PD-ABL-692

PD-ABL-692-A

GHANA POPULATION AND AIDS PROGRAM (GHANAPA)

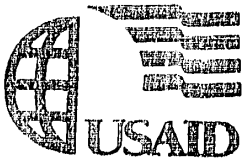
COMBINED PROGRAM ASSISTANCE APPROVAL DOCUMENT (PAAD)

641-0132

AND PROJECT PAPER (PP)

641-0131

UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT
MISSION TO GHANA



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ACTION MEMORANDUM TO THE MISSION DIRECTOR

FROM: Denise A. Rollins, Project Development Officer

DATE: September 28, 1994

SUBJECT: Ghana Population and AIDS (GHANAPA) Program (641-0131/641-0132) - PP/PAAD Approval and Authorization

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ACTION REQUESTED:

Your approval is requested to: (1) approve and authorize the Ghana Population and AIDS (GHANAPA) Project (641-0131) for total planned USAID funding of $31 million; and (2) approve the GHANAPA non-project assistance program (641-0132) for total planned USAID funding of $14 million and authorize the FY 94 obligation of $5 million.

BACKGROUND:

GHANAPA is a follow-on to the Mission's $35 million Family Planning and Health Program (FPHP) which was authorized in June 1991 to assist Ghana reduce its high level of fertility from an average of 6.1 children per woman to 5.5 children per woman by 1995. As a result of FPHP's efforts, Ghana has already reached--two years ahead of schedule--a Total Fertility Rate (TFR) of 5.5. This extraordinary success led the Mission to increase its commitment of resources to family planning now, rather than waiting to the expiry of FPHP.

GHANAPA builds on the success of FPHP and forges new ground. FPHP was designed to rebuild a re-emerging family planning program, while GHANAPA will expand the foundation of the program with regard to short-term contraceptive methods and add a new focus on long-term methods. GHANAPA is a $45 million combined non-project assistance and project assistance effort to: (1) increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate from 10 percent to 20 percent and shifting the method mix from 20 percent to 40 percent for long-term methods; and (2) 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 non-regular 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.

DISCUSSION:

The Mission Executive Committee formally reviewed and approved the PP/PAAD on September 12. The major issues raised at the review follow, along with the Mission's response:

- **Child Survival** - the PID ECPR cable requested Mission consideration of including child survival activities in GHANAPA. The Mission believes that child spacing and limiting are integral components of child survival and thus GHANAPA will lead to reduced infant mortality through these family planning methods. Additionally, other donors are focused on immunization and other child survival activities as a strategic objective, and Ghana's indicators in this area have improved significantly. The Committee, therefore, recommended that the PP/PAAD explicitly include information on child mortality and immunization and activities of other donors to address USAID/W concerns. This has been done in the executive summary and the "other donors" section.

- **US/Japan Coordination** - the PID ECPR cable raised the issue of Japanese-American coordination to eliminate duplication in AIDS prevention and control activities. The Japanese have, apparently, announced an amount of Yen to be used in Africa for AIDS prevention and control, but details are sketchy. The Mission is aware of a Japanese mission scheduled to arrive in Accra late September that will focus on AIDS. The Committee recommended that HPN Office meet with the mission to address the issue of coordination.

- **Endowment** - The Committee was comfortable with the rationale and analysis for the GSMF endowment, but believed that more explanation is required to justify an endowment for an independent, non-governmental center for population and development studies. This center, with substantial cooperation from the University of Ghana - Legon, will provide Ghanaians and other Africans with access to worldwide policy studies and research materials and will build local capacity to conduct studies on important population and development issues.

- **Conditionality** - Considerable discussion focused on the rationale for NPA and the conditionality itself. With respect to the NPA rationale, the Mission's Program Economist has strengthened the section to provide further analysis on

costs to be incurred by the GOG in implementing GHANAPA and the cost effectiveness of shifting from short-term to long-term contraceptive methods. The conditionality agenda has changed since the Review Committee as a result of negotiations with the GOG. Originally, the Mission had planned to request a GOG budget contribution of 16% to the MOH non-personnel recurrent budget. Since the conditionality also requires the GOG to meet agreed-upon family planning benchmarks as measured by couple years of protection, the GOG budget contribution has now been dropped.

- **Population and AIDS Coordinating Committee (PACC)** - The original conditionality agenda included a budget for PACC which would be included in the NPC budget. It was determined that the NPC will serve as the secretariat for the PACC and, therefore, any expenses incurred should be covered by the NPC. Thus, the line item for PACC has been eliminated in the conditionality.

- **Dollar Tracking Exemption** - The PID and Congressional Notification explicitly included the exemption and both documents have been approved. This information is now in the PP/PAAD.

- **Evaluations** - The evaluation schedule appeared to fund overseas consultants solely and there was little reference to local institution strengthening. The PP/PAAD now includes further detail on the level of local participation planned for monitoring studies and evaluations.

- **Audits** - The audit line item was considered insufficient for the six year life of project. However, the majority of the project assistance grant is not included in the bilateral agreement and audit requirements and resources to conduct the audits will be included in grant agreements with recipients.

NOTIFICATION TO CONGRESS:

STATE 229290 dated 9/25/94 informed the Mission that the Congressional Notification for GHANAPA project (641-0131 for $2.6 million) and non-project assistance (641-0132 for $5 million) expired without objection on August 23, 1994.

BUDGET ALLOWANCE:

STATE 207208 dated 9/3/94 provided the budget allowance for the obligation of $2.66 million in project assistance. STATE 16945 dated 5/4/94 provided the budget allowance for the obligation of $1 million in non-project assistance, and STATE 206914 dated 9/3/94 increased this amount by $4 million to a total planned NPA obligation amount of $5 million.

AUTHORITY

STATE 077357 dated March 25, 1994 delegated authority to the Mission Director to approve the GHANAPA PP/PAAD (641-0131 and 641-0132) for a combined total of $45 million.

JUSTIFICATION

GHANAPA has been thoroughly reviewed by the Mission, the RLA and the GOG and meets all the USAID requirements for project/non-project assistance design. The Mission's Executive Committee has recommended approval of the program.

RECOMMENDATION

That you indicate your approval of the $45 million Ghana Population and AIDS Program (GHANAPA) Program (641-0131/641-0132) by signing this memorandum below and the GHANAPA project PP facesheet; and that you authorize the $31 million GHANAPA project (641-0131) and the FY 94 obligation for the GHANAPA non-project assistance program by signing the Project Authorization and the PAAD facesheet.

Approved: Baba P. Sankoh

~~Disapproved~~: _____

Date: Sept. 29, 1994

Drafted:DARollins:public\gpa.act
Clearance: PRM:Baker date 9/28/94
HPNO:Llewellyn date 9/28/94
RLA:Knott date 9/28/94
CONT:Grizzard date 9/29/94
DDIR:Liberi ____ date ____

file: u:\public\docs\gpa.act

CLASSIFICATION

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROGRAM ASSISTANCE
APPROVAL DOCUMENT
(PAAD)

1. PAAD Number: 641-0132/641-T-605
2. Country: Ghana
3. Category: CASH GRANT
4. Date: SEPTEMBER 30, 1994
5. To: BARBARA P. SANDOVAL, DIRECTOR, USAID/GHANA
6. OYB Change Number: N/A
7. From: DENISE ROLLINGS, PROJECT DEV. OFFICER
8. OYB Increase: To be taken from: N/A
9. Approval Requested for Commitment of: $5 MILLION
10. Appropriation Budget Plan Code: 72-114/51014; GSS4-94-31641-KG39
11. Type Funding: [ ] Loan [X] Grant
12. Local Currency Arrangement: [ ] Informal [X] Formal [ ] None
13. Estimated Delivery Period: FY 94 - 95
14. Transaction Eligibility Date: N/A
15. Commodities Financed: N/A

16. Permitted Source		17. Estimated Source
U.S. only		U.S.
Limited F.W.		Industrialized Countries
Free World		Local
Cash	$5 MILLION	Other

18. Summary Description

The Ghana Population and AIDS Program (GHANAPA) is a six year, $45 million combined project and non-project assistance program, that will begin in September 1994, and continue through September 2000. GHANAPA has two components--family planning and AIDS/STD control. Consistent with USAID's strategic objectives, the goals of GHANAPA are to reduce Ghana's fertility rate and to help stabilize the HIV/AIDS epidemic in Ghana. The Program's purpose is to (1) increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate (CPR) from 10 percent to 20 percent and shift the method mix from 20 percent to 40 percent for long-term methods; and (2) 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 non-regular partner to 50 percent and number of people of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

With the Obligation of these funds, $9 million remains to be obligated into the Program.

GHANAPA non-project assistance will ;provide a cash grant to the GOG to support critical policy reform. The cash grant will be released in five yearly tranches (1995-1999) upon the GOG successfully meeting conditions precedent to disbursement. The conditions precedent are tied to performance indicators that require the GOG to meet family planning benchmarks and complete actions that increase overall ;provision of family planning and AID/STD prevention services. The conditionality agenda for the non-project assistance follows:

19. Clearances	Date
PRM:SBAKER	9/28/94
HPN:CLLEWELLYN	9/28/94
TAPSO:PWEISEL	9/29/94
CONT:LGRIZZARD	9/29/94
EXO:FSPEARS	9/29/94
DDIR:DLIBERA	

20. Action: [X] APPROVED [ ] DISAPPROVED

Authorized Signature: Barbara P. Sandoval — Date: 9.29.94

Title: MISSION DIRECTOR, USAID/GHANA

AID 1120-1 (5-82)

CLASSIFICATION

Conditions Precedent to Disbursement

First Disbursement: Prior to the first disbursement under the Grant, in the amount of Two Million United States dollars (US$2,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID, evidence that:

(1) The Grantee has met all conditions precedent to disbursement for each tranche of the Family Planning and Health Program non-project assistance;

(2) The Grantee has established a Population and AIDS Coordinating Committee (PACC) with policy and technical functions, to be chaired by the National Population Council (NPC) and comprised of senior officials from the Ministry of Finance and Economic Planning, Ministry of Health, NPC, University of Ghana/Legon, Ghana Social Marketing Foundation, Ghana Registered Midwives Association, Planned Parenthood Association of Ghana, Christian Health Association of Ghana, the Association of Voluntary Surgical Contraception and USAID. .

(3) The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon family planning benchmarks as measured by couple years of protection - **113,000 CYPs for short term** and **78,000** CYPs for long term, which represents an order of magnitude equal to eighty percent (80%) of the projected public benchmarks required to achieve program purpose;

(4) The Grantee has completed a contraceptive pricing study with recommendations for graduated price increases and an implementation plan which results in annual increases in cost recovery.

(5) The Grantee has allocated adequate resources, based on an annual program of work reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention and control activities.

(6) The Grantee has adopted action plans with specific timetables to include subdermal contraceptive implants, and more effective drugs for the treatment of STDs on the Essential Drug List and the National Formulary (EDLNF).

(7) The PACC has approved the 1995 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment from the Ministry of Finance & Economic Planning for provision of adequate resources to carry out these objectives.

(8) The Grantee has furnished to USAID specimen signatures of the responsible officers for GHANAPA on behalf of the Ministry of Finance and Economic Planning and the Ministry of Health, and the names of the banks and numbers of the interest-bearing accounts to be used to transfer U.S. Dollars during program implementation.

Second Disbursement: Prior to the second disbursement under the Grant, in the amount of Three Million United States dollars (US$ 3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID, evidence that:

(1) The Grantee is allocating adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed upon family planning benchmarks as measured by couple years of protection - **118,000** CYPs for short term and **99,000** CYPs for long term, which represents an order of magnitude equal to eighty-five percent (85%) of the projected public benchmarks required to achieve program purpose;

(2) The Grantee has completed the following actions: (a) revised its contraceptive pricing policy upon consideration of a contraceptive pricing study; (b) adopted a schedule of graduated price increases for contraceptives which shall result in the recovery of an increasing percentage of annual commodity costs by the year 2000 - based on the study and approved by PACC; and (c) disseminated the revised pricing policy to all public sector providers and implemented the first stage of price increases;

(3) The Grantee is allocating adequate resources, based on an annual program of work reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities;

(4) The Grantee has revised the Essential Drugs List and the National Formulary to include subdermal contraceptive implants and more effective drugs for the treatment of STDs, and has distributed the revised EDLNF to all Ghanaian health care practitioners;

(5) The Grantee has improved its contraceptive forecasting and stocking procedures to reduce the commodity pipeline to 21 months, to ensure that contraceptive commodities are used prior to their expiration date.

(6) The National Population Council has achieved the objectives of the 1995 annual workplan. The PACC has approved the 1996 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Third Disbursement: Prior to the third disbursement under the Grant, in the amount of Three Million United States dollars (US$ 3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID, evidence that:

(1) The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed upon annual family planning benchmarks as measured by couple years of protection - **130,000** CYPs for short term and **130,000** CYPs for long term, which represents an order of magnitude equal to ninety percent (90%) of the projected public benchmarks required to achieve program purpose;

(2) The Grantee is implementing a schedule of graduated price increases for contraceptives which shall result in the recovery, by public sector family planning services providers, of annual commodity costs at a level exceeding that achieved under the second tranche, as approved by the PACC;

(3) The Grantee has allocated adequate resources, based on an annual program of work reviewed by PACC, to the MOH to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities;

(4) The Grantee has reviewed its contraceptive forecasting and stocking procedures to ensure that the reduced pipeline is in place and that fewer commodity expirations have occurred.

(5) The National Population Council has achieved the objectives of the 1996 annual workplan. The PACC has approved the 1997 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment from the Ministry of Finance & Economic Planning for provision of adequate resources to carry out these objectives.

Fourth Disbursement Prior to the fourth disbursement under the Grant, in the amount of Three Million United States dollars (US$ 3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID, evidence that:

(1) The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon annual family planning benchmarks as measured by couple years of protection - **137,000** CYPs for short term and **167,000** CYPs for long term, which represents an order of magnitude equal to ninety-five percent (95%) of the projected public benchmarks required to achieve program purpose;

(2) The Grantee is implementing a schedule of graduated price increases for contraceptives which shall result in the recovery, by public sector family planning services providers, of annual commodity costs at a level exceeding that achieved under the third tranche, as approved by the PACC;

(3) The Grantee has allocated adequate resources, based on an annual program of work reviewed by the PACC, to the MOH to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities;

(4) The National Population Council has achieved the objectives of the 1997 annual workplan. The PACC has approved the 1998 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Fifth Disbursement: Prior to the fifth disbursement under the Grant, in the amount of Three Million United States dollars (US$ 3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID, evidence that:

(1) The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon annual family planning benchmarks as measured by couple years of protection - **143,000** CYPs for short term and **210,000** CYPs for long term, which represents an order of magnitude equal to one hundred percent (100%) of the projected public benchmarks required to achieve program purpose;

(2) The Grantee has implemented a schedule of graduated price increases for contraceptives which shall result in the recovery, by public sector family planning services providers, of annual commodity costs at a level exceeding that achieved under the fourth tranche, as approved by the PACC;

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(3) The Grantee has allocated adequate resources, based on an annual program of work reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities;

(4) The National Population Council has achieved the objectives of the 1998 annual workplan. The PACC has approved the 1999 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment from the Ministry of Finance & Economic Planning for provision of adequate resources to carry out these objectives.

UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT
MISSION TO GHANA

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PROJECT AUTHORIZATION

Name of Country: The Republic of Ghana

Name of Project: Ghana Population and AIDS Program (GHANAPA)

Project Number: 641-0131

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Ghana Population and AIDS Project (the "Project") for the Republic of Ghana (the "Cooperating Country"), involving planned obligations of grant funds not to exceed Thirty One Million United States Dollars (US$31,000,000) (the "Grant") over a period of six years, subject to the availability of funds in accordance with the USAID OYB/allotment process, to help finance foreign exchange and local currency costs for the Project. Except as USAID may otherwise agree in writing, the planned life of the Project is six years from the date of initial obligation.

2. The Project will assist the Cooperating Country to (1) increase the use of modern and effective family planning methods by expanding the capacity of public and private sectors to provide family planning services and shifting the method mix from short-term methods to long-term methods and (2) increase awareness and practice of HIV/AIDS risk reduction behavior. The Project will finance technical assistance, training, contraceptive commodities, equipment and materials, grants to non-governmental organizations, program support, monitoring studies and evaluations, financial management reviews and audits.

3. The Project Grant Agreement and other funding instruments, which may be negotiated and executed by the officers to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as USAID may deem appropriate:

a. Source and Origin of commodities, Nationality or Services

Commodities financed by USAID under the Project to the extent financed under the Development Fund for Africa, shall have their source and origin in the United States, the

Cooperating Country, or countries included in USAID Geographic Code 935, except as USAID may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States, the Cooperating Country, or countries included in USAID Geographic Code 935 as their place of nationality, except as USAID may otherwise agree in writing. Ocean shipping financed by USAID under the Project shall, except as USAID may otherwise agree in writing, be financed only on flag vessels of the United States or countries included in the USAID Geographic Code 935 and shall be subject to applicable minimum U.S. flag vessel usage requirements.

b. Conditions Precedent

Prior to the first disbursement under the Project Grant Agreement, or to the issuance by USAID of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID, in form and substance satisfactory to USAID, the following:

(1) A statement of the names and titles of the persons who will act as representatives (including the Ministry of Health) of the Grantee under the agreement, together with a specimen signature of each person named in such statement.

c. Covenants

The Cooperating Country shall covenant to:

(1) Provide adequate funds to the Ministry of Health to conduct family planning and HIV/AIDS control activities throughout the life of the project.

Barbara P. Sandoval
Mission Director
USAID/Ghana

Drafted:PDO:DARollins:public\gpa-aut
Clearance:PRM:SBaker SB date 9/28/94
HPNO:CELlewellyn CEL date 9/28/94
RLA:JKnott date 9/28/94
CONT:LGrizzard LWG date 9/29/94
DDIR:DMLiberi_____date_____

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: ____ — DOCUMENT CODE: 3

COUNTRY/ENTITY: GHANA

3. PROJECT NUMBER: 641-0131

4. BUREAU/OFFICE: AFRICA — 06

5. PROJECT TITLE (maximum 40 characters): Ghana Population and AIDS Project

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 00

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 94 B. Quarter 4 C. Final FY 99

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 94 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	1,660	- 0 -	1,660	5,500	500	6,000
(Grant)	( )	( )	( )	( )	( )	( )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country					6,666	6,666
Other Donor(s) PRIVATE SECTOR					2,827	2,827
TOTALS	1,660	- 0 -	1,660	5,500	9,993	15,493

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DFA	440B	440		- 0 -		1,660		6,000	
(2)									
(3)									
(4)									
TOTALS				- 0 -		1,660		6,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE COD

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate (CPR) from 10 percent to 20 percent and shift the method mix from 20 percent to 40 percent for long-term methods; and to 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 non-regular partner to 50 percent and number of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

14. SCHEDULED EVALUATIONS
Interim MM 09 YY 97 MM YY
Final MM 09 YY 00

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☐ 941 ☐ Local ☒ Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment)

I concur in the methods of implementation and the financial arrangements under the project.

WHGrizzard
Willard Grizzard, Controller

17. APPROVED BY
Signature: [signature]
Title: MISSION DIRECTOR USAID/GHANA
Date Signed: MM 09 DD 29 YY 94

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

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O. Budget

ACRONYMS

AIDSCOM	AIDS Communication Project
AIDSTECH	AIDS Technical Support Project
AIDS	Acquired Immune Deficiency Syndrome
AVSC	Association of Voluntary Surgical Contraception
CBD	Community Based Distribution
CBS	Consumer Baseline Study
CIDA	Canadian International Development Agency
CPSP	Country Program Strategic Plan
CP	Conditions Precedent
CPR	Contraceptive Prevalence Rate
CSP	Contraceptive Supply Project
CTU	Contraceptive Technology Update
DANIDA	Danish International Development Agency
DFA	Development Fund for Africa
DHPNO	Deputy Health Population and Nutrition Officer
DHS	Demographic and Health Surveys
DL	Drawing Limits
EDL	Essential Drug List
EEC	European Economic Community
EPI	Expanded Program for Immunization
FE	Financial Encumbrances
FLE	Family Life Education
FP	Family Planning
FPAP	Family Planning and AIDS Program
FPHP	Family Planning and Health Program
FPLM	Family Planning Logistic Management Project
FSN	Foreign Service National
GDP	Gross Domestic Product
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
GSMP	Ghana Social Marketing Program
GSMF	Ghana Social Marketing Foundation
GTZ	Germany's Gesellshaft fur Techische Zusammernarbeit
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immune Virus
HPNO	Health, Population and Nutrition Officer
HRDD	Human Resources Development Division
IEC	Information, Education and Communication
IEE	Initial Environmental Examination
IPPF	International Planned Parenthood Federation
JHPIEGO	John Hopkins Program for International Education
LMIS	Logistics Management Information System

P

MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MFEP	Ministry of Finance and Economic Planning
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
NACA	National Advisory Council on AIDS
NACP	National AIDS Control Program
NF	National Formulary
NPA	Non Project Assistance
NPC	National Population Council
NGO	Non-Governmental Organization
ODA	Overseas Development Agency
ORT	Oral Rehydration Therapy
OYB	Operational Year Budget
PACC	Population and AIDS Coordinating Committee
PASA	Participating Agency Service Agreement
PIP	Population Impact Project
PIL	Project Implementation Letter
PDO	Project Development Officer
PHC	Primary Health Care
PHRL	Public Health Reference Laboratory
PMU	Program Management Unit
PPAG	Planned Parenthood Association of Ghana
PPHA	Policy Paper on Health Assistance
PPPA	Policy Paper on Population Assistance
PVO	Private Voluntary Organization
RAPID	Resources for the Awareness of Population Impact on Development
SCF	Save the Children Fund
SDP	Service Delivery Point
STD	Sexually Transmitted Disease
TFR	Total Fertility Rate
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

Q

EXECUTIVE SUMMARY

A. Background Summary

USAID has been involved in population activities in Ghana since 1968 through various bilateral and regional projects. The current program, the Ghana Family Planning and Health Program (FPHP), established targets that addressed the Mission's strategic objective of reducing Ghana's total fertility rate (TFR) from 6.4 to 6.1 by 1995. This is to be accomplished by increasing the contraceptive prevalence rate (CPR) of modern methods from 5 to 15 percent by 1995, thus moving Ghana from the "emergent" phase of family planning programs (0-7 percent modern CPR) to the "launch" phase (8-15 percent modern CPR).

The 1993 Demographic and Health Survey (DHS) indicates that Ghana has achieved a modern CPR of 10.1 percent and a substantial decline in fertility among women age 15-49 as evidenced by the drop in TFR from 6.4 in 1988 to 5.5 in 1993. This drop in fertility of nearly one child per woman in a period of five years is remarkable in comparison to other family planning programs worldwide, and an outstanding achievement for sub-Saharan Africa.

The extraordinary success of the FPHP has led USAID to substantially increase its commitment of resources to family planning now rather than wait until the expiration of the FPHP. This is being done to take advantage of the progress and momentum of the program and to move the program through its next phase of development.

While TFR has dropped dramatically in recent years, contraceptive prevalence has risen modestly. There are a number of constraints that must be addressed to move Ghana clearly through the "launch" phase and into the next "growth" phase of population programs. GOG resources devoted to family planning and AIDS prevention and control activities are declining and there are provider practices, contraceptive pricing and commodity forecasting and stocking issues that need to be addressed. There is a lack of knowledge and information about contraceptives, particularly about specific methods and side effects, resulting in substantial discontinuation rates. Awareness and correct information about long-term methods is particularly low. There are also tremendous service delivery gaps, particularly with regard to clinical methods, men and adolescents. There is a real need to educate men and adolescents about the benefits of contraception and to proactively reach out to them.

While the HIV prevalence in Ghana is low relative to other African countries and public knowledge about AIDS/HIV is high, it is clear that the HIV/AIDS pre-epidemic phase is completed and that a sharp increase in HIV incidence should be expected in the next five to six years. Quick and effective action must be taken now to change risky sexual behavior and treat STDs, which are co-factors in the heterosexual transmission of HIV. Constraints exist in terms of resource allocations for HIV/AIDS activities, linkages between the spread of STDs and HIV/AIDS, risky sexual behavior and treatment of STDs with effective drugs, particularly for drug-resistant strains.

Overall program sustainability is a major concern facing Ghana's population efforts. At present, only 25 percent of the non-personnel recurrent budget for family planning program expenditures and 20 percent of the STD/AIDS/HIV program expenditures are covered by the GOG budget, with the remaining support coming from donors. While there is an effort to shift an increasing share of the burden from the public to the private sector, this is a long term process.

B. Program Summary

The Ghana Population and AIDS Program (GHANAPA) is a six year, $45 million combined project and non-project assistance program, that will begin in September 1994, and continue through September 2000. GHANAPA has two components--family planning and AIDS/STD control. Consistent with USAID's strategic objectives, the goals of GHANAPA are to reduce Ghana's fertility rate and to help stabilize the HIV/AIDS epidemic in Ghana. The Program's purpose is to (1) increase the use of modern and effective family planning methods by increasing the contraceptive prevalence rate (CPR) from 10 percent to 20 percent and shift the method mix from 20 percent to 40 percent for long-term methods; and (2) 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 non-regular partner to 50 percent and number of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent.

The family planning and AIDS/STD components will be largely integrated, utilizing many of the same public sector and NGO institutions. For example promotion and distribution of condoms will not differentiate between family planning and disease prevention use. Training programs for clinical family planning methods will include information on STD prevention and control as part of their curriculum. Support for activities which address primarily AIDS/STD prevention and control is specified in the appropriate section of the document.

GHANAPA is designed to follow the Family Planning and Health Project (FPHP) that started in 1991 with a one year overlap until FPHP ends. Non-project assistance, project assistance, USAID/Washington centrally-funded projects, Government of Ghana contributions and funding from grantees will be used to financially support GHANAPA. The program will be coordinated by a Population and AIDS Coordinating Committee (PACC) composed of all the involved public and private sector institutions implementing GHANAPA, and USAID.

- <u>Non-Project Assistance</u>

GHANAPA non-project assistance will provide a cash grant to the GOG to support critical policy reform. The cash grant will be released in five yearly tranches (1995-1999) upon the GOG successfully meeting conditions precedent to disbursement. The conditions precedent are tied to performance indicators that require the GOG to meet family planning benchmarks and complete actions that increase overall provision of family planning and AIDS/STD prevention services. The U.S. dollars will be initially deposited in a separate interest bearing

account in a U.S. bank. Since local currency will not be generated and the Mission has determined that the GOG's foreign exchange system is transparent and market-determined, the Mission has sought an exemption from the requirements of Section 536(b) of the 1994 Appropriations Act related to planned uses of dollars for the cash grant portion of GHANAPA. The exemption request was contained in the PID/PAIP approved by the ECPR in STATE 077357 dated March 24, 1994 and the Congressional Notification which expired without objection on August 23, 1994 (STATE 229290) and is contained in Annex N. The GOG will be required to contribute from its own resources to the USAID Trust Fund 10 percent of the yearly tranche release.

The policy reform agenda includes:

(1) GOG will establish a Population and AIDS Coordinating Committee (PACC) consisting of technical and policy-making functions to be chaired by the National Population Council and comprised all implementing organizations;

(2) GOG will make available to the Ministry of Health adequate resources to enable the Ministry to meet annual family planning benchmarks for couple years of protection. These benchmarks reflect a gradual shift from short to long-term methods;

(3) GOG revises the public sector contraceptive pricing policy;

(4) GOG allocates adequate resources and conducts HIV/AIDS/STD monitoring and prevention and control programs;

(5) GOG develops new clinical guidelines for family planning service delivery;

(6) GOG revises the Essential Drugs List and National Formulary to include all contraceptives and additional drugs for treatment of STDs;

(7) GOG establishes improved contraceptive commodity forecasting and stocking procedures.

These reforms are expected to help Ghana move toward effective and sustainable population and AIDS prevention programs by increasing the GOG budgetary allocation for family planning and STD/HIV/AIDS programs; improving public sector contraceptive cost recovery; reducing provider practices that impede service delivery; ensuring that all family planning methods and drugs for treatment of STDs are widely available; and guaranteeing that the commodity logistics system is adequate to handle the anticipated increase in demand for modern contraceptives. The Institutional and Financial Analyses indicate that the GOG has the capacity to implement these conditionalities.

■ Project Assistance

Project assistance will support increased demand for family planning services and improve family planning service delivery, particularly focusing on long term methods while continuing to expand the availability of short term methods; and improve diagnosis, treatment and tracking of STDs. GHANAPA will expand pre-service and in-service provider training; continue to strengthen the contraceptive logistics system; support multi-level Information, Education and Communication (IE&C) interventions; and coordinate public sector with private and Non-Governmental Organization's (NGO) sector efforts; and further strengthen the institutional capacity of the National Population Council (NPC) and of the National AIDS Control Program (NACP). Project funds will assist the Ministry of Health (MOH) to develop a system of licensing laboratories and laboratory professionals, promote safer sexual behavior through IE&C campaigns, and expand training for health care providers to identify and treat Sexually Transmitted Diseases (STDs) and HIV/AIDS. GHANAPA will also support the development of an improved HIV/STD sero-surveillance system and will provide contraceptives to the public sector, through the MOH, and private and NGO sectors through the Ghana Social Marketing Foundation (GSMF). Sustainability is an underlying consideration throughout the program which will be developed by increasing the channels through which GSMF distributes commodities and establishing an endowment to ensure GSMF operations beyond the end of the GHANAPA program.

C. Budget Summary

The GHANAPA Program consists of a $14 million Non-Project Assistance, and $31 million Project Assistance, which will be obligated through a $6 million bilateral Grant Agreement, a $11 million Operational Year Budget (OYB) transfer for contraceptive commodities and $14 million in grants for non-governmental organizations (NGO). The Office of Population of USAID/Washington's Global Bureau has agreed to provide up to an additional $13 million for technical assistance from centrally funded cooperative agreements based on requests. USAID's inputs will be complemented by the equivalent of at least $6.666 million from the GOG and $4.666 million from NGO grantees. The total program will be the equivalent of $69,332 million.

Table 1. **Summary Cost Estimate and Financial Plan (US $ 000)**

Project Outputs	USAID/Ghana FX	USAID/W	GOG Contribution LC	OTHER - NGOs FX	OTHER - NGOs LC	TOTAL
Non-Project Assistance						
1. Family Planning	11,000					11,000
2. HIV/AIDS/STDs	3,000					3,000
Total NPA	14,000					14,000
Family Planning Component						
1. Improved Policy	150	4,750	1,000			5,900
2. Increased Demand	400	1,500	1,200		291	3,391
3. More Services	19,705	5,350	3,500		3,000	31,555
4. Sustainability	5,500			1,375		6,875
Family Planning Total	25,755	11,600	5,700	1,375	3,291	47,721
AIDS/STD Component						
1. Improved Policy	140	500	66			706
2. Behavior Change	1,150	400	400			1,950
3. STD Diagnosis/Treatment	120		300			420
4. Better Surveillance	856	500	200			1,556
AIDS/STD Total	2,266	1,400	866			4,632
Monitoring/Evaluation	1,200					1,200
Audits	150					150
Program Support	1,629					1,629
GHANAPA PROGRAM TOTAL	45,000	13,000	6,666	1,375	3,291	69,332

D. End of Program Summary

By the year 2000, nearly 997,000 Ghanaian women will be using a modern method of contraception (vs. 328,000 in 1993). Of this number 361,000 (40 percent) will be using longer term, more effective methods, such as IUDs, NORPLANT®, injectibles and voluntary surgical contraception. This means that by the year 2000 the average Ghanaian woman will have five children in her life time, as compared to nearly six in 1993.

Additionally, the private sector will be providing more family planning and STD prevention, diagnosis and treatment services to Ghanaians by expanding distribution channels and information networks and more people will be aware of HIV/AIDS and practicing appropriate risk reduction behavior thereby controlling and preventing sexually transmitted diseases including HIV/AIDS.

Finally, the public sector will be allocating more resources to family planning and AIDS/STD Prevention activities by the end of the program. These efforts, along with establishment of endowments, will lead to greater sustainability of Ghana's family planning and National AIDS Control programs.

