEC shortcoming by collaborating on the development of an ambitious IEC strategy, which they presented to a donor’s meeting in 1997. However, that proposal’s hefty cost (approximately \$2 million for about 18 months of IEC activity) was beyond the capacity or interest of the donors, and to this day, long-term methods in Ghana do not enjoy any meaningful IEC support.
- **The readiness factor:** Several respondents suggested that GHANAPA’s focus on a shift from short-term to long-term FP methods was premature and incompatible with deeply entrenched Ghanaian beliefs and practices. This is not to suggest that the project should not have sought to expand the availability and quality of long-term methods—indeed, clients should have full access to the widest range possible of family planning choices. It is to be noted however, that the anticipated shift from 20 percent to 40 percent of users in just six years is not in accordance with deep and still unresolved popular fear and resistance to some long-term methods; to extensive, continuing provider biases against long-term methods; and, as discussed above, to a major lack of good information from trusted sources. AVSC implicitly recognizes these factors in a three-year follow-on proposal that it recently submitted to USAID/Ghana. That proposal describes AVSC’s intention to use the next three years largely to consolidate and improve the training and service delivery capacities it has helped to develop to date, with a much reduced focus on establishment of additional service delivery sites for long-term methods.

A summary assessment of GHANAPA's support for training and for the expansion of long-term method service delivery points shows mixed results, that is, when measured against the project's objective to increased practice (absolutely and proportionately) of long-term methods. Looking at changes over the 1993–98 period as reported in the respective DHS surveys, it appears that the percentage of women using minilaparotomy remains unchanged, at 0.9 percent of all currently married women. Likewise, vasectomy practice in both periods is effectively 0 percent. IUD use in 1998 actually fell (not in absolute terms, but as a percentage of overall users)—from 0.9 percent of users in 1993 to 0.5 percent in 1998.

The situation is different, however, in the case of injectables and Norplant. Use of injectables rose from 1.6 percent in 1993 to 2.2 percent in 1998—an increase of almost 40 percent; and Norplant use increased from 0 percent in 1993 to 0.1 percent—a relatively meaningful figure in view of that method's still limited availability. Assessment team conversations with MOH service delivery providers in the Eastern, Ashanti and Greater Accra regions found that the pill is still the most popular method among Ghanaian women (3.1 percent of users), but that the injectable is the fastest growing method. Indeed, given the pill's flat growth in use since 1993 (3.2 percent of users), it is very possible that the injectable may become users' preferred method within the near future.

### Contraceptive Supply and Logistics Improvement

USAID/Ghana has been working closely with the MOH and other partners (PPAG, GSMF) since the predecessor FPHP to improve contraceptive forecasting, stock management and distribution systems. This assistance—most of which has been provided by the Family Planning Logistics Management Project (FPLM) with Field Support funding by the Mission—has produced genuine results. With the exception of some relatively minor glitches, the FP program has not experienced any major stockouts or distribution mishaps in almost five years. Contraceptive procurement tables (CPTs) are prepared accurately and on time and the four contraceptive shipments scheduled for arrival in-country each year generally arrive on schedule, are cleared through the port without delay, and are warehoused consistent with good inventory management practices. The contraceptive management system's effectiveness is due in large measure to FPLM technical assistance over the years and to its logistics training programs for MOH (and PPAG) logisticians and warehouse managers. Importantly, these FPLM training modules are now being presented in Ghana (they were presented only in the United States until 1997)—a development which will help broaden the base of logistic management skills in the country.

That base is still spread very thin, however, especially since most program responsibilities have been devolved to the regions and districts. Commodity management personnel in those areas have depended on cascade training by central and other region-

level staffs who were themselves trained by FPLM staff in the United States and/or Accra. Some of this second- and third-generation training did not take place, however, because the MOH was not able to follow up on commitments to cover the in-country costs of the training. An FPLM team was in Ghana (in September 1999) to undertake a needs assessment of future training requirements, with special reference to training needs in these lower levels of the system. That assessment will also consider the implications and additional training requirements arising from a recent MOH decision to consolidate all MOH commodity responsibilities in the hands of its central stores—a decision which removes this responsibility from the MCH/FP, which has until now managed the forecasting, warehousing and distribution of contraceptive supplies in a vertical manner in relation to the regions. An FPLM training program scheduled for January 2000 (in Accra) will use the findings of the ongoing needs assessment to extend the reach of the FPLM training into the regions and districts and to train central stores' commodity management staff in FPLM-developed systems and procedures.

The shift from MCH/FP to central stores' responsibility for contraceptive commodities is a meaningful step by the MOH toward rationalization of its complex commodity management tasks. The shift will inevitably produce some disruptions, however, during the transition period. Unfortunately, the MCH/FP's key commodity management official—a Ghanaian national working at the Unit under a United Nations Population Fund (UNFPA) contract—resigned his post effective mid-September, depriving the Unit of the skills needed to facilitate a smooth transition of responsibilities from the Unit to central stores' staff. (In addition to his systemwide liaison duties, the contractor had initiated training of central stores personnel, analyzed and processed the quarterly contraceptive consumption reports from the regions, and served as the Unit's chief troubleshooter on contraceptive commodity matters.) USAID should be attentive to the possibility of lapsed and/or incomplete reporting from the Unit during the next several months, during which time the contractor's assistant—someone who has many other noncommodity-related duties—will be under considerable stress to maintain previous levels of responsiveness to the needs of the logistics system.

Aside from but related to the commodity management system—MOH personnel at the center and down through the regional and district levels share some dissatisfaction with GSMF's refusal to share contraceptive distribution data with the MOH (GSMF reports its data directly to the Mission). This complaint arises partly from the Ministry's belief that it is responsible for the collection, reporting and estimation of overall CYPs in the country, and at least to some extent, on the belief that GSMF raw distribution data should be objectively analyzed/verified before being accepted as indicative of actual contraceptive usage. GSMF re-supply data (i.e., the quantity of GSMF condoms, pills and VFT needed to re-stock the three distributors' inventories) do, over time, closely approximate real consumption of these products. As FPLM develops its next (January) training program, it might want to include a brief examination of this matter by the participants, at least to help neutralize it as a matter of (mild) dissatisfaction among the

parties.

### The Navrongo Project<sup>2</sup>

The Navrongo pilot project has developed an alternative service delivery model for FP/RH care in Ghana—a model which is convincing to the most senior MOH leaders and which may significantly influence the future shape of the Ghana FP/RH program. Thus, while the Navrongo project could not be closely examined during this assessment, the activity was reviewed briefly to identify some implementation issues which decision-makers may face as they consider broader replication of the Navrongo model or variants of that model.

At its simplest conceptual level, Navrongo simply implements an old but still current theory. For years, the MOH has invested heavily in the training and deployment of community health nurses (CHNs) in pursuit of an ideal that saw the CHNs serving people in the communities where the people live. In practice, however, and for many complex reasons, the CHNs ended up in static clinics—with perhaps 12–18 other MOH staff—all of whom might serve an average of 10 clients a day. (CHNs do, however, conduct periodic outreach activities). The essential goal of the Navrongo pilot project was to develop—and more importantly, to demonstrate—that the ideal model could be realistically and feasibly implemented within the context of scarce resources, and that this alternative model would produce significantly greater results than the prevailing service delivery model.

With regard to the resource question, the Population Council estimates that the cost of replicating the Navrongo model would be approximately US \$1 per capita. This would cover the cost of program management and oversight at the district level, the cost of motorbikes for the CHNs and bicycles for community volunteers, and operating costs, such as fuel, repairs, supplies, etc. Personnel costs are not reflected in this total (e.g., CHN salaries) because they are assumed to be a fixed cost that is already being covered by the MOH. Note that this estimate is about one half of the pilot activity's current cost (approximately \$2 per capita), which includes surveillance costs and expenses of related special studies and technical assistance. It is likely, however, that the replication effort would require continued donor support for some of these elements, including, for example, technical assistance. On the basis of results gained, this investment would seem to be sound: Navrongo results reported informally by the Population Council indicate that this approach has reduced the total fertility rate in the test area one full birth and that it has reduced infant mortality by approximately 40 percent.

These cost and impact figures are only illustrative, of course, and might vary depending on the specific shape of the model installed in any given area. In areas of high population density, for example, the model could include some continued reliance on fixed facilities

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<sup>2</sup> This discussion assumes that the reader is generally familiar with the Navrongo pilot project.

and no motorbikes. Other areas could mix and match Navrongo-type elements to address local needs. In sum, Navrongo is intended to be a flexible, adaptable model whose key characteristic would be its focus on reaching people essentially in their homes, in a way that engages the community itself in the identification of its own health care needs. This opportunity for health workers to meet and discuss sensitive issues, such as family planning in the home—with both husband and wife present—is viewed by the MOH as critical to overcoming the timidity, public embarrassment and male opposition which currently impede the success of the national FP/RH program.

#### Other Operations Research (Population Council)

In addition to its support for the Navrongo study, the Population Council assists in the conduct of other operations research activities at the Navrongo research facility. These include, inter alia:

- a number of studies to identify social barriers to increased use of family planning and ways to address them (e.g., focus on men and their objections to FP, religious leaders, traditional practitioners, village elders);
- a study of ways to increase community involvement in the support of community health nurses—including construction of local clinics for use by the CHNs; and,
- a study (under development) of female genital mutilation (FGM) practices in Ghana. Implementation of this activity has been delayed by local opposition and Population Council/Navrongo's inability thus far to identify any community-level organizers or Ghanaian counterpart researcher(s) for the project.

With the exception of the noted difficulties with the FGM study, the Population Council reports that the operations research activities it supports at Navrongo are proceeding smoothly. The major concern noted by Population Council staff is the absence of job security for Navrongo staff. Most of the incremental costs of the facility's research are covered by the Population Council (i.e., USAID funds channeled through the programmatic grant). The MOH provides some modest funding (Navrongo is technically an MOH NGO), but far less than the facility requires to function in the absence of Population Council support. Moreover, Navrongo's relatively close working relationship with the District Health Office—and with the MOH in Accra—has left unresolved, and perhaps somewhat strained, the facility's relationship with the Regional Health Administration. On its surface, this issue is not directly relevant to GHANAPA. At risk, rather, is the long-term viability of a research facility/capacity, which the Population Council considers to be a world-class resource in the process of conducting research pertinent to the needs of the larger African RH community.

## **Effectiveness of Implementation Arrangements**

The **FPLM** project has been very effective in helping GHANAPA (and FPHP) partners streamline, upgrade and manage their commodity management systems. It has accomplished this task, moreover, by relying on occasional technical assistance and training assignments by regional and Washington-based personnel, without the expense of maintaining an office in Ghana. Communications with the USAID Mission and other partners are good, and do not appear to suffer from the absence of in-country FPLM personnel.

**AVSC**'s effectiveness is due in good measure to an operational/logistic/program support process by which it works directly with regional- and district-level counterparts. Moreover, the trainees selected for participation in AVSC-sponsored training tend to be self-nominated, adding an important "bottom-up" dimension and strong sense of provider ownership to the training activities.

The **Navrongo** replication agenda calls for visits to the Navrongo test area by teams from all 10 regions, to be followed by the design of demonstration/pilot projects in each region. Five districts have already launched such pilots, but these initial efforts are reported to be experiencing startup problems. Such technical difficulties will inevitably arise as the activity is reproduced in areas that do not benefit from the intense technical assistance and oversight brought to bear in the test area. Aside from these hopefully minor problems, funding emerges as a critical factor in the expansion effort. The incremental costs associated with the model need to be covered from some source. The MOH has implied, via its leaders' strong statements of support for the expansion, that these costs will be met by savings to be realized elsewhere in the system, that is, as redundant fixed facilities and underemployed staff are re-deployed in favor of smaller CHN posts in the communities. Such massive shifts of personnel are difficult at best, however, and may face stiff resistance in the ranks. Moreover, the MOH is an organization with few resources, and has traditionally looked to foreign donors for virtually all support costs related to its FP/RH program. The donors will need to decide if they are prepared to take on this responsibility and for what length of time. USAID will have about one year to decide its own stake and interest in this effort. That is about how much time remains for the Mission to channel resources through the Population Council program grant for planning activities preparatory to any expansion. That grant has been ideal as a support mechanism for technical assistance related to the pilot project, but it is not an appropriate mechanism for the transfer and oversight of funds needed to cover the recurrent costs of an operational project. If the Mission does decide to participate in the expansion effort, it will have to do so directly with the MOH via its bilateral assistance channels, and/or engage the participation of a cooperating agency prepared to take on the task.

The key issue related to other operations research supported by the **Population Council** is its relevance to overall SO3 objectives established by USAID/Ghana and its partners.

Without going into the merits of supporting or not supporting Navrongo-based research because of the facility's broader value to the global RH community, USAID/Ghana should determine the relevance of specific, core-funded operations research activities, and decide whether or not to approve the undertaking of such operations research activity in Ghana.

USAID has been providing support to **GRMA** since 1987. This assistance has been designed to help GRMA become a more professional organization and to train its members to be effective providers of family planning, safe motherhood and other reproductive health care. Assistance provided under GHANAPA has evidently contributed to that goal. GRMA membership, however, is relatively small and may be shrinking; its output in terms of people reached is modest—and after more than 10 years of USAID assistance, any further support for such a small organization starts to appear unwarranted.

**PPAG** has effectively used assistance from INTRAH/PRIME, JHU/PCS, FPLM, and the Population Council over the life of the project in the development of service, training, commodity management, and IEC activities. PPAG youth centers probably met some social and skills enhancement needs of young people, but did not successfully address their need for RH information and services. Similarly, PPAG's male clinics helped some men deal with problems of sexual dysfunction or infertility, but did little to increase men's use of or support for family planning practice. The assessment team endorses USAID's plan to terminate support for PPAG youth centers and male clinics, and agrees with the Mission's intention to support the efforts of PPAG to reach out to men and adolescents through PPAG's CBD program. As the CBD program is asked to take on this added role, USAID and PPAG should take steps to address the continuing lack of adequate supervision of many PPAG CBD agents (as of September 30, 1998, 412 of PPAG's 906 CBD agents were without supervisors). PPAG's new strategy of concentrating on one district per region and forming local steering committees to oversee CBD agents/supervisors may help check the high attrition rate of CBD agents and supervisors. Provision of bicycles to these grassroots-level workers would also improve their ability to serve nearby communities.

**CEDPA** has had some success in helping religious organizations and youth groups constructively examine the social barriers to the exercise of reproductive rights in Ghana. While innovative, these activities have been few in number. Similarly, CEDPA's efforts to influence the policy environment at the district level via support for NGO advocacy networks are underway in very few parts of the country.

## **Recommendations**

1. GHANAPA's efforts to make quality long-term services available are not yet supported by any meaningful IEC campaign to educate and inform the public about

the availability, utility and safety of these methods.

**Recommendation: The IEC/demand generation recommendations (for family planning) discussed elsewhere in this report address this gap. The IEC messages developed in support of long-term services should directly address obstacles to acceptance of long-term methods, with special focus on clients' fears and misperceptions.**

2. GHANAPA's support for the expansion and qualitative improvement of long-term methods was appropriate in that it helped ensure that Ghanaian couples have access to a full range of contraceptive services. The project was overly ambitious and optimistic, however, in anticipating that this support would lead to a major shift in acceptor behavior from short-term to long-term methods, especially in just six years of project activity, and in the context of significant cultural and infrastructural constraints. Those constraints notwithstanding, certain long-term methods (i.e., injectables and Norplant) appear to be gaining in favor among Ghanaian women. Program managers should seek ways to respond to growing client interest in these methods.

**Recommendation: As it looks to the future shape of its program assistance, USAID/Ghana should focus on efforts to expand and improve the availability of basic FP services to ensure that all potential users have access to at least three FP/RH methods, including at a minimum, pills and condoms. Special efforts should be made to expand the availability of injectables and Norplant. Assistance for other long-term methods (IUD, voluntary sterilization) should concentrate for the midterm (3-4 years) on measures to improve the quality of existing services, thereby enhancing their credibility and acceptability among the general population. USAID should not invest in the expansion of service sites for minilaparotomy and vasectomy at this time.**

3. The policies, standards and protocols as developed and revised by the MOH with assistance from INTRAH and other organizations will be powerful tools in the improvement of quality of care throughout Ghana.

**Recommendation: USAID should urge the MOH (and INTRAH) to engage AVSC and other qualified (MOH and non-MOH) organizations to participate in the dissemination of these guidelines to regional- and district-level health care facilities, teaching institutions and health care providers.**

4. FPLM is the one place where overall contraceptive consumption and distribution data are collected. FPLM uses these data (updated midyear) to develop the Ghana program's annual procurement requirements for contraceptive products. While these data are obviously and most importantly related to the procurement process, they can serve another valuable function, namely the annual estimation of national

contraceptive use (CYP) attributable to MOH, PPAG, GRMA and GSMF efforts. The FPLM regional coordinator advises that FPLM could indeed perform this function at very little additional cost to the Mission.

**Recommendation: USAID should direct FPLM to develop a CYP estimation tool<sup>3/4</sup>based on contraception consumption and distribution data<sup>3/4</sup>which will provide program partners with an accurate ongoing estimate of CYPs versus program targets.**

5. Under its current practice, the MOH recruits nurses, midwives and nurse-midwives from their respective training institutions, and assigns them throughout the country, depending on need.

**Recommendation: Looking ahead to the possible expansion of the Navrongo model, the MOH might want to consider adopting a different recruitment and assignment practice for CHNs<sup>3/4</sup>notably the recruitment from and placement of CHNs back to their home communities.** Indeed, communities themselves could be brought into the process—by nominating young women from their own communities for training as CHNs, staying in contact with them throughout their training, and helping to construct and prepare the health posts and living quarters they would use upon their return to the community. District assemblies should also be urged by District Health medical teams to contribute to the cost of training, equipping and housing these CHNs.

6. GRMA has received USAID support for over 10 years. Its membership, however, appears to be decreasing in number, and its overall impact on availability of RH information and services in Ghana is marginal.

**Recommendation: USAID should allow the current grant to GRMA to expire as scheduled, and not execute a follow-on agreement.**

7. PPAG is experiencing a high attrition rate among its CBD workers and supervisors—evidently due to their dissatisfaction with their lack of mobility and inadequate compensation.

**Recommendation: PPAG should be encouraged to develop a low-cost incentive package to address the high turnover rate of its CBD personnel. This package might include bicycles, or in lieu thereof, modest reimbursement to cover transportation costs to villages beyond their home communities.**

## **IR 3.1.2: IMPROVED QUALITY OF REPRODUCTIVE HEALTH SERVICES**

### **Program Strategy**

High-quality service is crucial in attracting clients to a facility and retaining them as RH clients. GHANAPA was successful in promoting the development of MOH clinical guidelines for use in training and service delivery. JHPIEGO has played a valuable role for over 10 years in helping the MOH design and adopt in-service and pre-service curricula for health care providers. Both of these initiatives have a strong potential to be institutionalized in the Ghanaian health care system.

### **Performance: Project Activities**

#### Human Resource Development

##### Development and dissemination of standards and guidelines (INTRAH/PRIME)

In 1994, the MCH/FP established a task force to review and revise existing service delivery and training guidelines to ensure that they were up to date and uniform among all service providers. The first product of this effort—the *National Reproductive Health Service Policy and Standards*—was developed jointly by the MOH, NPC and representatives from all stakeholders (PPAG, GRMA, GSMF, AVSC, Nurses and Midwives Council [NMC], JHPIEGO, and FHI) with technical assistance from INTRAH/PRIME in 1996. The MOH disseminated this policy and standards document in November/December 1998 in three regions (Brong Ahafo, Ashanti and Eastern), targeting service providers, managers and supervisors from regional, district and primary levels. Representatives from these three regions met in mid-September 1999 to assess their progress in disseminating and adopting the policy and standards document within their regions and to provide suggestions to the MOH regarding ways to improve and refine the document.

The second product of the Ministry's effort to develop standardized operating procedures for all health care personnel was the draft National Reproductive Health Service Protocols, which were developed with technical assistance from INTRAH/PRIME and released by the MOH in October 1996. After several revisions, this protocol was published in final form in January 1999, as the *Ghana National Reproductive Health Service Protocols*. Unlike the previous draft version, this final document incorporates the MOH's protocols for safe motherhood, which had been developed several years earlier. The pace of dissemination of both documents—the Policies and Standards and the Service Protocols—is very slow.

### GRMA training of midwives in family planning and safe delivery

GRMA used grant funding from the GHANAPA project to organize a series of training sessions in FP, STD and safe delivery for its members in order to improve standards of midwifery practice in Ghana. GRMA has about 500 members, 400 of whom operate their own maternity homes. Thus far, GRMA has trained 454 members in family planning and safe delivery, including 98 from the public sector. Private sector members of GRMA receive contraceptive products from GSMF and the MOH. In addition, 264 GRMA midwifery assistants have been trained as CBD agents (project target: 300)—but only about a third of these agents sent regular activity reports to GRMA.

Many GRMA midwives trained under the project report that they are receiving new clients (referred primarily by the midwifery assistants) for family planning services. Twelve midwives were trained as family planning preceptors and regional trainers have also been trained to provide continuous education. One midwife has been trained in Norplant (target: 20), and 134 (target: 207) have been trained in IUD insertion. The project proposal called for the establishment of three training centers for IUD insertion; however, only two facilities were set up because the third had an insufficient client caseload. With technical assistance from INTRAH/PRIME, GRMA has developed and produced six self-directed learning/client-provider interaction modules on adolescent reproductive health. Some midwives reported (to the assessment team) that they found the first two modules too technical.

### MOH pre-service and in-service training in reproductive health

JHPIEGO has worked with the MOH since the late 1980's to help organize and institutionalize in-service training in family planning for nurse-midwives, with special emphasis on training in IUD insertion. JHPIEGO's role in this area (in-service training support) effectively ended in 1992–93, when the MOH assumed full responsibility for training in all reversible FP methods. The only JHPIEGO support provided for in-service training since 1993 has been the provision of occasional updates of training materials and technical assistance in the development (with INTRAH/PRIME) of the MOH policies, standards and protocols documents (discussed elsewhere in this report). Observations made during site visits in Koforidua and Kumasi found that the in-service training activities which JHPIEGO helped establish in those regional capitals were still being implemented, were highly valued by the participants, and were evidently contributing to the assurance of quality FP services in the MOH health system. Contrary to JHPIEGO reports, however, the MOH has not assumed any substantive budgetary responsibility for these programs—which are currently being funded by UNFPA. Information gathered at the MOH indicates that these training activities would likely cease or be dramatically cut back in the absence of UNFPA assistance.

JHPIEGO advises that its ongoing assistance program in pre-service training at two midwifery schools (Koforidua and Kumasi) reflects the MOH belief that in-service

training is not the most cost-effective or efficient way of providing basic education and training in RH topics. Bringing health care providers to an in-service workshop incurs many financial costs, disrupts service provision, and providers may perceive skills learned as add-on skills that are not necessarily included in a basic package of services. The MOH is therefore shifting its emphasis to supporting a balance of both in-service and pre-service training in RH.

JHPIEGO started its support for pre-service training in 1996 at two medical schools—primarily in response to USAID/Ghana suggestions that such training would help strengthen physician support for and involvement in provision of RH services. A subsequent informal assessment of that effort by JHPIEGO found that approximately 85 percent of medical school graduates in Ghana left the country (for the United States, the United Kingdom, South Africa), and the vast majority of the remainder were working in Accra or Kumasi. JHPIEGO consequently shifted its focus to the training of nurse-midwives, with the program’s locus in the two cities mentioned above. Their key collaborators are the MOH Human Resources Development Division (HRDD), the NMC, and the MCH/FP of the MOH. The training is structured to reflect the standards outlined in the National RH Policy and Service Protocols.

JHPIEGO reports that the pre-service training program is proceeding well, albeit with some problems they are working to address. These include inadequate length of training for tutors and clinical preceptors, erratic and unreliable communications with HRDD, and the need to strengthen HRDD and NMC engagement in the training as key stakeholders. JHPIEGO also notes its concern that several of the tutors in the two midwifery schools have not worked in clinical settings for several years. Their own training, moreover, was essentially knowledge based, whereas the JHPIEGO training model is skills based. To some extent, both factors impede the tutors’ effectiveness as teachers and mentors to a new generation of health care providers. JHPIEGO is very aware of this issue, and is developing interventions to strengthen the pedagogical skills of the tutors.

JHPIEGO is developing a proposal to USAID seeking Field Support funds to support a rollout of the pre-service training program to the other eight regions.

### **Effectiveness of Implementation Arrangements**

The JHPIEGO project manager has noted the difficulty in engaging and communicating with the several stakeholders (HRDD, MCH/FP, and NMC) involved in the in-service training program—a problem exacerbated by the lack of a JHPIEGO country representative. However, the appointment of a country representative would not be a cost-effective measure, given the size of the JHPIEGO program (about \$500,000 a year in Field Support). In the absence of a country representative, JHPIEGO should ensure that its in-country coordinator receive all the support required to maintain good communication among interested parties.

JHPIEGO's focus on pre-service training (versus in-service training) is appropriate, especially in view of the high maintenance costs (travel, per diem) of in-service training, and the latter's lower likelihood of being institutionalized and/or budgeted within the GOG if donor funding for the activity were to cease. However, if the Mission decides to react favorably to JHPIEGO's expansion proposal, it may want to test the GOG's commitment to the plan by calling for a gradual rollout, whereby additional training sites would be added as the GOG assumes financial responsibility for preceding sites.

INTRAH/PRIME has assisted in the development and production of the policies, standards and protocols guidelines discussed above. These materials will play a critical role in helping establish and maintain a high level of health care responsiveness to clients' RH needs in Ghana. MOH dissemination of these documents has been proceeding very slowly, however, and INTRAH/PRIME has probably been overly deferential to the Ministry's slow pace.

GRMA's grant funding from USAID under GHANAPA has supported the training of over 600 GRMA midwives and midwife assistants. An innovative training tool developed with INTRAH/PRIME assistance (a self-directed learning/client-provider interaction module on adolescent reproductive health) is currently being pilot tested by GRMA in three regions (Ashanti, Brong Ahafo and Eastern). GRMA also reports that GHANAPA has helped the organization establish effective linkages with other service providers and partners (MOH, PPAG, AVSC, GSMF, FHI, INTRAH and FPLM). The link with AVSC will obviously have to be improved to ensure that 19 midwives are trained in Norplant insertion within the next 11 months.

## **Recommendations**

Dissemination of the MOH's new policies, standards and protocols is proceeding very slowly, especially in view of their potential importance to improving health care provider skills and practices in Ghana. Moreover, training materials which JHPIEGO helped develop for pre-service training are based on the Ministry's new guidelines, yet few trainers at the midwifery schools have the final documents themselves. This is especially unfortunate because these training facilities can be an important medium for the dissemination of these important new guidelines.

**Recommendation:** INTRAH/PRIME should work more closely with the MOH to expedite dissemination of the policies, standards and protocols to all levels of the health system. USAID, the MOH and INTRAH/PRIME should ensure that all nursing and midwifery schools, medical schools, and other institutions responsible for training health service providers participate in the ongoing effort to broadly disseminate these new guidelines.

### **IR 3.1.3: INCREASED DEMAND FOR REPRODUCTIVE HEALTH SERVICES**

#### **Program Strategy**

The GHANAPA program strategy to increase the demand for reproductive health services was based on the premise that one fourth of women in a 1993 consumer-based survey reported that they wished to postpone their next birth and another fourth do not want anymore children. In order to transfer this unmet need into increased demand, the strategy acknowledges the need to bring potential users along a continuum from awareness and knowledge through interest and motivation to trials and retrial and commitment.

The GHANAPA project also notes the need to improve continuity and address misinformation, including fear of side effects. Another challenge for demand creation was the lack of unity of purpose and focus of the diverse groups conducting IEC to create demand.

Specifically, the strategy was intended to build general awareness and specific knowledge with an emphasis on long-term and permanent family planning methods as well as to develop client referral systems through extensive training of providers and counselors. Both the private and public sectors would develop campaigns and materials that focus on provider biases, misperceptions and client fears. A mix of print, television, video and performing arts media would be used and special target groups, such as males and youth, would be reached.

#### The Public Sector

In the public sector, the Ministry of Health's Health Education Unit (HEU) would be the implementing entity in collaboration with the Ministries of Education and Information and GSMF. The key to the strategy was a harmonized multilevel approach at the national and regional levels, which mixed involved easy-to-remember mass media campaigns, community mobilization and clinic-based outreach. Extensive training of health personnel and service providers was planned as well as the production of printed support materials. Focus groups were to be conducted to determine the nature and extent of the method-specific misinformation, particularly regarding long-term methods.

#### The Private Sector

In the private sector, GSMF was to take the lead with the promotion of branded method-specific products through advertising and marketing. It would also contract for consumer research and retail audits. PPAG and GRMA were also to carry out demand generation activities in conjunction with service delivery as well as to participate in national and regional IEC campaigns. PPAG would target youth through the creation of youth centers, men through male clinics, and underserved rural areas through community-based

distribution (CBD). Resources were also designated to be used for short-term overseas training in population communications and some IEC audiovisual equipment was to be purchased.

## **Performance: Project Activities**

### Policy and IEC Coordination

#### Public sector performance

The HEU was not able to take the lead as planned in developing and coordinating IEC activities in support of the GHANAPA project. NPA resources did not reach the HEU; the HEU was consequently forced to function with limited MOH resources which covered little more than salaries and administrative costs. Certainly, sufficient resources were not made available for the HEU to take the lead in developing strategies and engaging the regional and district levels as GHANAPA intended.

The HEU was expected to produce materials in collaboration with partners and provide copies and recuperate costs through sales. Few new materials were produced. Insufficient funding was available to produce sufficient copies to meet the needs of the MOH and its NGO partners when materials were produced. Sufficient resources also were not available to replenish depleted stock or older IEC materials that are still appropriate.

Despite the MOH commitment to the strategies in the GHANAPA project that called for a central role of the HEU to develop coordinated IEC, the Ministry did not ensure that the HEU had the resources to do so. The expertise of the HEU had been steadily developed over a decade of outside technical assistance and there was evidence of its successful use of IEC in the Family Planning and Health Program (FPHP). Over the past several years, however, it appears that IEC for reproductive health (including family planning, STD and HIV/AIDS) has been very low on the Ministry of Health's list of priorities. Even when IEC was included in approved budgets, allocations trickled in or never came at all. Ministry officials reported that resources earmarked for IEC were spent elsewhere—at times, on surveillance of communicable diseases, such as cholera, and for nurse uniforms.

It was unclear to what extent the HEU contributed to its own problems by being less than successful in lobbying for its share of resources within the MOH. There were also cases of the MOH having difficulty with accessing funds that were held by other departments but intended for IEC use. During this assessment, it was learned, for example, that US \$1 million in United Nations Population Fund (UNFPA) funds that were reserved for the MOH to spend on IEC for reproductive health have remained unspent. In another case of unused resources, audiovisual equipment (including television sets and video cassette players) procured under GHANAPA by the MOH for the HEU have spent several years sitting in storage waiting for the long delayed construction of an IEC Resource Center.

A recent evaluation of UNFPA programming was critical of the “weak coordination among the large number of (IEC) implementing agencies and lack of harmonization of activities to ensure efficiency and cost-effectiveness.” This was precisely one of the difficulties which the GHANAPA program strategy was expected to address. More recently, the project has had some success in pulling the IEC implementing agencies together to fashion a coherent and consistent IEC strategy. As the UNFPA report implies, the continuing challenge for these agencies will be to maintain effective coordination as they implement their respective components of this strategy.

### Media and Behavior Change Activities

#### Interpersonal communications

There was evidence of training of service providers and counselors in IEC for reproductive health. This training was often added onto existing in-service training and attempted to encourage adopting participative approaches, asking more questions than they had been, and listening to individual clients and groups and not simply imparting knowledge. There was evidence that two generations of plastic-covered flip charts are well used and well distributed.

Two thousand IEC nylon bag kits for use by community health nurses were developed collaboratively by the public and private sectors with technical support from JHU/PCS. The Community Health Education Skills Tool (CHEST) kit includes a diverse array of printed audiovisual materials and suggestions for games and activities. It also includes a guide on making IEC more interactive and participative than it is.