E. Monitoring and Evaluation Summary

The GHANAPA monitoring and evaluation plan follows existing guidance from AID/W on appropriate measures of program impact which place particular emphasis on people-level, gender disaggregated measures. The plan is built on the system currently in place under the Family Planning and Health Program. Crucial program performance and impact information will be collected through the following activities:

- Three Consumer Surveys planned as follow-up to the 1993 consumer baseline survey. These are scheduled to take place in 1995, 1997 and 1999. The studies are population-based and are designed to obtain information on knowledge, attitudes and practices related to use of family planning and HIV/AIDS. The 1995 survey will be redesigned to include information related to STDs.

- A Demographic and Health survey scheduled for 1998. Data collected from this survey is used to calculate total fertility rate and assess knowledge of family planning methods and contraceptive practices among Ghanaians. A module will be added to the 1998 survey to obtain more specific information related to risky sexual behavior leading to transmission of STDs and HIV/AIDS.

- Two Situation Analyses in health facilities planned for 1996 and 1998. These studies will be conducted to assess current practices by family planning service providers. The scope of these studies will include an assessment of STD treatment, to determine whether STD cases are managed as established by national guidelines.

The Mission will follow program implementation and progress toward achieving project benchmarks regularly during semi-annual portfolio reviews and the annual Assessment of Program Impact.

F. Implementing Institutions

GHANAPA will provide $14 million in NPA to remove identified constraints and encourage the GOG to directly fund Family Planning and AIDS control activities by the Health Education Unit (HEU), Maternal and Child Health/Family Planning Unit (MCH/FP), National AIDS Control Program (NACP) and Human Resources Development Division (HRDD) of the Ministry of Health (MOH), as well as the parastatal National Population Council (NPC).

The $31 million in project assistance provided by GHANAPA will include a $6 million bilateral grant agreement with the Government of Ghana for: (a) analytical and operational research on population and AIDS topics; (b) equipment and materials, (c) short-term participant training and (d) project support, evaluations and audits. USAID will directly provide $14 million for (a) grants to support activities of the Ghana Social Marketing Foundation (GSMF), the Ghana Registered Midwives Association (GRMA) and the Planned Parenthood Association of Ghana (PPAG); (b) a cooperative agreement with the Association for Voluntary Surgical Contraception (AVSC) to promote long-term contraceptive methods; and (c) grants for endowments for the Ghana Social Marketing Foundation and an endowed academic chair in the autonomous Center for Population and Development affiliated at the University of Ghana - Legon. $11 million in contraceptives will be procured through an OYB Transfer to the Central Contraceptive Procurement Project.

G. Program Assistance Initial Proposal (PAIP) and Project Identification Document (PID) - Executive Committee Program Review (ECPR) Guidance

USAID/Washington reviewed the PID and PAIP on March 2, 1994. The ECPR approved the original life-of-project amount of $32 million and the LOP for the program at $13 million. These levels were subsequently revised to $31 million and $14 million during Project Paper and Program Assistance Approval Document development as it became clear that additional non-project assistance resources would be required for the Government of Ghana to undertake the policy reform agenda.

Following are the issues raised by the ECPR during the PID/PAIP review as stated in the ECPR guidance cable STATE 077357 dated March 24, 1994, and the Mission's response to each:

1. ***Project's Focus*** *- "The concern was raised as to the Mission's decision not to include child survival activities in the program. While both the Mission's CPSP and the GHANAPA program do not focus on child survival and safe motherhood activities, Mission representatives noted that this is not meant to imply that these areas are not important. USAID/Ghana is currently conducting safe motherhood and breastfeeding activities through the Ghana Registered Midwives Association (GRMA). Although the primary focus of the GHANAPA Program is family planning and HIV/AIDS control, other reproductive health activities such as breastfeeding will continue to be supported. USAID/Ghana will include general language in the PP to note that they are providing assistance in these areas. The Mission will also include some information on what other donors are doing in these (in addition to providing more information on other donor activities). Additionally, the Mission was requested to include information in the PP discussing the impact of integrating the family planning and HIV/AIDS activities and to identify potential areas of overlap."*

Mission Response:

Through the Family Planning and Health Program, the Mission will continue to support maternal and child health activities such as breastfeeding. Under GHANAPA, the Mission will support efforts to reduce total fertility in Ghana by increasing the availability of contraceptives and services, particularly with respect to long-term contraceptive methods. Reducing total fertility benefits the health of mothers and children and reduces the workload and demands on overburdened health services. In Ghana, the first three infants born to a mother have a better chance of survival compared to infants born later in the birth order, and birth spacing intervals of two years or longer result in a better chance of survival--not only for the mother, but also for the new infant and the previous child. Most importantly, child spacing as part of a family planning program, is a significant child survival intervention.

Grants to GRMA and other local NGOs will provide support for reproductive health activities, although the major focus is on family planning services. The Ghana Social Marketing Foundation will also continue to promote and distribute oral rehydration salts as part of their ongoing social marketing program. Through non-project assistance conditionality, the Mission is ensuring that the Ministry of Health has sufficient funds to support GOG priorities, including child survival activities. UNICEF has been the major donor providing assistance to Ghana's Child Survival and Development Program. Other bilateral donors and NGO's are also supporting infant and child health activities. As a result of Ghana's emphasis and mobilization of funds for Child Survival and Development activities the Infant Mortality Rate (IMR), the best indicator for the health of a country, has declined from 100 per 1000 live births in the 1970's to 77 per 1000 live births in 1988 (DHS) and to 66 per 1000 live births in 1993 (DHS preliminary unpublished data). Total Immunization coverage among children aged 12-23 months has improved from 31 percent in 1988 (DHS) to 55 percent in 1993 (DHS). Further information on other donor support for child survival activities is contained in Section VII.E. of the PP/PAAD.

The GHANAPA family planning and HIV/AIDS components are fully integrated to the extent

possible. For example, technical assistance to the MOH and NGO Sector's IE&C programs will support both family planning and AIDS prevention messages. Condoms will be distributed and promoted for both family planning and STD prevention. Training programs for all family planning practitioners will include STD and HIV prevention. Surveys will collect information on both issues.

2. ***Other Donor Support to Family Planning and HIV/AIDS*** *- "The Japanese Government will be expanding their program in HIV/AIDS and Population and has identified Ghana as a priority country. In this regard, USAID/Ghana is encouraged to discuss with the Japanese the modalities for ensuring that both programs are complementary."*

Mission Response:

USAID/Ghana works closely with all donors to ensure complementary of programs. Through the Japanese-U.S. Agenda for Cooperation and Global Prospective agreement, USAID and the Japanese are supporting basic research on the HIV virus at the Noguchi Memorial Biomedical Research Institute. The Japanese fund equipment and technical assistance for Noguchi and USAID funds operating costs under the Family Planning and Health Program. No further assistance to Noguchi is anticipated under GHANAPA. The Mission understands that the Japanese plan to provide support to NGOs working on HIV/AIDS/STD prevention and control and will meet with a Japanese delegation in September 1994 to ensure that USAID programs are complementary. Further information on donor activities in family planning and AIDS is contained in Section VII.E. of the PP/PAAD.

3. ***Endowment Fund*** *- "The Mission is considering whether or not the endowment fund should be in U.S. dollars or local currency or a combination. USAID/W encouraged the Mission to continue the design process of the endowment fund pending the release of USAID/W guidance. While the establishment of the fund should be included in the project's authorization, the endowment may have to be approved in USAID/W if the forthcoming USAID/W guidance so requires. USAID/W requests that they be kept abreast of activities during the design process of the endowment."*

Mission Response:

USAID/W guidelines for the capitalization of endowments issued in STATE 201880 dated 7/28/94 requires USAID/W approval of all endowments. The Mission has included funds for establishment of the endowment in the project authorization per the ECPR cable, and will establish the endowment following USAID/W approval.

4. ***Conditionality*** *- "(a) It was agreed that Tranche One conditionality for the "establishment of a system for an improved public sector contraceptive pricing structure" will be rewritten so as to clearly specify that the magnitude of the increase and the schedule for future price adjustments will be determined from an analysis of contraceptive pricing structures and market forces; and (b) Also in Tranche One conditionality, the third policy for "improved contraceptive commodity forecasting and stocking procedures, the disbursement of funds will be provided after the new forecasting formula has been developed "and accepted" by the Government and staff trained on revised procedures."*

Mission Response:

(a) Tranche One conditionality requires a pricing study with recommendations and implementation plan to determine annual prices for contraceptive commodities; and (b) contraceptive commodity forecasting is a tranche two conditionality which must be fulfilled prior to disbursement of the tranche.

5. ***Institutional Analysis*** *- "The institutional analysis of the PAAD will have to address the capacity of the GOG to implement the program's required conditionalities."*

Mission Response:

The Institutional Analysis indicates that the GOG has the capacity to undertake the non-project assistance conditionality agenda. Under the FPHP, the Mission has had nearly two years of experience working with the Ministry of Health (MOH) and Ministry of Finance and Economic Planning (MFEP) on non-project assistance conditionalities. The GOG has met conditions precedent for disbursement of Tranche One and Tranche Two. Tranche Three disbursement has been postponed due to GOG delay in establishing an operational permanent National Population Council Secretariat. Final actions required to establish the NPC, such as passing the legislation, and reviewing the population policy implementation plan, are expected to be completed by the end of calendar year 1994. GHANAPA Tranche One conditionality requires the GOG to satisfactorily meet all FPHP conditions precedent to disbursement prior to disbursement of GHANAPA funds.

6. ***GOG Increase in MOH expenditures*** *- "Although the PID/PAIP proposes to encourage the GOG to increase the MOH expenditures in family planning from 25 percent to 40 percent, the Mission is encouraged to monitor the effects of these budget transfers on other sectors of the Government, especially those sectors where USAID has been actively involved."*

Mission Response:

GHANAPA conditionality has progressed from monitoring financial resources to measuring GOG accomplishments viz a viz agreed upon family planning benchmarks for couple years of protection. Thus the conditionality requires the GOG to allocate adequate resources to meet family planning benchmarks, rather than requiring a specific allocation of GOG resources.

The Mission, however, will continue to monitor effects of USAID conditionality requirements on the GOG Broad Based budget.

H. Summary Findings

GHANAPA was designed in full collaboration with the Ministry of Health and other GOG and non-governmental implementing institutions. The conditionality agenda and policy reforms have been vetted and approved by the GOG and are feasible in the time frame allotted. They are consistent with Ghana's Economic Recovery Program and the Ministry of Health's Medium Term Plan (1993-2000). Financial, economic, institutional, technical, social soundness and environmental analyses confirm that the Program will have significant positive impact on target beneficiaries as well as the country as a whole. It is therefore recommended that GHANAPA be authorized and obligated in FY 1994.

I. BACKGROUND

A. Country Overview

The Republic of Ghana is located on the western coast of Sub-Saharan Africa, on the Gulf of Guinea, and derives its name from one of the great West African trading empires which flourished from the 4th-11th centuries and included the famed university city of Timbuktu in what is now Mali. Lying in the tropical climatic zone, Ghana has four major geographic zones: low-lying plains on the southern coast; tropical forest areas in the west and southern interior; savannah woodland and swamps in the central Volta River region and savannah in the North. About 19 percent of the land is used for agriculture. The northern area is hotter and drier than the other regions and has experienced prolonged cultivation and soil degradation. Lake Volta, created by damming the Volta River, is the largest man-made lake in the world.

In 1470 Portuguese traders made contact with the coastal population, and later developed a gold mining and slave trade in the area. The British gained control over what is presently Ghana in 1901 after 74 years of fighting the peoples of the Ghanaian interior. The Convention People's Party, under the leadership of Kwame Nkrumah, won legislative elections in 1951 and in 1957 Ghana gained independence from Britain. Three years later, Ghana became a republic and Nkrumah was elected president. Thereafter, Ghana has been ruled by a series of military and civilian governments. The current government, democratically elected in December 1992, is led by President Jerry John Rawlings.

Ghana has a population of 17 million people and is one of the more densely populated countries in West Africa at about 110 per square mile. Seventy percent of Ghanaians reside in rural areas which are defined as villages or towns with less than 5,000 people. About 99.8 percent of the population is African, the balance being European and other non-African extractions. There are over 100 different ethnic groups, each with its own language and culture. The Akan, which includes the Ashanti whose heartland is around Kumasi, represent about 40 percent of the population. Another 20 percent are Ewe, mainly in the east, followed by the Ga in the south around Accra, and various other ethnic groups in the north, including the Gonja and the Dagomba. Due to the great diversity of dialects, no single native national language exists. English, the official language, is used in schools beginning in the 4th grade, business and government. Most Ghanaians are multilingual. Christians outnumber Muslims about two to one, with the Muslims concentrated more in the north. The rest of the population (about 35 percent) practice traditional ancestral religions.

B. Macroeconomic Overview

1. Macro Environment

Ghana, in the late 1950's and early 1960's, had one of the highest levels of income, as well as social and economic infrastructure, in sub-Saharan Africa. However, by the early 1980's, the standard of living of Ghanaians had declined. Industrial development based on import substitution and protected by tariffs and other barriers resulted in an industrial sector dominated by large-scale, capital-intensive and inefficient state-owned enterprises. Production in the agricultural sector in general and cocoa in particular, suffered from a declining market. Cocoa, Ghana's largest export at that time, is an excellent example: production declined from 450,000 MT in 1974 to approximately 150,000 MT in 1983.

Responding to the rapidly deteriorating economic situation, the GOG initiated a far-reaching reform program in 1983 which it continues to pursue. Reforms to date include liberalizing the foreign exchange and trade system, increasing producer prices for cocoa, eliminating most price and distribution controls and rationalizing the public investment program, which in turn greatly improved physical infrastructure. In the first 10 years of reform, fiscal and monetary policies reduced inflation, while donor inflows allowed Ghana to increase her foreign currency reserves and eliminate external payment arrears. These reforms and the resulting increased resource availability have helped Ghana to have one of the fastest growing African economies. Unfortunately, Ghana relaxed its fiscal prudence in 1992, raising a series of problems which have implications for GHANAPA. The following discussion summarizes how the situation developed.

Fiscal Imbalance The Government originally projected a budget surplus of 0.6 percent of GDP for 1992. Instead, the deficit, excluding foreign grants and capital expenditure financed by external project aid, amounted to 177 billion cedis, or 6% of GDP. The deficit was the result of a 70 percent wage increase for government workers, a poor cocoa crop, and declining world commodity prices. For 1993, the deficit decreased to 127 billion cedis, which was about 3% of GDP.

Inflation The annual inflation rate dropped to 8 percent in mid-1992. Subsequently, however, the large fiscal stimulus, reinforced by an increase in the money supply, allowed inflation to accelerate again. As of March, 1994, Ghana's Consumer Price Index had risen 21.5% over the prior year.

Fiscal Austerity In January, 1993, the Government attempted to eliminate the fiscal deficit by raising gasoline taxes by a dollar a gallon. Unfortunately, revenues from the gasoline tax were not sufficient to close the gap. A plan was submitted to Parliament for a further increase in the gasoline tax during 1993, but it was rejected.

In January, 1994, additional tax measures were announced, including a further 20% increase in gasoline prices plus measures to increase revenues from imported goods. Unfortunately, due to the rapid depreciation of the cedi, the 20% increase in gasoline price increase did little more than offset the increase in foreign exchange cost of purchasing oil from foreign suppliers. In 1994, the Government has financed the gap between recurrent expenditures and recurrent revenues by selling about half their shares in the crown jewel of their stock holdings, Ashanti Goldfields.

Foreign Exchange Rate: A symptom of the fiscal deficit was the rapid fall in the cedi. In essence, by deficit spending and expanding the money supply, the Government placed money in the hands of Ghanaians, who then spent it for imported goods. In a reflection of this, the balance of payments position deteriorated from $471 million in 1992 to $641 million in 1993.

The cedi depreciated rapidly between the summer of 1992 until early March, 1993 when a surge in donor assistance resulted in a temporary stabilization of the exchange rate at about 600 cedis to the dollar. That rate proved to be unsustainable, and from the summer of 1993 until the start of the sale of Ashanti Goldfields in February, the cedi fell rapidly, from 611 cedis/dollar in June, 1993 to 930 cedis/dollar in February. With the sale of shares in Ashanti Gold Fields, the cedi stabilized at that level and remains close to 940 as of July 25, 1994.

Future Fiscal Stability. In the short run, the fiscal situation will be enhanced through the sale of profitable parastatals. In the longer term, potential solutions include implementing a value added tax system, increased commodity prices, and budgetary restructure.

Value added tax systems are capable of raising large increments of revenue. The Government is likely to try to implement such a tax shortly. However, the VAT is difficult to administer, and will have to be put in place slowly, so it will be some years before its full revenue-raising capacity is reached.

Another possible source of revenue is higher commodity prices. There have already been increases in the price of gold and cocoa. Unfortunately, it is not possible to make forecasts of future commodity prices with any degree of certainty or to extrapolate past trends.

Either of the above options offers hope, but a more fundamental and certain solution would be an overhaul of the budget process which would allow the Government to maintain tighter control over expenditures. The Government, with the assistance of the World Bank, is attempting to implement this alternative. However, USAID is supporting the budgetary reform process by requiring the inclusion of $14 million in GHANAPA non-project assistance on-budget. This process will allow the MOH to adequately plan for and implement family planning and AIDS activities, rather than relying on off-budget resources that are never integrated into the Ministry's overall budget. Attempts to gain tighter control of the budget will take on even more importance during the life of GHANAPA.

2. Balance of Payments Analysis: The Need for Additional Foreign Exchange

The Government of Ghana estimates that Ghana's trade deficit was $641 million for 1993. The Mission believes that the balance of payments deficit could continue to grow. This will require continued assistance by the donor community for balance of payments support. The amount recommended for support under the GHANAPA Program will supply a small portion of the funds required. The actual amount programmed is limited by Mission OYB considerations.

Dollar funds will either be used to support the GOG's foreign exchange reserves through its accounts at the Bank of Ghana or be disbursed through the existing interbank system. Since the liberalization of a foreign exchange system in 1986, both the World Bank and the International Monetary Fund have strongly urged bilateral donors to follow their lead in using the interbank system. Most donors do so. The Mission recommends that the cash grant mechanism used in FPHP be continued under GHANAPA because of the ability of the GOG to disburse these funds in a legitimate and transparent manner. The great strides that the GOG has made in establishing a market oriented foreign exchange system should be rewarded by utilizing a system that has been fostered by the World Bank, IMF and international donor community.

3. Health Sector Macro-Economic Issues

NPA is critical to ensure that sufficient levels of resources are budgeted for family planning and AIDS prevention activities within the MOH. The MOH share of the GOG budget has steadily declined over the past few years, running a distant second to the education sector. The Ministry of Education budget as a percentage of the Government's overall budget has stabilized at 38 percent in 1992, 39 percent in 1993, and 39 percent estimated in 1994. The MOH total budget as a percent of the GOG's budget has fluctuated from 6.6 percent in 1992 to 7.1 percent in 1993 and 5.6 percent estimated in 1994. Of these amounts, roughly 60 percent of the MOH's recurrent[1] budget is allocated to personnel emoluments, leaving 40 percent for actual sector programs.

GOG percentage resource allocation to the MOH ***recurrent*** budget has ranged from 7.0 percent in 1984 to 10.9 percent 1990 to a peak of 13.3 percent in 1992 and a decline to 9.6 percent in 1994. Further analysis of the non-personnel recurrent costs, which are used for program operations of the MOH, as a percentage of GOG's total non-personnel recurrent budget also shows a significant reduction. The percentage has dropped from 24% in 1992 to 14% in 1994. The total MOH budget projected for 1994 has remained almost the same, in cedis, as the 1993 budget, while the GOG budget has risen 22%. The MOH has attributed the

[1] Recurrent costs of the MOH is comprised of six line items: (1) personnel; (2) travel and transport; (3) general expenditure; (4) maintenance and repairs; (5) other recurrent expenditures; and (6) subventions to organizations like the pharmacy board. Since personnel is basically a fixed cost, budget reductions often disproportionately affect items 2-5, which are required for operations. GHANAPA is, therefore, focussing on items 2-5.

reduction to cuts in pharmaceutical procurement and feeding of patients programs, but the concurrent increase in donor funding for the health sector, as shown in Table 2, has permitted the GOG to reduce its own spending in the health sector. The MOH's contribution to sector program is inadequate to cover all the programmatic needs. Thus, the majority of program activities (75 percent of the MOH's recurrent costs) are funded off-budget by the donors.

A recent Mission-funded Deloitte & Touche report found that USAID was the largest donor in the family planning and AIDS area, providing 55% of the funds compared to 16% provided by the GOG. Seven other donors fund the remaining 29% of expenditures. Gradual movement of donor support on-budget will facilitate the GOG's fiscal and budgetary planning process. Additionally, a major conclusion to be drawn from the report is that the MOH does not have separate budget line items for family planning and AIDS activities making it difficult to desegregate expenditures in these areas. The MOH has made a policy of integrating family planning into Maternal and Child Health activities within the context of primary health care. Thus, family planning expenditures are spread among several divisions such as Maternal and Child Health/Family Planning, Health Education Unit (HEU), Human Resource Development Division (HRDD), Medical Care (MC) and Policy, Planning, Monitoring and Evaluation (PPME). Likewise, AIDS prevention and control is also contained within several lines items such as Disease Control, HEU, HRDD, MC and PPME. Therefore, the Mission has tied NPA resource allocations not to specific line items, but to programmatic outputs.

Table 2 **MOH Budget Showing Donor Assistance (in millions)**

MOH BUDGET	1992 ACTUAL	1993 ESTIMATE	1994 ESTIMATE
MOH Personnel Item 1	¢12,186	¢26,365	¢27,764
Total GOG Personnel	¢105,571	¢227,600	¢274,554
% of GOG	11.5%	11.6%	10.1%
MOH Items 2-5	¢13,372	¢16,864	¢16,357
Total GOG Items 2-5	¢55,524	¢66,980	114,443
% of GOG	24.1%	25.2%	14.2%
Total MOH	¢33,722	¢56,463	¢56,960
Total GOG	¢508,624	¢791,135	¢1,010,033
% of GOG	6.6%	7.1%	5.6%
Total Donor	$30.23	$44.89	$71.96

The decrease in national funding levels and increase in dependence on international donors places the operation of public sector family planning and AIDS programs at risk when donor support declines, as occurred in the early 1980s. USAID non-project assistance funds from the current Family Planning and Health Project are being provided off -budget, contributing to this fiscal imbalance.

GHANAPA will provide resources under the NPA cash grant to allow the GOG to adequately fund the non-personnel recurrent budget of the Ministry of Health during the life of the project, following the example of support provided by the European Union. (The EU protects MOH non-personnel recurrent costs by providing funds for that purpose totalling about 50 percent of the Ministry's expenditures.) GHANAPA conditionality will require the GOG to make available adequate resources to the MOH to meet agreed-upon family planning benchmarks. This conditionality will, over time, lead to sustainability of family planning and HIV/AIDS/STD prevention and control activities by encouraging the Government to adequately plan and budget resources to accomplish specific outputs. .

As a complement to the USAID-funded program, the World Bank is encouraging the GOG to reduce its personnel costs in the social sector. GHANAPA will further encourage fiscal responsibility by making the MOH budget more transparent, through the devolution of family planning and HIV/AIDS/STD services to the private sector, and by improving cost recovery in the public sector.

4. Decentralization

The GOG is currently undergoing a process to decentralize governmental responsibilities, and the MOH is in the forefront of these efforts. Over the next five years the budgeting process for the MOH will devolve to the district assemblies, and the central MOH divisions will no longer be responsible for all budgeting decisions. As a result, the type of awareness raising provided to policy makers by the FPHP-funded Population Impact Project (PIP) will have to be conducted at the regional and district levels to ensure that population and AIDS activities are prioritized at all levels.

C. Exceptional Financial Requirements

GHANAPA attempts to provide not only short term support for family planning, but also long term sustainability through the creation of a $5 million endowment for the Ghana Social Marketing Foundation which will help support family planning programs over the coming decades. Implementing strategies for sustainability must be a priority if Ghana is to maintain a viable family planning program over the long run.

The Mission has estimated the impact of establishing a trust fund to help the GSMF. The analysis assumed an initial endowment of $5 million and a rate of return of 7 percent per year (which uses the historical returns available from a portfolio comprised of 50 percent stocks, 30 percent bonds, and 20 percent short term money market instruments). It also assumed that the endowment would not be touched during the life of GHANAPA, but rather that the earnings would be reinvested.

The results of these assumptions yielded an impressive increase in the sustainability of the GSMF. Following the end of GHANAPA in 2000, it is no longer necessary for USAID to supply additional funds to support the operating cost of the Foundation. (Note that it would

still be necessary for contraceptive products to be donated.) Starting in 2001, the trust fund would start yielding a return slightly larger than the operating cost. If that surplus was reinvested, by the year 2005, the endowment combined with revenue from the sale of contraceptives would be sufficient to pay for 10 percent of the cost of all contraceptive commodities in addition to covering all other operating costs.

GHANAPA also calls for an additional $0.5 million endowment to provide an endowed academic chair at the Center for Population and Development in the University of Ghana - Legon. This will help create a center of excellence which will contribute importantly to our success in the future. Resources to establish the endowments will be included in the USAID authorization, but excluded from the bilateral agreement with the GOG.

II. ANALYTICAL FRAMEWORK - FAMILY PLANNING COMPONENT

A. Background

At independence in 1957, Ghana had a population of about 5 million and one of the highest levels of social and economic infrastructure and income in sub-Saharan Africa. However, by the early 1980's, the relatively high standard of living of Ghanaians had been eroded by inappropriate development policies and strategies and high population growth. Real per capita GDP declined by an average of almost 2 per cent per year between 1965 and the early 1980's. The Economic Recovery Program, and sustained attention to stimulation of economic growth reversed this situation and the real GDP has grown at an average of 5 per cent per year over the past five years. However, Ghana's population growth rate has remained high, reducing the net per capita GDP to about $400 in 1993. The current population of Ghana is nearly 17 million with an annual growth rate of 3.1 per cent. The average Ghanaian woman has six children by the time she reaches her forty-fifth birthday. At the current growth rate, the population will double in 24 years, stressing the social and economic infrastructure and services. Based on this population situation, USAID, as part of its Country Program Strategic Plan (CPSP) in 1992, determined that reduction of fertility was to be one of its three strategic objectives. In that document, USAID targets a reduction in total fertility rate from 6.4 in 1988 to 5.0 by the year 2000. This reduction in fertility would reduce the population growth rate, which would lessen the burden on infrastructure and services and would increase net per capita income.

Current Family Planning and Health Program (FPHP)

Overall USAID bilateral assistance to Ghana in family planning began in 1968, but for political reasons experienced a hiatus in the early 1980's. This assistance can be divided into the following three time frames: (1) 1968-1981 when approximately $15 million was provided to initiate population programs contributing in an increase in the modern CPR from 0 to 5.4 percent; (2) 1981-1985 when severe economic and political constraints caused USAID and other donors to cease assistance resulting in contraceptive prevalence dropping to virtually zero; (3) 1986-1992 when approximately $18 million was provided, not including the current FPHP, to rebuild Ghana's population program, during which time the CPR rebounded from 0 to 5 percent in 1988 and approximately 9 percent in 1992.

In 1990, USAID designed the current $35 million FPHP program which is scheduled to end in 1996. The FPHP, comprised of project and non-project assistance, was designed to assist Ghana to move the 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 suggests that Ghana has already reached a modern CPR rate of 14.8 percent among married women. The 1993 Demographic and Health Survey (DHS) shows a more modest rise to 10.1 percent and a substantial decline in

fertility among women aged 15-49 as evidenced by the TFR of 6.4 in 1988 to 5.5 in 1993. Average contraceptive prevalence increase worldwide is slightly over 1 percent. Ghana has achieved at least this much of an increase in CPR. Worldwide experience has shown that a reduction in TFR of one child requires an increase in contraceptive prevalence of 15 percentage points. While there seems to be a lack of internal consistency in the DHS, factors such as abortion, periodic abstinence, post-partum abstinence, breastfeeding and others may be responsible for the decline in fertility without the concomitant rise in contraceptive prevalence. This issue is discussed more fully in the Technical Analysis (Annex F). The reduction in fertility is a remarkable achievement in a period of five years compared to other family planning programs worldwide, and an **outstanding** accomplishment for sub-Saharan Africa.

This achievement was accomplished by concentrating on the provision of short-term contraceptive methods such as condoms, pills and vaginal foaming tablets, through the MOH and the Ghana Social Marketing Program (GSMP) (low cost, private sector promotion and distribution), and initiation of long-term contraceptive methods such as IUDs, injectables and sterilizations in MOH facilities. These efforts have been coupled with strong information, education and communication (IE&C) campaigns in the public, private and NGO sectors. Based on analysis of the 1988 DHS, the 1993 DHS and the 1993 Consumer Baseline Survey, it appears that additional factors such as abortion, post-partum abstinence, marital patterns, to name a few, may be significantly contributing to the substantial fertility decline. This is discussed more fully in the Technical Analysis (Annex F).

At the same time, the FPHP has effectively utilized Non-Project Assistance (NPA) for policy reform to develop a supportive policy environment for population and family planning activities, as evidenced by frequent public statements by top government officials, especially the President and First Lady. The most notable policy reforms are: (1) acceleration of the establishment of the National Population Council, the highest advisory body to government on population issues, which helps to ensure the participation of the private sector, coordinates and monitors all population activities and represents the Government to donors and the international community on population issues; (2) revision of the National Population Policy which establishes the legal and regulatory framework, to include responsibility for implementation of the population program; (3) removal of restrictions on the sale and distribution of contraceptives, which greatly expands availability of services; and (4) liberalizing the advertising of contraceptives, which increases overall awareness and knowledge of family planning.

The FPHP has successfully used project assistance to strengthen Ghanaian public and private institutions involved with population activities. These include the National Population Council, the Ministry of Health's (MOH) Health Education Unit, Maternal and Child Health/Family Planning Division, and the National Traditional Birth Attendants (NTBA) Secretariat, the Ghana Social Marketing Foundation (GSMF), the Ghana Registered Midwives Association (GRMA), and the Population Impact Project (PIP) of the University of Ghana. During the final two years of the FPHP, these institutions will continue to be strengthened

through long-term technical assistance, allowing them to be able to function with limited short-term technical assistance under the new Program. Additionally, FPHP will continue expanding services, particularly of short-term methods, renovating facilities for delivery of long-term methods, working with NGOs, and training of service providers.

The success of FPHP has led USAID/Ghana to a decision to substantially increase its commitment of resources for family planning now rather than wait until the expiration of the FPHP. This is being done to take advantage of the progress that has been made and to move the program through its next phase of development. This also supports the Ministry of Health's Medium Term Plan (1994-1996) which has family planning, in particular long-term and permanent methods, as one of its top priorities. Recent analysis shows a growing demand for long-term methods as well as a need for strengthened institutional development. Therefore, the Mission decided to initiate the design and implementation of GHANAPA while seeing FPHP through to its conclusion. In preparation for the GHANAPA program, USAID/Ghana developed a population strategy in October 1993 which forms the background and framework for the increased level of assistance in this sector to the year 2000[2].

B. Sector Constraints

Ghana's recent success in family planning has been steady and it appears from the 1993 DHS that fertility has started on a strong downward trend. Worldwide experience indicates that all population programs evolve through five phases before reaching replacement level fertility. Based on modern contraceptive prevalence rate, these five phases are emergent (0-7 percent), launch (8-15 percent), growth (16-34 percent), consolidation (35-49 percent) and mature (>50 percent).[3]

As Ghana's program consolidates the launch phase and enters the growth phase, emphasis will need to shift to meet new challenges. Current service statistics indicate that 80 percent of all family planning acceptors utilize short-term methods and only 20 percent use long-term methods. **In order to achieve further declines in fertility, an emphasis will need to be placed not only on increasing the total number of contraceptive users, but also shifting demand to greater use of long-term methods.** Supply or delivery of long-term methods, defined in this program as injectables, IUDs, subdermal implants (i.e. NORPLANT), and sterilization, which, while the most effective, require greater inputs in terms of demand creation, training, equipment and facilities.