The kits were extensively field tested with 105 CBD agents over a period of one year. The reaction of the CBD agents was uniformly positive. They found that attendance at their talks increased, messages were better understood and the images stimulated more questions. They also found the “how-to” section improved the quality of their community activities. It is expected that an additional 3,000 kits will be produced and distributed. Limited MOH resources to conduct training in their use reduced the use of the first 2,000 kits in the field.

In the absence of any systematic measurement of interventions or supervision, it is impossible to determine the reach and impact of the interpersonal communications. Anecdotal evidence suggests that providers and counselors responded to questions asked by persons attending clinics and that providers explained contraceptive choices and made some effort to conduct outreach to communities near their service points and to community institutions, such as churches and women’s organizations. However, very limited supplies of print materials, such as pamphlets and posters, reduced the ability of service providers to conduct IEC activities.

There is the assumption that once service providers are trained in IEC and told to do it, they will. There is evidence that not all were in a position to do so. Many were handicapped by lack of resources for transportation. Others were constrained by the demands on their time to provide services.

### Mass media

There was little enthusiasm for mass media approaches to IEC among MOH policymakers. There was, however, a preference for interpersonal communications to be conducted by service providers at the clinic and community level. Use of the mass media was considered by some as being costly. This is despite the mass media's proven cost-effectiveness and the good penetration of radio and television in Ghana. (For example, the recently completed Ghana Youth Reproductive Health Survey of 6,000 youths found that three quarters of both boys and girls had some exposure to both radio and television.)

To gain perspective on the cost-effectiveness of mass media, examination of a 1992 evaluation of the "I care" campaign, which encouraged the use of family planning services, might be useful. In the regions where the campaign was conducted, using posters, billboards and a theme song played on the radio, the CYP almost doubled. By comparison, the CYP was only slightly higher in the other seven regions where there had not been a campaign.

A key issue regarding the use of mass media is the significant up-front costs (i.e., for production and airtime, particularly television). However, because the mass media can reach a large number of people quickly and repeatedly, the overall effect on a population can be significant. Of course, any discussion of the relative merits of interpersonal and mass media approaches to IEC should not be framed in an either/or way. IEC campaigns focused on inspiring behavior change work best when there is a coordinated mix of strategies such as the GHANAPA program intended. Most important is the need to ensure good links between the promotion of family planning and reproductive health services and the services themselves.

### IEC focus on imparting knowledge and not behavior change

According to the 1998 GDHS, knowledge of contraceptives is very high in Ghana, with over 90 percent of men and women knowing at least one modern method. The GDHS also points out that the most common reason women under 30 said they did not use contraceptives was out of fear of side effects. Another common reason cited was opposition by partner or parent to use. The IEC supported by GHANAPA has been focused on raising knowledge levels as to what contraceptive methods are available. It has not been focused on identifying and responding to obstacles even though the GHANAPA program plan clearly identified misperceptions and client fears as obstacles that need to be addressed to create demand.

### Promotion of long-term methods

GHANAPA's objective to shift contraceptive practice from short-term to long-term methods is discussed elsewhere in this document. From the point of view of those developing IEC strategies and materials to support this shift, the challenge was enormous. Not only was there a complex mix of methods (injectables, implants, IUDs, and male and female sterilization) to be promoted, there was an equally diverse group of target populations. These included female birth spacers as well as older men and women no longer interested in having children. Even the term "long-term method," which was used in the posters, means little or nothing to potential users of the services. The result was a convoluted message that did not result in creating the demand for long-term methods that was sought.

Regional launches of the long-term method campaign were held in all the regional capitals. They were organized collaboratively by the regional NPC officer and regional health officials and involved political and community leaders. Officials from the districts were also invited. There was evidence that some of the drama groups that had been established at the regional level to incorporate population messages into their work were invited to perform. The events generated media coverage in each region and some national attention. The intention was that the launches would cause a ripple effect and that district-level officials attending the launch would promote long-term methods down to the community level.

Regrettably, few if any activities were carried out following the launches and the long-term method campaign amounted to little more than a small number of posters and pamphlets which were quickly given out; no reprints were made.

### Private sector IEC efforts

Since the HEU did not have access to sufficient resources to play the central role in the development of IEC strategies and materials as was planned under GHANAPA, the private sector developed its own IEC materials or paid for the duplication of existing materials developed under the previous project. PPAG was the most productive. With technical assistance from JHU/PCS, it recently developed a series of "trigger videos" that use dramatizations designed to stimulate discussions. The videos were shown on national television and will be distributed widely to both private and public sector partners and shown regularly in PPAG clinic waiting rooms. Other PPAG-developed materials include an audiotaped recording of a popular Ghanaian comedian and some print materials in the form of posters and pamphlets.

### Social marketing promotion

Demand for branded contraceptive products sold in pharmacies and chemist shops has steadily grown since GHANAPA was developed. This growth has been the result of the

classic social marketing strategy of mixing mass media advertising with point of purchase and other promotions and vendor education. The media campaigns were particularly creative and dynamic using images of confident women who take control of their lives to promote a branded pill and strong, virile wrestlers to promote Champion condoms. In the wake of a 1993 media campaign which directly addressed side effects, sales of Secure pills tripled. There is also evidence that the advertising of a branded injectable increased demand in the public sector. Innovative promotions were conducted, such as including the cost of a condom in the price of a football match ticket. Female pharmacists, women's clubs and associations, and churches and transportation hubs were all locations where GSMF products were promoted. Pharmacists and chemical sellers also received training on reproductive health and easy-to-use reference materials. Framed certificates attesting to their training, posters and danglers (hanging point of purchase advertising) were handed out to decorate outlets. In the case of the chemical shops, the GSMF products being sold often represented up to half the volume of stock in the small stores. Advertisements for GSMF-branded contraceptives were also often the only products advertised.

#### Family Planning Outreach and Information for Youth

##### Community-based distributors (CBDs) and IEC

All the CBDs fielded under the GHANAPA project by PPAG and NGOs, such as the YWCA, were trained in IEC and expected to conduct group sessions and individual counseling as well as distribute contraceptive products. PPAG has almost 800 active CBD agents in communities. They were supplied with some support materials (often photocopies of materials from the MOH) and trained in how to organize community drama groups. Some were supplied with the CHEST kit. The GRMA private midwives trained 300 CBD agents as well. They were expected to go from door to door to promote contraception use. The YMCA, one of the NGOs trained by CEDPA, trained 40 CBD agents who were chosen by churches or district assemblies. The PPAG suggests that the better the CBD agents are supervised, the better the quality of their IEC activities. In the Eastern Region, community health nurses (CHNs) acted as supervisors and were able to answer technical questions raised by CBD agents.

There were common trends shared by each of the efforts of the different organizations to mobilize CBD agents. All the organizations using the CBD approach found it successful. That was especially the case when the community selected the CBD agent. PPAG now distributes more contraceptives through CBD agents than through its clinics. There was anecdotal evidence of CBD IEC activity. PPAG reports that CBD agents asked supervisors for wooden penis models to better demonstrate how to correctly put on condoms, their most popular product. The community dramas attracted large rural audiences and stimulated discussions despite often including some misinformation.

Although the CBD agents make a 40 percent profit on their sales, they still need to work part time at other jobs, which limits their time for promoting their products. This is particularly true for the many CBD agents who are farmers during the harvest season. Transportation is also a handicap for conducting IEC outside the community where the CBD agents are located. PPAG met its goal of establishing a total of 954 CBDs (including 654 CBD agents on board in 1994, plus 300 who were trained in accordance with PPAG's grant under GHANAPA). However, due to disinterest, attrition and family opposition to the selling of contraceptives, the number of active CBD agents currently active amounts to a total of 792. Finally, supervision tended to be more erratic than planned, especially when volunteers were used, as was the case with PPAG. In fact, PPAG has fewer supervisors working now than at the start of the intervention.

### IEC interventions for youth

Several public and private sector organizations are collaborating to develop interventions targeting population communications to youth. There is broad consensus and support for the interventions, which involve research, strategy development, materials development, and innovative activities. It is too early to expect impact from some of these initiatives, which are only now being completed. The high degree of collaboration between the participating organizations is impressive and the stage is well set for implementation. The successes include:

- Youth Talk, a 14-module curriculum which covers youth counseling, peer education and life education issues. It was produced by PPAG with technical assistance from JHU/PCS. Other collaborating partners include: NPC, the Ministry of Education, YMCA, GRMA, the Ministry of Health, and religious organizations. The modules cover a broad range of topics, including relationships, STDs, advocacy, sexual facts, community issues, and negotiating skills. Suggestions on how to use the document, including activities and how to engage youths in discussion, are also included.
- Under the direction of GSMF, in collaboration with the Ministry of Youth and Sports (MOYS), PPAG and other partners, a study of a sample of 6,000 youth was conducted that was instrumental in guiding the development of the youth interventions.
- A byproduct of the study was the development of a weekly radio program on reproductive health by and for youth. The program's content is developed with help from PPAG, GSMF, an advertising agency, JHU/PCS, and other partners who meet weekly with the teenagers. The only measure of the impact so far is the wide geographic diversity of the youths that call the station during the program, indicating wide coverage.

- In collaboration with the MOYS, football has been used as a vehicle for reaching male football players under age 20. Players on 60 teams in 3 cities are being reached with population messages at training camps. In exchange for their cooperation, the teams are given assistance with developing coaching skills. PPAG and the MOYS have jointly developed a logo which is appealing to youth and which is displayed on many products and activities related to youth.

### Youth centers

PPAG developed a dozen youth centers with the goal of attracting youths who were not receiving other social services. To attract them, recreational activities were organized, library services were provided, and minor ailments and STDs were to be treated. Materials produced, such as “Questions and Answers for Youth” and the “trigger video” for youth were also used at the centers. The difficulty with the centers was the limited number of students who were actually reached. Since the centers were only open from 8 a.m. to 5 p.m. on weekdays, youths that were in school as well as out-of-school youth who worked could not attend. Many more boys than girls used the centers. In the Cape Coast Center, the August attendance was 600 visits, of which only 2 were by girls. PPAG reports that 684 acceptors were identified through the 8 youth centers, including 65 new ones during the first quarter of 1999. Condoms were the most popular method used by the teenagers. Considering the cost of establishing and maintaining the centers and the relatively small number of youths reached, they do not appear to be a cost-effective mechanism for addressing the FP/RH needs of youth.

### Family life education

The Ministry of Education (MOE) is well aware of the challenge of teenage reproductive health measured by the high dropout rates of secondary school girls caused by unwanted pregnancy. The MOE has had some success with developing family life education but progress has not been made in linking young adults with reproductive health services or engaging school health services. As mentioned above, the Ministry of Education’s Curriculum Development Unit was involved in the development of the peer education curriculum, Youth Talk. PPAG’s work with schools was limited to selected vocational schools where the students are older and community sensitivity is less acute. There was no evidence of resources being sent from MOH or the MOF under GHANAPA to the MOE to support family life education.

### **Effectiveness of Implementation Arrangements**

The GHANAPA strategy for demand creation was heavily dependent on substantive participation by the MOH/HEU. Although the HEU had performed well under FPHP and had developed a well-trained and dedicated staff, its participation under GHANAPA was very limited.

Most JHU/PCS assistance under GHANAPA was originally intended to support MOH/HEU activities, which were in turn supposed to directly support service delivery aspects of the GHANAPA project. When the MOH/HEU found itself unable to take on a substantive role in IEC, JHU/PCS made its support available to a wide variety of public and private sector organizations working under the GHANAPA umbrella. This assistance contributed to the development of a diverse array of IEC training tools and materials. JHU/PCS thereby helped to keep IEC functioning in Ghana, despite the lack of any sustained IEC efforts on the part of the MOH. However, largely because these JHU/PCS activities were developed essentially in response to individual and often unrelated requests from diverse organizations, the overall JHU/PCS assistance program lacks a consistent theme, focus or strategy.

Implementation arrangements with the grantees, PPAG and GSMF, appear to be working well. Both PPAG and GSMF also proved to be good collaborators with other partners under GHANAPA and benefited from technical assistance provided by JHU/PCS. GSMF, relative to other grantees, was particularly independent and did not require technical assistance over the last year.

## **Recommendations**

1. GHANAPA envisioned a primary role for the MOH/HEU in developing and coordinating IEC activities in both the public and private sectors. The MOH/HEU was not able to fill that role, and shows little ability to do so in the near future. Clearly, the MOH's eventual readiness to assume this responsibility will be determined by the priority it attaches to the IEC task and the financial resources the GOG makes available for this purpose. In the absence of such a commitment on the part of the GOG, there is little point in proposing that USAID assume increased responsibility for IEC costs. USAID has noted its willingness to help meet critical IEC requirements that are beyond the short-term capacity of the MOH. This assistance could include, for example, support for the development, reproduction and distribution of selected promotional/information messages, and possibly support for IEC costs linked to the expansion of the Navrongo model or its variants.

**Recommendation: Following consultation with the UNFPA and MOH/HEU to avoid duplication of effort, USAID should assist the MOH in the development, reproduction and distribution of selected information/education messages (electronic/print/interpersonal) in support of the FP/RH program. Special care should be given to ensure that these messages address specific obstacles to FP/RH acceptance and practice in Ghana, namely fear of contraceptive side effects, misperceptions and rumors, and cultural biases, and that these messages provide practical, easy-to-use information on how and where clients may obtain FP/RH services.**

2. As noted above, JHU/PCS has played an important role in helping to maintain some IEC momentum in Ghana, despite the lack of a key MOH partner. However, in the continuing absence of substantive GOG support for IEC activities, JHU/PCS's efforts have not, in sum, approximated a strategically significant response to the program's overall IEC requirements. Given the high cost of the JHU/PCS program in Ghana (it is the most expensive line item—after contraceptives—in the Mission's Field Support budget) it is essential that this activity's resources be carefully targeted to achieve maximum results. This targeting is especially necessary in view of the need for more intense IEC/behavior change efforts in HIV/STD/AIDS prevention.

**Recommendation: JHU/PCS should develop and submit to USAID/Ghana a multiyear strategy and work plan indicating the rationale, elements, schedule, and estimated cost of the organization's future IEC activities in Ghana. This strategy/work plan should clearly describe how JHU/PCS assistance will address consumer fears and misperceptions related to family planning practice, and how it will effect behavior change among population groups at high risk of contracting HIV/STD infection. Moreover, and in keeping with the project management style of all other cooperating agencies in Ghana, this strategy/work plan should include a schedule for the replacement, within 2-3 years, of the expatriate JHU/PCS adviser with a host country national.**

3. Mass communication can be an effective means of reaching large audiences, especially young adults.

**Recommendation: To the extent manageable within the strategic and cost parameters of the above work plan, JHU/PCS should assist the MOH, NPC and PPAG in the development of prototypes of messages to be used in the electronic media. These prototypes would be adapted at the regional level, where attempts should be made to obtain free public services radio air time in local languages. Again, most of these messages should be selected to address obstacles to acceptance of FP/RH services.**

#### **IR 3.1.4: IMPROVED POLICIES FOR REPRODUCTIVE HEALTH SERVICES**

##### **Program Strategy**

The GHANAPA Project Paper notes that the overall policy climate in Ghana for population programs had (by 1994) significantly improved over the preceding five years. The project was not intended, therefore, to focus any substantial additional resources on efforts to help create a more favorable policy or regulatory environment for population activities in Ghana. GHANAPA was instead structured to address several factors (see section I, Introduction, Program Description) at the operational/GOG decision level which would, if implemented, greatly improve the overall effectiveness and long-term sustainability of Ghana's family planning program. The primary assistance tool which

USAID and the GOG employed to effect these changes was non-project assistance (NPA). USAID has also used the USAID/Washington–managed POLICY (formerly OPTIONS II) project to support specialized policy and advocacy activities to further GHANAPA objectives. Finally, USAID and the GOG look to key data collection activities, such as the Ghana Demographic and Health Surveys (GDHS) and the upcoming 2000 census, as vital resources to enhance popular understanding of population issues and to help policymakers develop appropriate responses to the country’s population concerns.