Constraints to achieving both an overall increase of users and a shift to a more effective method mix in Ghana consist of the following:

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[2] USAID/Ghana Population Sector Strategy, October 1993

[3] Principles for Family Planning Service Delivery in the Nineties, Family Planning Services Division, Office of Population, USAID, 1990.

- **Policy:** disparity in commodity pricing for short-term methods between the public and private sectors disproportionately burdens the public system and adversely affects sustainability in both sectors; customary practices impede the provision of services; inappropriate public sector commodity forecasting and stocking practices lead to imbalances throughout the system; inadequate public sector resource allocation to family planning results in disproportionately fewer resources at the national, regional and district levels of the family planning program; exclusion of certain types of contraceptives and drugs for effective treatment of sexually transmitted diseases (STDs) from the Essential Drugs List and National Formulary limits their overall availability, and; lack of a focused research and training program in population at national universities limits the development of political and popular support for population programs.

- **Demand:** magnitude of effort required to reach 20 percent modern CPR entails **more than a doubling** of the current number of contraceptive users and converting desire to space children or limit family size into demand for family planning services.

- **Supply:** insufficient numbers of trained personnel and inadequate equipment and facilities for provision of clinical methods hampers increased overall use and shift to long-term methods; limited services to certain target groups, e.g. men and adolescents, prevent expansion to currently undeserved populations; lack of systematic referral prevents potential users from receiving the most appropriate method.

- **Sustainability:** over-reliance on donor support for family planning in the public, NGO and private sectors reduces viability of the national program; low user fees and current commodity price structure limit potential for self-financing.

The following sections elaborate on the constraints outlined above and provide an analytic framework for developing the strategic approach of GHANAPA.

1. **Policy Analysis**

The policy climate in Ghana for population programs has significantly improved over the past five years. Increased awareness of population issues at the highest levels of government and among opinion leaders has greatly facilitated program success. Further improvement in the policy arena will include awareness raising efforts at all levels, strengthening of the capacities of the NPC Secretariat, reform of customary practices, adjustment of contraceptive commodity prices, and increased resource allocation to the National Population Council and the Ministry of Health in support of population and family planning activities. The following sections identify constraints which will require attention under GHANAPA:

a. *National Support for and Coordination of Population Activities*

Although there are clear indications that political support for population programs is improving in Ghana, awareness must be raised and consensus established on the new population policy throughout all levels of the political system in order to support a strong population and family planning program. Some policy makers, community leaders, and even health service providers are uninformed (or misinformed) about family planning and other broad population issues. Such commitment and awareness must be increased significantly if expanded population programs are to be successful.

There are, understandably, inconsistent perceptions of the respective roles of the ministries and NPC Secretariat as a coordinating body. Effective policy implementation requires a technically capable NPC Secretariat that can provide leadership for the overall program and facilitate and coordinate program efforts. These activities are diverse and require a large pool of analytic and technical skills which must be identified, developed and sustained.

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

While population studies are available at the University of Ghana, Legon in the Geography, Sociology and developing School of Public Health, and at the Regional Institute for Population Studies (RIPS), there is no focused program available for Ghanaian scholars leading to a concentration in population studies and research. Such a program would lead to higher visibility and status of population issues and improved policy environment.

b. *Commodity forecasting and stocking policy*

The current system of contraceptive commodity distribution, forecasting and stocking in the public sector leads to imbalances of contraceptive supplies throughout the system. The dispensed-to-client data based on a single month at the subdistrict level or a single quarter at the district and above leads to significant fluctuations which become magnified at higher levels in the system. Requests at each level also include the requirement to "top off" stock at each level below in order to meet the current policy of 4 months' stock at the service delivery point; 6 months' stock at the district level; 9 months' supply at the regional level; and 12 months' supply at the central medical store. This leads to an in-country pipeline of 31 months (4-6-9-12). At each level of the system, orders reflect not only need, but also the quantities necessary to maintain the respective pipeline requirements. Together, these policies lead to perceived shortages although sufficient quantities of commodities may exist, and to overstocking and product loss due to shelf-life limitations. It would be more appropriate to establish a policy which shortens the pipeline and forecasts need on the basis of quarterly data

at the sub-district level and semi-annual data at higher levels. Such a policy would eliminate imbalances throughout the system, reduce the chance of product expiry or damage in storage, and reduce the apparent periodic fluctuations by smoothing the commodity requirements over a longer period of time. Analysis of MOH's storage and transport capacity shows that the current system is sufficient for the growth projected under GHANAPA if the resupply policy is changed.

c. *Contraceptive pricing policy*

Prices in the public sector have not been increased since 1988, while the Ghana Social Marketing Foundation and NGOs such as PPAG have gradually raised the prices of their products in line with inflation. The disparity in prices of contraceptive commodities sold in the public and private sectors creates a flow of patients away from the private sector into the MOH delivery system. Furthermore, this price differential encourages some private sector suppliers to obtain their products through a Ministry or Health outlet rather than through the Ghana Social Marketing Foundation distribution system. Revision of the pricing structure is required to achieve a more sustainable market segmentation in which the private sector assumes a greater role, thus relieving an already overburdened public sector system.

d. *Government of Ghana resource allocation to family planning*

Currently, it is estimated that donors provide three times the GOG allocation for recurrent costs of the family planning program. While the GOG budget covers the cost of personnel and other capital costs, inadequate GOG resources are available for implementation of program activities. This has led to over-reliance on donor support reducing future viability of the national program in the event that donor support ceases or is greatly reduced. This situation is exacerbated by the fact that donor assistance has been separately budgeted (extra-budgetary). This results in the inability of the GOG to adequately plan for required family planning and AIDS activities through the normal annual budgetary process.

e. *Expansion of the Essential Drugs List*

The exclusion of certain drugs and contraceptives from the Essential Drugs List is also an issue that requires attention. The Essential Drugs List and National Formulary (EDLNF) specifies a limited number of drugs which are procured and available in public sector facilities. Inclusion on this list assures that these drugs receive priority ordering, customs clearance and distribution throughout the public sector system. NORPLANT®, a subdermal implant effective for five years, has recently been approved for general use in Ghana, yet has not been added to the EDLNF. In order to increase choice and assure that subdermal implants can be stocked in the public sector stores, they must be placed on the essential drugs list.

f. *Provider practices*

Certain restrictions or provider practices designed or intended to ensure high quality have the effect of limiting access to family planning services without necessarily improving quality. Results from the Situation Analysis Study of Family Planning Service Delivery Points in Ghana (1993) suggest the presence of provider bias in service delivery in Ghana because the providers are misinformed about the safety or efficacy of the method.[4] Table 1 shows provider biases regarding eligibility criteria. Nearly 90 percent of the providers interviewed who had provided family planning methods in the past three months would not provide **any method** to a woman with fewer than three children. Many providers would not provide family planning to unmarried clients or without the spousal consent of the married clients.

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

- 10 percent of providers cited 20 as the youngest age they would provide the injectable; another 12 percent said the lowest age would be 25; a further 10 percent reported that the lower age limit was 30

- 25 percent of providers would not provide foaming tablets to clients under 18

- 65 percent of providers would not provide the progestin-only pill to women over 35.

There are additional practices which result in denied access or high discontinuation rates. For example, provision of one cycle of oral contraceptives per visit or requiring a brief medical exam, even if the client is a continuing user with no adverse side effects or complaints, can result in a client suspending use of the method. Similarly, restrictions on who can provide certain methods may result in fewer users. These are simply examples of the current practices that must be addressed to ensure wider access to services, as well as a broader range of methods.

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

Table 3: Provider Eligibility Restrictions on Method Use by Method and Restriction

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

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

2. Demand Analysis

Under GHANAPA, the Mission is proposing to move from 10 percent to 20 percent modern CPR with a shift to long-term methods. In order to appreciate the magnitude of this increase comprised of 60 percent short-term and 40 percent long-term methods, the following table, generated by the TARGET MODEL[5] (see Annex F), provides the current and projected number of users by method:

[5] TARGET Model, Stover, J., Knowles, J., Wagman, A., Nortman D.: TARGET COST - A Model for Projecting the Family Planning Service Requirements and Costs to Achieve Demographic Goals, The Futures Group, 1991.

Table 4. Current and Projected Number of Users of Modern Methods

	1993		2000	
	Percent	Number (000's)	Percent	Number (000's)
Condoms	46	151	27	244
Oral Contraceptives	30	99	27	244
Vaginal Tablets	6	19	6	54
IUD	5	16	9	81
NORPLANT	0	0	1	9
Injectable	11	36	25	226
Female Sterilization	2	7	5	45
TOTAL USERS	100	328	100	903
TOTAL CYP[6]	350,000		955,000	

Sources: TARGET Model (see Annex F), Consumer Baseline Survey, The Futures Group, 1993, and Quarterly Service Statistics, USAID.

To meet the 20 percent CPR goal, the GHANAPA program projects **nearly tripling** the current number of total users of any modern method, including a **five-fold** increase in the number of IUD users, effecting a **six-fold** increase in the number of users of injectables and achieving a **six-fold** increase in the number of female sterilizations. The model is based on current method mix in Ghana and assumptions about relative changes in the method mix over time.

Although these targets may seem high, overall **desired** family size has dropped over the last five years from 6.4 to 5.3 children per woman, indicating that the potential for new users of contraceptives is significant. The 1993 Consumer Baseline Survey (CBS) indicates that **28 percent of women wish to postpone their next birth**, but are not currently contracepting. This suggests high unmet need for family planning. An additional **23 percent of married**

[6]Couple Years of Protection - contraceptive protection for a couple for one year. For example, four doses of the injectable, Depo Provera, annually yield one CYP. There are standard values used for each method which account for various factors which permit comparison of programs, although country- or region-specific values need to be incorporated to reflect local circumstances. For example, if women are sterilized on average at age 38, as they are in Ghana, they will not benefit from the full 12.5 average years of protection associated with sterilization. In this paper, the following values are used: Condoms -100/CYP; VFTs - 100/CYP; IUDs - 2.5 CYP; NORPLANT® - 3.5 CYP; Injectables - 4/CYP; Sterilization - 8 CYP; and Oral Contraceptives - 13/CYP. CYP data is collected quarterly through service statistics.

women want no more children, thus suggesting that the potential demand for sterilization is very high. **More than half of all women report that they are likely to use some form of contraception in the future.** These data clearly indicate that attitudes about family size have changed over the past five years, that there is a desire on the part of Ghanaian women to reduce their fertility and, that there remains high unmet need for contraception.

In order to translate this unmet need into increased demand and thus expand the use of effective contraception, potential users must move along a continuum from awareness and knowledge through interest/motivation, trial and assessment to retrial/commitment. The data below show a gap between trial (ever use) and current use suggesting the need to improve continuity.

Table 5. Percent of All Ghanaian Women Who Have Ever Used and Currently Use Contraception

	Ever Used (%)	Current Use (%)*
Any Modern Method	31.9	14.8
Pill	11.6	5.0
Condom	18.2	5.9
Vaginal Methods	5.0	1.0
Injectable	2.6	1.8
IUD	1.3	0.8
VSC	<1	<1

* one percent of all users are currently using multiple methods.

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

Lack of information on temporary methods is a major constraint to movement from trial (ever-use) to current use. The marked difference between current use and trial indicates that there is substantial method discontinuation. Former users report that they are not contracepting because of lack of knowledge, as well as because of fear of side effects (Table 4). This finding underscores the need for more method-specific information to increase knowledge and reduce health concerns. Partner disapproval of contraception indicates the need to educate men about the benefits of contraception.

Table 6. Reasons for Non-Use of Family Planning Methods

	Never Users (%)	Former Users (%)
Lack of knowledge	35	21
Fear of side effects	14	21
Partner disapproval	7	13
Religion	5	2
Other	27	25
Don't Know	12	15

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

The environment of acceptance and demand for clinical methods is much less developed than for the non-clinical methods. Awareness and knowledge of long-term methods is quite low as is knowledge of where to obtain these methods. Numerous myths exist about IUDs and there is little acceptance of even the concept of sterilization among either males or females. Therefore, demand generation activities must allay misplaced fears and improve acceptance of methods. Provider biases against certain methods also form a constraint which could severely limit acceptance and use of a method. Acceptance of sterilization, especially in a culture that reveres fertility, is a long term effort, requiring gradual shifts in attitudes with increased exposure from as many sources as possible and an emphasis on interpersonal and community based communication efforts.

The current referral system for long term methods is underutilized. Community outreach, CBD, pharmacists, and others will have to be trained to refer potential clients to an appropriate source. The development of referral systems will also be important to stimulate demand and trial of long-term, clinical methods.

Additional constraints to increasing demand for family planning services concern the agencies responsible for implementing IEC activities. Often these organizations do not have separate IEC units and these activities are handled by program officers who do not have the requisite training in communications. There is the absence of coordination and collaboration of the numerous organizations responsible for IEC activities, resulting in ad hoc implementation of activities and much overlap.

3. Service Delivery Analysis

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. The current and projected overall method mix is:

Table 7

Methods	1993	2000
Short-term	80%	60%
Long-term	20%	40%

The private sector currently supplies a majority of the short-term methods as shown in Table 7. During the course of the project, GHANAPA will promote increased use of long-term methods, from 20 percent of total method mix to 40 percent, and use of the private sector to deliver these methods, in order to foster increased sustainability. This is elaborated upon further in the Sustainability Analysis section of this document.

Table 8. Current and Projected Method Mix by Source

	1993		2000	
	Short-term	Long-term	Short-term	Long-term
Public	35%	85%	25%	75%
Private/NGO	65%	15%	75%	25%

Overall, there are several service delivery gaps in the current program which constrain the ability to make family planning services more accessible and more available to a wider group of individuals desiring these services:

- program for adolescents which provides information, counseling and services.
- post-abortion/post-partum services
- MCH clients
- males
- rural clients

Consideration of service delivery constraints follows separately for non-clinical methods (pills, condoms, vagina foaming tablets) and clinical methods (surgical contraception, IUDs, injectables, and subdermal implants).

a. *Non-clinical methods*

In addition to the public sector, short-term methods (pills, condoms, vaginal foaming tablets) are provided through a variety of private sector/NGO channels including the GSMF, GRMA and PPAG. Of the sixty-five percent of short-term methods supplied by the private sector, GSMF provides nearly 84 percent, the remainder being provided by PPAG, GRMA and other NGOs. Following is a brief description of the three major private sector/NGO organizations involved in the Mission's family planning activities, as well as information on other NGOs that receive assistance under FPHP and are expected to continue under GHANAPA.

o **Ghana Social Marketing Foundation**

The Ghana Social Marketing Foundation, established as the Ghana Social Marketing Program in 1985, is a non-profit, incorporated, private sector organization dedicated to improving the quality of life of individuals and families through the provision of affordable and accessible family planning and maternal and child health products and services. The organization became a private company in 1993, governed by a board of directors, is now the largest provider of private sector contraceptives in Ghana, and is a leader in coordinating private sector involvement in social issues.

GSMF has been receiving financial support and donated contraceptive commodities from USAID/Ghana under both the Contraceptive Supplies Project and the FPHP. Under FPHP, GSMF has received significant training and technical assistance which has strengthened the organization's financial management and administrative capabilities, established procurement procedures, and improved overall accountability. Technical assistance will continue through the completion of FPHP at which time GSMF will be ready to become a direct grant recipient of USAID funds.

GSMF capitalizes on the efficiency of the private sector to improve existing distribution channels to extend access to family planning products and services, and currently sells to over 4000 pharmacy and chemical retail shops throughout Ghana. GSMF currently sells two brands of condoms and one brand each of oral contraceptives, vaginal foaming tablets and oral rehydration salts.

By using three different distributors for their products, GSMF has now expanded their client base to include private midwives, supermarkets, gas stations, packaged goods stores, local markets and hairdressers with a goal of reaching 10,000 retail outlets by 1996. Plans call for the inclusion of injectables and IUDs to be sold to private doctors and clinics as the program emphasis shifts to long-term methods. GSMF engages in extensive product

promotion to increase awareness and knowledge about the benefits of the products, and training to ensure that retailers can provide correct information about the products.

As indicated from Table 9, the USAID-funded social marketing program has **quadrupled** its total sales since 1986. **Such a significant increase demonstrates that consumers are willing to pay for contraceptive supplies and speaks to the future sustainability of the program.** GSMF currently recovers 15 percent of its recurrent costs through sale of products. FPHP project assistance covers the remaining 85 percent. By the year 2000, GSMF projects increasing it share of recurrent costs to 54 percent.

Table 9. Social Marketing Commodity Sales According to Method by Year

	CONDOMS	FOAMING TABLETS	ORALS	TOTAL
1986	1,323,600	-	-	1,323,600
1987	2,519,100	544,200	284,900	3,348,200
1988	3,501,100	614,500	350,000	4,465,600
1989	3,214,300	724,700	431,300	4,370,300
1990	3,586,500	1,602,172	451,082	5,639,754
1991	3,748,300	1,911,332	453,839	6,113,471
1992	4,026,651	2,190,392	379,097*	6,596,140
1993	4,289,765	2,027,416	373,815	6,690,996
% INCREASE	224%	272%	31%	405%

*the decline in oral sales noted in 1992 and 1993 is a result of (1) supply problem due to start-up of new USAID/W contract for procurement of contraceptives; (2) difficulties with the local distributor. The worldwide contract is now in place and distribution has been expanded to include three local distributors.

Source: GSMF Quarterly Returns, 1986-1993.

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

PPAG is a private, NGO and is the local affiliate of the International Planned Parenthood Federation (IPPF). PPAG is the largest NGO provider of family planning services in Ghana, and currently provides 14 percent of the total short-term methods in the private/NGO sector. PPAG receives the majority of its commodities through IPPF with additional funding from the World Bank, and delivers them through a system of

community-based distribution (CBD), as well as through its family planning clinics. At times, PPAG has experienced commodity shortages or outages due to delays in the provision of these goods. PPAG is currently in the process of developing a 1995-2000 strategic plan which calls for the expansion of delivery of short-term methods particularly through its CBD program, as well as an increase in the delivery of long-term methods through its family planning clinics. PPAG places a particular emphasis on target groups such as adolescents and men. GHANAPA program plans to provide a grant to PPAG to expand its family planning programs, particularly with regard to long-term methods, and to reach undeserved populations.

o **Ghana Registered Midwives Association (GRMA)**

GRMA is a non-governmental organization which consists of 500 registered nurse midwives, who serve as private practitioners and provide pre-natal, delivery and family planning services to women throughout the country. Under the current FPHP, USAID/Ghana is providing funding to GRMA for the training of its members in general family planning information, and the provision of short and long-term methods. To date, 275 of the 500 have received training in family planning and currently receive commodities through the MOH and GSMF; 45 have been trained in IUD insertion. USAID funding to GRMA began in 1987 through a grant from REDSO/WCA to strengthen the organization, while USAID/Ghana funding through FPHP began in 1992 to help establish appropriate administrative and financial management structures. While thus far GRMA accounts for only a small percentage of the overall NGO provision of family planning services, it has provided approximately 40,000 new family planning acceptors. Over time GRMA will increase its overall share of family planning, further devolving provision of these services to the private sector thereby increasing program sustainability.

o **Other NGOs**

Under FPHP, USAID/Ghana currently provides funding for training in counselling and referral, IE&C materials, and contraceptives through the GSMF to 10 local NGOs as part of the community-based distribution program. The NGOs are selected based on their involvement in providing family planning services and referrals and on their ability to utilize messages developed under the IE&C activities of FPHP. This relationship is expected to continue under GHANAPA.

A major accomplishment will have been achieved if at project's end a substantial portion of the procurement and distribution of short-term methods is financially self-sufficient.

b. *Clinical methods*

In order to achieve a significant decline in fertility a shift to long-term methods must take place during the growth phase of Ghana's population program. This requires increasing the current number of users of long-term methods from 59,000 in 1993 to approximately 361,000 by the year 2000.

The following table shows the annual numbers of long-term procedures projected to meet these targets. While these numbers project a rapid growth, they are consistent with the demand analysis presented earlier. For these targets to be met, there must be a significant increase in the number of service delivery points for long-term methods and numbers of personnel trained in counselling and performing these procedures.

Table 10. Numbers of Procedures Projected Annually by Type of Procedure

	VSC	NORPLANT*	IUD
1994	4,050	921	15,140
1995	4,920	1,341	18,820
1996	5,850	1,830	23,010
1997	6,870	2,409	27,710
1998	7,950	3,067	32,980
1999	9,130	3,813	38,820
2000	10,310	4,560	44,660

Source: TARGET Model (see Annex F)

* In some years, TARGET requires fewer NORPLANT® insertions because the denominator (women of reproductive age) is increasing at a faster pace than the numerator (percent of method mix).

The service delivery capacity for provision of clinical contraceptive methods is not well developed in the public, NGO or private sectors. To date the major emphasis has been the training of public sector providers to deliver these services, although there has been limited private sector training.

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

The training that has been done has also not been well orchestrated and documented. Some providers have been trained in general family planning, others in IUD insertion, others in sterilization. Space in the training courses for clinical methods is limited by the availability of clients for the practical training. More providers could be trained if additional training sites were established at locations with ample case loads. There is no clear record of IUD trainees, where they are, or whether they are currently practicing. Since future efforts require the development of demand concurrently with the development of a service delivery capacity, it is critical to be able to identify and locate past and present trainees.

An analysis of training requirements to perform the number of clinical procedures necessary indicates that a total of one-hundred additional doctor/nurse teams are 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 counselling and referral. Since 1991, pre-service training in IUD insertion has been included for all nurse-midwives and public health nurses, of which there are a total of 250 graduates each year. However, not all of the nurse-midwives assigned to the public sector are given IUD kits and not all are put in clinical service units where they can practice. A full assessment of public service midwives will need to be conducted to ascertain how many are currently performing IUD insertions, and how many additional will need kits to perform these procedures. In the private sector, 275 of the approximate 500 registered nurse-midwives have been trained in general family planning, and forty-five of those have received clinical training and are currently performing IUD insertion.

There are currently fifteen sites providing sterilization procedures throughout the country. In 1993 the Association for Voluntary Surgical Contraception (AVSC) conducted an assessment of 100 additional service delivery points to determine their suitability as sites where long-term (clinical methods) could be offered. These sites consisted of university teaching hospitals, 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, and concluded that of the 100 sites, 35 require major renovation (> 3.5 million cedis [approximately $4,000 at the rate of ¢915 = $USD1]) and 20 require minor renovation (< 3.5 million cedis). The remaining sites require equipment only, no assistance at all, or renovation is not possible because the space is rented.

The analysis indicates that once renovated and equipped, these 100 sites plus the existing fifteen will be adequate for providing the required number of procedures. However, these facilities are also utilized for other types of surgery and operating room access for family planning procedures has been cited as a constraint by providers. This issue will be addressed by reaching agreements with each facility regarding availability for provision of long-term family planning methods.

4. Sustainability Analysis

As discussed here, a financially sustainable program is one that generates sufficient revenue to recover its recurrent costs. Strategies directed towards building long-term financial sustainability in family planning or in other sectors typically focus on two potential national sources of funds to sustain activities: budgetary support from the government at various levels; and cost recovery mechanisms, which require beneficiaries to pay for services.

In 1992, based on available estimates, donors provided three times the GOG contribution, or $9 million of $12 million in recurrent costs. While the GOG primarily covered personnel, which is a significant contribution on the part of the Government, minimal resources remained available for implementation of program activities.

In addition to budgetary allocations, the Ministry of Health also utilizes a system of user fees and charges for most drugs, including contraceptives, to recover costs for all health-related services. Pilot studies have shown that clients are able and willing to pay for general health services: the MOH surpassed 15 percent recurrent cost recovery within a two year period and 20 percent within a four year period in two tested districts. However, the experience with cost recovery for family planning commodities has not been as successful. Due to the current public sector prices of commodities, which have remained constant since 1988, the MCH/FP division estimated that the contribution from commodity sales in 1992 amounted to only 5.5 percent of the total cost of commodities (MCH 1992 Annual Report). This reinforces the need to establish a more consistent pricing system between the public and private sectors as discussed in the Policy Analysis section.

In order to increase the overall viability of the MOH family planning program, a combination of strategies needs to be utilized: the Government of Ghana's contribution to recurrent costs for family planning activities must be significantly increased; pricing for contraceptive commodities must be adjusted; and a shift of family planning activities to the private sector must take place as well as a shift from short to longer-term methods.

As indicated previously, the private sector currently supplies and will continue to supply the majority of short-term family planning methods, and is anticipated to take on an increasing share of long-term methods in the future. Within the private sector, the GSMF provides the majority of the commodities for short-term methods. As in all social marketing programs, the Foundation receives donated commodities. GSMF is currently recovering 15 percent of all recurrent costs including advertising, training, research, warehousing and packaging, and personnel. By the year 2000 it is anticipated that the Foundation will recover 54 percent of these costs through income generated by sales. Under a second scenario, with additional financing through means of an endowment or trust, it is projected that GSMF would be able to recover all recurrent non-commodity costs by 2001, addressing the sustainability of a major portion of the national program.

Given maximum utilization, long-term methods are more cost effective than short-term methods, thus contributing to overall program sustainability. However, shifting from short- to long-term methods requires additional resources for training, equipment and clinic renovation as outlined in the Supply Analysis section. In addition to an overall transition to more effective methods, a shift from the public to the private sector needs to occur in order to move towards increased program sustainability. Based on an analysis of service delivery statistics, 85 percent of long-term methods are currently delivered through the public sector. By increasing the use of private practitioners and NGOs, the desired shift in the delivery of services can be accomplished, thus reducing the burden on the MOH. However, this transition will be gradual and the MOH will continue to provide the major share of long-term methods for the foreseeable future. As the shift begins to take place, the program will move from approximately $15/CYP (USAID investment) in 1993 to $10/CYP by the year 2000 at project's end.

Experience in successful family planning programs worldwide (e.g. Thailand, Indonesia, Colombia) has shown that given prolonged low contraceptive prevalence levels, subsidy is necessary for an extended period of time. The experience in Ghana follows this same pattern. Despite recent improvements in the economy, it seems unlikely that family planning service delivery in Ghana--in the public or private sector--will become fully sustainable in the near future. Donor resources will continue to be needed. However, implementing strategies for sustainability, as outlined above, must be a priority if Ghana is to maintain a viable family planning program over the long run.

C. Program Strategy

Evidence from worldwide family planning programs indicates that as countries move from the launch to the growth phase, the challenge is to make family planning information and services more broadly available and continue to increase prevalence. Despite the initial successes in Ghana, in which demand for family planning has significantly increased, there is a need to consolidate these efforts and maintain the momentum. GHANAPA will focus on improving the overall policy environment for family planning which includes consolidating national support and reducing barriers to service delivery, continuing to expand short-term methods consistent with demand, while increasing the sustainability of the supply and shifting the focus from short-term to long term methods which entails a shift in relative supply source from the public to private sector. Sustainability will be enhanced as a result of increased budgetary outlays for family planning flowing from budget reforms linked to GHANAPA conditionality, establishment of a private sector endowment and an endowed chair at the Center for Population and Development at the University of Ghana/Legon. At the same time, the consumer will be asked to bear a growing share of the cost of service provision, even though some subsidies are expected to continue into the next decade.

To assist the GOG in undertaking budgetary reform, shifting from short term to long term methods and devolving more activities to the private sector, the GOG will require additional resources. Given that the majority of resources in both family planning and AIDS is provided

by the donor, long-term sustainability can only be achieved if the GOG begins planning and budgeting appropriately to fund activities. NPA is therefore an integral component of the Mission's strategy in assisting the GOG. The GHANAPA strategy with respect to NPA is based on the GOG's increasing need to devote more resources to family planning and AIDS activities. Since resource allocation in both family planning and AIDS is difficult, if not impossible, to desegregate, conditionality is based on the GOG meeting output indicators related to CYPs and process indicators that allow for appropriate planning and budgeting rather than on specific amounts allocated to family planning and AIDS.

D. Program Description

1. Program Goal and Purpose

The **goal** of the family planning component of the GHANAPA program is the same as the Mission's strategic objective in this sector, i.e., to reduce Ghana's fertility rate. The goal level performance indicator is to reduce the total fertility rate from 5.5 to 5.0 by the year 2000.

The **purpose** of the family planning component is to 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 overall method mix.

The component will consist of the following elements: (1) improved policy environment; (2) increased demand for family planning services; (3) improved service delivery; and (4) greater sustainability.

2. Program Elements

Under GHANAPA, activities in the private sector will be supported directly with grants to the NGOs, while public sector activities will be supported through the bilateral grant agreement and non-project assistance (NPA). Additionally, contraceptives procured from the United States will be provided for both the public and private sectors. Release of NPA funds will be contingent satisfactorily meeting conditions precedent to five tranche disbursements. NPA and conditions precedent for release of funds are discussed fully in Section VIII.

a. Improved Policy Environment

As discussed in the Constraints section of this document, six key policy issues are to be addressed in GHANAPA which will contribute to an improved policy environment for family planning.

(i) National support and coordination of population activities:

Effective policy support requires leadership and coordination of all program efforts. The National Population Council (NPC) has taken the lead in revising and building consensus for the new Population Policy and will be responsible for implementing the policy in its capacity as the highest advisory body to government on population issues. Through its Secretariat (established during FPHP), the NPC will be responsible for guiding and coordinating plans of action for policy implementation; promoting the integration of population into development planning; maintaining a population data bank to promote exchange of information on population issues; interacting with donors and coordinate donor input; and generally providing national leadership on population issues so that there are strong supportive working relationships among implementing agencies. To implement its role as the primary coordinating body for family planning, the NPC will chair a Population and AIDS Coordinating Committee (PACC) comprised of the implementing entities under GHANAPA.

The PACC will coordinate all GHANAPA activities and, to be effective, will be chaired by the NPC and include members from the NPC, Ministry of Health, Ministry of Finance, Accountant and Controller General, USAID, GSMF, GRMA, PPAG, CHAG, AVSC, and Population Impact Project (PIP) at the University of Ghana/Legon. The PACC will be a consensus forming body that will review annual workplans of implementing entities, review quarterly progress and make recommendations on project implementation.

To do this, the NPC needs to be strengthened as an organization to help build a national consensus on population policy through effective policy implementation; coordination of activities in the private as well as public sectors; monitoring of all population activities; and overall leadership for family planning activities. The NPC will receive population policy formulation technical assistance from the PIP at the University of Ghana at Legon. PIP, partially funded under FPHP, has the sole aim of making Ghanaians, especially policymakers, opinion leaders, and researchers aware of the impact of rapid population growth on development. PIP organizes workshops, seminars, RAPID (Resources for the Awareness of Population Impacts on Development) presentations, and materials for dissemination. PIP will work with the NPC to raise leadership awareness of relationships between population growth and development and about the positive socio-economic and health effects of lower fertility.

Both the GOG and USAID will fund activities focused on strengthening the NPC. Five technical advisory committees have been established within the NPC to assist the organization in developing a coherent and effective strategy for national consensus building. Those committees include: Research coordination, monitoring and evaluation (RCME); Population information, education and communication (PIEC); MCH/Family Planning services; Training; and Population policy and programs (PPP). Other NPC activities planned to be undertaken during GHANAPA include:

- Workshops and seminars at the regional and district levels to raise awareness about population issues employing RAPID-type presentations;

- IEC campaigns at the regional and local level to raise awareness about the newly promulgated population policy among local government officials and the general public;

- Observational study tours for influential policy makers to other developing countries which have successful population authorities.

- Strategic planning workshops, formulation of annual workplans, training NPC staff and developing their capability to administer the MIS developed under FPHP.

The GOG budget will support capital, personnel and other recurrent expenditures (i.e. short term local technical assistance) of the NPC and its secretariat. NPA Conditionality will be used to ensure that the GOG meets annual obligations to the NPC including for population policy formulation based on annual workplans and training plans reviewed by the PACC.

The GHANAPA project will support study tours for approximately eight NPC secretariat staff and council members ($100,000) and limited equipment such as computers, fax machines, photocopiers, etc. ($50,000), bringing the project contribution for this activity to $150,000.

Additional resources, outside of the GHANAPA Program, will be available to supplement project activities. Demand-driven technical assistance will be made available to the NPC and PIP for policy formulation and implementation. During the six year life of project, up to fifty three person months (at an estimated cost of $1,325,000) of technical assistance will be available from the centrally-funded Options for Population Policy Project (OPTIONS) and RAPID projects to assist the NPC and PIP. OPTIONS activities are designed to support the policy development process and help countries formulate comprehensive national population policies that endorse and encourage family planning. RAPID raises leadership awareness of relationships between population growth and development and about the positive socio-economic and health effects of lower fertility.

(ii) *Commodity forecasting and stocking policy:*

A recent assessment of the MOH contraceptive logistics system advised that changes in the resupply policy were required to ensure the adequacy of the system for the increase in commodities projected under GHANAPA. This policy includes both the length of the pipeline (stocking at all central, regional, district and clinic levels) and the method for forecasting future requirements. Recommended changes include shortening of the pipeline to 21 months (9 central- 6 regional- 4 district- 2 sub district) and forecasting need based upon quarterly data at the clinic level and semi-annual data at higher levels.

GHANAPA conditionality will require the development of a new forecasting and stocking policy which will adjust the pipeline to 21 months by Tranche Two and implementing

forecasting adjustments implemented by Tranche Three. Principal nursing officers, district and regional health management teams as well as MCH/FP staff in Accra will be trained in stocking procedures and the Logistics Management Information System (LMIS) and the corresponding forms will be revised. Evaluation of the new pipeline policy will take place during the third year of GHANAPA.

Additional resources, outside of the GHANAPA Program, will be available to supplement project activities. Demand-driven technical assistance will be made available to the MOH for policy development, training and evaluation of the stocking policy. During the six year life of project, up to fifty three person months (at an estimated cost of $1,325,000) of technical assistance will be made available from the centrally-funded Family Planning Logistics Management (FPLM) Project. FPLM helps improve the capability of developing country public and private sector organizations to administer more effective and efficient contraceptive logistics systems. The FPLM project will not only be available to work with the public sector, but will also be available to provide limited assistance to grantees (GRMA and PPAG) with forecasting and MIS development.

(iii) *Contraceptive pricing policy*:

A key policy objective of GHANAPA is the establishment of a system for a new public sector contraceptive pricing structure. Once in place, this pricing policy will have the effect of alleviating some of the client burden in the public sector (by devolving more to the private sector), increasing cost recovery, and diminishing the leakage of public sector products into the private sector outlets. With FPHP assistance, the NPC has initiated a pricing study with technical assistance from the Options for Population Policy (OPTIONS) project to develop a new pricing structure and a schedule of annual price adjustments. The policy will be developed collaboratively by the NPC, the MOH, the GSMF, and other key service providers such as PPAG and the GRMA. The study will address and make recommendations to the NPC concerning the following:

- effect of price increase on utilization in the public and private sectors;
- relationship between income and demand for products (based on the Ghana Living Standards Survey);
- cross-elasticity, i.e., consideration of how price changes in one product affect demand for other products (method switching);
- clients' switching between public and private sectors following price changes;
- impact of price increases on cost recovery for the public sector;
- impact of price increases on diversion of product from the public to private sector.

GHANAPA tranche one conditionality will support the establishment of a new contraceptive pricing structure and a new price schedule. Each successive year tranche requires that the contraceptive pricing structure be reviewed and analyzed and adjusted as per the policy. Up to four person months (estimated at $100,000) of demand-driven technical assistance through the centrally-funded OPTIONS Project will be made available to assist the NPC conduct evaluations of the pricing policy in the third and fifth years of the Program. The evaluations will examine: (1) the extent to which the new pricing structure has been adopted; and (2) the effect of the policy on demand and product leakage. Recommendations will be made regarding the need for additional policy changes, if any, concerning the pricing structure.

(iv) *Government of Ghana resource allocation to family planning:*

Currently, GOG resources available for program activities in family planning are insufficient to achieve program goals. Donor assistance to the MOH has often been accessed through an extra-budgetary process (off-budget), thereby eliminating the need for careful budgeting and advance planning of activities all levels. Through GHANAPA NPA conditionality, the GOG will now be required to provide adequate resources to the MOH to achieve agreed-upon family planning benchmarks for couple years of protection. This represents a major shift in the budgeting process for the GOG and is expected to lead to greater overall sustainability. Gradually, it is hoped that the other donors will begin to move their resources on-budget which will allow the MOH to adequately plan and budget for priorities within the sector, thereby improving overall budget management by linking fiscal responsibility with expenditures. As part of the conditionality agenda, annual work plans and training plans will be required from the various units within the MOH charged with implementing family planning (as well as AIDS prevention) activities. This element also ties in with the cost recovery activities discussed above under "contraceptive pricing structure" and with the conditionality mentioned earlier concerning financing of NPC activities related to "national support and coordination for family planning."

The MOH family planning benchmarks are based on CYP calculations generated by the TARGET Model (Annex F) which estimates method mix and quantities required to reach 20 percent CPR. In 1993, 59 percent of all CYPs were provided by the public sector; 48 percent of short term methods and 87 percent of long term methods were delivered by the MOH. In order to simultaneously shift emphasis to the private sector and to more effective methods, by the year 2000 it is expected that the public sector will decrease its share of the short-term CYP to 25 percent and the long-term to 75 percent. To accomplish this, the GOG must meet the following CYP benchmarks: 118,000 in short-term methods and 112,000 in long-term methods in 1995; 130,000 and 145,000 in 1996; 137,000 and 185,000 in 1997;143,000 and 231,000 in 1998; and 145,000 and 283,000 in 1999.

(v) *Expansion of essential drugs list:*

NORPLANT® has already been approved by the MOH for general use in Ghana. However, the MOH will need to add NORPLANT® and other subdermal implants to the Essential

Drugs List (EDL) to ensure that the contraceptive is widely available in MOH facilities nationwide. To do this, the MOH will need to revise the EDL which requires an analysis and approval by the Pharmacy Board and other GOG agencies involved in pharmaceutical purchasing, distribution and use. GHANAPA conditionality will require the MOH to develop a plan of action to include subdermal contraceptive implants (as well as additional STD drugs) on the EDL by Tranche One, and actual inclusion of the implants on the EDL and distributed to all MOH providers by Tranche Two. Technical assistance to conduct the study is being provided under FPHP, and actual implementation will not require additional resources under GHANAPA.

(vi) *Provider practices:*

Changes in provider practices that serve to restrict access to services or to specific methods of contraception are critical to the success of Ghana's family planning program. An important objective of GHANAPA is the elimination of misinformation that impedes the provision of services. The MCH/FP of the MOH will play a key role in activities directed towards improving provider practices which have worked to limit access to contraception or to certain methods, for example, because of the age, marital status or parity of the client. Specific activities under this area are outlined below:

- Clinical Guidelines

MCH/FP is in the process, under FPHP, of harmonizing the currently existing service delivery and training guidelines, establishing a task force to review and revise the guidelines to ensure that they are up-to-date and uniform among all service providers. Initial dissemination of the guidelines through training of trainer workshops in three regions will be followed by subsequent workshops in the remaining seven regions. Training in turn will be done at the level of the regional and district health management teams, and also through incorporation into the pre-service training curriculum. All training will be completed by the end of 1996. The impact of the new guidelines then will be documented and evaluated to determine whether practices have changed and how training and supervision of service delivery providers improves adherence to the guidelines. Additionally, changes in access to family planning that result from dissemination of guidelines and training will be documented through small surveys. MCH/FP will publish and distribute the new guidelines. They will produce 4,000 handbook-sized copies, and 1,500 desk-sized copies to ensure that each health worker receives a copy, and that there are sufficient copies available in schools, libraries, teaching institutions and other locations. This activity was initiated under FPHP and will continue under GHANAPA.

MCH/FP will help organize contraceptive technology updates (CTUs) seminars that will be addressed to three groups: policy and program leadership at national, regional, and district levels; key clinical trainers and service providers from MOH, NGOs and private sector facilities; and pre-service faculty from health training schools. These seminars will provide the most recent information on specific methods, management of side effects, and suitability

of methods for certain clients resulting in increased method-specific knowledge and increased access to a fuller range of methods. CTUs will be held for at least 400 doctors and 2,000 midwives.

Some of the CTUs may be carried out in conjunction with a proposed Anglophone West Africa regional workshop on medical barriers that would be organized by one or more centrally funded projects to provide the most accurate, current information available on methods and their side effects. This workshop will be for service providers and program managers from anglophone West African countries to acquaint them with the concept of "medical barriers" and provide a forum for information exchange. Participants from the workshop would then disseminate the information learned through the regional and district provider network.

- Study of Provider Practices

An in-depth study of provider practices will be conducted under GHANAPA to add to our knowledge concerning the existence and nature of such practices and the ways in which they limit access to the full range of contraceptive methods for certain groups of potential clients. Although there is information available from the recently conducted Situation Analysis concerning restrictions on the provision of contraceptives to certain categories of clients, the reasons for such provider attitudes and behaviors were not addressed. To understand the basis for these practices and adequately address them through training and contraceptive technology updates, a provider survey will be conducted. This study will form the baseline for the evaluation of these changes. It is anticipated that the NPC and MOH will work with the Ghana Statistical Service to conduct this study. Additional analyses of the Program Managers' Questionnaire from the Situation Analysis (1993) also will be conducted to further elucidate these provider practices. Up to forty person months of demand-driven technical assistance will be made available to the MOH/NPC from each of two (total of 80 person months) centrally-funded projects (INTRAH/PRIME Project and Family Health International) to develop and disseminate the guidelines and to conduct the CTU seminars and study. The estimated cost is $2.0 million. Approximately $100,000 will be made available in Project costs to publish and disseminate the results of the various policy studies and guidelines.

Summary of USAID Assistance: Improved Policy Environment

In summary, to improve the policy environment for family planning activities, $250,000 in GHANAPA project assistance will be provide for study tours, equipment and materials. Approximately $4.75 million in demand-driven technical assistance from centrally-funded projects will be made available at the request of GHANAPA implementing entities.

b. Increased Demand for Family Planning Services

As indicated in the constraints section, GHANAPA projects more than doubling the current number of total users of any modern method. Demand generation for both short- and long-term methods requires a concerted effort to increase general awareness and method specific knowledge with an emphasis on long-term methods and develop client referral systems. To increase awareness and knowledge, GHANAPA will support the development of information, education and communication (IEC) campaigns and materials to focus on provider biases and misperceptions, and client fears and misconceptions about specific methods. Client referral systems will be developed through extensive training exercises targeted at providers and counselors to ensure that clients are aware of facilities that offer family planning services.

The NPC is responsible for overall coordination of all activities in the population sector at the national, regional and district levels. The technical advisory committee on Population Information Education and Communication (PIEC) has developed an implementation plan that will guide the development of the national IEC and training strategy for both the public and private sectors, thus alleviating some of the coordination and oversight issues experienced in the past. This strategy will be the cornerstone of all demand creation activities under GHANAPA for message design and material development including print, television, video and performing arts media; emphasis on special target groups such as males and youth; and emphasis on long-term and permanent methods.

Public Sector

In the public sector, the MOH Health Education Unit (HEU) is the implementing entity for the public sector in collaboration and concert with other relevant groups, such as the Ministry of Education, Ghana Institute of Journalism, Ministry of Information, and the Ghana Social Marketing Foundation. Emphasis will be placed on demand generation for groups not specifically targeted under FPHP for whom service delivery gaps have been identified including adolescents, men, maternal and child health clients, and post-partum and post-abortion women. HEU's communications strategy will include reinforcing target audiences' intentions to use modern contraception and encouraging them to actually begin use; providing method specific information in messages and materials targeted to specific groups; and moving the target audiences to discussion with a family planning provider and to communication with sexual partners about family planning. HEU will conduct research, including focus groups, as appropriate in the development of these campaigns.

In implementing its communication strategy, the HEU will develop multi-level interventions that utilize mass media campaigns, as well as community mobilization and clinic-based outreach to MCH clients. National campaigns will be thematic, such as the "We Care" campaign launched in 1990, so that media strategies are harmonized and clients and providers can associate family planning information and services with a concept that is easy to remember and can be built upon. Specific national and regional health education activities will include the following:

- Conduct focus group research to determine the nature and extent of method-specific misinformation particularly regarding long term methods;

- Conduct one workshop per year for representatives of the HEU, MCH/FP and other relevant health personnel from regional and district levels to review current information on client KAP, discuss new messages and plan IEC activities;

- Conduct one workshop per year for regional health officers and program managers to design messages and materials that are culturally acceptable, ensuring that all materials support and complement each other;

- Design and conduct at least one thematic national-level IEC campaign per year of the project;

- Produce and disseminate copies of all new print medium materials to public sector service delivery points;

- Provide adequate supplies of new IEC materials to private sector outlets and NGOs at economic cost;

- Increase the use of videos/folk media to raise the level of awareness and educate the general public on population issues;

- Expand the network of IEC motivators by training satisfied users, agricultural extension and other community workers in each region;

- Train 2500 providers (250 in each of 10 regions) on community mobilization techniques, counselling and IEC skills;

- Train 1300 providers (130 per region) in communication and counselling skills

All concepts, themes, and messages will be designed to complement and support IEC activities in the private sector; i.e., method-specific approaches developed by HEU will complement and reinforce private sector brand-specific initiatives. Partnerships will also be maintained between the national and regional levels. Specifically, the national level will coordinate ideas and undertake mass production of high quality materials suitable for the regions. The regional level will contribute ideas, message requests, and adaptations of generic sample materials and plan regional IEC campaigns. Particular attention will be directed towards estimating the quantities of materials required and to ensuring adequate distribution to all end users. The new IEC Resources Center, to be located at the Korle-Bu complex, will play a major role in making such materials available to all regions, along with IEC materials from elsewhere in Africa and the world.

Private Sector

An integral component of social marketing is advertising and marketing. GSMF will collaborate closely with HEU in developing and disseminating information in line with the national IEC strategy. In addition to participating in method-specific advertising/IEC activities, GSMF will also develop and conduct brand-specific marketing and advertising through its network of retail outlets and NGOs. GSMF will also contract for consumer research and surveys; retail audits, pre-testing of advertisements and promotional items including brand and method-specific consumer research (e.g., focus groups, point of purchase surveys). GSMF will also conduct one new advertising campaign each year to promote the social marketing products.

Both the Planned Parenthood Association of Ghana (PPAG) and the Ghana Registered Midwives Association (GRMA) will carry out demand generation activities in conjunction with service delivery. For example, GRMA will include IEC message delivery in its basic training program for 200 nurse-midwives, and as a component of the Community-based Distribution (CBD) training to be provided to 500 maternity home attendants.

Further, it is expected that both PPAG and GRMA will participate fully in national and regional IEC campaigns, both method and brand specific, as well as those campaigns targeted to special populations. As appropriate, both groups will also participate in research (e.g., focus groups) to develop these campaigns and supporting materials.

PPAG, which currently operates in 7 of Ghana's 10 regions, will focus primarily on special populations: undeserved rural areas, adolescents, and males. Demand generation through IEC will form a part of activities for all three groups. For rural areas, CBD training will include attention to outreach, community mobilization and IEC motivation for 385 new agents, and reproduction and distribution of IEC materials as part of national campaigns in conjunction with the HEU. The adolescent activities will include designing innovative, locality-specific IEC strategies and dissemination techniques, based on the results of Knowledge, Attitude and Practices (KAP) studies, and carrying out a range of IEC activities targeted to youth. Similarly, specific IEC activities will be carried out directed towards males, as follows:

- Developing targeted IEC materials;
- Carrying out special IEC activities, including home visits, lectures, groups discussions, and symposia for target groups;
- Organizing 2 one-day seminars in each of seven regions with PPAG presence for opinion leaders, including traditional and religious leaders to gain support for the family planning program; and
- Organizing family planning IEC and services for the Driver's Union and 2 Auto Garages in each of the seven regions included in this project.

Summary of USAID Assistance: Increased Demand for Family Planning Services

The GHANAPA project will support $100,000 for short-term overseas training for approximately 10 individuals from the MOH and private sector to attend programs such as the Johns Hopkins University Program for International Education in Reproductive Health and $300,000 for IEC audio visual equipment and materials, bringing the Project contribution for this element to $400,000.

The public sector, through the HEU, may receive up to 60 person months (totalling $1.5 million) of demand-driven technical assistance made available through the centrally-funded Johns Hopkins University Population Communications Services (PCS) Project. PCS supports communications projects in developing countries in all stages of communication program design and implementation, including audience identification, message design, media mix, production of materials, interpersonal communication and evaluation. Some technical assistance may also be made available to the private sector.

c. **Expanded Provision of Family Planning Services**

In order to achieve the increase in contraceptive use and concomitant lowering of fertility targeted under GHANAPA, substantial attention will be given to increasing access to family planning services. Efforts will continue to expand delivery of the temporary, supply methods (oral contraceptives, condoms, VFTs), but increased emphasis will be placed on assuring access to permanent and long-term methods, including injectables, IUDs, subdermal implants, and voluntary surgical contraception (VSC). This change in emphasis is expected to result in a shift in the long-term methods, share of total method mix from 20 to 40 percent.

Simultaneous attention will be focussed on the strengths of the private/NGO sector in service delivery; this will be accomplished through grants to three local organizations: Ghana Social Marketing Foundation, Ghana Registered Midwives' Association and Planned Parenthood Association of Ghana and $10 million in contraceptive commodities (an additional $1 million in condoms is committed to AIDS/STD prevention activities described later). All three private sector organizations will be required to participate as members of the PACC. Participation will include annual submission of work plans (inclusive budgets and training plans) for PACC review, attendance at regularly-scheduled meetings, presentation of quarterly service statistics and analysis of factors affecting achievement of private sector family planning targets.

(i) ***Non-Clinical (Short-term) methods***

While many of the constraints to short-term delivery methods (orals, condoms and VFTs) are being addressed under the FPHP, expansion of availability nationwide through new distribution channels will require additional pre-service and in-service training of providers in counselling and service delivery to target groups such as adolescents, males, post-partum, post-abortion clients. For short-term methods, the private sector is the major provider of

services and will continue to lead in this area where it is important that those with the necessary skills and facilities be able to provide complete reproductive health care for Ghanaian women.

- Public Sector

GHANAPA will continue to provide $5 million in contraceptive commodities (half of the total $10 million) to the MOH for distribution to over 600 facilities. As discussed in the policy section, NPA conditionality will require the GOG to provide adequate funds to the MOH to meet agreed-upon CYPs annually (see Conditionality Agenda). The MOH from its own budget will be responsible for:

- pre-service training on contraception and family planning services for all nursing students at the 7 midwifery schools and 10 nursing schools;
- contraceptive technology updates (CTUs) for 100 nursing, midwifery and public health nurse (PHN) tutors per year.
- in-service training on interpersonal relations, counselling and referral for at least 150 family planning providers per year;
- pre-service training for all nurse midwives and public health nurses in counselling and referral.

- Private Sector

In the private sector, GHANAPA will provide direct grants to GSMF, GRMA and PPAG to expand service delivery to groups not currently being reached under FPHP. Following are descriptions of the planned activities by organization:

- *Ghana Social Marketing Foundation*

Currently the largest provider of short term methods, GSMF will continue to be a major implementing organization. GSMF was formed under FPHP and has received significant training and technical assistance to strengthen the organization's financial management and administrative capabilities, establish procurement procedures, and improve overall accountability. Technical assistance and provision of donated commodities will continue through the completion of FPHP at which time GSMF will be ready to become a direct grant recipient of USAID funds under GHANAPA.

GSMF will continue to supply condoms, orals and foaming tablets and will continue to contract with GIHOC Pharmaceuticals for central level warehousing and repackaging. Further, GSMF will maintain its agreements for distribution of commodities through its

networks with DANAFCO, STARWIN and Johnson. Additional distributors will be engaged for non-traditional outlets.

By the end of GHANAPA, the GSMF will be expected to have expanded its base of providers to 12,500 outlets or service delivery points, including pharmacies, chemical retail shops, gas stations, supermarkets, packaged goods stores, local markets and hairdressers. Additional commercial outlets may include hotels, kiosks, or other types of retail shops, particularly those that are likely to reach into the rural areas.

In addition to commercial outlets, GSMF will continue to expand social marketing through linkages with NGOs. NGOs can play an important role in creating a supportive environment for the use of family planning by providing a forum for reaching women and men to increase knowledge about methods and to encourage them to try various contraceptives. GSMF is currently working with ten local NGOs which were selected on the basis of geographic distribution and their special access to important undeserved populations. Under FPHP, the centrally-funded Center for Development and Population Activities (CEDPA) Access to Family Planning through Women Managers project has provided technical assistance to organizations such as the YWCA .

Under GHANAPA, up to 10 months ($250,000) of demand-driven technical assistance will be made available to NGOs from CEDPA to reach new contraceptive users through women's networks, alternative development institutions and private sector organizations. GSMF will continue to coordinate the NGO program and distribute commodities to the participating organizations as well as expand the program to 10 additional NGOs. The GSMF grant will fund workshops, training of trainers, opinion leaders sensitization sessions; administrative costs; and limited equipment procurement. Specifically, GSMF will:

- Recruit and train 8,000 new and existing commercial providers;
- Provide limited, local, technical assistance with program management, supervision and logistics to NGOs.
- Provide financial support to start-up 10 new NGO-CBD programs and maintain existing 10 NGO programs;
- Conduct training for 1,000 CBD agents and supervisors affiliated with the NGOs; and
- Reproduce and distribute method-specific and general family planning and STD information materials to all 12,500 service delivery points (SDP).

In March 1995, USAID will provide a grant to GSMF for $3,000,000 to cover personnel, training, advertising, marketing, equipment, research, warehousing, packaging and distribution, and support to NGOs, and approximately $5 million in contraceptive commodities for distribution to the private and non-profit sectors. GSMF is expected to

achieve 160,000 short-term CYP by the end of GHANAPA. They are currently not involved in distributing long-term methods, but plan to add these methods for provision to private practitioners.

Up to seventy five person months ($1,875,000) of demand-driven technical assistance will be made available to GSMF from the centrally-funded Contraceptive Social Marketing III (SOMARC) project. SOMARC focuses on using techniques and resources of commercial enterprises to increase the availability and use of contraceptives. Together with the CEDPA assistance to local NGOs and SOMARC, available centrally-funded projects total $2,125,000.

■ **Ghana Registered Midwives Association**

Under GHANAPA, GRMA will continue to develop and support the efforts of the private midwives to provide family planning services for women in their communities. GRMA will prepare current members (currently 500) for an active role in providing family planning services through:

- basic training for an additional 150 private midwives in long and short term methods, counselling, IEC message delivery, and contraceptive management and logistics, bringing the total to 600 midwives trained in short term methods and 300 trained in long term methods;

- providing up to five days of continuing education on contraceptive technology updates and training in the proper treatment of STDs for 200 midwives over the life of the project;

- training 500 maternity assistants as CBD agents and training of a core of 30 CBD trainers.

To augment the outreach activities of the midwives, GRMA will also train 500 maternity home attendants as CBD agents (including IEC motivational training) to greatly reduce missed opportunities with potential clients. GRMA will select 30 midwives, 3 from each region, to organize the training of maternity home attendants. This core group will work with selected trainers of CBD agents from PPAG to complete the training of maternity assistants.

GHANAPA will continue to supply and distribute subsidized contraceptives for GRMA members through the GSMF network. During the life of the grant (commencing in FY 1996), GRMA is expected to distribute 435,740 condoms, 165,160 cycles of pills and 250,148 VFTs, achieving 31,000 CYP per year by project's end, or a total of 125,000 CYP over the life of the project representing a four-fold increase over their current program.

Upon completion of FPHP-funded activities in January 1996, USAID will provide a grant totalling $1,000,000 to GRMA to cover the costs of reviewing and updating of management systems, conducting annual workshops and bi-annual meetings for 40 regional representatives to upgrade skills and enhance performance in monitoring and supervision; observational study tours for two GRMA members per year and expanding membership of the organization.

(Currently FPHP-funds long-term technical assistance through the American College of Nurse Midwives. This cooperative agreement will end in November 1995). In addition to the GHANAPA-funded grant, twelve person months ($300,000) of demand-driven technical assistance from the centrally-funded Family Planning Management Development (FPMD) will be made available to GRMA. FPMD will help to institutionalize effective management, quality assurance and sustainability principles which serve as a foundation for organizational development processes of family planning organizations.

■ Planned Parenthood Association of Ghana

In the course of developing the population sector strategy, several gaps in service delivery were identified that would benefit from additional resources. In addition to rural areas, which can be addressed through CBD programs, other special populations or target groups for attention in GHANAPA include adolescents and males. PPAG has recently completed a strategic plan covering 1995-2000 which calls for the expansion of delivery of short-term methods particularly through its CBD program, a focus on adolescents and males, and an increase in the delivery of long-term methods through its family planning clinics.

PPAG will be given a grant by USAID to expand delivery of short-term methods through three specific areas: CBD, services for adolescents, and special attention to the role of males in family planning. IEC activities directed towards these populations were addressed in the Demand Generation section above.

Community Based Distribution: PPAG currently has 815 CBD agents, 82 supervisors and 60 trainers. With support from GHANAPA, PPAG will increase the number of agents to 1,200 by 1997, and the number of supervisors to 120. Activities will include: initial training of 385 new CBD agents, 38 new supervisors and continuing education for all 1,200 CBD agents throughout the life of the project.

Adolescents: The need for more accessible information and services for adolescents will be addressed in GHANAPA primarily through support to PPAG. Currently, PPAG operates a Family Life Education (FLE) Project in five regions: Greater Accra, Eastern, Ashanti, Central and Western. FLE Clubs and four youth centers (in Accra, Akropong, Cape Coast and Kumasi) have been established to provide a forum for both in-school and out-of-school youth for information and discussion about adolescent reproductive and sexual health related issues. GHANAPA support to PPAG will include the following:

- Upgrading the four existing youth centers to enable them to provide adequate and quality family planning services;

- Establishing four new centers in Takoradi, Sunyani, Tamale and Ho that will provide the full range of IEC, counselling and family planning services for adolescents;

- Conducting 2 baseline KAP studies (one in each group of four regions) of in-school and out-of-school youths to investigate the socio-cultural factors affecting reproductive and sexual health;

- Providing group counselling sessions;

- Conducting home visits to recruit new family planning acceptors among the adolescents;

- Maintaining adequate backup and referral systems between the adolescent centers and PPAG clinics.

Male Involvement: Working in the seven regions where PPAG has a presence, the organization proposes to undertake activities to improve knowledge about contraception and to increase the use of modern family planning methods among men in those regions. Support under GHANAPA will cover the following activities:

- Conducting a KAP study among the Daddies Clubs, Industrial centers, and functional literacy groups before the introduction of project activities;

- Strengthening Daddies Clubs in three regions, and forming new clubs in the other four regions, so that there will be three clubs in each region by 1997;

- Pilot studies of factory-based family planning service delivery in four industrial centers in each region (in addition to employee-based programs sponsored by GSMF);

- Conducting a workshop on family planning for 10 facilitators in each of six regions who are affiliated with functional literacy groups for males. These facilitators will then form the link between PPAG and their own groups, and will also provide family planning services to their members.

- Conducting a five-day training workshop for Hotel Managers (5 for each of 7 regions) to enable PPAG to provide nonprescriptive methods through these hotels;

- Carrying out a pre/post test assessment of knowledge and attitudes of participants in the seminars and workshops;

- Maintaining an adequate backup and referral system between these activities and PPAG's clinics.

In carrying out these activities to expand service delivery, it is anticipated that the majority of the required contraceptives commodities will be obtained by PPAG directly from International Planned Parenthood Federation (IPPF). However, as needed, GHANAPA will provide commodities to PPAG through the GSMF, thereby assuring PPAG of a constant supply of

short-term methods, and further increasing the commercial distribution of short-term commodities.

USAID will provide a $1.5 million grant to PPAG to undertake the above activities and to cover personnel, equipment, vehicles, rent, and local and external technical assistance in program management, operations research, financial and strategic planning, and logistics management. It is expected that some of the technical assistance would be provided as direct support from IPPF/London to the affiliate. Up to ten (10) person months of short-term demand-driven technical assistance from the centrally-funded FPLM project will be made available for commodity forecasting and management. Additionally, up to seven (7) person months of operations research assistance from the Population Council's Operations Research Technical Assistance Project will also be made available. The estimated cost of 17 months of technical assistance is $425,000, bringing the total package to PPAG to $1.925 million.

(ii) ***Clinical (Long-term) Methods:***

Service delivery capacity for long term methods remains the most significant constraint to shifting the method mix. GHANAPA requires increasing the current number of users of long-term methods from 48,000 in 1993 to approximately 236,000 by the year 2000. The public sector currently provides 85 percent of the long term methods and has the largest number of facilities compared to the private sector. In order to achieve the shift in method mix with more emphasis on long-term methods, GSMF will expand and diversify its product line to include Depo Provera and IUDs (and possibly NORPLANT®) and the number of trained providers and facilities will also be increased. As service delivery sites for clinical methods expand, there will be a need to ensure that high standards of quality are maintained. Through a cooperative agreement with AVSC and centrally-funded technical assistance from Johns Hopkins Program in International Education in Reproductive Health (JHPIEGO), quality of care will be addressed by oversight of clinical practice sites to ensure infection control, medical monitoring and supervision, and management information.

- Increased Training

Training providers in the delivery of long-term methods (IUDs, implants and VSCs) requires classroom and practical experiences in appropriate training sites to ensure that correct clinical procedures are followed. Pre-service training for health professional students and in-service training for health professionals will be provided under GHANAPA. Pre-service training is the responsibility of the MOH's HRDD and in-service training is handled by MCH/FP. Both divisions collaborate in developing and revising curricula for the various courses. The MOH budget will also support the expansion from 5 to 10 new regional MOH training centers for long-term family planning service delivery.

In addition to GOG supported training activities, the Association for Voluntary Surgical Contraception (AVSC) will be a major player in the expansion of training and delivery sites for long-term methods in both the public and private sectors. AVSC is a U.S. non-profit

organization and recognized world leader in the field of clinical family planning service provision, particularly with respect to voluntary sterilization services. AVSC will support the MOH in designing and conducting training programs. Approximately $4 million will be provided to AVSC from two USAID sources to support these efforts. The Mission will award a cooperative agreement totalling $3 million to primarily support the AVSC Ghana office, training, technical assistance for clinical facilities expansion and other capital and recurrent costs. The centrally-funded AVSC project will make available up to $1 million for ancillary technical assistance from the home office.

Under FPHP, JHPIEGO assisted the MOH in establishing the majority of IUD service delivery capability in Ghana. In order to maintain the quality of training and care for IUD insertions, JHPIEGO will assist AVSC and the MOH in developing an overall standardized training system which includes reviews of protocols and training materials, development of training strategies at the regional level, and ensuring quality of care. Up to sixty (60) person months (estimated at $1.5 million) of demand-driven technical assistance from the centrally-funded JHPIEGO project will be made available to support these activities.

In consultation with MOH, the following training will be conducted either through the GOG budget, the AVSC cooperative agreement or JHPIEGO technical assistance:

- pre-service training in IUD insertion for 200 midwifery students;
- training for clinical supervisors at the IUD practicum sites to ensure standardization of practice and quality assurance.
- training in IUD insertion for 160 nurse-midwives and doctors per year (including 20 private midwives each year);
- clinical training for 340 physician/nurse teams in the public and private sector in performing mini-lap (VSC) under local anesthesia. A total of 39,000 mini-laps are anticipated during the project period.
- clinical training of approximately 110 nurse midwives and 20 doctors in post-partum IUD insertion, half of whom will be in private sector.
- training in subdermal implant insertion and removal for 40 doctors and 200 nurse midwives. Approximately 13,000 women will receive implant services.

Expansion of Service Delivery Sites

Service delivery site expansion is a critical element for training and performance of actual procedures. There are currently 15 sites for VSC procedures in Ghana. Since VSC sites have special requirements and can be used for other clinical procedures as well, GHANAPA, through the AVSC cooperative agreement, will bring the total number of VSC sites to 115

including 31 private facilities and 7 PPAG clinical sites. AVSC will provide technical assistance, equipment, and supervision for renovating or rehabilitating the sites and training in actual clinical procedures. The GOG budget will finance the construction materials, labor, architectural and engineering contracts and maintenance of the sites.