## **Performance: Project Activities**

### Improved Policy Environment

#### Non-project assistance (NPA)

The NPA component of GHANAPA was originally intended to include five annual cash grants to the GOG (totaling \$14 million), with each annual tranche to be released upon the GOG successfully meeting conditions precedent (CPs) to disbursement. These CPs were tied to performance indicators that required the GOG to meet family planning benchmarks and to complete actions that would increase overall provision of family planning and AIDS/STD prevention services. During the negotiation phase of GHANAPA, USAID and the GOG agreed that progress under the NPA would not be measured by any specific changes in financial allocations by the GOG, but rather by the GOG’s attainment of family planning benchmarks. The presumption behind this agreement was that the GOG would have to allot adequate (additional) resources to attain these benchmarks. In keeping with the spirit of this understanding, USAID and the GOG agreed that neither party was obliged to monitor the disposition of the financial resources provided under the NPA arrangement.

In several important respects, the NPA component of the project worked well. Most of the key benchmarks were achieved, even if they were generally met later than planned. For example,

- The National Population Council Secretariat was established and proceeded to exercise its intended tasks, that is, to coordinate overall program efforts in RH and to help stimulate implementation of RH policies and programs at regional and district levels.
- Commodity forecasting and stocking policy were significantly improved (see IR 3.1.3., Program Strategy discussion) and a contraceptive pricing study conducted by the MOH with POLICY project assistance effectively eliminated disruption to contraceptive sales through the commercial sector.

- The Essential Drugs List and National Formulary (EDLNF) was expanded to include certain contraceptive products as well as drugs and reagents needed for the testing and treatment of STDs.
- The MOH has effectively used technical assistance from JHPIEGO, AVSC and INTRAH/PRIME to improve provider counseling and health care skills and to help eliminate provider biases, which impeded the delivery of RH information and services to certain clients.

Without losing sight of these achievements, it must be said that the NPA fell short of meeting its essential goal—to promote the additional allocation of GOG financial resources to family planning and to diminish GOG reliance on donor support for its FP/RH programs. The analysis of MOH budget documents (undertaken during this assessment) indicates that overall GOG budgetary outlays to the MOH have been rising modestly over the past five years. GOG expenditures for health, excluding foreign-financed capital expenditures, amounted to 1.06 percent of the gross national product in 1998, and the GOG's expenditure trajectory in the health sector will fall only slightly short of meeting its target of 1.4 percent by 2001. MOH units responsible for implementation of family planning (and HIV/STD prevention) activities have not, however, seen any increase in GOG funding—either during the life of the NPA mechanism or since its termination—and virtually all RH-related units of the MOH continue to rely as heavily as ever on donor support. In specific instances, this lack of GOG financial participation created some serious obstacles to project implementation (e.g., the lateness and inadequacy of GOG funds expected to cover the cost of renovation of AVSC-assisted clinics, the absence of resources needed by the MOH/HEU to provide IEC support for the FP/RH program, and nonavailability of NPC funds for regional- and district-level operations of its population offices).

This low level of GOG support for its own FP/RH program might suggest that the government attaches a low priority to this sector. That does not, however, appear to be the case. At all levels of the health delivery system, program managers and health care providers share a strong sense of mission with regard to their clients' FP/RH needs. At the national level, politicians from cabinet ministers to parliamentarians to the president of the republic have gone on record calling for a vigorous and expansive response to Ghana's population and reproductive health challenges (albeit with less emphasis on HIV/AIDS). These leaders and GOG FP/RH program managers have correctly observed, however, that the donor community has been willing to address these needs to such an extent that the GOG has been able to allocate its very scarce resources to other areas of the health sector. While this pattern of response is not consistent with hoped for outcomes of the NPA, it is the most rational and likely GOG response under the circumstances—and was probably inevitable in view of USAID's early decision to forego any clear linkage between the NPA and specific increases in MOH outlays for FP/RH.

After a long Congressional hold on NPA funds in 1997–98, USAID effected a unilateral, de facto termination of the program in 1998 (later formalized by a July 1999 Project Implementation Letter). Senior GOG counterparts in the MOH, MOF and NPC report that they were surprised and disappointed at the suddenness of the 1998 action—evidently taken by USAID without any prior consultation with the GOG. That disappointment is heightened by a GOG perception that the NPA was generally successful, as evidenced by the GOG’s responsiveness to the NPA’s benchmarks/CPs. Indeed, it is at least partly on the basis of this perception of the NPA as a successful instrument of bilateral cooperation that the GOG (including the leadership of the MOH and MOF) continues to urge USAID to participate in the GOG’s “common basket” approach to health sector assistance.

To be sure, the GOG—including the leadership of the MOH—cites several reasons for its preference that donors pool their assistance resources. Most notable among these is the MOH position that pooling would enable the Ministry to reflect its own priorities in its health sector programming rather than the priorities of donor agencies. The MOH also believes that USAID’s participation in the ‘pool’ would free the Ministry from its obligation to comply with USAID’s complicated accounting procedures, “buy American” procurement requirements, and other obligations which—in the words of a senior MOH policymaker—“compel the MOH to be inefficient.”

### POLICY project

The POLICY project (implemented by The Futures Group International) has worked at several levels of the GOG to assist in the development of government and popular support for population and HIV/AIDS prevention activities.

At the uppermost level, the POLICY project (and its predecessors Resources for the Awareness of Population Impacts on Development [RAPID] and OPTIONS I and II) have worked since 1986 with the Population Impact Project (PIP) located at the University of Ghana at Legon to heighten population awareness and action among government and political leaders, business and industry executives, religious leaders, health personnel, and the media. POLICY has also worked closely with the National AIDS Control Program to help NACP develop and disseminate a national AIDS policy and with the National Population Council to support the NPC’s advocacy work in population and HIV/AIDS prevention through national-, regional- and district-level governmental bodies.

POLICY’s work outside of Accra has focused on efforts to strengthen the population and HIV/AIDS prevention advocacy role of district-level NPC population officers. All of this assistance is thus far limited to four districts in Eastern Region (plus some very modest support for the Regional Population Office in the regional capital). The primary task of these district-level personnel is to raise the awareness of the district assemblies to population and HIV/AIDS issues and to secure from them additional budgetary support

for population and HIV/AIDS prevention programs at the local level. These district-level staff members are also working closely with local-level NGOs to enhance the latter's capacity as advocates for stronger population and HIV/AIDS prevention efforts by local government jurisdictions, village leaders, religious and social welfare groups, and the general public.

POLICY has also provided support to the MOH for the preparation of a contraceptive method-mix analysis and a contraceptive pricing study, both of which helped the MOH undertake key policy decisions in these two areas.

The Futures Group's support for PIP (through Future's several policy-related projects) has been successful in attaining its goals. PIP has established a long and constructive record of performance in arranging national fora on population issues, sponsoring RAPID-type presentations to national leaders, and making the media sensitive to population issues. Indeed, PIP's success has been important in creating the favorable policy environment that now prevails in Ghana regarding population matters. That same success, however, calls into question the necessity for USAID to continue providing institutional support for PIP through the POLICY project. At the very least, POLICY should continue to provide PIP with the most current and/or updated policy-awareness tools and literature—materials that PIP can use to support its awareness-enhancement role. But regarding financial assistance, it is probably time to declare success and cease further support for the program.

POLICY support for the NPC at the national level is very modest; but again, the population policy environment in Ghana is sufficiently well developed that further USAID investment in this area will encounter diminishing returns on the effort.

The POLICY project's advocacy enhancement work at the regional and district levels has not yet demonstrated any significant successes. Meetings of regional- and district-level population and AIDS committees are taking place, and key individuals and groups are evidently being educated on the issues. But so far, this effort has not produced any substantive program initiatives or funding flows at local levels. This relatively low level of results is not due to any lack of enthusiasm or intensity of effort by the district-level NPC staff involved, but rather to the diffusiveness and ambiguous relevance of the message they are being asked to deliver to local-level leaders and communities. The GDHS indicates, for example, that public knowledge regarding family planning is already extensive, so any additional input which district-level population officers might provide on FP would be marginal—taking note that these personnel are not being asked to address continuing client awareness problems regarding contraceptive side effects, rumors, husbands' attitudes, etc. Even public consciousness raising about HIV/AIDS is not riveting the attention of local leaders and the public because the message still lacks relevance for most audiences, that is, at the personal level.

What appears to be needed is a focused message which would be perceived by local leaders and the public as critically relevant to their communities' well-being, and which would concurrently address a matter of pressing national concern: the need to protect young adults—and the country—from a future AIDS epidemic. It has been frequently pointed out that Ghana is enjoying a temporary “holiday” from the HIV virus. HIV prevalence is still low by Africa standards, and the public—perhaps understandably—is not yet alarmed by the prospective threat of AIDS to Ghana, or more importantly, to their own lives. Policymakers and the medical community are certain, however, that in the absence of vigorous measures now—during this brief window of opportunity—the virus will most surely take hold in Ghana with potentially devastating effect. NPC, NACP and the POLICY project should re-direct and re-focus their program of cooperation to support a concerted effort to bring the HIV-prevention message home to leaders and communities. Youth and young adults should be the special focus of this program in view of their very high vulnerability to the virus and their still limited access to the information and services they need to prevent unwanted pregnancy, avoid STDs, and prevent the transmission of HIV.

#### Data Collection and Analysis (GDHS and 2000 Census)

The Ghana Statistical Service (GSS) released the preliminary results of the Ghana Demographic and Health Survey in May 1999, and will present the final report to a public meeting of GOG leaders, technical personnel and the media in October of this year. As reported above, the GDHS findings were at once satisfying and disappointing. They showed that fertility in Ghana has continued to drop—to 4.6 births per woman in 1998—but that contraceptive prevalence fell short of expectations. Moreover, the gap between the CPR and its theoretical impact on fertility evokes questions about other factors influencing Ghanaian couples' fertility management practices. Some of these factors emerged from the study: an 8 percent decline in the percent of women currently in union over the last five years, a trend toward later marriage, and a rise in age at first birth. Other factors have been suggested, including a high rate of pregnancy loss (miscarriage/abortion), especially among young adults, and a higher than assumed effectiveness of the natural family planning (Billings method) practiced by many of Ghana's Catholic population. These unanswered questions should provide the framework for a dialogue between GSS and Macro International regarding the secondary analysis agenda for the GDHS.

GSS reports that planning for the 2000 census is proceeding generally on schedule. Indeed, the Minister of Finance was cited by senior GSS officials as having assured GSS that the necessary funds would be made available to carry out the census field work, most likely in April 2000. (Many of the enumerators will be school teachers, so the precise schedule must be developed in close consultation with the Ministry of Education, that is, to ensure that the field work does not disrupt the academic calendar).

## **Effectiveness of Implementation Arrangements**

**Non-Project Assistance:** As discussed above, the NPA mechanism was successful in several respects, less so in others. Since NPA is no longer used nor likely to be used in support of GHANAPA, any future oriented discussion of its utility is not needed here. The NPA experience is instructive with regard to USAID's ongoing dialogue with the GOG concerning the common basket approach, and whether SO3 objectives might be advanced by the Agency's participation in that funding system. Based on this assessment, the lessons of the NPA are clear in signaling that USAID should not participate in the common basket approach. To do so would once again place at risk the very program initiatives which USAID and its partners—not least of which is the MOH—have collectively agreed to support. Without the earmarking of USAID resources for specific activities and programs, there is little reason to expect that these activities would receive the resources they need to succeed. (This observation is offered with considerable regret, given USAID's presumed preference that GOG priorities would themselves ensure that USAID funds would find their way to GOG parties responsible for program implementation. The experience with NPA, however, tells us that this outcome cannot be assumed.)

**National Population Council:** In keeping with the provisions of GHANAPA, the NPC perceives its key role to be the coordinator of overall GOG population activities, with special reference to the coordination (and occasional rationalization) of donor assistance to the sector. GHANAPA was explicit in expecting NPC to exercise these roles and called for the establishment of the Population and AIDS Coordinating Committee (PACC) as NPC's primary mechanism for exercising its coordinative responsibilities. The NPC had some initial difficulty in carrying out its role until 1996, when NPC Secretariat staff was finally in place and an executive director was assigned. Once the Secretariat was organized, it collaborated with USAID to ensure that the many USAID-funded cooperating agencies (CAs) active in Ghana structured their assistance efforts in ways which responded to real needs of the country's population program. NPC and USAID also successfully adopted some useful changes in these CAs' assistance modalities—calling on them, for example, to conduct more training in Ghana, rather than in the United States, and to thereby expand the reach of the CAs' skills transfer efforts.

In practice, however, the NPC's role was limited. Lacking an overall sense of USAID's priorities, the NPC tended to focus on the specifics of an individual CA's program, but without substantive knowledge as to how each CA program fit into the Mission's strategy. The limits of the NPC's coordinative function were further underlined during the annual meeting of USAID-supported CAs, when it became clear that most of these agencies had already developed and generally agreed to their collaborative programs with local counterpart organizations well before they presented their proposals at the annual meeting. Meanwhile, since host country NGOs, such as GSMF, GRMA and PPAG, signed their grant agreements directly with USAID, none felt any compelling need to collaborate with or report to the NPC.

During this period (late 1996–early 1998), USAID was in a position to reinforce NPC’s role, but by adopting a relatively passive posture regarding both the NPC and the cooperating agencies, probably contributed to the marginalization of NPC’s role at that time. More recently, USAID’s execution of a SOAG with the Ministry of Health in February 1999 signaled yet another step back from its relationship with the NPC.

The key question at this juncture is whether USAID should seek to re-invigorate its relationship with the NPC, and to what end. Little is to be gained now by efforts to strengthen an NPC coordinative role which never functioned well in relation to the donor agencies. Indeed, during the project period the NPC was not especially effective in managing its own internal responsibilities: it did not lobby for additional GOG resources for implementing arms of the GOG reproductive health program; and it was not able to ensure that NPC offices in the regions and districts received adequate funding to perform their mandated tasks. But as explained in the following section (Recommendations) USAID—and more importantly, the GOG—should look to the NPC to help further other aspects of the country’s population/RH agenda.

**POLICY Project:** The Futures Group has been consistently responsive to its program partners in Ghana (PIP, NPC, NACP, and USAID). Over the years, this support has contributed significantly to the creation of a favorable environment for population activities in the country and has helped create a cadre of academic, technical and managerial professionals who can sustain that environment into the future. It would be helpful to the Mission, however, if The Futures Group clarified the operational and funding relationship between its Field Support–funded activities in the country and its Core–fund supported activities (e.g., its capacity-building efforts with district-level NGOs). USAID should be made aware of—and explicitly approve—all Core–funded activities under way in Ghana. (Note that this same requirement applies to the Population Council with regard to operations research activities it is supporting at Navrongo).

**GDHS and the 2000 Census:** GSS reports that its working relationships with Macro International Inc. (in support of the GDHS), and the U.S. Bureau of the Census (BUCEN—in support of the census) have been constructive, positive and very helpful. GSS was especially appreciative of the speed with which USAID/Ghana moved to mobilize BUCEN assistance for the census, and noted the high quality of the BUCEN consultants who have visited the country.

## **Recommendations**

1. By its actions over the past two years, USAID has signaled to the NPC Secretariat that USAID’s view of the Secretariat’s role in furtherance of GHANAPA/SO3 objectives has changed. Given NPC’s earlier centrality to GHANAPA (establishment of the NPC Secretariat was a CP to release of NPA funds) USAID is obliged to explain its new position clearly and unambiguously to NPC. This discussion should

focus on the following points:

- USAID does not look to the NPC Secretariat to coordinate USAID assistance efforts in the population/reproductive health sector. USAID nonetheless continues to look to the NPC as the one branch of the GOG responsible for articulating and fostering GOG policies and programs supportive of the country's population and reproductive health goals.
- To help ensure the long-term effectiveness and sustainability of USAID (and other donor) assistance in the reproductive health sector, USAID looks to the NPC to effectively lobby the GOG for a genuine reordering of priorities, whereby GOG financial support for reproductive health efforts would be brought into closer consonance with GOG policy declarations.
- USAID is prepared to work closely with NPC and the NACP—especially at the district level—to develop a public awareness campaign designed to address the reproductive needs of young adults, with special reference to avoidance of unwanted pregnancy, STDs, and transmission of HIV. POLICY project participation with NPC and NACP would be reoriented away from its current focus on broad population and reproductive health issues, and would be refocused on the development of this sharper, more closely targeted campaign.