In addition to the 10 regional MOH training sites for clinical methods, the GRMA will establish three sites for IUD clinical training. This will allow the organization to raise the number of training slots available to their members from the current level of 20 per year to 54 per year starting in year three of the Project. In consultation with the MOH, AVSC and JPHIEGO will assist GRMA to oversee infection control, medical monitoring and supervision. By the year 2000 approximately 200 private midwives will have completed supervised clinical experience in IUD insertion at the new sites. The sites will be located at maternity homes with high IUD insertion rates in the Southern, Mid and Upper belts of the country. The MOH has agreed to accept additional private midwives into the didactic training sessions, if these sites are established and meet their training standards. They will also provide preceptors for the practical training.

Summary of USAID Assistance: Expanded Provision of Family Planning Services

In summary, to ensure the expansion of service delivery, USAID/Washington will make available up to $5.35 million in technical assistance from centrally-funded projects. The GHANAPA project will provide $10 million in contraceptive commodities, $8,500,000 in grants and cooperative agreements, $505,000 for short-term training, study tours and conferences/seminars, and $650,000 in equipment such as mini-lap kits, IUD kits, computers and printers, bringing the total project contribution to $25,055,000.

d. Greater Sustainability

Financial and technical sustainability are critical to the success of the family planning program in Ghana. The two basic principles set forth in GHANAPA which will achieve greater financial sustainability are a shift to long-term, more effective methods of contraception and a greater role for the private sector in the delivery of family planning services. GHANAPA will support the establishment of a $5 million endowment for the GSMF to cover operational costs and commodity procurement over time, and a $500,000 endowed chair for the Center for Population and Development at the University of Ghana/Legon to promote population policy development and research. The endowment grants will be made to a U.S. based non-governmental organization as required by USAID Washington regulations, separate from the bilateral grant agreement.

Technical sustainability will be achieved through the grants to GSMF, GRMA and PPAG described above which will provide technical assistance in strategic planning, management training, financial planning and management, commodities marketing/advertising/packaging and warehousing, and contraceptive logistics management.

The estimated cost of this element is $5.5 million (exclusive of the GOG's conditionality requirement).

3. Project Outputs and End of Project Status

Discrete project outputs for each element of the program are outlined in the log frame matrix in Annex B. The end of project status indicators will quantify progress related to the overall goal and purpose of the family planning component. The following indicators will be used to measure the success of the program:

* Reduce TFR from **5.5 to 5.0**
* Increase CPR for modern contraceptive use among women in union from 10% to 20%.
* Increase percent of CPR derived from longer lasting methods from 20% to 40%.
* Increased percent of total demand satisfied for all contraceptive methods rises from 26.4 percent to 50 percent[7].
* Increased public sector cost recovery for contraceptives rises from 5 percent to 15 percent[8].

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[7] 1993 Consumer Baseline Survey, Futures Group

[8] Republic of Ghana, Ministry of Health Maternal and Child Health/Family Planning Division 1992 Annual Report.

III. ANALYTICAL FRAMEWORK - HIV/AIDS/STD PREVENTION AND CONTROL COMPONENT

A. Background

Unlike other communicable diseases, AIDS most affects young adults between the ages of 14 and 45. AIDS is already the leading cause of adult death in a number of African cities causing social, economic and political disruption. The economic impact is noted in the World Development Report (1993)[9]: " ...AIDS will cause a slowing of growth of income per capita by an average 0.6 percentage points per year in the ten worst-affected countries in sub-Saharan Africa."

Since the first AIDS cases in Ghana were confirmed in 1986, the Ghanaian government has been candid in reporting on the HIV/AIDS epidemic. Although the HIV epidemiological surveillance system will not be fully functioning until late 1994, the limited data generated indicate that HIV prevalence in Ghana is low compared to other African countries. HIV seroprevalence data based on blood samples from four pilot sentinel sites indicates that the 1992 HIV rate among the general population was between two and four percent. By contrast, the Cote d'Ivoire HIV prevalence was this rate five years ago but is now estimated at 10 percent. However, it is clear that the HIV/AIDS pre-epidemic phase is completed and that a sharp increase in HIV incidence should be expected in the next five to six years. To slow the rise in the prevalence rate of HIV infection in Ghana, focused and quick action needs to be taken to change sexually risky behavior and treat STDs which can put an individual at increased risk (two to nine fold) of contracting HIV/AIDS.

In the first years of the epidemic, many cases in Ghana were imported from neighboring countries, especially by commercial sex workers returning to their villages after becoming infected in the cities of the Cote d'Ivoire. Women accounted for 70 percent of the cumulative cases, and more people were affected in the semiurban and rural areas than in the urban core. The Ashanti and Eastern regions accounted for the highest proportion of reported AIDS cases in 1992, with estimated incidence rates of 22 and 14 per 100,000 respectively. Another study reported 18 percent HIV seropositive in women in an Eastern region village due to a large number of women who had recently returned after becoming ill. Greater Accra and Brong Ahafo follow these two regions in the proportion of reported AIDS cases. With the increase of transmission within Ghana, the national epidemiological pattern is shifting to the urban areas and to a more equal male/female ratio. However, women continue to be disproportionately affected by the AIDS disease. As of September 1993, women accounted for 70 percent of the reported cumulative AIDS cases. According to the National AIDS Control Program (NACP), as of December 31, 1993, a total of 12,303 AIDS cases had been diagnosed, but this is believed to be a major underestimation of AIDS cases in Ghana.

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[9]World Development Report 1993, Investing in Health, The World Bank, Oxford University Press.

In recognition of the compelling data from other African countries and the opportunity to limit the spread of HIV/AIDS while the rates are comparatively low, the Government of Ghana established the NACP in 1988 and finalized the Medium-Term Plan for HIV/AIDS the following year. The objectives of the medium-term plan include:

- determining the extent and pattern of HIV infection.
- providing information to the public concerning the epidemic and promoting condom use for prevention.
- developing a national program for the control of sexually transmitted diseases (STDs) which are a cofactor for infection with HIV.
- providing adequate clinical management and social support to affected individuals.
- providing adequate laboratory services for the diagnosis of HIV infection.
- ensuring safety of blood transfusions.
- establishing a monitoring and evaluation system for the AIDS prevention and control program.

The MOH's NACP coordinates the HIV/AIDS control activities of the MOH and other government ministries and NGOs. The Health Education Unit (HEU) of the MOH is conducting AIDS awareness campaigns in coordination with the Ministry of Information and Ministry of Education. The Public Health Laboratory Program and Epidemiology Division are developing a HIV and STD sero-surveillance system. The STD control program operates two STD clinics in major urban areas and the National Blood Bank program screens for HIV in the blood supply.

According to the NACP, approximately 80 percent of MOH non-personnel expenditures for AIDS/STD control activities are funded by external donors, including WHO/UNDP, EEC, the Dutch, German and British governments, with USAID being the largest contributor through the FPHP NPA. The remainder of these expenditures are covered by the MOH. The MOH projects a total 1994 recurrent and capital budget of $6.7 million for AIDS/STD control. Of this amount, $4.9 million represents donor financing, and the remaining $1.8 million, MOH expenditures. USAID provides $4 million, roughly 91 percent of total donor resources in AIDS/STD control; that figure includes approximately $3 million in capital expenditures and technical assistance for the laboratories. Total recurrent AIDS/STD expenditures for 1994 are estimated at $3.7 million. This level is expected to increase slightly over the next few years.

USAID assistance to Ghana's AIDS Control Program began with $1.3 million for discrete prevention activities (1988-1991) through buy-ins to the AIDSCOM and AIDSTECH projects. In recognition of the potential negative effects of the epidemic on Ghana's economic development, HIV/AIDS control was included as a target of opportunity in the 1992-1996 Country Program Strategic Plan. The FPHP was amended August 19, 1991 to add $5 million for an AIDS control component. Many interventions required for HIV/AIDS control could be built upon those already being provided in the population sector, such as social marketing of condoms, IE&C activities, message development workshops, and training of health providers.

The purpose of the FPHP AIDS component is to increase the effectiveness of HIV/AIDS prevention and control efforts through expanded activities in IEC, laboratory services and health information systems.

The FPHP has provided a resident advisor and funding for IEC campaigns with the MOH and in the private sector, which have successfully raised the awareness of Ghanaians to the AIDS problem. IEC activities are being conducted by the Health Education Unit of the MOH and the GSMF. Under FPHP fifteen NGOs will receive training and promotion materials in order to incorporate AIDS control activities into their ongoing programs. The GSMF has distributed low cost condoms throughout the country through pharmacies, chemical sellers and community based distributors, resulting in a twenty fold increase in the use of condoms.

The FPHP has provided a resident laboratory technical advisor for the development of a public health laboratory system and the construction of a system of four Public Health Reference Laboratories (PHRL). The advisor is also training public and private laboratory technicians in HIV testing techniques and general laboratory management skills. A serosurveillance system for determining prevalence rates of HIV and syphilis is also being developed with FPHP assistance and should be functioning in 1994. (Further discussion under Sero-surveillance System.)

The FPHP has conducted several studies concerning HIV/AIDS in Ghana. These surveys provide considerable information on Knowledge, Attitudes and Practices (KAP) of Ghanaians concerning AIDS. The results of those surveys, which are discussed in technical analysis (Annex F) indicate that, although there is general awareness in the general population concerning AIDS, more effort needs to be placed on getting Ghanaians to see themselves as personally at risk to encourage behavior change.

A high potential exists for rapid expansion of the AIDS epidemic through heterosexual transmission since the presence of sexually transmitted diseases increase susceptibility to and infectiousness of HIV two to nine fold. Although the private sector is treating more STDs than the public sector, almost all support to STD prevention and control has been to the public sector. Theoretically all MOH health facilities are capable of managing STD's, but most Ghanaians go to pharmacists or private sector providers for treatment.

The preliminary results of a recent facility-based survey of private sector sexually transmitted disease diagnosis and treatment suggest that STDs are common in Ghana. In the practices of private doctors, midwives and in mission hospitals, patients with possible STD's accounted for over four percent of all outpatient visits. This contrasts with less than one percent of all outpatient visits in the public health centers.

The Christian Health Association of Ghana (CHAG) mission hospitals saw the most patients (98 patients per hospital in four weeks) followed by doctors (23 patients per practice in four weeks) and midwives (10 patients per practice in four weeks). Drug vendors (Pharmacists and Chemical Sellers) also see substantial numbers of patients with possible STD's.

Based on these data, it is estimated that a minimum of 400,000 STD cases are treated in the private and private health facilities annually. This represents an estimated incidence of about 2000 cases per 100,000 population. However, it is generally believed that many STD cases go unreported because the majority are treated in the private sector (e.g. pharmacists and chemical sellers) where there are no case records. Thus, the incidence of STDs is probably much higher that 2000 cases per 100,000.

Only thirty-four percent of all potential STD clients had seen a health care provider before coming to the drug vendor, suggesting that two-thirds of possible STD cases were seeking primary STD care from the drug vendors.

The AIDS component under FPHP successfully targeted messages to the general population to raise awareness of AIDS. The NACP must build on the successes of FPHP in promoting AIDS awareness and developing a means to track the epidemic. The NACP will have to shift its focus to prevention of transmission of HIV by reducing high-risk sexual behavior, treatment of STDs and continuation of an effective surveillance system to track the epidemic.

B. Sector Constraints

Individuals who have many sexual partners are both more likely to acquire HIV and transmit it to others. Computer models[10] [11] have shown that: (1) HIV infection through contaminated blood, although tragic, is not a major factor in the epidemic; (2) casual sexual partnerships may give rise to a self-sustaining epidemic, but spread will be slow; (3) groups with high-risk behaviors will greatly accelerate the spread of HIV infection throughout the remainder of society; and (4) a reduction of high-risk behaviors not only protects the lives of the individuals involved in those behaviors but has the potential to slow significantly the spread of the epidemic throughout society. The issues surround not only education concerning behavior change but the appropriate political environment in which to initiate new programs

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[10]Auvert B, Moore M, Bertrand WE, et al.: Dynamics of HIV infection and AIDS in a central African city. International Journal of Epidemiology, 1991.

[11]Anderson RM, May RM: Epidemiological parameters of HIV transmission. Nature 333:514-519, 1988.

and replicate successful ones.[12] The presence of other STDs has recently been shown to greatly increase the likelihood of heterosexual transmission of HIV.

To slow the HIV prevalence rate, greater emphasis must be placed on decreasing sexually risky behavior by using condoms, reducing the number of sexual partners and treatment for STDs. Constraints to encouraging less risky sexual behavior and treatment for STDs consist of the following:

1. **Policy Analysis:** The unpredictable nature of long term donor support, dependency on external donors and inadequate public sector resource allocation result in public sector AIDS and STD control activities which are both insufficient and unsustainable; and exclusion of certain STD treatment pharmaceuticals from the Essential Drugs List limits their overall availability.

2. **Sexual Behavior Analysis:** Misconceptions concerning HIV transmission, and belief that they are not at personal risk of contracting AIDS constrain individuals' willingness to make required behavior changes to prevent HIV and STD infection.

3. **Sexually Transmitted Disease Analysis:** Lack of knowledge of adequate STD diagnosis and treatment by many health providers, especially in the private sector; unavailability of effective drugs to treat STDs in the public sector, and their high costs constrain the ability to provide treatment; lack of perceived seriousness of STDs by the general public restricts their willingness to seek treatment.

4. **Monitoring and Surveillance:** The lack of good STD/HIV prevalence data limits the ability to plan and program resources; insufficient information on disease patterns and STD drug resistance reduces effective diagnosis and treatment; inadequate laboratory capability limits the effectiveness of clinical and public health diagnosis.

The technical analysis (Annex F) elaborates on the constraints outlined above and provides an analytical framework for developing the strategic approach of GHANAPA's HIV/AIDS/STD control component.

C. Program Strategy

There is a fair amount of worldwide experience with interventions designed for AIDS prevention. These interventions have been successful in assisting people to change their behavior and in improving community response to the epidemic. Studies have demonstrated improvement in consistent condom use from less than 10 percent to over 70 percent; decrease

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[12]Potts, M and Feldblum, PJ: Changing Behavior: Barrier Methods in High-Risk Populations in Heterosexual Transmission of AIDS, ed. Alexander, NJ, Gabelnick, HL, Spieler, JM, 1990.

in STD monthly incidence rate from 13 percent to 0.5 percent; decreases in annualized rates of HIV from 15 percent to 3 percent.[13]

Voluntary counseling and testing has been shown to induce behavior change in Rwanda and Uganda. An evaluation study conducted in Uganda by CDC at the AIDS Information Center, showed that the program was able to induce positive behavior change among seropositive and seronegative clients i.e. reduction in sexual partners and increased condom use.

The most effective communication programs have been those with peer education activities, wherein special attention is paid to the selection and training of the counselors. Successful mass media campaigns have been ones in which entertainment is used and in which there is incorporation of AIDS messages into "normal life."

The policy of USAID/Washington on HIV/AIDS emphasizes the need to develop a multi-sectoral approach to HIV/AIDS prevention and control. Because substantial resources are required for AIDS prevention and control, USAID's policy stresses investment in interventions considered to be most cost effective. Decreasing the sexual transmission of HIV remains the cornerstone of the Agency's program by concentrating on the following combined interventions:

- policy dialogue with host country decision makers;
- promoting safe sexual behavior through information, education and communication;
- increasing the demand for, access to and use of condoms; and
- controlling STDs through improving the provision of STD diagnosis and treatment services.

In line with international experience and USAID/Washington policy, GHANAPA will build on the FPHP momentum in raising HIV/AIDS awareness, fostering appropriate linkages between the family planning and AIDS prevention and control components, and supporting the laboratory network to monitor the epidemiological progression of AIDS. GHANAPA will add major elements of changing risky sexual behaviors and controlling STDs in order to actually affect the course of the disease in this next phase.

Because other donors are supporting the National Blood Transfusion Service's protection of the blood supply in Ghana, (the Dutch Government is providing $230,000 through WHO, and the European Union $98,000 for laboratory reagents and supplies in 1994, and the African

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[13]Gary Slutkin, Effective Interventions for Prevention: Key Elements of Success, World Health Organization Global Program on AIDS, 1993.

Development Bank is negotiating further support), GHANAPA has not been asked to provide further assistance in this area.

The program will support STD and HIV/AIDS prevention and control activities nationwide, while encouraging emphasis in the four regions which are currently the most affected and are not receiving significant support from other donors: Eastern, Ashanti, Brong Ahafo and Greater Accra.

D. PROGRAM DESCRIPTION - HIV/AIDS/STDS COMPONENT

1. Program Goal and Purpose:

The **goal** of the GHANAPA AIDS component is to help reduce the rate of increase of HIV prevalence in Ghana by the end of the program by maintaining the average annual rate of HIV incidence at no more than 1 percent among the adult population during the next six years. For the purpose of establishing program targets, it is assumed that the current HIV prevalence is 3.36 percent in 1994. Progress toward the goal will be measured through the sero-surveillance system which will begin in late 1994 for baseline data, and thereafter will provide accurate information on the progression of the epidemic each year.

The **purpose** of the AIDS component is to increase awareness and practice of risk reduction behaviors. This will be measured by increasing the proportion of respondents who report using a condom during the most recent act of sexual intercourse with a non-regular partner to 50% and increasing the proportion of people citing at least two acceptable ways to prevent HIV infection from 61 percent to 75 percent. The baseline for condom use will be established in the 1995 Consumer Survey. The baseline for knowledge about HIV prevention was established by the 1993 Consumer Baseline Survey. Progress will be monitored through the consumer surveys planned for 1995, 1997 and 1999.

The HIV/AIDS/STD component of GHANAPA will consist of the following elements: (1) improved policy environment; (2) promotion of safe sexual behavior; (3) better diagnosis and treatment of sexually transmitted diseases; and (4) improved HIV/STD laboratory and surveillance systems. Most of the support will be provided to the NACP through the GOG budget tied to NPA conditionality, complimented by specific project funded technical assistance, condoms, and other inputs. STD programs in CHAG institutions will also receive funding given GHANAPA's strategy of supporting non-governmental organizations and the fact that Ghanaian's choose to use CHAG facilities for STD treatment.

2. Program Elements:

a. Improved Policy Environment

To address weaknesses in the policy environment with regards to HIV/AIDS/STD Control, the project will focus on increasing public sector resource allocations to HIV/AIDS/STD Control

activities, expanding the Essential Drugs List and National Formulary, and accrediting Public and Private Laboratories.

(i) Public sector resource allocation to HIV/AIDS/STD programs

GHANAPA will assist the MOH to address the resource allocation issues by enabling the GOG to increase and sustain the budgetary allocation to MOH. NPA will be provided to the GOG conditioned on the availability and expenditure of non-personnel recurrent expense funds by the MOH. As discussed in the family planning section, GHANAPA conditionality will require the GOG to fund the MOH non-personnel recurrent cost budget at 16% of the GOG total non-personnel recurrent budget. This will ensure that sufficient budget allocations are available to implement the national HIV/AIDS program at all levels of the system. The MOH will provide the resources required by the NACP Program Management Unit to prepare policy, plan programs and coordinate the national effort. The GOG will insure that HIV/AIDS/STD control activities are prioritized in budget guidelines issued to regional and district level planners. The MOH will further analyze the effects of decentralization on the HIV/AIDS/STD control program and disseminate information to policy makers, opinion leaders and representatives from other ministries, NGOs and the commercial sector through four regional workshops in each year of the project.

In view of the NACP's limited staff and MOH's need for additional expertise in HIV/AIDS , short-term local technical assistance will be funded by the MOH to assist the Program Management Unit of the NACP and the regional and district AIDS committees to plan and conduct program planning, coordination and policy development activities such as the following:

- collaborative program planning, development and coordination among the relevant divisions of the MOH, regions, districts, NGOs, selected Ministries and the private sector;
- development of a strategy for educating policy makers and community leaders about critical AIDS issues and their relevance for Ghana;
- adaptation, with the assistance of PIP, of generic AIDS simulation models to Ghanaian conditions and development of presentations for key policy makers and opinion leaders;
- development of clear-cut policies on HIV/AIDS related counseling and testing, rights and responsibilities of seropositive and AIDS patients, guidelines and algorithms on STD diagnosis and treatments etc.;
- development of a strategic framework and analytical agenda for research, analysis and information dissemination on HIV/AIDS and STDs; and

- completion of studies on HIV/AIDS/STD legislation and policies including: testing and counseling; advocacy for people living with HIV/AIDS; program management and coordination; intersectoral collaboration.

(ii) *Essential Drugs List and National Formulary (EDLNF):*

Another important problem which will require policy direction is the absence of effective STD treatment drugs on the Essential Drugs List (EDL) and National Formulary (NF). The EDL is the approved list of drugs which can be purchased by the MOH Central Medical Stores for public sector pharmacies. The NF provides treatment guidance for all MOH physicians and paramedical workers, and can only recommend pharmaceuticals which are included on the EDL. The EDL and NF are published together in one volume which is used as a reference book for practicing providers, pharmacists and in training institutions. Therefore, the absence of appropriate STD treatment drugs in the EDL significantly reduces the opportunity for patients to receive effective treatment.

Currently, there is a general agreement on the urgent need to revise the EDLNF taking into account recent data on STD drug resistant patterns in Ghana and in the region. Of particular importance are drugs that are effective against penicillin resistant gonorrhea, gonorrhea in pregnant women, chlamydia in non-pregnant women as well as syphilis in men and gonococcal ophthalmia in neonates.

The NACP is currently recommending that the following drugs be included in the EDLNF: Ceftriaxone, Ciprofloxacin, and Cefixime. Other drugs such as doxycycline, clotrimazole and kanamycin are also being discussed among experts. Since an important policy objective of GHANAPA is to make effective STD treatment available, the MOH will be required through Non-Project Assistance conditionality to:

- Prepare a plan of action to revise the EDL to include additional effective STD drugs for the first tranche;

- Revise the EDL to include additional effective STD drugs and include the NACP recommended treatment guidelines in the NF, develop a program of action for training in the use of the NF, and produce and distribute 2500 copies of the combined EDLNF in the public health facilities in Ghana for the second tranche.

The inclusion of effective STD drugs in the EDLNF should increase their availability and affordability for patients seeking care in the public sector, since the Central Medical Store purchases only drugs listed in the EDLNF.

CHAG institutions, which see the largest number of STD patients in Ghana, will also benefit from this action since they are permitted to buy drugs from the MOH medical stores. Patients seeking care in the private sector should also receive more effective treatment as a result of the change in the national treatment guidelines.

Under GHANAPA conditionality, the MOH will revise and disseminate STD treatment guidelines to the public and private sector and train health providers in the updated treatment protocol. In this regard, project funds will be allocated under the family planning component for the production and distribution of 4000 copies of the EDLNF and to train health care providers in the **private sector**.

The GOG will also finance a study to be commissioned by the MOH on the availability and use of the newly introduced STD drugs in the public and private sector and their effect on the Central Medical Store budget and the private sector STD drug market. GHANAPA will encourage other donors to assist the MOH in the procurement of the STD drugs. Extensive training and education of the health providers will be conducted to limit the misuse of these drugs.

The GHANAPA project will fund $100,000 in short-term training and study tours and $40,000 for two studies on socio-economic impact of AIDS, bringing the project total to $140,000. Up to twenty (20) person months of demand-driven technical assistance (estimated $500,000) will be made available through the centrally-funded Family Planning Management Development Project to support policy activities.

b. ***Promotion of Safe Sexual Behavior***

Misconceptions concerning HIV transmission, and perceptions concerning personal risks of contracting HIV remain constraints to reducing individual risk prevention through behavior change. The major focus of GHANAPA's HIV/AIDS/STD component will be to promote safer sexual behavior in order to reduce the spread of the epidemic.

The MOH and the private sector will use the following information, education and communication (IEC) strategies to reduce the number of sexual partners, promote proper and consistent use of condoms and to seek treatment for STDs.

(i) *IEC Campaigns*

The NACP will assist the HEU of the MOH to plan and design coordinated IEC campaigns on FP and AIDS/STD prevention and control. After consultation with the Regional and District AIDS committee and, in collaboration with the HEU, the NACPs program management unit will organize an annual planning and consultation workshop. The purpose of the meeting is to prepare and budget an integrated plan and guidelines for national and regional IEC campaigns.

The HEU will include and refine the following message themes: HIV and its transmission routes, individual vulnerability to HIV, the need for behavior change to reduce exposure, proper condom use, and to provide care and support to HIV positive individuals and AIDS patients and the importance of seeking treatment for STDs.

In collaboration with the Ministry of Information (MOI) and GSMF, the HEU will manage a coordinated family planning and AIDS/STD annual nationwide awareness mass media campaign. This will involve the development and placement of educational radio and TV spots and articles in the newspapers.

The NACP and HEU in collaboration with the Ministry of Education (MAE) School Health Unit and Curriculum Development Unit will develop AIDS and STD educational programs in Junior and Senior Secondary Schools to supplement the UNFPA sponsored Family Life Education programs. The MAE and HEU will develop an action plan for the development of the curricula and training materials and guidelines for the students and teachers. Technical Assistance to support HEU activities will be provided by the centrally funded Population Communications Services Project budgeted under the family planning component.

The Regional and District AIDS Committees (RDAC) will work with the Regional and District Health Management Teams to plan coordinated campaigns on FP and AIDS/STD, taking into account the specific IEC related AIDS and STD needs at the regional and district level. An annual budgeted detailed regional and district IEC implementation plan will be developed/updated.

The Regional and District Health Campaigns committees will manage regional and district IEC community-based campaigns, supported by regional and district educational radio programs and messages in local language, as available. Community based interventions will be conducted through outreach activities by health care providers of the MOH, community health educators such as traditional leaders (Chiefs and Queen Mothers), teachers, assembly men and women, church leaders, community development officers, peer groups and NGOs.

Target audience segmentation will be included as additional behavioral and HIV/AIDS and STD epidemiological data become available. Up to twelve person months (estimated at $300,000) of demand-driven technical assistance will be made available through the centrally-funded PCS project to help the NACP and HEU develop the AIDS and STD related IEC strategy.

(ii) *Training*

Since April 1991, the UNDP has supported the NACP efforts to strengthen the psycho-social counseling skills of health care providers. This effort has resulted in the establishment of health facility based counseling units in each of the ten regions, 50 counselor trainers, 400 counselors placed throughout the regions, a manual for training counselors, a manual on infection control for health workers and clinical management guidelines for AIDS patients. Despite this effort, the 1993 Situation Analysis reported that 44 percent of health care providers would not provide information and counseling on AIDS to family planning clients.

Building on its proven experience in IEC/counseling training and in consultation with the Regional and District AIDS Committees (RDAC) and the Regional Training units, the NACP

PMU will organize an annual planning and consultation workshop with HEU and Human Resources Development Directorate to plan, budget and integrate the specific IEC training needs of the NACP with the counselling in HEU's annual work plan.

NACP will assist the HEU of the MOH in the development and update of training materials including:

- customized AIDS and STD IEC training materials for health care providers in the private and public sector and;

- training modules on AIDS and STD counseling for health care providers, community groups and NGOs.

The Regional and District AIDS committees (RDAC) will work with the Regional and District Health Campaign Committees in planning and budgeting for AIDS/STD training needs of the health care providers in the public sector. The training manuals and guides developed by the HEU and NACP will be available for use by the regions and districts.

Up to four person months (estimated at $100,000) of technical Assistance will be made available to support NACP and HEU in specific AIDS and STD strategic planning and material development through the centrally-funded PCS Project.

(iii) *Increased Access and Commodity Distribution in the Private Sector*

An important part of the behavior change interventions supported under GHANAPA will be the promotion of correct condom use which has begun under FPHP. Since the 1988 DHS in Ghana there has been a dramatic increase of condom use among married women increasing from 0.3 percent in 1988 to 5.9 percent in 1993. Nearly 20 percent of men report current use of condoms. The GSMF has used social marketing techniques of promotion and distribution to double its total sales of condoms in recent years; approximately 8.9 million condoms were sold in Ghana in 1993, up from 4.0 million in 1992.

Condoms will be made available through the GSMF and the MOH in sufficient quantities to meet the expected growing demand. A total of 85.5 million condoms will be provided by GHANAPA for both family planning and AIDS/STD control. The value of these condoms provided for the HIV/AIDS/HIV control is approximately $1 million (roughly 20 million condoms). The condom social marketing activities will target all sexually active populations for family planning and AIDS/STD prevention. Individuals practicing high risk behaviors involving multiple partners will also be targeted.

GSMF's plan for promoting and advertising condoms will be based on the established targets, result of prior and new surveys, as well as marketing and sales objectives. Promotional messages will include specific brand advertising with emphasis on the correct use of condoms.

In addition to commercial outlets, GSMF will continue to work to expand social marketing of condoms through linkages with the GRMA, 12 local NGOs and 5 companies and through closer ties with private medical practitioners. NGOs can play an important role in creating a supportive environment for the use of family planning and AIDS/STD prevention by providing a forum for reaching women and men to increase knowledge about methods and encouraging them to try various contraceptives. The capacity of the selected NGOs and companies to provide formal and informal training will be strengthened and that a cadre of AIDS resource persons will be available at the community level by the end of FPHP.

GSMF will continue to include updated AIDS/STD education in its regular training package and will organize one-day training sessions on AIDS and STDs for the 5000 pharmacists and chemical sellers.

About 250,000 leaflets and 10,000 posters on STDs will be provided to the pharmacists and chemical sellers for the information of the STDs patients by the GSMF. GSMF will receive technical assistance for the development of the training materials through the centrally funded SOMARC project as budgeted in the family planning component.

PPAG, GRMA and CHAG will also participate in efforts to promote safer sexual behavior. The NGOs will use their grant funds to purchase promotional materials developed by the HEU. This will include posters, brochures, pamphlets and video and radio cassettes, and complement the public sector IEC activities.

Summary of USAID Assistance: Behavior Change

In summary, the GHANAPA project will provide $1 million for condoms, $130,000 for IEC study tours and $20,000 for audio visual equipment. USAID/Washington will make available up to $400,000 in technical assistance for behavior change.

c. ***Increased Diagnosis and Effective Treatment of Sexually Transmitted Diseases***

STD control can be divided into prevention and treatment efforts. GHANAPA will encourage all family planning services to provide STD prevention services to their mostly female clients, in the form of counseling and condom promotion for those considered at high risk. GHANAPA will support improved STD treatment in all MOH and CHAG health facilities through training. GRMA, private practitioners, pharmacists and chemical sellers will also receive training in order to provide better treatment for people with STDs.

(i) *Public Sector Training*

The NACP in collaboration with the training unit of the MOH and private organizations such as CHAG, GRMA and PPAG will build on its proven experience with STD control and develop a customized training program including training materials on the proper prevention, diagnosis and treatment of STDs for the various categories of health care providers. The

training program will be designed and updated every year taking into account the training requirements and peculiarities of the various target groups and organizations.

The MOH, from its own resources, will organize training for health providers and a system of continuing education on STDs in the public sector. The NACP will organize the training of trainers for CHAG, GRMA, and PPAG by training a total of 25 trainers for these organizations.

(ii) *Private Sector Training*

In the private sector, it is envisioned that each organization will be responsible for training its health providers, building on its trained trainers and using the training manuals developed by the NACP.

- Christian Health Association of Ghana (CHAG)

The Christian Health Association of Ghana (CHAG) maintains 107 mission hospitals throughout Ghana and treats more STD patients per facility than any other type of facility. CHAG institutions are subvented, with the MOH budget providing salaries for CHAG personnel but currently making no provision for other recurrent expenses. Other non-personnel recurrent costs are covered by CHAG.

Because STD diagnosis and treatment is an essential element of HIV/AIDS prevention and CHAG institutions have such a high STD patient load, NPA conditionality will require the GOG to provide direct funding for CHAG non-personnel program activities in order to strengthen and support the CHAG health institutions that wish to participate in STD clinical management and counseling. The CHAG secretariat is an established and well known body which facilitates and coordinates the purchasing of drugs and coordinates training for its associated Mission hospitals and clinics. The MOH has established strong linkages with CHAG, whose facilities function as District Hospitals in some districts.

Under GHANAPA, the MOH will assist CHAG to improve STD services by providing resources for program activities and training programs. With the financial assistance provided by the GOG through GHANAPA NPA, CHAG will organize the formal and informal training of 120 medical officers and 1055 professional and 2140 non- professional nursing personnel, as appropriate. It is anticipated that an average of 2 five-day training workshops for the medical officers and 4 five-day workshops for the medical assistants will be organized on STD care annually.

Specific training on counseling and partner notification will be conducted for an average of four nurses in each of the 107 CHAG health facilities. GHANAPA will support two workshops for 25 professional nurses annually; and will provide training of trainers for 20 professional nursing personnel annually;

Training materials and equipment such as overhead projectors, flip chart easels and color video monitor, as well as educational materials will be purchased by CHAG with GOG funds. NACP personnel and two person-month of local consultants per year from the project will assist CHAG in the supervision and monitoring of the training activities.

- Ghana Social Marketing Foundation (GSMF)

GSMF will include an update AIDS/STD education package in the training for 5000 pharmacists and chemical sellers and facilitate the training of trainers for the private practitioners as part of its grant. It will support four seminars on STDs per year and provide educational materials for the private medical and dental practitioners.

GSMF will also benefit from Project funded local and external TA provided through the HEU and NACP for the regular update of the training package. Approximately 250,000 leaflets and 10,000 posters on STD will be provided to the pharmacists and chemical sellers for the information of the STD patients.

The GSMF will collaborate with NACP and HEU to develop messages and materials for private sector pharmacists, chemical sellers and health care providers. GSMF grant funds discussed in the family planning section will be used to undertake these training activities.

- Ghana Registered Midwives' Association

GRMA will organize formal and informal training of its members using the five trainers trained by the NACP in STD care. GRMA will develop and include a training plan on STD in its on-going activities. IEC/counseling training modules and guidelines developed by HEU and NACP will also be included in the STD training. GRMA will incorporate STD training into the refresher training provided to its members. The GRMA grant discussed in the family planning section will fund these training activities.

The GHANAPA project will provide $120,000 for overseas short term training for STD program managers.

d. Improved HIV/AIDS/ STD Sero-Surveillance Systems and Laboratory Capability

FPHP has established an HIV/AIDS/STD sero-surveillance system in 10 regional laboratories. The system allows for the collection of 1,500 blood samples per region per year (15,000 yearly total) to track trends in the HIV/AIDS and STD incidence covering high (STD patients), medium (tuberculosis patients) and low (antenatal patients) risk populations. Information from the sero-surveillance system will help identify areas with high HIV/STD prevalence rates requiring focused campaigns. Also, effective operation of the system will improve the GOG's ability to plan and target for AIDS/STD interventions nationwide. As part of GHANAPA NPA conditionality, the MOH will annually report on the sero-surveillance system, including analysis of its results, to track sero-incidence trends.

GHANAPA will also continue USAID's support for HIV and STD laboratory diagnostic capability in Ghana. GOG resources will be made available for the operation of the Public Health Reference Laboratory (PHRL) system which includes the national reference laboratory at Korle Bu Hospital, two zonal branches of the PHRL in Kumasi and Tamale, the regional laboratory at Sekondi-Takoradi and other health laboratories. Under FPHP, a long-term laboratory technical advisor has assisted the Health Laboratory Services of the MOH to improve management, strategic planning and quality and infection control. As indicated in the Environmental Examination, the MOH has established proper disposal facilities and techniques for blood samples used in the diagnosis of STDs, or HIV testing.

Summary of USAID Assistance: Sero-Surveillance System and Lab. Capability

The GHANAPA project will provide a total of $821,000 for this element to fund six person months of expatriate short-term technical assistance ($150,000) for laboratory management, strategic planning and quality control; short term training ($230,000) in laboratory techniques for regional lab supervisors, epidemiological surveillance; a needs assessment ($35,000) of the cost effectiveness of voluntary testing services; and selected reagents and other chemical supplies ($441,000) that cannot be purchased in-country by the MOH for the functioning of the HIV/STD serosurveillance system. (It is estimated that over the six year life of project, reagents for about 150,000 screening HIV tests will be provided and another 46,200 confirmatory HIV tests.)

The centrally-funded Population Council Operations Research Project will make available up to 20 person months (estimated at $500,000) of operations research to test and analyze intervention approaches and services related to integrating HIV/AIDS activities into family planning programs.

3. **End of Project Status**

Discrete project outputs for each element of the program are outlined in the log frame matrix (Annex B). The end of project status indicators will quantify progress related to the major elements of the STD/AIDS component: improved policy environment, decrease in risky sexual behavior, improved treatment of STDs, and improved laboratory surveillance of STD/HIV prevalence.

The Goal level indicator is:

- The average rate of annual HIV incidence maintained at no more than one percent as measured by the national sero-surveillance system.

The End of Project Status (EOPS) indicators at the purpose level are:

- The proportion of respondents who report using a condom during the most recent act of sexual intercourse with a non-regular partner increases to 50%.

- The proportion of people citing at least two acceptable ways to prevent HIV infection rises from 65% to 75%,

Other indicators which will be used to monitor progress in HIV/AIDS/STD prevention and control at the output level include:

- The proportion of pregnant women aged 15-24 who test seropositive for syphilis in the national serosurveillance system is reduced by 50% against the 1994 baseline figure.

- Reported consistent use of condoms by men with multiple sexual partners increases from 25% to 50%

IV. DISCUSSION OF KEY ASSUMPTIONS

The key program assumptions are taken from the logical framework in Annex B. If the GHANAPA Program goal of reducing fertility is to be achieved, political stability and economic growth must continue in Ghana and neighboring countries. Without regional stability, Ghana could become overwhelmed with refugees from other countries, many of whom may carry the HIV virus. Indeed, this assumption is valid for all levels of analysis for if Ghana returns to a period of great political and economic instability as occurred in the early 1980s, the proposed program may not be able to meet any of its targets. However, the program in itself, through balance-of-payment support provided by the NPA, and the social impact it will have in reducing population and HIV/AIDS pressures, will have an affect on stabilizing the economy and political environment. The goal level also includes assumptions about continued political support for family planning and AIDS control activities and about the current HIV prevalence rate in Ghana, estimated at between 2-4 percent. The Mission will have more accurate data on HIV prevalence through the epidemiological surveillance system which will be in place and operating in December 1994.

If GHANAPA's purpose of increasing the use of modern and effective family planning methods and knowledge and use of HIV/AIDS preventive practices, is to be accomplished, it is assumed that other donors' support for family planning and AIDS activities will continue. Although USAID is the largest donor in both areas, other donors play key roles in supporting activities that increase the effectiveness of USAID's program.

It is assumed that men, who contribute to the decision making process in determining family size, will support family planning efforts. It is also assumed that better information and counselling about modern methods of contraception, including post-partum and post-abortion services, will lead to modern contraception among those who want to control their future childbearing. Further, it is assumed that those who wish to limit their fertility, or to space their births, will use modern methods of contraception to the extent that those methods are readily available. Likewise, it is assumed that practitioners will respond positively to better information and training and will change their current practice of restricting choices for potential users of family planning services. Evidence to date has shown that the predominate mode of HIV transmission in Ghana is sexual contact, and it is assumed that this will not change in the foreseeable future.

Assumptions for achieving an improved policy environment for family planning are based on the need for continued political and financial support for family planning in both the private and public sectors. The national government is currently very vocal in supporting these activities; such a commitment must be instilled at the local level. Government political and financial commitment to promoting family planning is critical to the long-term viability of the program. GHANAPA has identified several policy areas that require additional government attention. Alleviating contraceptive price differences between the public and private sector is a significant reform that will increase revenues for the public sector and contribute to future financial sustainability of the program. While the higher prices might initially result in

decreased demand for services, the Mission experience with social marketing indicates that Ghanaians are willing to pay for contraceptives at a market-determined rate. Thus, we assume that price increases will not act as a disincentive to the demand for services.

Additionally, regulations and practices that impede the provision of family planning services and inefficient forecasting and stocking practices will be addressed. This implies that training and new clinical guidelines are sufficient to improve practitioners' provision of appropriate family planning services and that these interventions will be effective. Finally, greater GOG financial contributions to family planning activities are essential if the family planning program is to continue beyond the year 2000. In order for this to occur it is assumed there will be close cooperation and coordination between the Ministry of Health and the Ministry of Finance and Economic Planning.

One of the major outputs of GHANAPA is to increase demand for family planning. Available data indicate that there is substantial unmet need for effective family planning services, particularly for long-term methods. The challenge for the Program is to ensure that the increased demand does not outstrip the supply of services. Thus the assumption is that supply will keep pace with demand.

Sustainability involves both the financial and institutional future of the family planning program. In that regard, a number of assumptions are made about increased user fees for contraceptives, the capacity of the private sector and the GSMF's ability to recover recurrent costs and commodities. Essentially, with a new pricing structure in place the cost of contraceptives will be greater, but with greater control over family size, there will be more disposable resources available and more demand for effective, long-term and permanent family planning services. Furthermore, we assume that the private sector is able to respond to the increased demand for services and that with the assistance of an endowment, the GSMF will continue to be a major supplier of family planning commodities in Ghana after GHANAPA's end in the year 2000.

The Mission has estimated the impact of establishing a trust fund to help the GSMF. The analysis assumed an initial endowment of $5 million and a rate of return of 7 percent per year (which uses the historical returns available from a portfolio comprised of 50 percent stocks, 30 percent bonds, and 20 percent short term money market instruments). It also assumed that the endowment would not be touched during the life of GHANAPA, but rather that the earnings would be reinvested.

The results of these assumptions yielded an impressive increase in the sustainability of the GSMF. Following the end of GHANAPA in 2000, it is no longer necessary for USAID to supply additional funds to support the operating cost of the Foundation. (Note that it would still be necessary for contraceptive products to be donated.) Starting in 2001, the trust fund would start yielding a return slightly larger than the operating cost. If that surplus was reinvested, by the year 2005, the endowment combined with revenue from the sale of

contraceptives would be sufficient to pay for 10 percent of the cost of all contraceptive commodities in addition to covering all other operating costs.

The most significant assumption for the AIDS/STD component of GHANAPA involves the HIV prevalence rate in the general population. Ghana's neighbors, particularly the Ivory Coast, are experiencing rates as high as 10 percent of the general population. Insufficient data are available on actual prevalence in Ghana, but based on ante-natal sentinel sites conducted in 1992, indications are that Ghana's HIV prevalence is under 5 percent of the general population in most parts of the country, although some pockets are as high as 18 percent. More definitive data prevalence will be available near the end of 1994 when the serosurveillance system is operational. It is assumed, therefore, that the HIV/AIDS situation in Ghana has not already reached epidemic proportions and that the Ghanaian population, in general, can be convinced of its vulnerability and will change risky sexual behavior.

V. MONITORING AND EVALUATION PLAN

A. Introduction

The GHANAPA monitoring and evaluation plan follows existing guidance from AID/W on appropriate measures of program impact which places particular emphasis on people-level, gender disaggregated measures. The plan is built on the system currently in place under the Family Planning and Health Program; most of the data collection activities proposed for the GHANAPA Program are already in place in the existing project. The most significant changes are (1) a proposed series of population-based studies which are intended to give more detail on knowledge, attitudes and practices with regard to HIV/AIDS and STDs and (2) two facility-based studies of STD case management. Under FPHP, several local organizations, such as the Ghana Statistical Service, have participated in conducting monitoring and evaluation activities. In an effort to continue building local capacity, these such local organizations will continue to implement most of the studies under GHANAPA, with technical assistance when necessary.

The M&E system for the GHANAPA program will undergo a shift in emphasis for monitoring program impact. Because data is collected from both service delivery facilities and the population, more attention will be paid to the question of linking facility data to population data. Planning for data collection activities will ensure that information from facilities and populations located within the same census enumeration areas.

Under GHANAPA there will be a move in the direction of ensuring that data collected for the Program will be referenced by a geographical unit (such as the census enumeration areas or by district) for analysis of data by distribution and density. This tool will help identify areas that might be underserviced and make sure that Program interventions are targeted.

Based on the Evaluation Schedule and Budget (Table 11), the USAID/W centrally-funded OR-TA project and the DHS III project will contribute $1.4 million to undertake evaluation, monitoring, special studies and the 1998 DHS. The GHANAPA project will fund $1.2 million for the 1997 and 1998 Consumer Surveys, local costs of the 1998 DHS, commodity pricing studies, special studies, and mid-term and final evaluations.

B. Monitoring Program Impact

The impact monitoring system will include the tracking of benchmarks indicating the status of program performance in these areas:

- creating a policy environment for improving planning and policy for family planning as well as AID/STD activities;
- increasing the use of modern, more effective family planning methods;
- increasing awareness and approval of family planning methods;

- expanding/improving access to and availability of family planning services;
- improving sustainabilty of the Family Planning and AIDS Control Programs in both the private and public sectors;
- increasing knowledge and practice of HIV/AIDS risk reduction behavior;
- improving diagnosis and treatment of STDs; and
- improving HIV/STD surveillance.

Both the policy-based program assistance component and project assistance component contribute to achievements in these areas. The program assumes a correlation between the planned policy changes on the one hand and, on the other, increased availability of family planning services as well as improved prospects for overall sustainability of the family planning and AIDS efforts in Ghana.

Grantees under the GHANAPA as well as the Ministry of Health are expected to collect much of the data which will be used to assess program performance on a quarterly basis, that is the service provider statistics used to calculate couple years protection. Other information on program performance and impact will be collected under contracting arrangements at time intervals as specified in the tables contained in Annex L . The tables contain the performance monitoring plans for (1) the Mission Strategic Objective, reduce fertility and for (2) the Target of Opportunity, to increase knowledge and practice of HIV/AIDS risk reduction behavior. Information on program benchmarks will be collected and reviewed internally by USAID on an annual basis. This information will in turn be reported to USAID/W in the Assessment of Project Impact.

The Logical Framework (Annex B) contains specific Objectively Verifiable Indicators to measure progress towards achieving the program purposes and benchmarks at the output level.

C. Users of Information

The major information users under GHANAPA will be all organizations represented on the Populations and AIDS Coordinating Committee: USAID and all beneficiary organizations. This includes: the Ministry of Finance and Economic Planning (MFEP), the Ministry of Health (and relevant units such as MCH/FP, HEU, NACP, HRDD, HRU, the Pharmacy Board, PPME and others), the National Population Council (NPC), the Ghana Registered Midwives Association (GRMA), the Ghana Social Marketing Foundation (GSMF), the Christian Health Association of Ghana (CHAG), Planned Parenthood Association of Ghana (PPAG), the Association for Voluntary Surgical Contraception (AVSC) and the University of Ghana- Legon.

D. Monitoring and Evaluation Responsibilities

The responsibility for monitoring rests with USAID through its Health, Population and Nutrition Office, and with the GOG. This includes all the implementing agencies: the Ministry of Health (MOH), the National Population Council (NPC), the Ghana Social

Marketing Foundation (GSMF), Planned Parenthood Association of Ghana (PPAG), the Ghana Registered Midwives Association (GRMA), the Association for Voluntary Surgical Contraception (AVSC) and other grantees under the program.

USAID, through the HPN office, and the GOG, through MOH and MFEP, are responsible for overall monitoring of program performance and impact. The HPN office of USAID will track project and program assistance benchmarks through reports received from MFEP, MOH, all grantees and through special analysis and evaluation.

The Population and AIDS Coordinating Committee (PACC), which is comprised of the relevant technical implementing agencies, is responsible for monitoring progress in: (1) fulfilling the program assistance grant conditions precedent; (2) providing financial and in-kind inputs from the GOG; and (3) program impact.

The National Population Council, which under GHANAPA plays an expanded role in population activities, will be responsible for keeping PACC informed on achievement of policy benchmarks, maintaining statistics on population and family planning, along with initiating certain special studies planned under GHANAPA, most notably the commodity pricing studies.

The MOH will be responsible for dissemination of new policies and procedures as well as key data needed for programming decisions to the regional and district levels.

The NPC Secretariat will take over responsibility for the management information system developed under the Family Planning and Health Project. NPC will collaborate with USAID/HPN and the MOH through the PACC to ensure that all key family planning and maternal and child health data is routinely generated, updated, analyzed and integrated.

All participating grantees and other implementing organizations will maintain records on the implementation of their activities and will provide the NPC Secretariat with statistics on the changes in project benchmarks (related to CYP, expansion of service outlets and training of service providers).

E. Monitoring and Evaluation Strategy

Semi-Annual Portfolio Review

USAID will conduct an in-house evaluation two times a year to examine progress in program implementation and progress toward end of project benchmarks. These semi-annual portfolio reviews are conducted for the periods October 1 - March 30 and April 1-September 30. The Mission will report to AID/W for the period ending March 30. Data collected for the period ending September 30, will include information on program performance and impact which is reported to AID/W in the annual Assessment of Program Impact.

Mid-term External Evaluation

The mid-term evaluation is planned about 30 months after the signing of the program and project agreements.

The evaluation will review the following:

- *management of inputs;*
- *status of outputs;*
- *progress in attaining purpose-level objectives;*
- *any management changes required for timely fulfillment of the policy program and project objectives;*
- *adequacy of benchmarks and indicators for assessing overall impact at final evaluation and recommended modifications in baseline monitoring (if these are required);*
- *technical assistance requirements and progress toward institutional self-sufficiency of GSMF;*
- *technical assistance requirements and ability of PPAG to continue playing an increasingly greater role in project implementation;*
- *technical assistance requirements and ability of GRMA to continue playing an increasingly greater role in project implementation;.*
- *institutional questions and relationships*
- *impact of program assistance tranches on policy changes.*

Final External Evaluation

The final evaluation will take place seven months before program completion. The evaluation will review the following:

- *review of the number of benchmarks achieved;*
- *review of progress made in attaining purpose-level objectives and progress of the policy and project components in realizing input and output targets;*
- *analysis of the macro-impact of the policy changes brought about the by accomplishment of the program conditionalities, especially those which are aimed at improving sustainability of family planning efforts in the private sector;*
- *assessment of impact on beneficiaries due to increasing numbers of service providers, availability and accessibility of supplies and increased information;*
- *assessment of project success in moving toward sustainability (with regard to program interventions targeted to both the public and private sectors) and reducing subsidies on commodity prices;*
- *assessment of the impact of price increases, resulting from the removal of subsidies, on the demand for contraceptives; and*
- *assessment of both the attainment and potential for attainment of sub-goal and goal-level objectives.*

F. Sources of Data for Program Outputs and Population Outcomes

1. NPA Conditionality documentation

   Outputs related to improvements in the policy environment for FP activities (for details see policy matrix (Annex A) and discussion under NPA in section IX)

2. FP Service Statistics and Commodities Data

   Quarterly service statistics from MOH, PPAG, GSMF, GRMA,AVSC
   FPLM reports from annual TDY visit (information on reported stockouts and pipeline)

3. Facility Based Data

   Situation Analysis (to assess FP service delivery and STD case management in private and public sector facilities) - 1996, 1998 (GSS in coordination with NPC, and NACP PMU)

4. Population Based Data

   Consumer surveys 1995, 1997, 1999 to provider information on knowledge, attitudes and practices related to family planning, HIV/AIDS and STDs (collaborative effort between NPC, GSMF, NACP) DHS 1993, 1998 (GSS)

Information in attached table 11 provides information on institutional responsibilities for collecting and disseminating data.

G. Special Studies

A pricing study to determine income and price cross elasticities for commodities and serve as a basis for revising current MOH commodity prices will be carried out under the FPHP. Commodity prices will then be reassessed in years 3 and year 5 of the GHANAPA project to confirm that annual price adjustments as conducted under the new contraceptive pricing policy are appropriate. Additional studies include:

Study of bio-hazardous waste disposal in Ghana according to guidance provided by Africa Bureau Environmental Officer.

Two KAP studies will investigate socio-cultural factors affecting reproductive and sexual health among adolescents

Pilot studies of factory-based family planning service delivery will be initiated in four industrial centers in each region.

A KAP survey on family planning among Daddies Clubs, Industrial centers and functional literacy groups will be conducted.

Studies on community-based distribution will compare different approaches to service delivery

Assessment of alternative strategies for supervision and retraining in the case of CBD agents and service delivery by GRMA

H. Evaluation Schedule and Budget

Table 11

EVALUATION ACTIVITY	DATE	TYPE	AGENCY	COST	COMMENTS
COMMODITY PRICING STUDY	1995	Special Study	NPC	FPHP funded	FPHP (OPTIONS buy-in)
Study of Bio-hazardous waste disposal re IEE	1995	Special Study	USAID	$25,000	GHANAPA Project funded
CONSUMER SURVEY Family Planning, AIDS/STDS	1995	Special study	NPC in coordination with GSMF and NACP	FPHP funded	Modules on ORS and treatment and prevention of malaria which were included in the 1993 survey will be dropped. A module will be included which is designed to gather information on attitudes and practices related to HIV/AIDS and STDs (identical to the module to be included in the DHS) .
KAP STUDY AMONG ADOLESCENTS	1995	Special study	PPAG	$50,000	OR-TA project centrally-funded
PILOT STUDY OF FACTORY-BASED FAMILY PLANNING SERVICES	1995	Operations Research	PPAG	$35,000	OR-TA project centrally-funded
KAP SURVEY AMONG MEN ON FAMILY PLANNING	1995	Special study	PPAG	$40,000	OR-TA project centrally-funded
COMPARISON OF DIFFERENT APPROACHES TO SERVICE DELIVERY USING COMMUNITY BASED DISTRIBUTORS	1996	Special Study	GSMF/GRMA	$50,000	OR-TA project centrally-funded

EVALUATION ACTIVITY	DATE	TYPE	AGENCY	COST	COMMENTS
ASSESSMENT OF ALTERNATIVE STRATEGIES FOR SUPERVISING AND TRAINING CBD AGENTS	1996	Special Study	GRMA	$25,000	OR-TA project centrally-funded
SITUATION ANALYSIS FP provider practices STD case management	1996	Operations Research	GSS	$200,000	OR-TA project centrally-funded
CONSUMER SURVEY Family Planning -- AIDS/STDs	1997	Special study	NPC in coordination with GSMF and NACP	$65,000	GHANAPA Project
COMMODITY PRICING STUDY	1997	Special study	NPC	$75,000	GHANAPA Project
MID-TERM EVALUATION	1997	External program evaluation	USAID	$165,000	GHANAPA Project
SITUATION ANALYSIS FP provider practices STD diagnosis & treatment	1998	Operations Research	GSS	$200,000	OR-TA project centrally-funded
DHS	1998	Special study	GSS	$800,000 $500,000	DHS III project centrally-funded GHANAPA Project (local costs)
CONSUMER SURVEY Family Planning --. AIDS/STDs	1999	Special study	NPC in coordination with GSMF and NACP	$65,000	GHANAPA
COMMODITY PRICING STUDY	1999	Special study	NPC	$75,000	GHANAPA Project
FINAL EVALUATION	1999	External program evaluation	USAID	$165,000	GHANAPA Project

VI. FINAL FEASIBILITY ANALYSES

Several analyses were undertaken in preparation for the preparation of this document. They are attached as annexes, or are available on file in the HPN Office of USAID Ghana and the Africa Bureau of USAID/Washington. The conclusions of these analyses are summarized below.

A. Economic Analysis Summary (Annex H)

GHANAPA is a six year project totalling over $75 million U.S. This includes project assistance, non-project assistance, donated commodities, technical assistance and host government contribution. The benefits of the program, which has lowering of fertility and stabilization of the HIV/AIDS epidemic as its goals, include increased resources for health and education resulting from the reduced population growth rate. It is estimated that program efforts will result in a population which is 2 million fewer by 2010 than would be expected in the absence of the program. This, in turn, would result in reduced poverty and social inequity, the empowerment of women, improved nutritional status and increased rate of economic development. The analysis estimates that this reduction in fertility would reduce annual GOG expenditures on health care by $8 million USD and on primary education by $30 million by the year 2010. It is estimated that the HIV/AIDS component of the project will result in the prevention of 20,000 cases of AIDS over the next twenty years, resulting in a contribution of $120 million USD to the Ghanaian economy by these individuals.

B. Financial Analysis Summary (Annex H)

Financial sustainability is a major principle of GHANAPA which is expected to be realized through a shift to more effective methods of contraception and assumption of a greater program role by the private sector. Non-project support will provide a policy environment conducive to increased private sector participation, through commodity pricing changes, harmonized clinical guidelines to be used in the public and private sectors, and support to the National Population Council which is the coordinating body for all population activities in Ghana.

MOH has recently seen its share of the GOG recurrent non-personnel budget decline from 24% in 1992 to 14% in 1994. This may be a function of additional donor support. Program assistance will encourage increased budgetary support to the Ministry of Health for family planning and AIDS/STDs activities, another factor contributing to financial sustainability. The non-project assistance funds will no longer be extrabudgetary-- a phenomenon in the previous project (FPHP) which has resulted in the view that these funds "augment" the regular GOG allocation. The GHANAPA funds will be "on budget" and be part of the regular budgeting and planning process, so that as and when donor support diminishes, family planning and AIDS activities should be adequately budgeted for through the established procedures. The Ministry of Finance and Economic Planning has the capacity to provide and track the level of support required in the NPA conditionalities.

The commodity pricing changes mentioned above will also permit the Ministry to recapture a more favorable percentage for purchase of commodities. Currently, all commodities are donor-provided, and sold at subsidized prices, either in public sector clinics or through various channels of the Ghana Social Marketing Foundation such as pharmacies, chemical sellers and community based distributors.

A sustained commitment to family planning and AIDS activities in concert with increased government revenues should result in increasing budgetary commitment to the sector which will render sufficient resources beyond the completion of GHANAPA in the year 2000.

C. Institutional Analysis Summary (Annex G)

The major emphases of the GHANAPA family planning component will be to effect two shifts in the program: (1) a move to more effective long-term and permanent methods of contraception; and (2) an increased role for the private sector in the delivery of family planning services. In addition to the Ministry of Health, the organizations in the private/NGO sector which will receive direct support under GHANAPA are the Ghana Social Marketing Foundation (GSMF), Ghana Registered Midwives' Association (GRMA), and the Planned Parenthood Association of Ghana (PPAG). The AIDS component of GHANAPA is comprised of three elements: behavioral change, improved treatment and diagnosis of sexually transmitted diseases, and improved monitoring and surveillance. The National AIDS Control Program is responsible for the public sector activities; the Christian Health Association of Ghana (CHAG) will be a major participant in the private/NGO sector.

- *Ministry of Health*

The issues which pertain to the public sector are much the same as they were when the current family planning and health project began. These include the lack of financial, institutional and manpower resources. Government has relied on donor assistance to fund the majority of program activities (recurrent budget). Much of the MOH's recurrent budget is allocated for curative rather than preventive programs. The MOH has recently undergone a reorganization in which decentralization plays a major role. The regions and districts are now responsible for budgeting and planning of all activities. At this level of the system, the commitment of MOH to implementing Ghana's population policy, needs continuous reinforcement so that adequate funds are set aside to conduct the required activities. This project will address these constraints through conditionality requiring budgetary commitment to the MOH to accomplish program activities. Technical assistance will be provided to assist the Ministry Units in various aspects of the program including strategic planning, management, IEC, and policy, training and commodities logistics management. Provided with the financial resources and TA, the MOH is capable of meeting the impact indicators and other NPA conditionalities.

- Ghana Social Marketing Foundation

The Ghana Social Marketing Foundation (GSMF) is a non-profit private sector organization dedicated to improving the quality of life for Ghanaians through the provision of affordable and accessible family planning products and services. GSMF has received significant technical and financial support from USAID since 1986. Since that time, GSMF has quadrupled its sales of contraceptive commodities. GSMF sells to 5000 pharmacies and other outlets; at the completion of GHANAPA this is envisioned to be 12,500 which should not be difficult as there are currently three distributors operating with the possibility of further expansion. GSMF is planning to reorganize by adding long-term and clinical methods manager, a public relations manager and a financial manager to its current staff of three. As an organization they will require technical assistance in financial management, strategic planning, some limited assistance with social marketing (particularly as the organization expands its product line to include long-term methods), and market research. Much of this technical assistance is envisioned in the years one and two prior to or early on in the direct grant/endowment.

- *Ghana Registered Midwives Association*

The Ghana Registered Midwives' Association in an NGO with nearly 500 members who provide prenatal, delivery and family planning services. Support to GRMA started in 1988 and has continued to support training in general family planning, clinical methods (IUD insertion), management, and business skills. Prior to this period of time, GRMA was a civic organization; it has now blossomed into becoming a major channel for the delivery of services in the private sector. As an organization GRMA has begun the process of strategic thinking and envisions a quadrupling of its family planning coverage during the life of the project. There is currently a resident advisor in place from the American College of Nurse Midwives through whom support from USAID is received; in preparation for the advisor's departure in late 1995, GRMA will require strengthening in management skills, strategic planning and financial management.

- *Planned Parenthood Association of Ghana*

The Planned Parenthood Association of Ghana currently serves the largest number of clients in the private/NGO sector. It is an affiliate of the International Planned Parenthood Federation (IPPF), based in London, and receives support from IPPF, World Bank and other donors. In the past two years, a new executive director has joined PPAG, providing a vision of how the organization can implement its four-pronged strategy of increasing knowledge and acceptance of contraception; ensuring wider availability;, particularly in the rural areas; improving staff and volunteer capacity; and sensitizing decision makers on population issues.

PPAG's comparative advantages include its programs for youth, males and its community-based distribution program. This will interface well with the identified gaps in service delivery. PPAG will require some strengthening in commodity management, MIS, IEC and research which will provided under GHANAPA as part its technical assistance plan.

- *Christian Health Association of Ghana*

The Christian Health Association (CHAG) mission hospitals see more STD patients than private doctors or midwives. There are 107 CHAG facilities in Ghana, and therefore CHAG becomes a critical player in a strategy designed to change behavior and improve diagnosis and treatment of STDs. In some districts, the CHAG hospital serves as the district hospital, hence the linkages between CHAG and the MOH already exist. The MOH provides for CHAG personnel, but does not support recurrent expenses. Through NPA funding, MOH will support strengthening of CHAG's STD clinical procedures, management and counselling.

D. Technical Analysis Summary (Annex F)

1. Family Planning

The 1994 mid-year population of Ghana is estimated to be 16.9 million, with an annual growth rate of 3.0 percent. This implies a doubling of population in twenty three years, putting tremendous pressure on already overstretched social and economic infrastructure and services. Currently, a Ghanaian woman will have an average of 5.5 children by the time she reaches her forty-fifth birthday. Factors contributing to this high rate of fertility include early age at marriage, a youthful age structure, low contraceptive prevalence, and falling mortality rates.

A Consumer Baseline Study conducted in April 1993 suggests that Ghana has already reached a modern CPR rate of 14.8 percent among married women. The 1993 DHS shows a more modest rise to 10.1 percent. Nevertheless, the DHS suggests a substantial decline in fertility from a TFR of 6.4 in 1988 to 5.5 in 1993. This is a remarkable achievement in a period of five years compared to other family planning programs worldwide, and an **outstanding** accomplishment for sub-Saharan Africa. Average contraceptive prevalence increase worldwide is slightly over 1 percent. This is equivalent to a reduction in fertility from an average of six and a half children per woman in 1988 to an average of five and one half children in 1993.

This achievement was accomplished by concentrating on the provision of short-term contraceptive methods such as condoms, pills and vaginal foaming tablets, through the Ghana Social Marketing Program (GSMP) (low cost, private sector promotion and distribution), and initiation of long-term contraceptive methods such as IUDs, injectables and sterilizations. These efforts have been coupled with strong information, education and communication (IEC) campaigns in the public, private and NGO sectors.

- *Policy*

Although there are clear indications that political support for population programs is improving in Ghana the political commitment must become much more broad-based throughout all levels of the political system in order to support a strong population and family planning program. Some policy makers, community leaders, and even health service

providers are uninformed (or misinformed) about family planning and other broad population issues. Such commitment and awareness must be increased significantly if expanded population programs are to be successful.