**Recommendation: USAID should work with the NPC Secretariat to explain USAID plans and priorities, underline USAID recognition of NPC's role as an advocate for change within the GOG, and engage the NPC (and NACP) in an effort to forestall the arrival of an HIV epidemic in Ghana.**

2. NPC Regional Population Offices (RPOs) are autonomous units, which stand apart from the Regional Health Administration, and indeed from all other elements of regional government. In at least one region, this administrative isolation has insulated the RPOs from access to any funds (with the exception of some funds that flowed erratically from the NPC in Accra), which it needed to operate and maintain an office and outreach activities. In one office visited during this assessment, for example, no funds were available to operate the USAID-provided vehicle, and the office's phone and electricity were about to be disconnected for lack of funds to pay utility bills.

**Recommendation: The NPC should develop a mechanism to ensure that adequate GOG funds are made available to its regional- and district-level offices.** One measure which the NPC might consider would be to place its RPOs in the office of the regional administrator (effectively the governor's office), thereby mirroring at the regional level the placement of the NPC in the office of the president. This placement would give the RPO additional visibility and credibility and would help ensure adequacy of operating resources for the RPO.

### **III. PERFORMANCE ASSESSMENT: HIV/AIDS/STD PREVENTION**

#### **IR 3.1.1: INCREASED ACCESS TO REPRODUCTIVE HEALTH SERVICES**

##### **Program Strategy**

When the GHANAPA project was developed, the Ghana Social Marketing Foundation (GSMF) was already the largest provider of condoms in Ghana and a major implementing organization. It has had strong financial management and administrative capabilities and well-established procurement procedures since its inception in 1993. It was considered ready to become a direct grant recipient under GHANAPA.

Under GHANAPA, it was expected that GSMF would expand its base of providers from 4,000 to 12,500 outlets and develop new types of outlets beyond its existing network of pharmacies and chemical retail shops. The list of potential new outlets suggested included gas stations, packaged goods stores, local markets, hairdressers, hotels, and kiosks in rural areas.

Beyond the usual training, marketing, research, warehousing, packaging, and distribution that GSMF does, it was also expected that GSMF would provide technical assistance to and coordinate an expanding number of NGOs. This would involve help with program management and supervision, the training of new CBD agents and the provision of commodities. The grant to GSMF would also fund workshops, training of trainers and opinion leaders and administrative costs. Technical assistance was to be provided to GSMF from the centrally funded Contraceptive Social Marketing III (SOMARC) project.

##### **Performance: Project Activities**

###### Private Sector Condom Distribution (by GSMF)

Condoms were well promoted by the GSMF and the commercial advertising agencies with which it contracts to develop promotions. Condom sales have steadily grown in both the private and public sector as a result of advertising and promotions. For many chemical shops and CBD agents, condoms are the most important products they sell. The GSMF has used mass media and point-of-purchase advertising effectively.

GSMF can also be commended for addressing in its advertisements some of the obstacles to condom use among women. Advertisements showing couples who care for each other and use condoms will contribute to reducing the reluctance of women to carry and use condoms because of their association with sex workers. Continued efforts on reducing the stigma attached to condoms would be welcomed. In 1998, condom sales, primarily through pharmacies and chemical shops, increased by 30 percent.

## Effectiveness of Implementation Arrangements

GSMF has proven to be a reliable grant recipient as it brings the efficiency of the private sector to the population sector. As was mentioned previously, GSMF under GHANAPA was expected to move towards greater financial self-sufficiency. However, GSMF has a number of project responsibilities that do not directly contribute to product sales and cost recovery. The training of pharmacists and chemical shop sellers, collaboration with the public sector and NGOs, and other activities may have good programming value but they probably are not contributing directly to GSMF's financial independence. A recent evaluation of GSMF recommended that its cost efficiency be improved. That, presumably, would entail linking promotion efforts directly to increases in sales. Such a streamlining of the product marketing would improve cost recovery but it might also compromise GSMF's valuable and reliable work collaborating with its public sector and NGO partners.

## Recommendations

1. Condoms are not being widely used for family planning in Ghana, but are essential to block the transmission of HIV and STDs.

**Recommendation:** The findings of this assessment lead to the endorsement of the recommendation of the recent GSMF evaluation that **the condom targeted for family planning, Protector Plus, be dropped and GSMF focus on condoms for preventing STD and HIV transmission.**

2. GSMF plans to promote Panther as a premier product with new, more sophisticated packaging. It also plans to target Champion to lower income groups. Champion is already the preferred condom of youth. Its image of strength, association with sports and low cost will make it the ideal product for young adults.

**Recommendation: Considering the importance of condoms to the reproductive health of young adults, the Champion condom should be as aggressively targeted to young adults as is possible.** If community sensitivities pose a problem, the brand name Champion should be associated as much as possible with youth interventions, even if the words "condom" and "AIDS" are not mentioned.

3. Several GSMF project responsibilities do not contribute to and may detract from its ability to become more self-sufficient.

**Recommendation: To accurately track GSMF's progress toward self-reliance, the cost of its noncommercial activities (collaboration with the MOH, training for NGOs) should be accounted for separately from GSMF's costs for social marketing activities.**

4. GHANAPA's HIV/AIDS/STD-prevention strategy focuses on measures to reach high-risk segments of the population.

**Recommendation: GSMF should encourage its new sales team to establish sales outlets in bars and hotels and other appropriate environments likely to reach high-risk clients.**

### **IR 3.1.2: IMPROVED QUALITY OF REPRODUCTIVE HEALTH SERVICES**

#### **Program Strategy**

The 1993 Situation Analysis reported that 44 percent of health care workers would not provide information and counseling on AIDS to family planning clients—despite a fairly intensive effort by the United Nations Development Programme (UNDP) (begun in April 1991) to help NACP strengthen the counseling skills of health care providers. GHANAPA therefore sought to deepen and broaden training activities to include more public health care providers and to expand client counseling skills to key elements of the private sector, including GRMA, private practitioners, pharmacists, and chemical sellers.

#### **Performance: Project Activities**

##### Training of Health Professionals in STD Management and Prevention Counseling

##### Family Health International (FHI)/Implementing AIDS Prevention and Care Activities (IMPACT) Project

In 1995, the MOH initiated steps to revise the Essential Drug List to include more effective drugs for treating STDs. Having completed this exercise in March 1996, the MOH—with assistance from FHI/IMPACT—revised its practitioner guidelines for the management of STDs to include the appropriate use of these drugs and further revised the guidelines to incorporate a syndromic treatment regime for management of STDs. Over the past three years, NACP has trained more than 100 doctors (from five regions) in the use of these new guidelines. The training schedule is behind schedule, however, and does not appear likely to meet its training target of 250 doctors by the end of the project. The key reason for the delay is a lack of GOG funds needed to conduct the training activities. There also appear to have been some delays due to scheduling conflicts on the part of NACP and FHI/IMPACT program managers.

FHI/IMPACT also provided technical assistance to the NACP to help develop a national quality assurance program within the public health laboratory system. Working with the Public Health Reference Laboratory (PHRL) in Accra, FHI/IMPACT helped develop standard operating procedures (SOP) for the entire laboratory system from the national level to the district and subdistrict levels. Specifically, this technical assistance helped produce SOP manuals for the teaching hospitals, the other three PHRLs, district

hospitals, polyclinics, and health centers. These manuals provide operating instructions for all laboratory technologists at regional, district and subdistrict laboratories and at the four PHRLs. Once training in the use of the new SOP is completed, the laboratory system should have the capacity in place to accurately diagnose HIV/STDs and other diseases at all levels of the health system.

The NACP and FHI/IMPACT understood that funding for the dissemination of these manuals—and for the training of laboratory technicians in their use—would be provided by the MOH. This funding has not yet been made available and no dissemination or training activity has occurred since the materials were produced. The assessment team was informed by NACP that FHI/IMPACT is now considering the possible provision of some funding which will initiate dissemination and training activities, possibly as soon as October 1999.

#### Ghana Registered Midwives Association (GRMA)

GRMA members have participated in MOH training programs in treatment and referral of STD cases, including use of the syndromic method for STD diagnosis. The training also focused on patient counseling and contact tracing. For the period January–June 1999, GRMA midwives report having seen 1,612 STD cases. They also treated 267 partners and referred 76 clients for further treatment.

#### Training of Pharmacists in Client Education (by GSMF)

Pharmacists and chemical shop sellers are a key group for promoting condoms and for encouraging the treatment of STDs. There is evidence that pharmacists and chemical sellers are the front line for the treatment of STDs. Thus far under the GHANAPA project, GSMF trained 200 pharmacists and 600 shop assistants. Judging from anecdotal evidence gathered during this assessment, those trained had increased their knowledge of STDs and their role in the prevention of HIV infection. They had detailed reference materials with illustrations and instructions on how to take histories. They were aware of medicines to be used for treatment of STDs. They were all trained to refer clients to other services or treatment. As mentioned previously, there was evidence of a high level of appreciation for the training and enthusiasm regarding their affiliation with GSMF.

### **Effectiveness of Implementation Arrangements**

The revised Guidelines for STD Management produced by NACP are gradually being adopted for use by both public and private sector practitioners. Their dissemination and use would be accelerated, however, if NACP and FHI/IMPACT developed a clear work plan and schedule for training MOH physicians in the remaining five regions.

FHI/IMPACT has been very helpful to the PHRL in strengthening its capacity to serve as a key element in Ghana's HIV surveillance system. However, the PHRL's continuing

inability to obtain GOG funding for the dissemination of the SOP manuals and for the training of laboratory personnel has been a major handicap in ensuring that quality laboratory procedures for HIV/STD testing are in place at all levels of the health care system.

### **Recommendations**

- 1. The NACP should expedite its training in STD management and prevention counseling, with special reference to the five regional training units that have not yet received this training.**
- 2. The Public Health Reference Laboratory should, in consultation with the Institutional Care Division of the Ministry of Health, develop a work plan and budget to complete dissemination of the Standard Operating Procedures within 7- 12 months.** It is further necessary to engage district hospitals and health centers in a dialogue about the need for all health laboratory personnel to be trained in the use of these manuals and encourage these institutions to use some of the internally generated funds for this activity to ensure improved HIV/AIDS/STD capability to the lowest level of the health care system as possible.

### **IR 3.1.3: INCREASED DEMAND FOR REPRODUCTIVE HEALTH SERVICES**

#### **Program Strategy**

Constraints to the promotion of safe sexual behavior include, most notably, misconceptions concerning HIV transmission and the belief of those engaging in risk behavior that they are not at risk. The program strategy focused on encouraging the reduction in the number of sexual partners and the promotion of the proper and consistent use of condoms. The strategy called for increasing knowledge levels on STDs and promotion of seeking treatment for them. The support of HIV-positive individuals and AIDS patients would also be encouraged.

IEC campaigns were to be planned and developed by the Health Education Unit with assistance from the National AIDS Control Program (NACP). Other partners were to be the Ministry of Education School Health and Curriculum Development Units, which would develop AIDS and STD educational programs in junior and senior secondary schools.

The Regional and District AIDS Committees (RDAC) would work with the Regional and District Health Management Teams to plan and coordinate IEC campaigns on family planning and AIDS/STDs. It was intended that the regional and district strategy would take advantage of regional radio stations, particularly programming in local languages. It was also intended that outreach activities be conducted by the MOH health care providers and that community groups be engaged, including traditional and religious leaders,

teachers, assembly men and women, peer groups, and NGOs. Technical assistance to help develop the AIDS and STD-related IEC strategy would be provided to the NACP and the HEU by JHU/PCS.

## **Performance: Project Activities**

### IEC and Behavior Change Activities

#### Behavior change promotion

The GHANAPA strategy for responding to the challenge of HIV/AIDS from the point of view of IEC and behavior change was overly ambitious and unfocused. The goal of having 50 percent of men use condoms in sexual relations outside of marriage was not only an enormous challenge but it was impossible to measure since no baseline was established to measure against it. The GDHS indicates that knowledge levels regarding HIV/AIDS are high but risk behavior remains common.

#### Role of the Health Education Unit (HEU)

There was very little evidence of IEC interventions to promote positive behavior change for HIV/AIDS prevention in the public sector. More posters were observed promoting tuberculosis prevention during the assessment field trips than posters promoting HIV prevention (ironically, preventing HIV infection is the best means of preventing tuberculosis). The lack of coherent, effective and focused IEC campaigns at the national and regional levels is alarming considering the HIV threat on Ghana's borders. There was no evidence of any IEC efforts to increase awareness of risk for HIV infection or correct misconceptions on HIV transmission.

As was the case with the IEC for reproductive health described above, resources to develop strategies and interventions did not reach the MOH/HEU, which was intended to be the focal point for the HIV/AIDS IEC and behavior change efforts.

#### 1994 IEC campaign

Though many more campaigns were expected from the NACP under GHANAPA, a multimedia campaign was launched in late 1994, which promoted partner fidelity, condom use and discussions about AIDS. The 3-month campaign used television and radio spot advertisements. The radio advertisements were in six different languages. Billboards, question-and-answer booklets about HIV/AIDS and other materials produced by the HEU were also produced. Technical assistance was provided by JHU/PCS.

Studies conducted before and following the campaign found that the campaign had no effect on the knowledge that mutual fidelity with an uninfected partner was a means of preventing HIV infection. However, the number of men who knew that condoms

prevented transmission doubled from 27 to 50 percent. Those with higher levels of exposure to the intervention had more positive attitudes towards condoms and use them more than those with lower levels of exposure.

#### FHI/IMPACT support

**Uniformed Forces STD/HIV Prevention: Police Service:** Uniformed forces were listed as a key target population for HIV/AIDS prevention in the GHANAPA project. Though some effort was made to make headway with the Armed Forces through the sale of condoms in canteens, little progress was made until last year when the Police Service obtained technical assistance from FHI/IMPACT. Together, they rapidly conducted research, developed a strategy, and produced materials, including posters and a pamphlet that speaks openly and frankly about the vulnerability of the police to STD and HIV infection. The pamphlet describes the challenge HIV presents to police and describes the goals of the strategy. It is designed to convince the officers located around the country of the danger and the need for them to take action. FHI/IMPACT also worked with the Police Service to develop a peer education training manual and to incorporate HIV/AIDS/STD prevention into the police training program for new recruits as well as for police officers who receive periodic in-service training. So far, nine recruits and five instructors have been trained as peer educators. At the leadership level of the Police Service, awareness training in HIV/AIDS/STD prevention has been given to the inspector general and to 20 police commanders, including the head of the Police Training Unit. Senior officers have also been informed during their annual refresher training. An STD clinic has been set up in the Police Hospital in Accra. A doctor/nurse team has been trained to enable them to offer counseling services.

**Ghana Armed Forces (GAF):** FHI/IMPACT is involved in discussions with the GAF Health Directorate regarding possible assistance to the GAF for HIV/AIDS prevention activity. A draft subagreement between FHI/IMPACT and GAF has been prepared, and if approved by USAID, will support capacity building in behavior change within the military. This assistance will include training of counselors, training of nurses as health educators, improving the capacity of military laboratories to undertake sentinel serosurveillance, and development of IEC materials.

**Truck drivers:** GSMF's work with truck drivers is just now beginning. GSMF has decided to focus its IEC and condom promotion on transportation centers and ensure that condoms are available at those key locations.

#### **Effectiveness of Implementation Arrangements**

As was the case with the support of the HEU under GHANAPA, insufficient MOH resources were able to reach the NACP, especially those which were to be spent on behavior change communications. With the exception of the 1994 campaign, IEC has been underused.