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

Effective policy implementation will require a technically capable National Population Council (NPC) Secretariat that can provide leadership for the overall program and facilitate and coordinate program efforts. The NPC Secretariat has been given the mandate to conduct a very ambitious program over the next few years. These activities will require a large pool of analytic and technical skills which must be identified or developed as well as sustained technical assistance until this capacity is built.

One key constraint to program coordination and policy implementation is the interim nature of the Secretariat which has insufficient staffing, and is overloaded with responsibilities. Upon creation of the permanent Secretariat, these staffing issues should be resolved. However, the responsibilities of the Secretariat will be diverse and will require a large pool of analytical, technical and political skills which, as noted, will take some time to create.

A second issue is the need to develop strong, supportive working relationships among the ministries and involved agencies and the NPC/Secretariat. At this time there are, understandably, inconsistent perceptions of the respective roles of the ministries and NPC Secretariat as a coordinating body.

- *Demand for Modern Contraception*

In 1993, somewhat more than one-quarter of currently married women in Ghana do not want more children. Though this is about the same proportion as in 1988, the proportion of married women who report being undecided about whether to have another birth has doubled from 9 percent in 1988 to 19 percent in 1993.

For short-term methods, lack of awareness and knowledge of individual methods continue to be major barriers to use. Thirty-five percent of never users state that they are not using contraceptives due to lack of knowledge; 14 percent cited fear of side effects as a reason for non-use. Service statistics in districts that had information campaigns indicated an increase in awareness and trial of modern contraceptives as a result of the campaign.

Another factor that is particularly important in Ghana is the extent to which husbands or partners are knowledgeable about, or approve of the use of contraception. Data from the

Situation Analysis show that 16 percent of MCH clients do not know whether their partner approves or disapproves of family planning, suggesting it has not even been discussed.

Demand is even lower and the supply infrastructure is much less developed for the long-term clinical than for the non-clinical methods. Demand generation for long-term methods must be coordinated with and targeted to the development of the delivery infrastructure. Once an area has a critical mass of providers who are trained in the techniques and who have the time and access to the facility to perform them, specific demand generation activities can be targeted to that area. Referral systems are needed because there far fewer potential service sites for long term methods. Community based distributors, pharmacists, and others need to be trained to refer potential clients to an appropriate source.

- *Delivery of Services*

Ghana's family planning program has proceeded to the phase wherein it is essential to place emphasis on availability of different methods and expand private sector participation in the program. While the increase in modern method prevalence that Ghana has recently experienced is outstanding, without a concomitant change in method mix, there will not be corresponding decline in total fertility nor a slowing of the population growth rate. The current method mix is comprised of 80 percent short-term methods (condoms, pills, vaginal foaming tablets), with the remaining clients using long-term, more effective methods such as the IUD, injectables, voluntary surgical contraception. A more effective public/private sector collaboration is essential to efficiently direct both public and private sector resources to be maximally effective.

Overall, there are several service delivery gaps in the current program including programs for adolescents which would provide **services** in addition to information and counseling, post-abortion/post-partum services, and rural areas.

Currently short-term methods are provided through the public sector and several channels in the private/NGO sector: The Ghana Social Marketing Foundation (GSMF) is a private, non-profit organization providing affordable family planning products, which ha quadrupled its sales since 1986. This demonstrates that consumers are willing to pay for contraceptive commodities. GHANAPA will continue to support GSMF for the delivery of short-term methods through a direct grant and an endowment. Planned Parenthood Association of Ghana (PPAG) serves more clients than any other NGO. The comparative advantages of PPAG are their programs for males, youth and a large community-based distribution program for which GHANAPA will provide support. The Ghana Registered Midwives' Association (GRMA) is a non-governmental organization which consists of approximately 500 registered nurse midwives, who serve as private practitioners and provide pre-natal, delivery and family planning services to women throughout the country. While thus far GRMA accounts for only a small percentage of the overall NGO provision of family planning services, it provided nearly 5000 couple years of protection in 1993 and is an important channel for provision of family planning and other reproductive health services in the private sector.

NGOs can play an important role in creating a supportive environment for the use of family planning by increasing knowledge, and providing a distribution network for non-clinical methods. NGOs should be used to provide support and distribution to areas of low prevalence that are unserved by either the public or the commercial sectors, or where more intensive proactive support is required.

Long-term methods will require added emphasis under GHANAPA if the desired fertility decline is to be achieved. The users of long term methods must increase from 69,000 in 1993 to 295,000 by the tear 2000. This will require substantial expansion of both the training and service delivery sites for clinical methods.

In the longer term, to increase the sustainability of family planning service delivery in Ghana, the private sector must play an even greater role in the provision of services.

- *Sustainability*

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

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

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

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

2. Acquired Immunodeficiency Syndrome (AIDS): An Overview

Since its discovery in 1981, AIDS has spread rapidly throughout the world, and has become a public health problem of extraordinary scope and unprecedented urgency. In December 1993,

the World Health Organization's Global Program on AIDS (WHO/GPA) estimated that about 15 million adults and close to two million children under five throughout the world have been infected with the HIV virus. Sub-Saharan Africa, with less than 10% of the world's population, accounts for about 58% of total HIV infections, two-thirds of adult AIDS cases and 90% percent of pediatric AIDS cases worldwide. World Bank's simulations indicate "a slowing of growth of income per capita by an average 0.6 percentage point a year in the ten worst-affected countries in sub-Saharan Africa." It is believed that STDs, those with ulcerative lesions such chancroid and syphilis in particular, are now believed to have facilitated the rapid spread of HIV in sexually active persons. Most available data suggest that both the susceptibility to HIV infection and the infectiousness of an HIV-infected individual are increased several fold by the presence of other STDs.

The prevalence of HIV infection appears to be rising in Ghana. Limited HIV seroprevalence data from antenatal sentinel sites indicate that HIV positive rates in 1992 among pregnant women ranged between 1.0% and 4.6% in most parts of the country, although some pockets were as high as 18%. Until recently, such high prevalence rates were unknown. Eighty-six percent of all cumulative 11,853 AIDS cases identified as of September 1993, were in the 20-49 age group, with those aged 20-29 being the most seriously affected. Unlike most other countries, HIV/AIDS in Ghana affects more people in the semi-urban and rural areas than in the urban core. As of September 1993, the Ashanti and Eastern Regions accounted for the highest number of reported cases. Also, women remain disproportionately affected, accounting for 70% of the cumulative cases.

Limited data are available on the prevalence of STDs in Ghana. However, based on a recent USAID/Ghana commissioned study, the technical analysis estimated that a minimum of 400,000 STDs cases are treated in the public and private facilities. This represents an incidence of about 2000 cases per 100,000 population.

Cost effective interventions available to combat the spread of HIV/AIDS include the promotion of condom use and the reduction in the number of casual sexual partners and STD control. In this regard, the FPHP, in collaboration with other donor's inputs, has made significant strides. Most Ghanaians are aware of AIDS and know it is transmitted sexually. Also, current condom use among females and males has reached 6.1% and 19.7%, respectively. The surveys also reported that 83 percent of Ghanaians know that sexual fidelity is the best way to prevent AIDS. Despite these achievements, high risk sexual behaviors remain common and only 25 percent of men who have ever used a condom report that they use it **every time** they have sex.

Most importantly, to date, almost all support to STD prevention and control has been to the public sector, although, as in many other African countries, many Ghanaians prefer the private sector, including pharmacies, chemical sellers, itinerant drug peddlers and traditional healers. The recent USAID/Ghana commissioned study indicated that most of the STD cases are seen in the private health facilities. In the three health care practices of private doctors, midwives and mission hospitals, patients with possible STD accounted for over four percent of all

outpatient visits. This contrasts with the estimated less than one percent of all outpatient visits in the public health centers. The CHAG mission hospitals saw the most patients. STDs accounted for 4.4 percent of all customers for pharmacists and 3.8 for chemical sellers.

STD care appears to be poor both in the private and public sector and none of the drugs on the Essential Drug List and National Formulary list remain adequately effective in treating antibiotic-resistant N. gonorrhea and other important STD conditions. The absence of effective STD drugs in the EDLNF significantly limits STD control efforts both in public and private sector.

USAID/Ghana concluded that the following proposed strategies: building on the successes of FPHP in promoting AIDS awareness and condom use, shifting its focus to prevention of transmission of HIV by reducing high-risk sexual behavior and supporting the private sector and complementing other donor's support in STD control, and encouraging the GOG to include effective STD drugs in the EDLNF are technically sound.

The technical analysis also points out the importance of supporting MOH's efforts in developing and maintaining an adequate laboratory network and effective surveillance system. Most importantly, it indicated the critical need to improve the NACP capacity in program management, coordination and policy development. This is of utmost importance given the new USAID/Ghana approach in Non Project Assistance which requires an improved programmatic involvement and utilization of the MOH's resources at the central, regional and district levels. Additionally, the technical analysis indicated the need to encourage other donors to assist the MOH in the procurement of effective low cost STD drugs. It also emphasized the importance of maintaining the appropriate linkages between the Family Planing and AIDS/STDs which has been of utmost importance for the achievements of the NACP.

Based on the regional epidemiological data and the proposed scenarios provided by the Epimodel, the technical analysis recommended that the goal of the project be to help stabilize the HIV/AIDS epidemic at no more than 1.5 percentage points above the estimated 1994 adult prevalence rate of 3.36 percent. It also proposed that the purpose of the project be to maintain the average adult HIV incidence at no more than 1.0 percent during the next six years. (Note: Following consultations with USAID/W/CDIE, the Mission elevated the recommended purpose level to the goal level and revised the purpose level to "increase knowledge and practice of risky sexual behavior. This new purpose level indicators is suggested in recent World Health Organization publications on AIDS/STDs.

E. Social Soundness Analysis Summary (Annex E)

The core question addressed by the analysis is whether the proposed expansion of family planning services and the intended increase in the consumption of modern contraceptive methods are socio-culturally feasible. In other words, how can this program be carried out and sustained without unduly hurting the socio-cultural sensibilities of the people? The

analysis focussed on assessing the socio-cultural context of fertility regulation, focusing on women as participants and as beneficiaries; determining the structure and pattern of decision-making concerning family planning including the role of men; assessing the impact of rural-urban differences; and assessing the level of knowledge of the community about AIDS/STDs control and prevention in relation to sexual behavior change, with a focus on adolescents.

In Ghana, although traditional means of limiting fertility exist, factors and consequences of social change--urbanization, migration Western education, religion, and medicine, money-based economy, etc.--have rendered some of these modes of fertility regulation unacceptable. For example, the use of charms or herbal preparations may be regarded in urban areas as primitivism, and the practices either of prolonged physical separation or polygamy may present too great a financial burden. The attitude of males is clearly critical in decision-making concerning use of contraception, and women continue to be valued for their child-bearing role. Nevertheless, the forces of modernization have made some inroads into the dominant role played by men. Specifically, women who are more educated and/or earn a stable income are demanding a greater role in decision-making concerning their welfare and that of their children.

In summary, with respect to family planning, the social soundness analysis suggests that the socio-cultural terrain and the political climate make GHANAPA a feasible program. At the individual and national levels, there is now in Ghana an awareness of the impact of uncontrolled population growth on the development and welfare of both the individual and society. Thus various structures and programs have been put in place. However, in a pronatalist and largely gemeinschaft[14] society like Ghana, the pay-off of these cannot be felt immediately. Nevertheless, it may be quickened when the fears and aspirations of the people are given due cognisance in any interventionist measures.

Concerning the proposed activities on HIV/AIDS, the analysis of the awareness/knowledge and attitudes of adolescents--the focal target group examined for the social soundness analysis--about AIDS show clearly that there is a lot to do to save Ghanaian adolescents from the scourge of HIV/AIDS infection. Barred by the larger society from procuring contraceptive devices (We may recall the provider eligibility restrictions whereby some providers simply refuse contraceptive services to certain categories of people including adolescents) the schools cannot help either because AIDS and Contraception are not included in the syllabus. Thus both teachers and students are ignorant of modes of transmission and prevention of HIV infection. The report concludes that specially targeted IEC materials are of primary importance, and that thorough pre-testing is necessary to be certain that the messages are well understood. Further, it is suggested that materials also be developed in the vernacular for the benefit of those in the rural areas who have received their education through the Non-Formal Education sector.

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[14]A society in which social relationships between individuals are based on common feelings, kinship or membership in the community.

F. **Environmental Examination Summary Findings** (Annex C)

A categorical exclusion is recommended on the basis that this project is a program involving health care, population, and/or family planning services, under section 216.2(c)2(viii) of USAID's Environmental procedures (Reg 16).

A negative determination is requested for the activities dealing with sexually-transmitted disease case management because this component of the project does not anticipate any activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.) The project may include the provision of HIV/AIDS prevention and control commodities (such as disposable gloves, syringes and other protective materials). These commodities may be distributed to regional hospitals and health centers.

Although blood may be drawn for the purpose of STD diagnosis, or HIV counselling and testing, proper disposal facilities and techniques are already in use. In this regard, it has been determined through discussions with the Ministry of Health, that commodities provided through the project will be used appropriately and will be disposed of safely. USAID/Accra, based on Ghanaian government regulations for disposal of contaminated medical commodities, and planned monitoring of how these regulations are followed during the project, is confident that the HIV/AIDS prevention and control commodities supplied under this project will be disposed of in an environmentally safe manner.

Further, following the guidance provided in State 93 264038 (Annex C), the Mission Environmental Officer will provide the Bureau Environmental Officer with a more complete report on bio-hazardous waste disposal in Ghana. This study will be conducted during the first year of the program. GHANAPA project resources will be used to finance the study which is included in the Program's Monitoring and Evaluation Plan (Section V).

VII. PROGRAM MANAGEMENT AND IMPLEMENTATION ARRANGEMENTS

Implementation of GHANAPA will commence immediately after authorization of the Program Assistance Approval Document (PAAD) by the Mission and signature of the grant agreements by the Government of the United States and the Government of Ghana.

A. Management Arrangements

GHANAPA will be coordinated by a Population and AIDS Coordinating Committee (PACC) consisting of representatives of USAID and all the beneficiary organizations, including the Ministry of Finance and Economic Planning, the Ministry of Health, (and its relevant units), the National Population Council, GRMA, GSMF, PPAG, CHAG, AVSC, the University of Ghana-Legon, and other organizations as may be required. The PACC will be officially recognized by the Government of Ghana and will be chaired by the NPC, whose Secretariat shall also serve as secretary to prepare agendas and record and distribute minutes. The PACC will have policy formulation and technical functions.

In the policy area, the PACC will establish a policy committee consisting of representatives of the MFEP, MOH, NPC and USAID, to ensure that the National Population Policy is supported by the GHANAPA implementing institutions. For example, it will monitor progress toward meeting CYP objectives, funding levels for the NPC, and other conditions precedent, and ensure that GHANAPA supported activities conform to the regulations of the GOG and USAID. The policy committee will meet quarterly.

The PACC technical committee, composed of all the member organizations, will meet monthly to discuss technical implementation issues, coordinate activities, and make recommendations to the various parties concerning program implementation. The technical committee will review work plans of the member institutions to ensure that all activities are complementary and contribute to the GHANAPA objectives. The PACC will review member institution's progress in population and AIDS activities, recommend candidates for training and travel financed by GHANAPA and serve as a forum to discuss issues affecting program implementation.

The PACC will be a consensus forming body, but can not appropriate the legal responsibilities of its individual members under the GHANAPA program. Member institutions, including the MFEP, MOH and USAID, will be expected to consider the recommendations of the PACC when approving specific budgets and activities. The PACC policy committee has, however, been charged with approving NPC workplans and budgets as part of NPA conditionality.

Brief descriptions of the major institutions of GHANAPA follow.

1. USAID: USAID maintains a bilateral Mission in Ghana with an Office of Director, Office of Finance, Office of Program and Project Development, and Office of Management and Administration. Three technical units; Office of Health, Population and Nutrition (HPN), Office of Education and Human Resources Development and Office of Trade, Agriculture and Private Sector complete the Mission. The GHANAPA program will be managed by the HPN Office with support from other Mission units.

The HPN Office is responsible for providing leadership and promoting effective policies for the U.S. Government's health, population and nutrition development assistance in Ghana and implementation of all health, population and nutrition development projects within USAID/Ghana's portfolio. HPN is also responsible for direct liaison with appropriate GOG departments and officials, with other donors and with relevant non-governmental organizations and private sector entities on matters concerning health, population and nutrition development.

The HPN office is responsible for ensuring that US Government funds are used in accordance with official policies, in the most efficacious technical manner to achieve the agreed objectives. Its professionals work with over ten GOG units, five major Ghanaian NGOs, and at least fifteen US based contractors and cooperative agencies to implement FPHP and GHANAPA programs. Additionally, many small contracts must be managed for studies, evaluations, audits and reports.

HPN Office staff includes a chief with overall coordination responsibility for the Mission's population and AIDS control activities, a deputy chief who manages non-project assistance activities, laboratory services and basic research under FPHP, two FSN professionals with responsibility for training, IE&C, commodity logistics and health care financing, and a Technical Advisor in AIDS and Child Survival (TAACS) who handles operations research, demography and evaluation. The HPN Office will be assisted by the Office of Program and Project Development (OPPD), Controller's Office, Management and Administration Office, Contracting Officer and, legal services from USAID's Office of Regional Economic Development Support for West and Coastal Africa (REDSO/WCA). USAID/Washington will provide additional support through the Global Bureau's Population and Health Offices and the Africa Bureau.

As a result of the overlap with FPHP, GHANAPA will create additional management and technical duties for the HPN Office and will require the services of additional staff. The $35 million FPHP started in April 1991 and will continue until 1996. This project contains both population and AIDS control components and includes both non-project and project assistance mechanisms. FPHP has institutional contracts with four expatriate resident advisors who will complete their assignments in October 1995. USAID's experience with FPHP indicates that under GHANAPA, it will not be necessary to continue the services of the institutional contractors. Instead, the HPN Office will provide both the managerial and technical support that is necessary to implement GHANAPA as it devolves more responsibility to the beneficiary organizations.

The HPN office has conducted an analysis of its present staff and the increased demands of managing the GHANAPA program and has determined that it will require additional staff persons in the office. Two new positions may need to be created to assist the Mission in program management and administration, monitoring and evaluation, coordination of technical assistance requirements from centrally-funded projects, management of the cooperating agency agreement, financial planning and oversight, preparation for annual tranche reviews, and development of annual work plans in cooperation with the MOH, centrally-funded projects and AVSC. Other responsibilities include managing the HIV/AIDS/STD component, the GSMF Grant and the endowments within the office. The Mission will request this assistance from the Western Consortium Population Fellow Project.

Additionally, the HPN office plans to request a Program Assistant. This person will be responsible for routine administrative tasks such as preparing project implementation orders, and other documents required to manage the additional grants.

The Technical Advisor for AIDS and Child Survival (TAACS) has been funded by central USAID Washington project. However, the central funding will end in January 1995 and the GHANAPA Project will be required to assume the costs of this person.

2. **Ministry of Health**: The MOH will be the lead implementer of the GHANAPA Program. As a line ministry of the Government of Ghana, it is responsible for establishing national health policy as well as providing preventive and curative health services.

The GHANAPA program will be implemented by most of the MOH units. The technical analysis (Annex F) details the specific responsibilities of each unit. The Minister, and the Director of the Policy, Planning, Monitoring and Evaluation (PPME) Unit and the director of the External Aid Coordination Unit of the Ministry of Health will all be named signatories of the bilateral agreement.

The MOH is participating in the government's decentralization program. It is expected that the regional and district level units of the MOH will play an increasing role in the implementation of GHANAPA. The MCH/FP and NACP Units will monitor and report the effects of decentralization on the implementation of their respective project components. The Population Impact Program of the University of Ghana -Legon will provide information to MOH policy makers at the regional and district levels to help make them aware of the importance of family planning and AIDS activities.

3. **Ministry of Finance and Economic Planning:** The International Economic Relations Division (IERD) of the MFEP will be responsible for coordinating GHANAPA financial activity within the ministry. The Minister, Deputy Minister and Director of IERD will be named signatories for implementing the NPA program.

B. Implementation of the Non-Project Assistance Cash Grant

1. Authorization and Obligations

For the GHANAPA cash grant, USAID and the GOG will obligate Development Fund for Africa funds in five tranches, 1994-1998. The first tranche of $2 million will be obligated upon signature of the grant agreement in late FY 1994. Disbursement of these funds will occur in April 1995 as a result of satisfactorily meeting conditions precedent to first disbursement. The second through fifth obligations will require annual amendments to the Program Agreement, as well as amendments to the PAAD authorization. These obligations are planned at $3 million in FY 95, $3 million in FY 96, $3 million in FY 97, and $3 million in FY 98. These funds will be released when the GOG meets the conditions precedent, probably in April of the following year, eg, FY 95 funds will be released in April of 1996 which will provide time for the government to prepare the previous year's expenditure review. The annual increments may increase or decrease subject to the availability of funds.

The USAID/Ghana Mission Director will authorize the PAAD, subsequent authorization amendments, and all tranche disbursements in accordance with existing USAID delegations of authority. Transfer of the amounts obligated will be contingent upon satisfaction of conditions precedent (CPs) discussed in Section D below. Once it has been determined, through tranche review procedures established for the GHANAPA program, that the GOG has provided sufficient evidence of having satisfied all CPs for a given tranche, USAID will notify the Minister of Finance and Economic Planning and the Minister of Health in writing by means of Program Implementation Letters (PIL) and commence tranche disbursement procedures. Upon issuance of the PIL, USAID will deposit disbursements into a separate interest-bearing dollar bank account in a U.S. bank, designated by the GOG. The Bank of Ghana will submit bank records and regular reports to USAID indicating that funds have been received and the amount of interest earned.

2. USAID Responsibilities

In conformance with USAID delegation of authority, the USAID/Ghana Mission Director will be responsible for determining whether the GOG has satisfied the conditions precedent for disbursement of each tranche. The USAID/Ghana Mission Director will be assisted by the Mission's Health Population and Nutrition Officer in maintaining continuous policy dialogue with appropriate GOG organizations, and implementing the program according to the Agreement. USAID will contract with a local accounting firm for annual financial assessment of the MFEP disbursements to the MOH and NPC budgets.

The implementation status of the program will be assessed semi-annually, annually and during two external evaluations of the overall GHANAPA Program. A detailed monitoring and evaluation plan is included in Section VII and detailed disbursement arrangements will be provided in an early Project Implementation Letter.

3. GOG Responsibilities:

The GOG is responsible for fulfilling conditions precedent to disbursement for each of the five tranches, and for implementing the GHANAPA Program. A Population and AIDS Coordinating Committee, chaired by the National Population Council and consisting of representatives of the MFEP, MOH, NPC, GSMF, GRMA, PPAG, AVSC, University of Ghana, Legon and CHAG will monitor the GOG's advancement toward meeting the CPs and will assist the MFEP in preparing documentation for providing evidence to USAID. The Chief of the USAID HPN Office will serve on the PACC.

Following is a list of GOG implementing agencies and their responsibilities for executing the non-project assistance component of GHANAPA.

- The Ministry of Finance and Economic Planning (MFEP) will be responsible for meeting the conditions precedent to disbursement for each tranche and specifically for the CP related to GOG budget allocations to MOH and NPC (see Conditionality in next section), notifying USAID of the status of each tranche, serving as a permanent member of the PACC and for ensuring that funds are available to carry-out Program activities.

- Ministry of Health (MOH) will be responsible for implementing their CPs (see Conditionality in next section). Each implementing unit will be represented on the PACC to ensure that programs in family planning and AIDS control are carried out at all levels including national, regional and district.

- The National Population Council (NPC) will assume responsibility for chairing the PACC meetings to monitor program implementation and achievement of program benchmarks, as well as coordinating public and private sector family planning activities and managing the sub grant to PIP.

C. Implementation of Project Assistance

The major distinguishing characteristic of this project is that there is a year overlap with the current FPHP, which adds another layer of responsibility for all implementing entities.

1. USAID/Ghana Mission

The USAID/Ghana Health, Population and Nutrition Office (HPN Office) will participate in the PACC as a voting member and will be responsible for implementation of the project component including:

- Informing all parties of the GHANAPA program through project startup workshops;

- Establishing and managing grants to GSMF, GRMA, PPAG, and other Ghanaian NGOs as required;

- Arranging all participant training and travel outside of Ghana as approved in the Training Plan;

- Providing all contraceptives to the MOH or GSMF warehouse "door to door" as programmed;

- Establishing and monitoring all endowments.

- Coordinating all technical assistance, both short and long-term as funded by the GHANAPA Project or by USAID/Washington;

- Monitoring and Evaluation functions.

2. Government of Ghana Implementing Agencies

The Government of Ghana (GOG) implementing agencies for the project component are the Ministry of Finance and Economic Planning (MFEP) Ministry of Health, and The National Population Council.

The Supply Division MOH will receive, store and distribute all USAID-donated contraceptives provided to the MOH. The supply division will distribute contraceptives to public health regional and district facilities.

The University of Science and Technology (UST) Teaching Hospital, an MOH facility, will be responsible for collaborating with AVSC to train doctor-nurse teams in sterilization procedures and quality control of training -related facilities and maintenance of equipment. The MCH/FP Division of MOH will coordinate with AVSC in selection of doctors and nurses to receive training.

The Health Education Division will be responsible for planning and implementing information, education and communication (IEC) campaigns and related activities to promote family planning and the use of contraceptives.

The National Population Council will be responsible for implementing the population policy at central, regional and district levels.

3. Cooperating Agencies

The services of AVSC will be obtained through a cooperating agency agreement for a five year period to begin in September 1994. The AVSC will assist the MOH to develop facilities

and training capacity for the provision of long term methods including surgical contraception, IUD insertion and NORPLANT®.

4. Private Sector Organizations

The Ghana Registered Midwives Association will receive a grant to expand and strengthen the network of private midwives who are providing short and long term methods through their private clinics. They will also establish a community based distribution system by training maternity assistants for community motivation and distribution activities.

The Planned Parenthood Association of Ghana (PPAG) will receive a grant to expand the existing network of community-based distributors, to strengthen and expand the adolescent services program and to initiate a program of outreach to offer family planning services for men at clubs and work place locations.

The Ghana Social Marketing Foundation will receive a grant to continue advertising, marketing and distribution of contraceptives to the private sector through 12,000 retail agents and through selected NGOs with special access to communities.

5. Centrally-Funded Projects

All centrally funded projects will be funded from core USAID/Washington Global Bureau Office of Population funds. The following projects, (or their follow-on projects) will provide technical assistance to the Program as required:

(i) Association for Voluntary Surgical Contraception (AVSC): Some support from the Office of Population's cooperative agreement with AVSC will be available to supplement the mission cooperative agreement with AVSC to expand the capacity of the service delivery system to deliver long-term methods. Central resources will support New York and regional office salaries and travel, consultants required, and part of the subproject costs.

(ii) Contraceptive Social Marketing III: SOMARC: CSM III assistance will provide support to GSMF and act as the institutional partner for GSMF. This includes assistance in marketing and contraceptive logistics; management training, strategic planning, and financial management. This assistance will begin as the FPHP project phases down.

(iii) POLICY/OPTIONS: Policy is a new policy project currently being developed that will incorporate OPTIONS, RAPID and other activities. OPTIONS and/or the new Policy project will provide support to the NPC and act as an institutional partner for the NPC. Support will also be provided for instituting a rational pricing structure for contraceptives; expansion of the essential drugs list; technical assistance to PIP; and conducting secondary analyses of the 1998 DHS, particularly exploring reproductive health variables and linking the data analysis to operations research.

(iv) Information, Education and Communications (IEC)/Johns Hopkins University/Population Communications Services (JHU/PCS): The Office of Population's IEC program will provide support to the HEU, and act as an institutional partner for the HEU and provide specific IEC assistance to PPAG, GRMA and NPC. USAID will also explore with JHU the possibility of holding the JHU communications course in Ghana in conjunction with the University.

(v) Family Planning Logistics Management (FPLM): FPLM will provide targeted technical assistance to the MOH to ensure that the public sector logistics system is functioning properly through periodic assessments and technical assistance visits and logistics management training for MCH/FP personnel. In addition FPLM will provide some technical assistance in logistics management to PPAG.

(vi) Operations Research (OR/TA): The OR/TA project will support the Navrongo research station, and conduct variety of studies and analyses. OR/TA will also provide technical assistance to PPAG in strengthening their OR capacity.

(vii) JHPIEGO: In conjunction with AVSC, JHPIEGO will provide assistance supplemental to AVSC's cooperative agreement with USAID for long-term method training and other training assistance.

(viii) INTRAH/FHI: INTRAH and FHI will continue their support for updating and disseminating clinical guidelines and providing contraceptive technology updates for MCH/FP, other MOH, GRMA, PPAG, NPC and others.

(ix) PRIME: The follow-on to the PAC II project will continue INTRAH activities in clinical guidelines, and contraceptive technology updates, and provide technical assistance in STDs for training for GRMA, and MOH.

(x) Demographic and Health Surveys (DHS): conduct and analyze 1998 DHS, including secondary analysis of DHS data.

(xi) CEDPA: Provide support to NGOs.

(xii) EVALUATION: The Evaluation project will provide support for using appropriate indicators and developing appropriate evaluation systems.

6. OYB Transfers

Operating Year Budget (OYB) transfers will be made yearly from funds authorized to the USAID/Ghana Mission to the Central Contraceptive Procurement Project (CPSD) (936-3057). These funds will be used by the CPSD to supply family planning commodities for the MOH and the GSMF from their worldwide contraceptive procurement contracts. Contraceptive procurement tables will be developed by the MOH MCH/FP division and the GSMF and

presented to the USAID Mission on a yearly basis. The Mission approves the procurement and forwards the requests to the CPSD which will supply the commodities through their contractors and freight forwarders directly to the MOH or GSMF warehouse, including shipping, insurance, and customs clearance.

A total of eleven million dollars ($10 for family planning and $1 for AIDS/STD prevention) is programmed for contraceptive procurement as follows:

1995	1996	1997	1998	1999
$2,000,000	$3,000,000	$3,000,000	$2,000,000	$1,000,000

The contraceptives available under the CPSD include: condoms, with and without printed packaging; oral contraceptives; vaginal foaming tablets; NORPLANT®; the Copper T-380-IUD; and Depo Provera. Estimates of the annual requirements are estimated by the TARGET Model in Annex F and will be adjusted annually based on contraceptive procurement tables (CPTs) developed jointly by implementing agencies and USAID, with technical assistance from a centrally funded cooperating agency.

7. **Endowment:**

As a means to promote sustainability, the GHANAPA Program will include endowments for two beneficiaries - the Ghana Social Marketing Foundation, and an endowed academic chair for the Center for Population and Development to be located at the University of Ghana - Legon. The use of USAID funds for endowments was authorized for the first time in FY 1990 legislation and expanded in 1993 and 1994. According to recent draft USAID/Washington guidelines, all endowments will have to be for non-governmental organizations, be approved by the Africa Bureau and the funds must be invested in the United States.

A grant to cover the endowments will be made directly to a U.S.-based NGO with experience in both African development projects and managing endowments, such as the African American Institute, Trans Africa, or Africare. The grant will be competed to find the institution which can provide the best services for the beneficiaries. The NGO will act as trustee to invest the funds and manage subagreements with the GSMF and the board of directors of the Center for Population and Development. They will also provide technical assistance in institutional development, fund raising and the management of endowments to the beneficiaries. This grant will be obligated outside the bilateral agreement so that it may be approved separately by USAID's Africa Bureau without holding up the bilateral agreement. The grant will contain all the details of the purposes, management and conditions of both endowments.

a. Ghana Social Marketing Foundation

In addition to the direct grant to GSMF which will be provided to cover operating expenses during the life of GHANAPA, as described in Section III, an endowment will be established to provide for recurrent costs beginning in the year 2000. Through this endowment, GHANAPA's assistance to the private sector's family planning and AIDS programs will continue long after the Project Assistance Completion Date.

USAID will enter into a grant agreement with the U.S. based NGO trustee which will specify the terms of the endowment. The trustee will concurrently enter into an agreement with the GSMF which specifies the technical assistance to be provided and conditions under which the GSMF will receive the funds. Both agreements will be subject to approval of USAID/Ghana and the Africa Bureau.