## **Recommendations**

- 1. Recent efforts to target the uniformed forces and travelers at transportation centers should be encouraged. More specifically, USAID should continue to focus its HIV/AIDS/STD prevention efforts on high-risk groups who are most vulnerable to infection (e.g., truck drivers, miners and sexually active unmarried youth).**
- 2. The MOH sentinel surveillance system is collecting district-level prevalence data on STDs and HIV. NACP, the NPC and the MOH should provide these prevalence data, especially data regarding youth, to region/district-level population and AIDS committees to reinforce the latter's efforts to conduct advocacy work at these levels.**

### **IR 3.1.4: IMPROVED POLICIES FOR REPRODUCTIVE HEALTH SERVICES**

#### **Program Strategy**

GHANAPA's policy agenda in HIV/AIDS/STD prevention focused on efforts to educate policymakers and community leaders about the threat of HIV/AIDS and the relevance of that threat to Ghana. Specific activities included the creation of a national surveillance system with the sensitivity needed to accurately gauge HIV prevalence in the country and the development of AIDS simulation models to reflect Ghanaian conditions and the presentation of those models to key policymakers and opinion leaders

#### **Performance: Project Activities**

##### Advocacy through Computer Modeling and Policy Development

The POLICY project has worked closely with NACP to develop a computer-assisted RAPID–AIM model, which can be used to educate government leaders, business and trade groups, religious leaders, academics, and community groups to the implications and consequences of HIV/AIDS in Ghana. Thus far, POLICY has trained 18 presenters of the model. A print copy of the presentation has also been produced and will be distributed widely to decision-makers in the country.

Information on HIV prevalence obtained from Ghana's sentinel serosurveillance system (see below) has been incorporated into the RAPID–AIM model to improve its use as an advocacy tool with policymakers. The model and its related print materials have been used to support presentations to two Parliamentary subcommissions (Population and Women). This already has yielded dividends as two districts (Adansi West and Kwaebibirem) have made HIV/AIDS a priority issue to be tackled in those districts.

### Support for National Surveillance

The National Serosurveillance System established in 1994 is evidently working efficiently. Data generated by that system indicate that the current national HIV-prevalence rate is approximately 4 percent. The sentinel surveillance system shows, however, that there is sometimes significant district-to-district variation in HIV prevalence.

The National Public Health Laboratory in Accra has developed the capacity to provide effective quality control of the HIV-testing process at regional laboratories. The PHRL plays this role by conducting annual, 1-week training sessions for all laboratory personnel from the sentinel system's 22 sites and by reviewing/confirming all HIV-positive samples from these sites. As an added quality-control and training measure, the PHRL also sends some positive samples back to regional laboratories to assess the latter's reliability in performing sample verification procedures. (It should be noted that the PHRL system—comprised of the four PHRLs in Accra, Kumasi, Tamale, and Sekondi—was established to help detect outbreaks of several diseases and was not to be focused solely on detection/verification of HIV. The four laboratories have not been able to fill this larger role; they have not been able to test for syphilis, for example, because they lack the necessary reagents. But the Accra facility is serving an effective, if more limited role, in the country's HIV-surveillance system).

As mentioned above, FHI/IMPACT worked with the PHRL/Accra to develop SOP manuals for the entire MOH laboratory system, including regional laboratories and laboratories at teaching hospitals, district hospitals, polyclinics, health centers, and the other three PHRLs.

### **Effectiveness of Implementation Arrangements**

POLICY project assistance in development of the RAPID-AIM model has been timely and effective. The model shows good potential as a device to enlist the support of senior decision-makers for a more vigorous response to the threat posed by the HIV virus.

Assistance provided by FHI/IMPACT to the PHRL has enabled the PHRL to play a key role in the country's HIV-surveillance system. That assistance will be more effective, however, once the SOP manuals are disseminated to other elements of the surveillance system.

A major unresolved problem is NACP's continuing inability to obtain adequate funding to participate in the development of IEC campaigns to promote real behavior change, especially among high-risk populations. Training to improve diagnosis and effective treatment of sexually transmitted diseases will not have its full impact if people who are vulnerable to STD and HIV infection are not aware of the link between STDs and HIV

infection and their own vulnerability. They also need to be made aware of the availability of services and be persuaded to use them with their sexual partners.

### **Recommendations**

1. Earlier in this report, it was recommended that the POLICY project assist the NPC and NACP in developing an awareness campaign focused on the reproductive needs of youth and young adults. It was also noted that such a campaign should be structured so that it brings the issue of adolescent reproductive health home to families and communities at the district level and below. For this approach to be relevant and/or successful, it should use data that are meaningful and familiar to the target audiences.

**Recommendation: POLICY should revise the RAPID-AIM model to incorporate to the fullest extent possible district-level population and HIV-prevalence data.**

2. AIDS is a societal problem. The need for a multisectoral response to HIV/AIDS/STD is urgent.

**Recommendation: The current structure of the program and its location in the Disease Control Unit should be reviewed in order to give the program the visibility and resources necessary for effective implementation of a national response to the threat posed by HIV/AIDS.**

## IV. CONCLUSION

GHANAPA is a large and complex project. Its design, however, is relatively straightforward: it lays out clear objectives, identifies implementing partners with responsibilities appropriate to their capabilities and puts in place all of the resources which the design identifies as essential to the project's success.

In most respects, all of these resources were applied as planned—with the notable exception of the abruptly terminated NPA component—and all of the cooperating agencies contracted/funded by USAID/Ghana have performed essentially as called for in their agreements. In consequence, the project has produced the following significant accomplishments:

- Modern contraceptive prevalence is over 13 percent. While USAID/Ghana is not satisfied with this figure—it is well short of the 20 percent target called for in the Project Paper—it is in fact relatively good when compared with CPRs elsewhere in Sub-Saharan Africa.
- Long-term family planning methods are not yet a meaningful factor in Ghana's FP/RH program, but a good start has been made in establishing clinical facilities for the services, in training service providers, and in overcoming serious provider biases against such methods. Moreover, at least two long-term methods—injectables and Norplant—show strong promise for the future.
- Ghana's contraceptive management system is orderly, efficient and effective. The absence of any significant stockouts or overstocking situations in five years is an admirable record for any developing country.
- Oral contraceptives and condoms are being marketed at affordable prices through more than 3,000 outlets.
- The lessons of a USAID-supported operations research project (Navrongo) have been embraced by the leadership of the Ministry of Health as a model of what may become a more efficient, effective health care system that delivers essential FP/RH services to people in their own communities.
- Protocols and guidelines developed for health care providers have the potential to standardize and improve service delivery at all levels of the health care system.

- The total fertility rate of 4.6 is in fact better than the 5.0 target set forth in the GHANAPA design—and even though the project cannot claim full credit for that figure, it is clear that this TFR could not have been attained in the absence of the project.
- Public awareness of HIV/AIDS is high. It has not yet been translated into the necessary level of behavior change, but a foundation has been laid for that next essential step.
- The GOG's sentinel surveillance system is in place, and can serve as an accurate early warning system for any upsurge in HIV prevalence. This system indicates that current HIV prevalence in Ghana is approximately 4 percent.

GHANAPA has had its disappointments, however. As noted, contraceptive prevalence targets have not been met, a shift in the FP service mix from short-term to long-term methods never occurred, IEC support for the FP program and substantive behavior change efforts in HIV/AIDS prevention did not take place as planned, and the GOG is apparently as dependent as ever on donor support for most aspects of its FP/RH program. These shortcomings seem to arise from a number of factors, including

- an overly ambitious set of targets—and timetable to achieve them—in the project design,
- an inadequate flow of GOG resources which key partners—such as the MOH/HEU and the MCH/FP—needed to play their expected roles in the project,
- disruptions in the flow of USAID–assistance resources caused by the Congressional hold on NPA for several months and USAID's subsequent termination of that support mechanism, and
- inadequate USAID staff/managerial time to address critical project needs during the Congressional hold and for some months after termination of NPA (late 1996–early 1998).

The recommendations offered in this report may help to address the programmatic shortcomings noted above. USAID, moreover, demonstrated its heightened commitment to the project (or more correctly, to SO3) last year by assigning new and additional staff members to its Health, Population and Nutrition (HPN) Office. Their evident activism in approaching the project's many continuing challenges bodes well for the future success of SO3 in Ghana.

Looking to that future, the key crosscutting recommendations that emerge from this assessment include the following:

- USAID, in partnership with the POLICY project and the GOG, should re-orient its policy and advocacy investments to focus on efforts to increase public awareness of the threat posed by HIV/AIDS and measures the public can take to avoid infection. This initiative should be concentrated, moreover, on measures needed to communicate with young adults and adolescents at the district level and should include specific information they need to prevent unwanted pregnancy and to avoid transmission of STDs and HIV. Importantly, this communication/advocacy strategy needs to be complemented by strengthened efforts by the public and private sectors to ensure that young adults and youth have full access to FP/RH services.
- The centerpiece efforts of the USAID–assistance program in FP/RH should concentrate on the basics, that is, measures needed to ensure that all sexuallyactive Ghanaians have access to at least three and preferably four FP methods—including, at a minimum, pills and condoms. Special attention should be given to training and service extension efforts which will expand the availability of injectables and Norplant. USAID should postpone, at least for 3–5 years, any significant efforts to increase the availability of minilaparotomy and vasectomy, but should ensure that in-place service and training facilities receive the modest support they require to consolidate and improve their current capacities—on the premise that they may become centers of excellence for these services in the future.
- This more focused program should be backed up by a vigorous IEC/behavior change strategy, which would employ print, interpersonal and mass media to provide accurate, practical information about FP/RH methods and promote their use. USAID’s participation in this effort should be targeted on specific but closely coordinated IEC initiatives of the MOH/HEU and other partners, and should not—in the continuing absence of any meaningful MOH funding for its own IEC program—be used to cover general operating costs of the HEU.
- The Navrongo pilot project shows considerable promise as a model for expansion in Ghana. USAID should support the MOH’s efforts to apply the lessons of the Navrongo experience broadly in other parts of the country. In providing this support, USAID should be attentive to still unresolved questions regarding the long-term sustainability of the Navrongo model once it is removed from the intensely supportive, relatively generous (in terms of project inputs) environment enjoyed by the pilot study. USAID support for the expansion, then, should be limited to inputs which the GOG itself can provide in the future (monitoring, training, some IEC) or which are needed on

an infrequent basis during the early phase of the expansion (technical assistance). USAID should not invest in cost or capital-intensive requirements such as motorbikes, clinic construction/equipment, fuel or other operating expenses of the activity, but should look to MOH investment in those items as a demonstration of the GOG's long-term commitment to the model.

- All of the current elements of the GHANAPA project contribute in some way(s) to the attainment of the project's overall objectives. As the Mission looks to the future, however, it should consider the best way to use its modest assistance resources—a decision process that can call for some difficult choices. Specifically, USAID should
  - allow its current grant agreement with GRMA to end on schedule and not renew it in the future;
  - JHU/PCS' role should be defined and targeted tightly, and its in-country office gradually should be phased out (with the exception of a host country national coordinator) over the next 18 months;
  - the POLICY project's support for the creation of a favorable population policy should be ended (it has succeeded), and, POLICY efforts should be re-focused on district-level activities to address the threat of HIV/AIDS, especially among young adults; and,
  - as noted above, USAID should postpone—at least for 3–4 years—any further support for the expansion of minilaparotomy and vasectomy services.

This consolidation of USAID's program effort will free resources needed to address the significant challenges of the future, and will enable USAID SO3 managers to focus on the achievement of substantive results.

## **ANNEXES**

A: Scope of Work

B: References

C: Persons Contacted

D: Tables Derived from the 1998 Ghana Demographic and Health Survey (GDHS)

**ANNEX A**

**SCOPE OF WORK**

**(provided by USAID/Ghana)**

## 1.1 BACKGROUND

USAID has supported population/family planning activities in Ghana since 1968 through various bilateral, global and regional projects. In 1991, HIV/AIDS/STD prevention was added to the health and population portfolio. The current Ghana Population and AIDS Program (GHANAPA) is a six year, \$45 million combined project and non-project assistance (NPA) program. The purpose of GHANAPA as outlined in the initial project and program documents, is (1) to increase the use of modern and effective family planning methods and (2) to help stabilize the HIV/AIDS epidemic.

The Objectives for GHANAPA are as follows:

Increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate from 10% to 20% and shift the method mix from 20% to 40% for long-term methods, and

Increase awareness and practice of HIV/AIDS risk reduction behaviour by increasing the reported use of condoms during the most recent act of sexual intercourse with a non-regular partner to 50% and the number of people citing at least two acceptable ways to prevent HIV infection from 61% to 75%.

The project component of GHANAPA includes activities to support both family planning and HIV/AIDS prevention. The approach is integrated to the extent that the same public and private sector institutions work in both sub-sectors, condom distribution does not distinguish between family planning and HIV prevention and training covers both sub-sectors. Specific activities in family planning include social marketing of contraceptives, training of health professionals in contraceptive technology, community-based distribution of contraceptives, contraceptive logistics management, institutionalization of the National Population Council (NPC), advocacy, policy and guideline revision, and operations research. Through GHANAPA, an endowment was established to enhance the sustainability of social marketing efforts. In HIV/AIDS/STD prevention, specific activities include support of 22 sentinel surveillance sites and 10 regional laboratories, IEC campaigns, social marketing condoms and improved treatment of STDs.

The NPA component of GHANAPA was a cash grant to the GOG to support changes in macro-environment, including policy reform. Three annual tranches were released totaling \$8 million. The conditions precedent were tied to performance indicators that require the GOG to meet family planning benchmarks. Specifically, the NPA agenda included (1) establishment of a

1.1 (Continued)

Population and AIDS Coordinating Committee, (2) provision of adequate resources to meet couple years protection targets and to conduct HIV/AIDS/STD monitoring prevention and control activities (3) revision of the public sector contraceptive pricing policy, (4) development of new guidelines for family planning service delivery, (5) Revision of the Essential Drug List to include contraceptives and STD drugs, and (6) improved contraceptive commodity forecasting and stocking procedures.

Since GHANAPA was approved, a number of changes and developments have occurred that influence implementation of the Mission's activities in the population and health sector. These are:

- Management by Strategic Objectives and Results.

During 1997, the Mission produced a revised version of the Country Program Strategy for Ghana that included Strategic Objective # 3 (SO3) Improved Family Health. Developed in collaboration with partner agencies, SO3 is comprised of three sub-sectors: Population/Family Planning (including maternal health), HIV/AIDS prevention and child survival. To better support the MOH Maternal and Child Health care programs, USAID and partners produced a revised Results Framework that focuses on two Intermediate Results (IRs): Increased Use of Reproductive Health Services and Increased Use of Selected Child Survival Services. A Strategic Objective Agreement was signed with the Ministries of Finance and Health in February 1999 to cover the remaining years in the Country Program Strategy (through 2001).

- Termination of the remainder of the NPA component of the GHANAPA agreement

Also in 1997 after an extended congressional hold, it became necessary to terminate the NPA component of GHANAPA

- Expansion of the Project Component of GHANAPA to include child survival and to increase support of Family Planning and HIV/AIDS

In September 1998, a third component was added to the project to support the MOH's child health program and increase the use of selected child survival interventions. With this amendment the scope of support for family planning and HIV/AIDS prevention has also increased.

- The Ghana Demographic and Health Survey (GDHS)

The third GDHS was conducted during late 1998/early 1999. Expected in April, the findings of this national survey will contribute both to the assessment of past achievements and to the development of future plans.

**1.2 TITLE**

Assessment of the Ghana Population and AIDS (GHANAPA) Project No. 641-0131.

**1.3 OBJECTIVE**

The objective of this exercise is to assess the GHANAPA project in light of program developments outlined above and in relation to the SO3 results framework. The results of this assessment will be used to inform future directions of the program.

**1.4 STATEMENT OF WORK**

**PURPOSE**

The purpose of this assessment is to assess the principal activities supported under GHANAPA to:

(1) identify and describe the achievements made to date, (2) assess the relevance of current activities to the revised SO3 results framework (3) assess the effectiveness of implementation arrangements, and (4) make recommendations regarding future program direction.

**TERMS OF REFERENCE**

To achieve this purpose, it is expected that the following general issues will be addressed:

- Progress made through GHANAPA in attaining input and output targets and in realizing SO and IR level objectives;
- Impact on beneficiaries due to increasing numbers of service providers, improving the quality of services, increasing the availability, accessibility and affordability of supplies and information, education and communication;

**ADDITIONAL SPECIFIC QUESTIONS TO BE ADDRESSED BY THE ASSESSMENT TEAM**

The following is a list of specific questions, the team will be expected to address. Additional questions for individual program components may evolve as the assessment gets underway.

(1) To what extent have each of the USAID grantees contributed to achievement of results as defined in the project and in the revised SO framework (AVSC, PPAG, GRMA, GSMF)?

(2) Assess the extent to which GSMF has succeeded in making low cost contraceptives, especially condoms, accessible to its target market. Assess its progress towards and potential for

1.4 (Continued)

sustainability. How does the research carried out by GSMF contribute to achievement of its objectives?

(3) What role has the NPC played achievement of results? How effective is NPC at coordinating activities of multiple implementing entities? What is the nature of the relationship between NPC and the MOH? What are their respective roles and are these roles appropriate to achievement of SO and IR level results?

(4) Has the Technical Assistance from Cooperating Agencies under GHANAPA been appropriate and effective? How has this assistance contributed to the achievement of results?

(5) What has been the impact of IEC activities? Have the IEC activities been sufficiently integrated into service delivery programs?

(6) What has been the impact of the focus on Long-Term Methods? Is the focus on long-term methods appropriate in this context?

(7) Were the objectives of the NPA achieved? What are the policy changes brought about by the USAID and by NPC? What was the impact of the NPA and of its early termination? What, if any, policy issues continue to constrain delivery of family planning services?

(8) What can be done to improve the overall coherence, coordination and impact of the program in light of targeted results and available resources? How can USAID consolidate activities over time?

TEAM COMPOSITION

Four evaluators are required. One of the team members will be identified to serve as the team leader. The specific skills and experience desired are as follows:

Experience with International Reproductive Health Programs, including population/family planning, HIV/STD prevention, safe motherhood, in the following areas:

- Community Outreach - Information, Education and Communication - Logistics - Operations Research - Policy - Program design and evaluation - Quality Assurance - Service Delivery - Social Marketing - USAID Management

The specific titles of the team members are relatively less important than filling the mix of skills listed above. At least one team member will be a physician

TIMETABLE

1.4 (Continued)

The evaluation will be conducted in September 1999. Two of the team members will spend two days in Washington DC for briefing and preparation prior to the assessment. In country, the team will work for four weeks with additional days as needed for the team to complete any follow up and close out the activity.

**SPECIFIC TASKS**

Background Reading - Team members will read all relevant project documentation (see attached illustrative list)

Meetings and Interviews - The team members will arrange to meet with USAID representatives, MOH officials, NPC members and representatives from all of the partners agencies.

Meet with or interview by telephone key program managers from G/PHN Cooperating Agencies with activities in Ghana.

Field Visits - The Team will travel within Accra and to at least two regions to assess public NGO and private sector activities, services and institutions through interviews with clients, clinic staff, supervisors, regional managers and staff in related institutions as well as observations of relevant activities.

The team will compile and analyze their findings, develop conclusions and recommendations and prepare the draft report before leaving Ghana.

1.6 **REPORTS**

The team will submit the following products according to the schedule outlined below:

Workplan: The team will submit a workplan including a list of issues the assessment will address, data collection methods to be used and activities to be undertaken by various team members within two days of arrival in country. This workplan will be reviewed by the assessment committee to ensure that the assessment will cover all key issues.

1.6 (Continued)

Assessment Report Outline: The team will submit its recommended outline of the report within two weeks of arrival in country. The assessment committee will review the draft outline and the Team will incorporate any suggested changes into the final outline.

Draft Report: Ten copies of the complete draft of the report will be submitted to USAID/Ghana at least three days prior to the team's departure from Ghana. The report will be reviewed and a debriefing meeting held with the assessment committee and the opportunity given to review, comment and suggest recommendations on all the assessment findings and recommendations. The Team will include these in the final report.

Final Report: The team will revise and edit the draft report subsequent to the preliminary review and will submit the final drafts for review within 45 days from the team's departure from Ghana. Once the assessment committee has cleared the report, the Team will submit 15 copies of the report along with a Microsoft WORD diskette copy to USAID/W for mailing to USAID/Ghana. The final report will include the following elements:

Executive summary-maximum 4 pages, including a concise statement of conclusions and recommendations. Body of the Report - maximum 40 pages Appendices - including this SOW, a description of the methodology, a bibliography and a list of persons/agencies contacted.

# **GHANAPA EVALUATION SUPPLEMENT TO SOW PURPOSE AND SPECIFIC QUESTIONS**

## **Overall Issues:**

What can USAID do to support and increase in CPR?

## **Key Specific Questions**

- Please describe to what extent have each of the USAID grantees (AVSC, GRMA, GSMF and PPAG) contributed to the achievement of results as defined in the project and revised in the SO3 framework?
- Has the technical assistance from cooperating agencies under GHANAPA been appropriate and effective? How has this assistance contributed to the achievement of results? (PRIME, FPLM, JHU/PCS, POLICY, CEDPA, POP Council, JHPEIGO, IMPACT, OR/FRONTIERS)
- What role has the National Population Council (NPC) played in achievement of results? How effective is NPC at coordinating activities of multiple implementing entities? What is the nature of the relationship between NPC and MOH? What are their respective roles and how do these functions contribute to achievement of SO and IR level results?
- What has been the impact of IEC activities? What is appropriate role of IEC support in the future?
- What has been the impact of the focus on long term methods? Is the focus on long term methods appropriate in this context?
- Were the objectives of the NPA achieved? What are the policy changes brought about by USAID and by NPC? Please comment on the impact of the NPA and of its early termination? What, if any, policy issues continue to constrain delivery of family planning and reproductive health services?
- What can be done to improve the overall coherence, coordination and impact of the program in light of targeted results and available resources? How can USAID consolidate activities over time?
- What progress has been made in the area of HIV/AIDS prevention? What recommendations can be made for future HIV/AIDS prevention support?

**ANNEX B**  
**REFERENCES**

## REFERENCES

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**ANNEX C**

**PERSONS CONTACTED**

## **PERSONS CONTACTED**

### **UNITED STATES**

#### **USAID/Washington**

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Joanne Jeffers, G/PHN/POP

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James Phillips, The Population Council

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Kirk Lazell, HPN

Marian Kpakpah, HPN

Laurie Gulaid, HPN

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Dr. Henrietta Odoi Agyarko, Head, Maternal and Child Health/Family Planning Unit (MCH/FP)  
Dr. Nii Ayittey Coleman, Director, Policy, Planning, Monitoring and Evaluation (PPME)  
Dr. Lawrence Ahadzie, Head, Surveillance System  
Dr. Gloria Quansah-Asare, Deputy Head, MCH/FP  
T. C. Corquaye, Executive Secretary, Food and Drugs Board  
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Victoria Assan, MCH/FP  
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Joyce Adu-Manteaw, Community Health Nurse, MCH/FP, New Juaben  
Mary Ardey-Kotei, Head, Health Education Unit (MOH/HEU)  
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Dr. Dela Dovlo, Former Head, MOH/HRDD  
Seth Acquah, Head of Fellowships, MOH/HRDD  
Said Al-Hussein, Head of Training, MOH/HRDD  
Dr. Kweku Yeboah, Head, National AIDS Control Program (MOH/NACP)

### **Ministry of Finance (MOF)**

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Eva Mends, IERD

### **National Population Council (NPC)**

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Yaa Aperwokin, Director, Policy, Monitoring and Evaluation  
Dr. Kwame Ampomah, Director, Information, Education and Communication/Reproductive Health (IEC/RH)  
Steven Grey, Population Officer

### **Government Statistical Service**

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Dr. Daasebre Oti-Boateng, Government Statistician

## **Koforidua**

### *Regional Health Administration*

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Dr. Joseph Taylor, Medical Superintendent, Central Hospital, MOH  
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Margaret Awuah, Senior Nursing Officer, Family Planning Unit  
Lily Melomey, Principal Nursing Officer

### *Koforidua Regional Hospital*

James Allotey, Laboratory Technologist in charge of HIV Screening and the Blood Bank  
Nelly Anyimah, Senior Staff Nurse Midwife, Counseling Unit  
Rose Nani, Senior Community Health Nurse, Counseling Unit

### *Midwifery Training School*

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Martha Serwaah Appiagyei, Principal Nursing Officer

### *Regional Population Office*

Kofi Abirah, Regional Population Officer  
Kofi Agyei, Deputy Regional Population Officer

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Daniel Mensah-Lartey, Technician

*Regional Population Office*

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**AVSC International**

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**CEDPA**

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**Ghana Social Marketing Foundation (GSMF):**

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Kojo Lokko, Chief, Technical Operations

**INTRAH/PRIME**

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**Johns Hopkins University/Population Communications Service (JHU/PCS)**

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**Planned Parenthood Association of Ghana (PPAG)**

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Regina Akai-Nettey, Program Officer, Service Delivery  
Gladys Annan, IEC Manager  
Jeff Kitcher, Former Regional Manager, Central and Western Regions  
Araba Fosu, CBD Coordinator, Cape Coast  
Esther Ewusi-Mensah, Program Assistant, PPAG Youth Centre, Cape Coast  
A.A. Boakye-Yiadom, Area Manager, Kumasi

**The POLICY Project**

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Dr. Benedicta Ababio, Resident Consultant

**Other Donors**

**United Nations Population Fund (UNFPA)**

Moses Mukasa, Country Representative, Accra

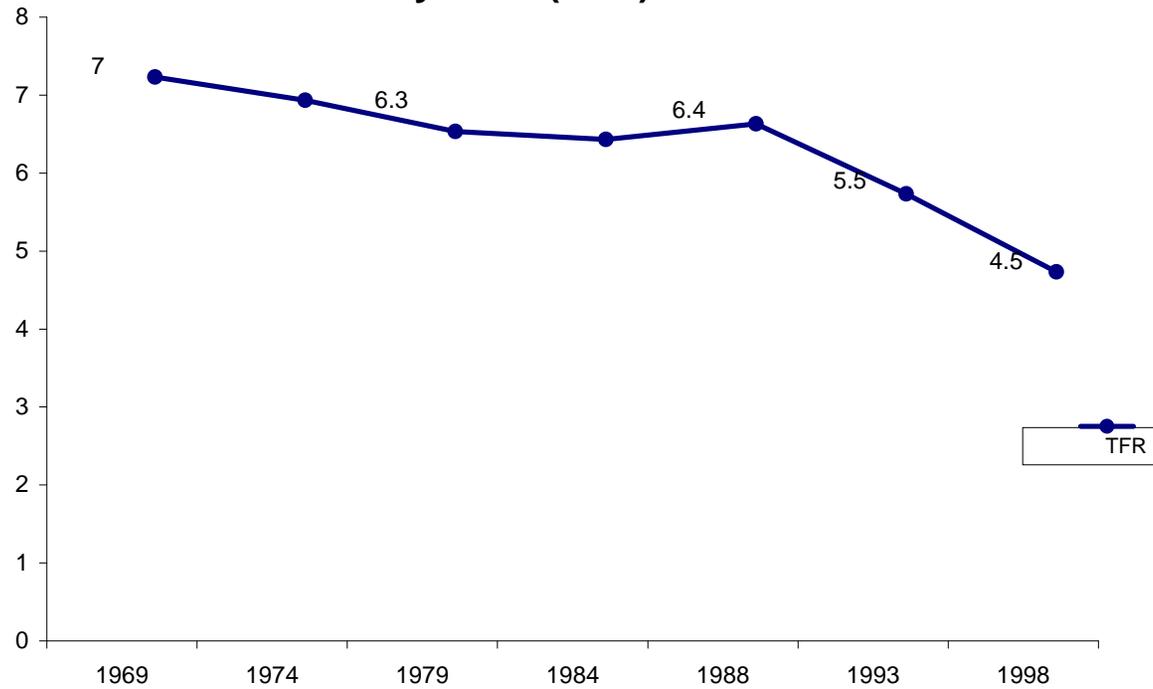
**Other**

Stephen Addo, Chemical Seller, Atwedie, Ashanti  
Kwaku Gyamena, Chemical Seller, Nkawkaw  
Samuel Wiafe, Chemical Seller, Nkawkaw  
Patience Quashigah, Principal Nursing Officer, New Juaben District  
Grace Nkrumah Mills, Acting District Director of Health Services Asuogyaman District  
Isabella Rhule, Acting District Director of Health Services, Fanteakwa District  
Ruth Gyan, Registrar, Nurses and Midwives Council  
Dr. Sophia Winful, District Director of Health Services, Akwapim South

**ANNEX D**

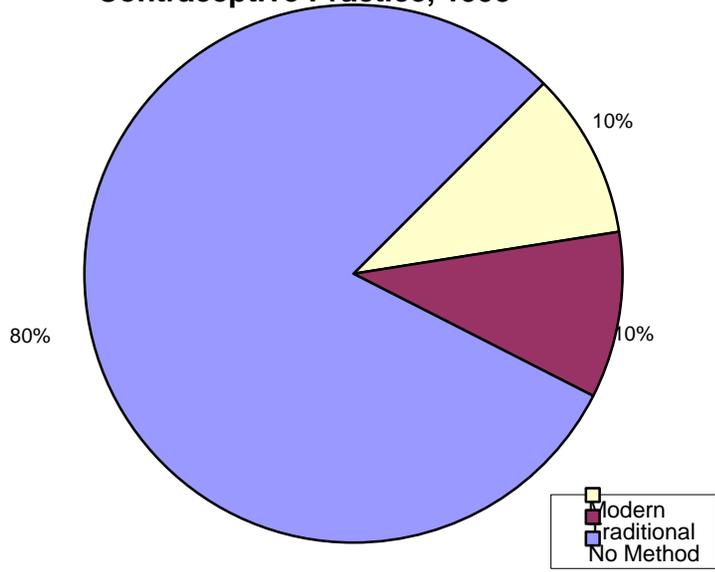
**TABLES DERIVED FROM THE  
1998 GHANA DEMOGRAPHIC AND HEALTH SURVEY (GDHS)**

### Total Fertility Rate (TFR) 1969 - 1998

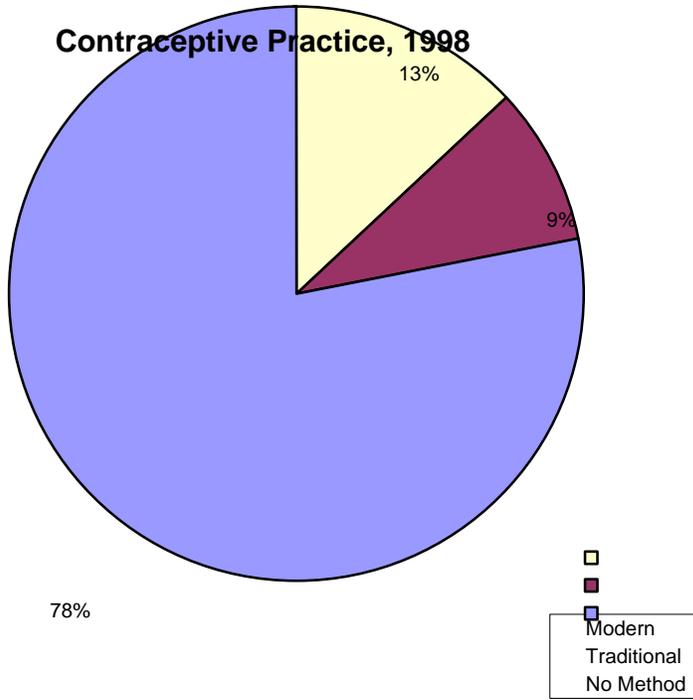


Fertility continues to decline sharply and disproportionately to contraceptive use. For a discussion of some of the other proximate determinants of fertility in Ghana, see chapter 5 of the 1998 Ghana Demographic and Health Survey (GDHS).

**Contraceptive Practice, 1993**

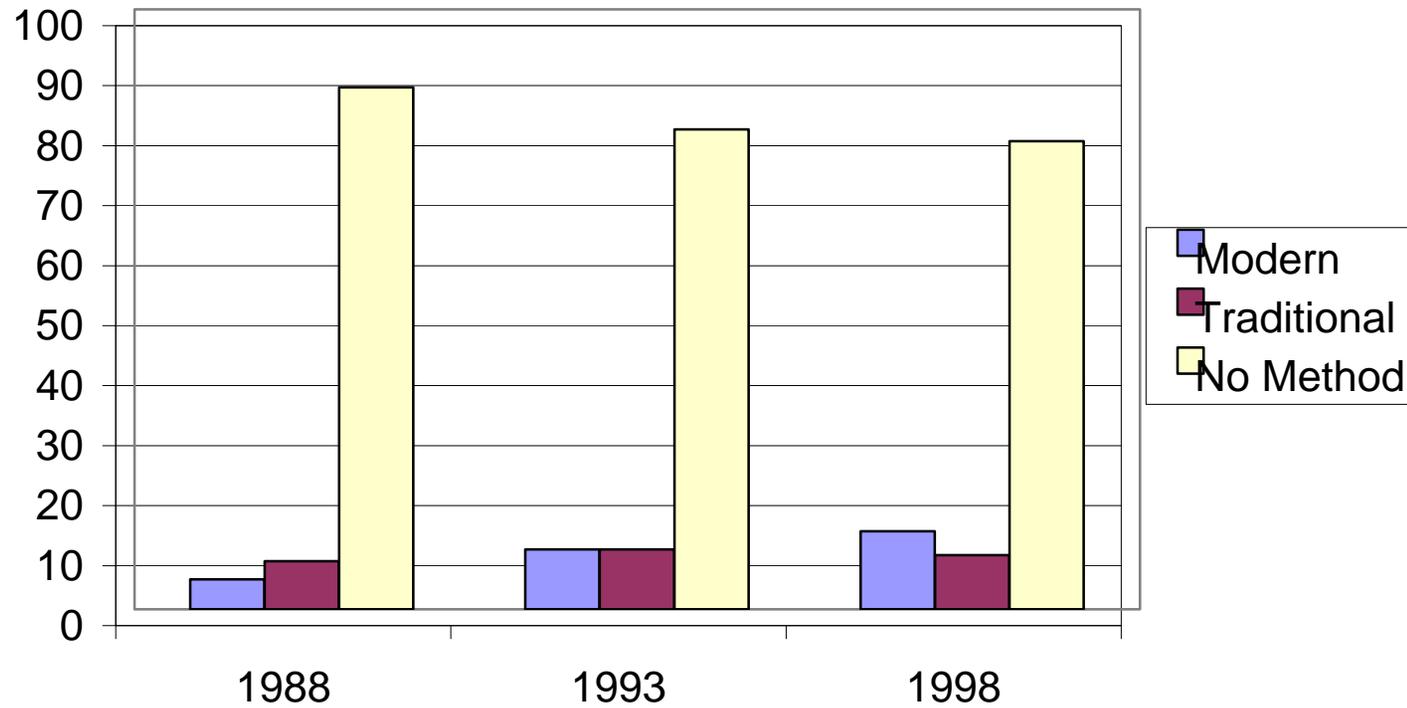


**Contraceptive Practice, 1998**

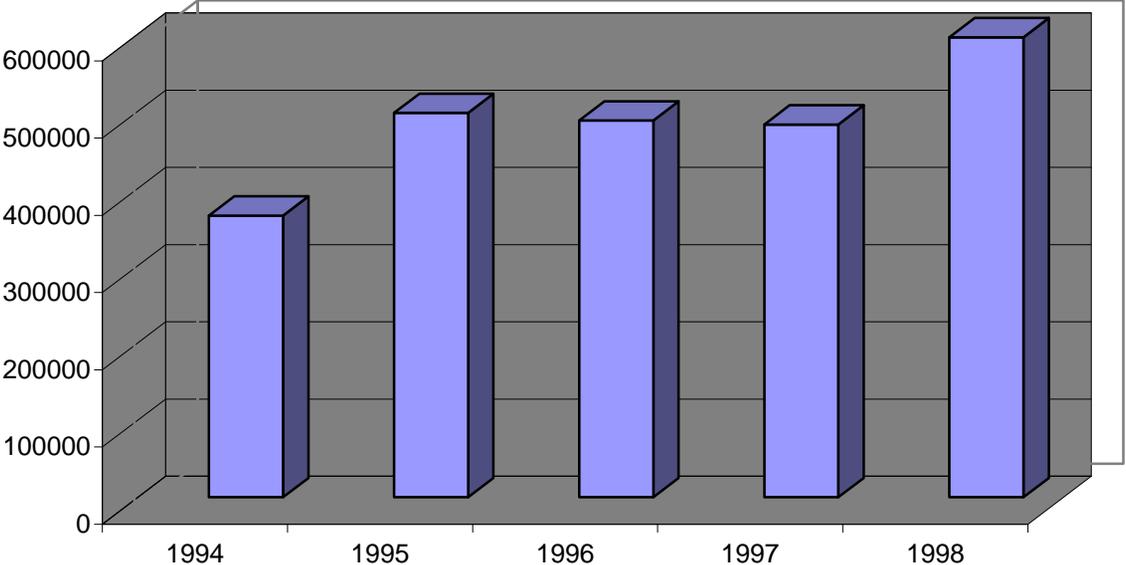


Modern method prevalence has increased from 10 percent in 1993 to 13 percent in 1998.

## Contraceptive Practice, 1988 - 1998

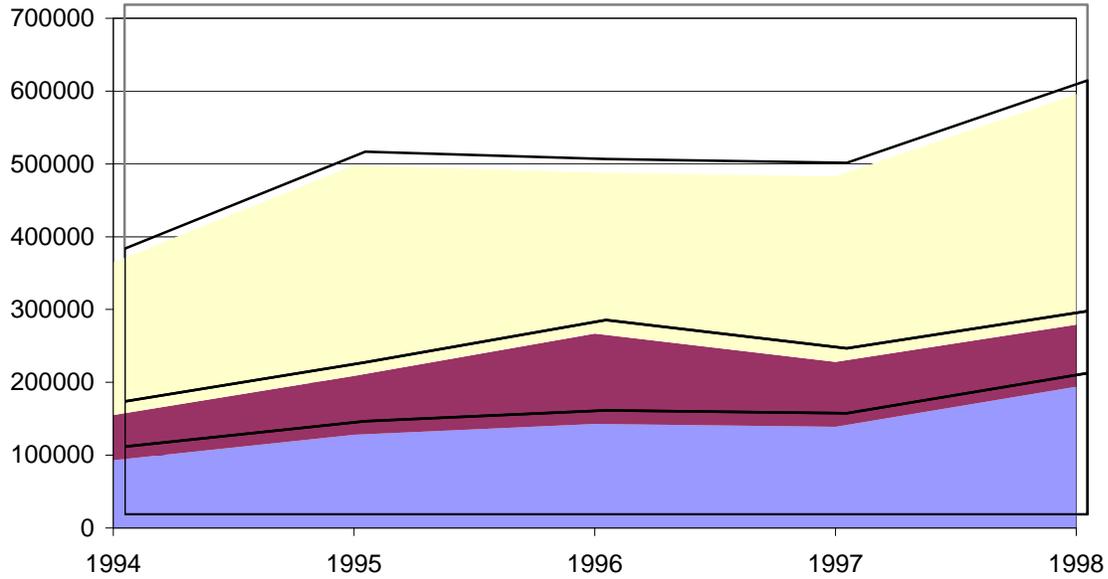


### CYP for Total Program 1994 - 1998

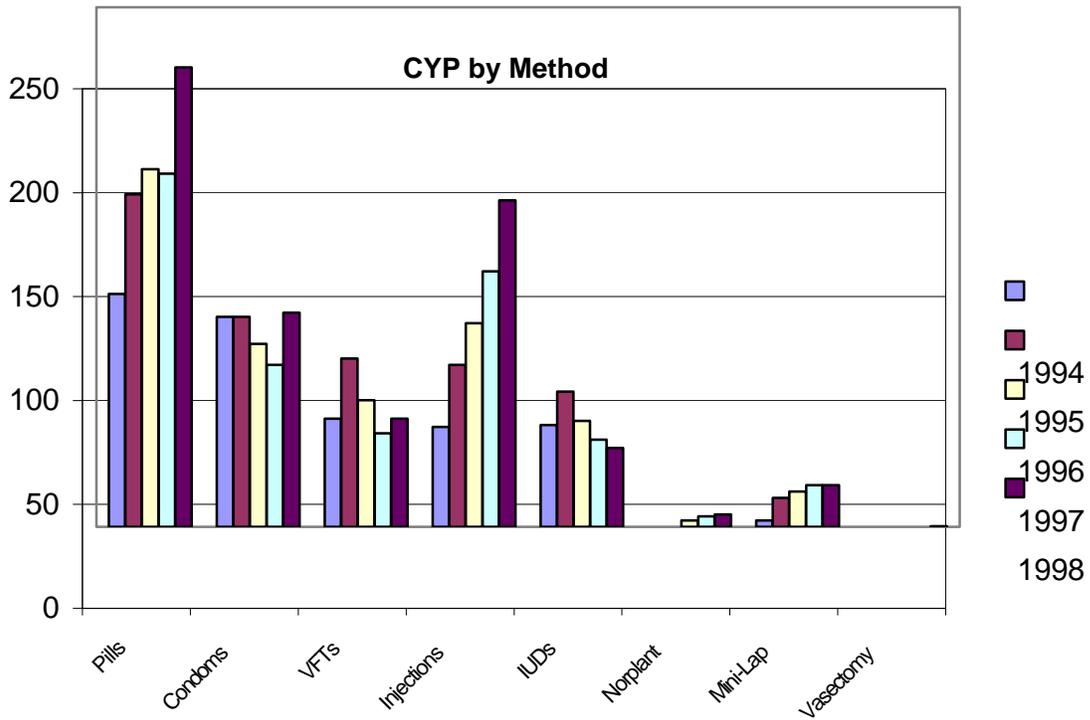


CYP for the program as a whole increased over the course of the project. Information on CYP by source of supply and by method are shown on the following pages. All main sources (MOH, GSMF and PPAG) show increases since 1997, following a declining trend during the period 1996-97.

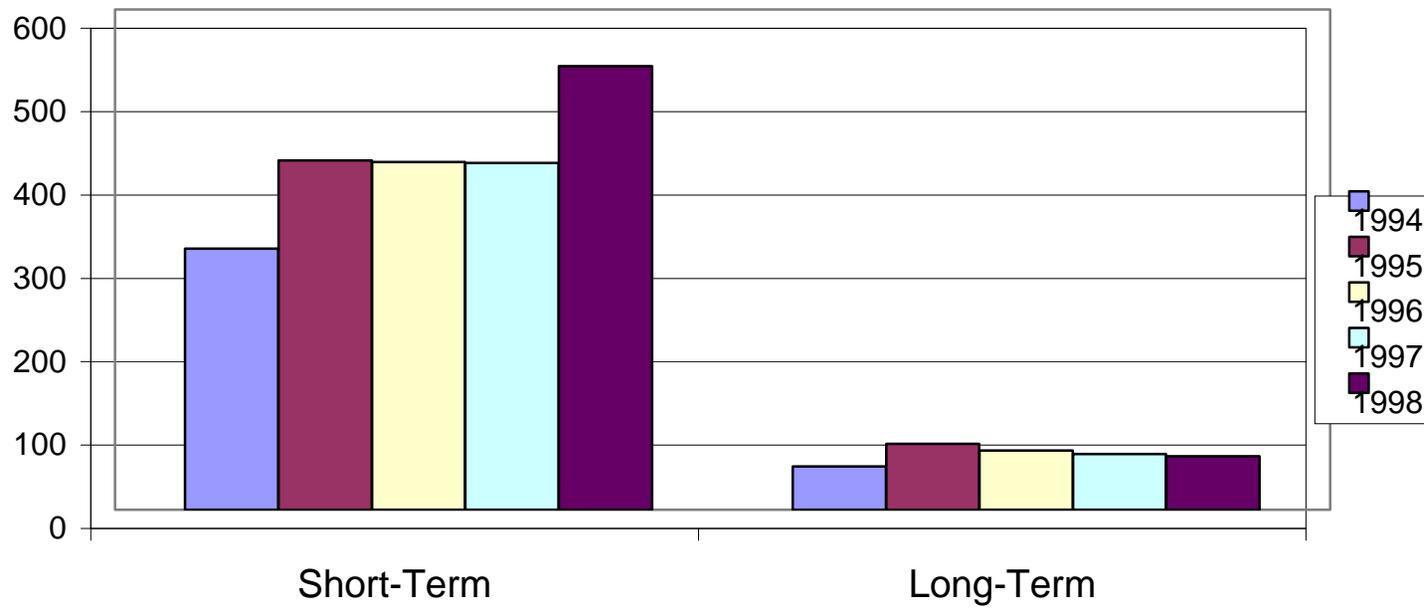
**CYP by Source of Supply  
1994 - 1998**



GSMF PPAG MOH

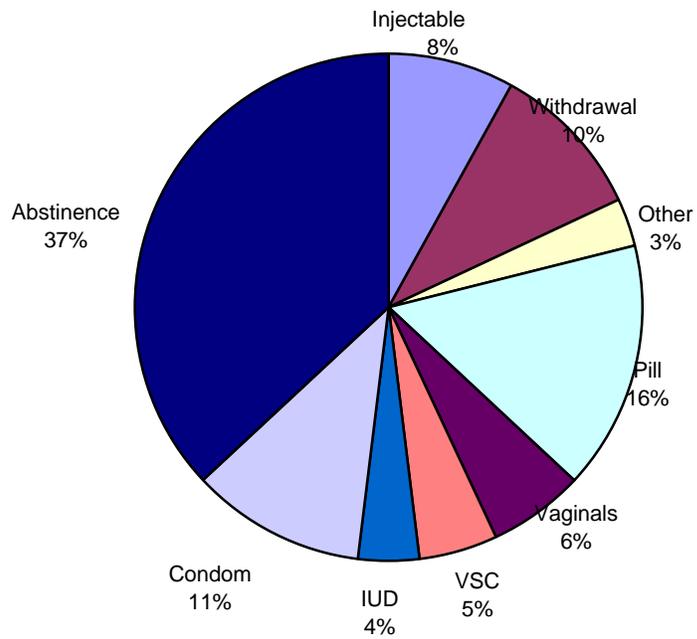


### CYP by Short-term and Long-term

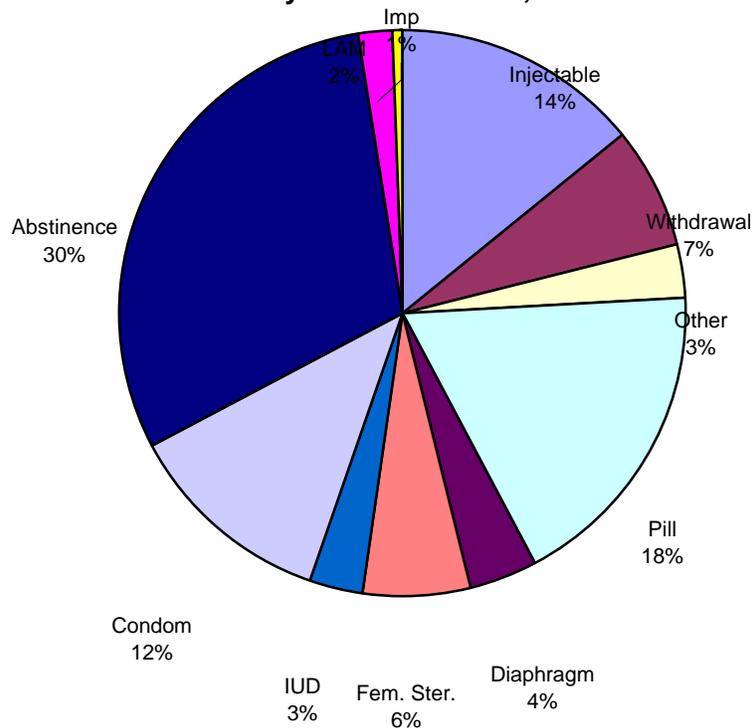


CYP for longer acting methods has declined slightly as a percentage of the total CYP.

**Method Mix  
Currently Married Women, 1993**



**Method Mix  
Currently Married Women, 1998**



The principal difference between the method mix in 1998 versus that of 1993 is less dependence on abstinence and withdrawal as methods of family planning and greater use of injectables.