The endowment will be invested in the U.S. with interest reinvested until the year 2000. At that time, the interest from the accumulated endowment fund will be made available to the GSMF on a yearly basis to supplement profits from the sales of donated commodities to cover the recurrent costs of promotion, training and administration, and eventually, to be used to purchase additional contraceptives. In order to receive funds from the endowment, the GSMF will have to meet a set of minimum criteria as contained in the grant agreement designed to assure USAID and the trustee that the GSMF is functioning properly.

USAID will maintain oversight function of the endowment during the life of the GHANAPA Program. In the year 2000 the trustee will begin the transfer of the endowment fund to the GSMF. Such a transfer would be in stages, upon GSMF meeting a second set of criteria to be specified in the grant agreement, for example its fund raising success, its influence on policy, and its leadership in the health field. If the GSMF is unable to meet the criteria, the funds may be provided for another Ghanaian NGO working in the population field.

b. Endowed Chair for the Center for Population and Development, University of Ghana - Legon

The University of Ghana - Legon has a rich history of supporting academic programs and research in Population. The UNFPA funded Regional Institute for Population Studies (RIPS) is a center for academic and research activities for all of West Africa. The Population Impact Project (PIP), located in the Department of Geography and Resource Development, has been supported by USAID through the RAPID Project of the Futures Group. PIP is very influential in promoting the importance of population to high level Ghanaian policy makers. The Departments of Sociology and Community Medicine also have population and family planning oriented programs. Additionally, the University is developing a School of Public Health, which will include courses in population and family planning.

The goal of the Center for Population and Development is to enhance and consolidate the conduct and dissemination of pioneering research in population, resources, environment and

development in Ghana. The center will also serve as a source of up-to-date information and a resource center for students, researchers and professionals in the field.

The University of Ghana - Legon strategic development plan promotes the use of endowed chairs and programs for special professorial appointments in departments, faculties, or disciplines to attract experienced, world-class academics willing to teach, especially at post graduate levels, and to lead sustained research.

The Center for Population and Development will be an autonomous center, with its own board of directors, affiliated with the University. The University will reorganize its population activities around the Center and provide office space, secretarial services and other support as its contribution. A Western Consortium Population Fellow will be requested to be financed with USAID/Washington core funds for the first two years to collaborate with the trustee to help establish the Center and prepare it for independent functioning under its Board of Directors. The independence of the Center's administration will provide a buffer from the vacillations of government university funding and should attract support from other donors for the endowment. The Center will attract professors and students from across the University to teach and conduct research in population and development issues. As an independent organization, the Center can accept outside contracts to support its research activities.

The Chair will be endowed by a $500,000 grant to be held in trust by a U.S.-based NGO. The trustee will manage the investment of the endowment, provide technical assistance for the institutional development of the board of directors of the center and eventual transfer of the endowment to the board. The endowment will be allowed to increase under the management of the NGO trustee for two years while the Western Consortium Fellow is assisting the development of the Center and its establishment as a private non-governmental organization. . The interest will then begin to be provided to the Center to: (1) fund a dollar denominated salary and benefits in order to attract and retain a high level professor; (2) provide research funds for population activities; and (3) provide support for the Center.

Seven percent of the total endowment, at least $35,000, will be guaranteed to the University annually from this investment to ensure a minimum of funds for salary and other fixed costs. If the endowment produces interest greater than 7%, the additional amount would be divided with 50% going to increase the principal to build the endowment, and 50% going to the Center. If the interest rate fall below 7%, the trustee will have to use the principal to make up the difference. Other organizations will be challenged to contribute to the endowment.

8. Dollar Tracking Exemption:

The PID/PAIP, approved by the ECPR in STATE 077357 dated March 24, 1994, stated that the Mission would request an exemption from the requirements of Section 536(b) of the 1994 Appropriations Act related to planned uses and tracking of dollars for the cash grant portion of GHANAPA. Subsequently, the Mission included the exemption request in the Congressional Notification for GHANAPA (Annex N), which expired without objection on

August 23, 1994 (STATE 229290). The GOG has developed a foreign exchange allocation system that is open and non-directive and it would be intrusive and contrary The section on dollar tracking provides a more detailed description of the GOG's transparent and open interbank system.

D. Illustrative Financial Plan

The GHANAPA Program consists of $14 million in NPA, and a $31 million Project, which is divided into a $6 million bilateral grant agreement, a $11 million Operating Year Budget (OYB) transfer to the Central Contraceptive Procurement Project and $14 million in grants to NGOs, including local NGOS, a cooperative agreement with AVSC and a grant to a U.S. NGO to establish and manage the endowments. The GOG will provide at least $6.666 million in local currency and in kind as counterpart funds, and the equivalent of $1.4 million (10% of NPA) to the USAID trust fund. The NGOs will provide at least $4.666 million in additional cash or in kind for managing the endowment as counterpart to their grants. Some of this counterpart will be realized from the return to project funds from the sales of contraceptives and services. The Population Office of the USAID/Washington Global Bureau has agreed to provide approximately $13 million worth of technical assistance from centrally-funded cooperative agreements to be used for the GHANAPA Program. The total Program budget will therefor exceed $69 million.

TABLE 12: **Summary Cost Estimate and Financial Plan (US $ 000)**

Project Outputs	USAID/Ghana FX	USAID/W	GOG Contribution LC	OTHER - NGOs FX	OTHER - NGOs LC	TOTAL
Non-Project Assistance						
1. Family Planning	11,000					11,000
2. HIV/AIDS/STDs	3,000					3,000
Total NPA	14,000					14,000
Family Planning Component						
1. Improved Policy	150	4,750	1,000			5,900
2. Increased Demand	400	1,500	1,200		291	3,391
3. More Services	19,705	5,350	3,500		3,000	31,555
4. Sustainability	5,500			1,375		6,875
Family Planning Total	25,755	11,600	5,700	1,375	3,291	47,721
AIDS/STD Component						
1. Improved Policy	140	500	66			706
2. Behavior Change	1,150	400	400			1,950
3. STD Diagnosis/Treatment	120		300			420
4. Better Surveillance	856	500	200			1,556
AIDS/STD Total	2,266	1,400	866			4,632
Monitoring/Evaluation	1,200					1,200
Audits	150					150
Program Support	1,629					1,629
GHANAPA PROGRAM TOTAL	45,000	13,000	6,666	1,375	3,291	69,332

Tables 13 and 14 divide the Project by outputs and inputs. The Family Planning and AIDS/STD control components are treated separately. These estimates are approximate as GHANAPA is an integrated family planning program and many of the inputs will assist both the Family Planning and AIDS outputs.

TABLE 13: **Costing of Project Outputs/Inputs - Family Planning Component**

Project Inputs	(US$000 or equivalent) Project Outputs				TOTAL
	Policy	Demand	Services	Sustain.	
Family Planning Component					
A. Technical Assistance					
B. Training	150	150	700		1,000
C. Grants to NGOs			8,500	5,500	14,000
D. Commodities					
1. Contraceptives			10,000		10,000
2. Equipment/Materials	100	155	500		755
Sub-total Family Planning Inputs	250	305	19,700	5,500	25,755
E. Monitoring, Evaluations and Studies	300	300	300	300	1,200
F. Audits	38	38	38	36	150
G. Program Support	407	407	408	407	1,629
Family Planning Component GHANAPA Project Total	**995**	**1,050**	**20,446**	**6,243**	**28,734**
USAID/W centrally-funded technical assistance/studies DHS/KAP/CS	4,750	1,500	5,350		11,600
GRAND TOTAL	5,745	2,550	25,796	6,243	40,334

TABLE 14: **Costing of Project Outputs/Inputs - AIDS/STD Prevention and Control Component**

Project Inputs	Project Outputs				TOTAL
	Policy	Behavior Change	STD Rx Treatment	Surveill-ance	
AIDS/STD Control Component					
A. Technical Assistance				150	150
B. Training	100	130	120	230	580
C. Commodities					
1. Condoms		1,000			1,000
2. Laboratory Supplies/equipment		20		441	461
D.Special Studies	40			35	75
AIDS/STD Component GHANAPA Project Total	**140**	**1,150**	**120**	**856**	**2,266**
USAID/W centrally-funded projects	500	400		500	1,400
GRAND TOTAL	640	1,550	120	1,356	3,666

Table 15 projects expenditure by fiscal year. The Host Country and other categories are again estimates, actual Host Country expenditures are estimated to be much higher.

TABLE 15: **Projection of Expenditure by Fiscal Year**

Fiscal Year	AID (US $ 000)			Host Country	NGO Counterpart Funds	Total
	NPA	PRO.	Central			
1994	2,000	1,316	1,800	1,111		6,227
1995	3,000	8,010	2,200	1,111	933	15,254
1996	3,000	7,635	2,200	1,111	933	14,879
1997	3,000	5,858	2,600	1,111	933	13,502
1998	3,000	5,252	2,200	1,111	933	12,496
1999	0	2,929	2,000	1,111	934	6,974
Total	14,000	31,000	13,000	6,666	4,666	69,332

E. Other Donor Support Activities

Ghana's donors collaborate closely in the health and family planning sector. Donors in the sector meet once a month to discuss program implementation, health sector issues, technical resources and planning, both short-term and medium-term. As a result of this close coordination, donors have been able to shape their projects to compliment other activities and avoid duplication. USAID is considered by the other donors and the GOG to be the lead donor in family planning and AIDS, with a comparative advantage due to its level of resources and wealth of experience and its successes, especially in the private sector.

Major multilateral donors in the health sector are the World Bank, Africa Development Bank (ADB), European Economic Community (EEG), UNICEF, UNDP, UNFPA, and the World Health Organization (WHO). Major bilaterals, in addition to USAID, include the British (ODA), Danish (DANIDA), German (GTZ), Japanese (JICA), the Dutch governments and the Saudi Fund for Development. ODA is supporting the health sector with about US $18 million over 3 years and DANIDA with US $ 22 million over 5 years'. Other external Non-Governmental organizations that support the health sector are Save the Children Fund (UK) and World Vision International.

There is a considerable amount involved in donor assistance to the health sector. Analysis of known donor commitments over five years (1991-1996) revealed an amount of over 100 Million U.S. dollars to the health sector giving an average yearly support of 20 million U.S. dollars.

Donor support provided to the Ministry of Health in 1994 (including technical assistance and project administration cost) is however estimated to exceed $54 million. In addition to donor support, the MOH has budgeted the cedi equivalent of $55 million for recurrent expenditures and the cedi equivalent of $8 million for capital expenditures. Thus, the 1994 MOH budget totals $115 million. In previous years, GOG actual expenditures have covered approximately 30 percent of their proposed recurrent budget.

Analysis of the 1994 budget shows that many donors are concentrating on strengthening systems and structures which impact on the MOH primary health care (PHC) systems. This involves strengthening general management, drugs and logistics management, transport systems, manpower management and the establishment of Health Management Information Systems (HMIS). The ADB will finance hospital rehabilitation and the provision of equipment; EEG supports the recurrent budget with emphasis on budget lines that affect PHC and rural health services; the World Bank project supports district PHC, drug infrastructure and management and MOH reorganization; ODA will provide medical equipment, support subdistrict health development and financial and manpower management. The Japanese Government is assisting the Noguchi Memorial Institute to conduct basic research in HIV viruses. Under the Common Agenda for Cooperation in Global Perspective the Japanese are expected to provide additional support to NGOS, in coordination with GHANAPA.

Several donors support specific regions - DANIDA in the Upper West; SCF (UK) in the Eastern region, GTZ in the Northern region and World Vision International in the Western region. there are some donors who support specific programs or areas. JICA regularly supports biomedical research in the Noguchi Memorial Institute and provides equipment for EPI. DANIDA supports a national TB control program.

In the area of family planning, there are 3 major donors - USAID, UNFPA and the World Bank. To date a substantial part of the resources for AIDS and STD control continue to be provided by USAID. However other donors including GTZ, EEG, WHO and the Dutch Government do contribute to this activity.

Donor Coordination:

Coordination of GHANAPA with other donors involved in family planning and AIDS/STD control has, and will, continue to strengthen policy dialogue, ensure complimentary programming, and stretch the impact of resources. The donors meet monthly to discuss program implementation, health sector issues and technical resources and planning. USAID has played an active role in the meetings and will continue to do so. The table below summarizes the current donor support in the health sector.

Table 16 **CURRENT DONOR SUPPORT TO THE HEALTH SECTOR IN GHANA.**

AGENCY/PROJECT	DESCRIPTION	COST (U.S. $)
UNICEF:1991-95 Plan of Action	Support in safe motherhood, nutrition, PHC and water & sanitation with a focus on regions and districts.	9.6 Million
UNFPA: GHA\89 P01: 1991-95 Strategy MCH/FP services	Mgt. strengthening in MCH, supply of contraceptives, equipment & vehicles, construction of comm. clinics, overseas and local training.	3.4 Million
World Bank: Cr 2193: 1991-95	Supply of contraceptives, vaccines and drugs construction of 40 DMO bungalows equip 33 DHMT offices, rehabilitation of all medical stores & PHC management support including equipment for district hospitals in Northern Sector.	27 Million
ADB II 1993 - 1995	Rehabilitate and equip 3 district hospitals (Kibi, Yendi & Keta).	13.6 Million
ADB I 1991 - 1995	Major rehabilitation and equipping of Korle-Bu KATH and Efia Nkwanta hospitals.	16 Million
USAID: 1991-96: Family Planning and Health Program	Contraceptive & ORS supply, TBA program and AIDS control with the necessary training and support for activities.	35 Million
JICA: annually	Cold chain equipment and vehicles	300,000
SCF: 1991 - 1995: Program of Assistance	Transport policy and management at national level.	240,000
	Support to Eastern region MOH in management strategy, HMIS, AIDS control etc.	300,000
WVI: 1992 - 1994	PHC support to Western region involving vehicles, EPI equipment and training.	154,000
SAUDI FUND FOR DEVELOPMENT: 1993 - 1998	100 rural Health Centers.	20.35 Million
GTZ: 1994 - 1998	Laboratory support for AIDS	1.1 Million
	PHC support Northern Region	-
DANIDA: 1994 - 1998	Support to Training Institutions	8 Million
	National TB Control	4.7 Million
	PHC support UWR	9.7 Million
ODA: 1993 - 1996	Support in equipment & maintenance, financial subdistrict development, Policy Development and Human Resource Development	18.2 Million

AGENCY/PROJECT	DESCRIPTION	COST (U.S. $)
NETHERLANDS GOVERNMENT: 1993	AIDS reagents, laboratory equipment, dental consumables & equipment, blood transfusion supplies	2.4 Million

Other than USAID, major donors providing specific family planning assistance to Ghana are the UNFPA and the World Bank. The ODA in 1993 provided $1,600,000 through the UNFPA for family planning commodities for the Ministry of Health. The Dutch Government also in 1993 provided $ 154,000 worth of Neo-Sampoon through the UNFPA to the Ministry of Health, DANIDA, The GTZ and SCF are providing family planning assistance as part of their Primary Health Care program in the Upper West, Northern and Eastern Regions respectively.

1. **The United Nations Fund for Population Activities (UNFPA)**

The UNFPA's U.S.$ 3.4 Million project cover:-

- Management strengthening support for the MCH/FP activities in the Ministry of Health
- Supply of contraceptives, equipment and vehicles
- Construction of community clinics
- Overseas and local training program for the Ministry of Health.

2. **The World Bank**

The World Bank's population and family planning assistance of $2,040,000 supports the PPAG in the supply of commodities and in expansion of both clinic and community-based distribution programs.

The goals of major donors in family planning, the UNFPA and the World Bank are closely aligned with that of the USAID. Donors activities are relatively well coordinated and are mutually supportive. This process is expected to continue as the Ministry of Health further develops its ability to effectively coordinate all donor agencies.

VIII. CONDITIONS AND NEGOTIATING STATUS

A. Negotiation Strategy

USAID/Ghana has negotiated the conditionality requirements of the GHANAPA Program cash grant in order to remove certain constraints to the successful completion of the GHANAPA objectives and to build toward program sustainability. Under the cash grant there are five sets of conditionality responding to five yearly releases, or tranches, of US Dollars. These conditionalities address establishment of the Population and AIDS Coordinating Committee; achievement of specific family planning program impact benchmarks and budgetary allocations and expenditures for the MOH; contraceptive pricing policy; MOH HIV/AIDS/STD monitoring, prevention and control activities; revision of the Essential Drugs List and National Formulary; budgeting and allocations for the National Population Council; and revision of contraceptive commodity forecasting and stocking practices.

USAID's allocation of $14 million in NPA will assist the GOG in defraying the increase in non-personnel recurrent costs associated with GHANAPA, and it will help to induce the GOG to undertake difficult policy reforms, such as shifting the mandate for provision of short-term family planning interventions form the public to the private sector, increasing the public sector's capacity to provide long-term family planning methods and integrating family planning and AIDS prevention programs into the national budget while elevating their role in the national development agenda.

At $14 million over 6 years, or approximately $2.3 million per year, the NPA represents the minimum increase in sectoral funding, exclusive of personnel remunerations, that will be required to meet the objectives of GHANAPA. For its part, the GOG will be expected to meet the increased personnel costs associated with GHANAPA implementation, as well as any additional expenditures to meet program objectives as Ghana's economy and health sector programs expand.

Ultimately, the impact of the policy program is a synergism of efforts for a long-term directed and concerted program for a steady increase of contraceptive prevalence and eventually, declines in fertility, the population growth rate, and the growth of the HIV/AIDS epidemic.

B. Conditionality Rationale

The following is a description of the rationale for each Condition Precedent as negotiated with the Government of Ghana. The conditions precedent are presented in section C and are summarized in the Policy Matrix (Annex A).

1. **Completion of Conditions Precedent for the Family Planning and Health Program**

The GHANAPA program builds upon the advances of the Family Planning and Health Program. At the time of signing the GHANAPA Grant Agreement, the Government of Ghana has not completed the last of the conditions precedent for the FPHP, which was the establishment of the National Population Council and its Secretariat. Since the NPC is to play a major role in GHANAPA, it is essential that it be established prior to the implementation of GHANAPA.

2. **Population and AIDS Coordinating Committee**

As discussed above, the GHANAPA program will be coordinated by PACC. As a condition to receiving the first tranche of NPA, the government of Ghana will formally establish the PACC which will funded through the National Population Council and will be composed of representatives of the involved Ministry of Health units, MFEP, National Development and Planning Commission (NDPC), GSMF, GRMA, PPAG, CHAG, AVSC, University of Ghana at Legon, and other organizations as required. (The NDPC has been included as it may be the umbrella organization of the NPC.) USAID will also be represented as a member of the PACC. The PACC will consist of two committees, a policy committee, which will meet quarterly, and a technical committee, which will meet monthly. The PACC policy committee will have specific responsibilities concerning establishing budgetary levels for the NPC based on annual workplans.

3. **GOG allocates adequate resources to the MOH to meet agreed-upon annual family planning benchmarks as measured by couple years of protection:**

a. Family Planning Benchmarks: The GHANAPA family planning component's purpose is to 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 and a shift in long-term methods from 20 percent to 40 percent of overall method mix. Couple years of protection is seen as an excellent indicator of progress as it represents both demand and supply, and can be calculated quarterly from service delivery data. The Target Model contained in the Technical Analyses (Annex F) has been used to estimate the couple years of protection (CYP) from all sources, by method, required to achieve this purpose, as summarized below:

Table 19 - **Total Program CYP in Thousands Required to Meet Objectives**

	1994	1995	1996	1997	1998	1999	2000
Condoms	172	191	208	222	233	241	244
Orals	118	138	158	179	201	222	244
VFTs	24	28	33	38	43	49	54
Injectables	52	71	94	120	151	186	227
IUDs	30	38	47	56	67	79	90
Norplant	3	4	5	7	9	11	14
Female Sterliz.	32	39	47	55	64	73	82
Total CYP	431	509	592	677	768	861	955

In order to move toward sustainability through greater private sector participation, the Ministry of Health's proportion of short-term contraceptives is expected to shift from 48% in 1993 to 25% in the year 2000 and the proportion of long term methods from 85% to 75% by project's end. The actual level of short term CYPs provided by the MOH is expected to decline, as the private sector increases its share, resulting in a major policy shift. The public share of program couple years of protection is given in Table 20 below.

Table 20 **Public Sector CYP in Thousands Required to Meet Objectives**

	1994	1995	1996	1997	1998	1999	2000
Condoms	77	79	80	78	74	68	61
Orals	53	57	60	62	63	63	61
VFTs	11	12	13	13	14	14	14
Injectables	45	60	77	97	119	143	170
IUDs	25	31	37	43	50	58	65
Norplant	2	3	4	6	7	8	10
VSC - F	26	30	35	40	46	49	54
TOTAL CYP	239	273	306	339	371	404	435

The figures in Table 20 represent an apportioning of the total program effort based upon a projection model and assumptions concerning the pace of the shifts to long-term methods and the private sector. The figures depict an order of magnitude rather than precise annual estimates. Hence, the conditionality benchmarks as shown below in Table 21, are defined as 80% of the aggregate CYPs for both short and long-term methods for 1994 and 1995; 85% for 1996; 90% for 1997; 95% for 1998; and 100% for 1999 and 2000. The benchmarks which the Ministry of Health will be expected to achieve are as follows:

Table 21 **Public Sector CYP Benchmarks (in Thousands) Required to Meet Conditionality**

	1994	1995	1996	1997	1998
Short-term	113	118	130	137	143
Long-term	78	99	130	167	210

While the total number of CYP required is increasing, the level of short-term method CYP provided by the MOH actually decreases by the end of the project in accordance with the policy objective to emphasize more effective methods of contraception and devolve responsibility for delivery of short-term methods to the private sector.

The MCH/FP unit of the MOH will present a copy of its annual work plan, training plan and budget estimations to indicate to the PACC and USAID that appropriate actions are being taken to promote family planning demand generation and service delivery. The PACC will be required to analyze all service statistics on a quarterly basis to determine how well each service provider; ie. MOH, GSMF, PPAG, GRMA, is doing in the delivery of services. The MOH will analyze progress and factors affecting the meeting of CYPs in yearly report to USAID.

b. **MOH Budget**: In order to sustain and achieve the GHANAPA objectives, the Ministry of Health must receive sufficient government resources to carry out program activities. The GOG budget, including the MOH's, is divided into recurrent and capital costs. Recurrent costs are composed of:

Item 1 - Personnel
Item 2 - Travel and Transport
Item 3 - General Expenditure
Item 4 - Maintenance and Repairs
Item 5 - Other Recurrent Expenditures
Item 6 - Subventions (to organizations like the pharmacy board)

Since personnel is basically a fixed cost, budget reductions often disproportionately affect Items 2-5 which are required for operations. GHANAPA is therefore focussing on Items 2-5.

Analysis of the GOG recurrent budget over the years has shown the MOH maintaining a second position after the Ministry of Education. Percentage of total GOG recurrent resource allocated to the MOH has ranged from 7.0 percent in 1984, 10.9 percent in 1990 to a peak of 13.1 percent in 1993 and a decline to 10.1 percent in 1994. Further analysis of the non-personnel cost (items 2-5) of the MOH as a percentage of GOG's recurrent budget (from the 1994 Broad Based Budget Summary) also shows a significant reduction in funds available for the MOH program activities as shown in Table 22. The percentage has dropped from 24% in 1992 to 14% in 1994. The MOH has attributed the reduction to cuts in pharmaceutical procurement and feeding of patients programs. Allocation for drugs and feeding as a percentage of the MOH non-personnel recurrent budget has declined from 43.1% in 1992 to 16.4% in 1994. Despite low levels of resource allocation, Family Planning and AIDS program activities have continued with moderate successes as a result of availability of substantial extra-budgetary funds from donor sources.

Table 22 - **MOH/GOG Budget Showing Donor Assistance (in millions)**

MOH/GOG BUDGET	1992 ACTUAL	1993 ESTIMATE	1994 ESTIMATE
MOH Personnel Item 1	¢12,186	¢26,365	¢27,764
Total GOG Personnel	¢105,571	¢227,600	¢274,554
% of GOG	11.5%	11.6%	10.1%
MOH Items 2-5	¢13,372	¢16,864	¢16,357
Total GOG Items 2-5	¢55,524	¢66,980	¢114,443
% of GOG	24.1%	25.2%	14.2%
Total Donor	$30.23	$44.89	$71.96

The Ministry of Finance and Economic Planning must, therefore, ensure that the decline in the level of operating funds available to the Ministry of Health must not affect its ability to reach the CYP benchmarks. This will be especially important after 1995 when the current Family Planning and Health Project ends, and the "off budget" Non Project Assistance funds ares no longer available to finance family planning and AIDS control activities.

c. Budget Guidelines: Since decentralization of planning and budgeting is expected to take place over the next six years, the MOH policy and planning guidelines and the MFEP budget guidelines to regions and districts will play an important role in ensuring that funds are requested and expended for family planning activities. A copy of the pertinent guidelines prioritizing family planning activities will be made available to USAID and the PACC.

d. Work and Training Plans: Although with decentralization, there will not be a separate line item for family planning in the MOH budget, the MCH/FP unit will be

responsible for developing national work plans for family planning, and coordinating family planning training activities with the Human Resources Development Division, and other MOH units. These plans should be summarized and presented to USAID, so they can be analyzed by the PACC.

e. **Clinical Guidelines:** A major constraint in the provision of family planning services is inappropriate clinical practices by some health care providers. The development and dissemination of clinical guidelines will help educate family planning providers to change some of the outdated attitudes. The guidelines will also be instrumental in developing pre-service curricula for medical, nursing and midwifery schools.

The MOH and National Population Council are currently coordinating the preparation of guidelines with technical assistance from FHI and INTRAH provided under the Family Planning and Health Program. The guidelines will be ready for approval before the release of the second tranche of NPA funds.

4. **Revised Contraceptives Pricing Policy:** Disparity in commodity pricing for short-term methods between the public and private sector disproportionately burdens the public system and adversely affects sustainability in both sectors. To encourage the GOG to revise its current contraceptive pricing policy, the National Population Council is conducting a study to determine the appropriate pricing structure of short-term contraceptive supplies. This analysis will form the basis for the establishment and implementation of a more rational public sector pricing policy by the MOH in collaboration with the NPC, GSMF, MFEP, PPAG and GRMA.

5. **MOH's HIV/AIDS/STD Prevention and Control Program:**

a. **Budget:** The government agrees to fund the MOH's HIV/AIDS/STD prevention and control program activities as part of the MOH budget. As with the family planning, the National AIDS Control Program will be responsible for ensuring that budget guidelines to the national, regional and district levels prioritize HIV/AIDS/STD activities. The NACP will prepare a separate analysis of factors affecting the MOH's ability to meet its objectives.

b. **National Sero-surveillance System:** As part of the public sector's HIV/AIDS/STD control program, the MOH has established a national sero-surveillance system which will test 15,000 blood samples a year for HIV and syphilis. The GHANAPA project will provide test kits and reagents for this testing, while the GOG will be responsible for funding its operation. The NACP will, therefore, be requested to provide annual reports of the results of the system along with analyses of the HIV epidemic's progress and identify problem areas.

c. **Annual HIV/AIDS/STD Work and Training Plans:** The NACP will develop annual work and training plans to assist the coordination of HIV/AIDS/STD programs throughout the Ministry of Health, including assistance for NGOs. These will be presented to USAID for analysis in the PACC. Since CHAG Mission hospitals and clinics have been shown to treat

the most cases of STDs in Ghana, it is important that their health providers also have access to the best information. The MOH has therefore agreed to fund CHAG training programs for STD prevention, counseling and treatment upon request from CHAG which will be included in the MOH's STD training plans and reports of activities presented to the PACC.

6. **Revised Essential Drugs List and National Formulary**: The current GOG's Essential Drug List and National Formulary, does not include subdermal contraceptive implants and the more effective STD drugs. The National Formulary which is provided to both the public and the private sector, gives guidelines on procedures and standardized management protocols for diseases and other health conditions at the various levels of the health pyramid. A revised EDLNF which will be made available to all health providers along with appropriate training would improve provider practices in family planning and effective management of STD's.

7. **Signatories Assigned and Bank Account Established**: The GOG will assign several officials from the Ministry of Health and Ministry of Finance and Economic Planning to be able to approve program implementation documents. An interest bearing dollar account will be established in a U.S. bank to receive the NPA funds upon completion of the tranche conditionalities.

8. **National Population Council**:

The NPC is a parastatal organization which functions as the highest advisory body on Population to the Government of Ghana. It is tasked with providing policy guidance and coordinating the implementation of population activities in all sectors of government, non-governmental organizations and the private sector. The NPC is to play a pivotal role in GHANAPA in implementation of policy activities, as well as chairing and supporting the PACC.

The NPC will develop annual workplans for its activities, with indicators for specific objectives it intends to accomplish. Once PACC has approved these workplans, NPA conditionality will be based on the NPC providing evidence that the objectives have been met. Funding for NPA activities will be guaranteed by the MFEP, either through the national treasury or other sources.

9. **Improved Contraceptive Commodity Forecasting and Stocking Procedures:** Inappropriate public sector commodity forecasting and stocking practices within the MOH has led to imbalances throughout the system. A 1993 Family Planning Logistics Management Study of the National Contraceptive supply system showed that changes in the public sector inventory management could result in cost savings through reduction of the required pipeline. GHANAPA NPA will assist the MOH in the revision and implementation of public sector guidelines for forecasting contraceptive requirements at all levels of the system. These activities will ensure that the MOH logistics system can accommodate increased quantities of contraceptive commodities and alleviate stockouts and commodity expiration by reducing the pipeline from an average of 31 to 21 months.

C. Conditionality Agenda

1. Conditions Precedent to Tranche Disbursement

Tranche 1: (1995) Prior to the first disbursement under the Grant, in the amount of Two Million United States dollars (US$2,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID:

Condition Precedent No. 1: The Grantee has met all conditions precedent to disbursement for each tranche of the Family Planning and Health Program non-project assistance.

Evidence Required

(1) USAID FPHP Program Implementation Letter confirming that all conditionality has been met.

Condition Precedent No. 2: The Grantee has established a Population and AIDS Coordinating Committee (PACC) with policy and technical functions, to be chaired by the NPC and comprised of senior officials from the MFEP, MOH, NPC, University of Ghana at Legon, GSMF, GRMA, PPAG, AVSC, CHAG and USAID.

Evidence Required

(1) GOG official letter to the NPC to establish the PACC and authorize the NPC Secretariat to initiate coordinating meetings

(2) PACC 1995 program of work.

Condition Precedent No. 3: The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon family planning benchmarks as measured by couple years of protection.

Evidence Required

(1) Assessment of 1994 quarterly service statistics indicating MOH progress in achieving family planning benchmarks for Couple Years of Protection (CYP) at 113,000 for short-term methods and 78,000 for long-term methods, and an analysis of factors affecting achievement of family planning benchmarks.

(2) Analysis of the GOG 1995 approved budget indicating GOG and MOH non-personnel recurrent (items 2-5) levels.

(3) The GOG 1995 General Budget Guidelines and MOH Policy & Planning Guidelines.

(4) Summary of the 1995 MOH family planning program of work including training plan.

Condition Precedent No. 4: The Grantee has completed a contraceptive pricing study with recommendations for graduated price increases and annual implementation plans which results in commensurate increases in cost recovery.

Evidence Required

(1) Contraceptive pricing study with recommendations and implementation plan.

Condition Precedent No. 5: The Grantee has allocated adequate resources, based on an annual program of work to be reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities.

Evidence Required:

(1) The GOG 1995 General Budget Guidelines and MOH Policy and Planning Guidelines and an analysis by MOH of the factors affecting the HIV/AIDS/STD prevention and control program.

(2) Analysis of the results of 1994 national sero-surveillance system including status of HIV and syphilis, issues/problems, recommendations and implementation plan.

(3) Analysis of the 1995 MOH HIV/AIDS/STD program of work and training plan, including STD training for CHAG institution personnel at a level approved by PACC.

Condition Precedent No. 6: The Grantee has adopted action plans with specific timetables to include subdermal contraceptive implants, and more effective drugs for the treatment of STDs on Essential Drugs List and the National Formulary (EDLNF)

Evidence Required:

(1) Plan of action to include subdermal contraceptive implants in the EDLNF.

(2) Plan of action to modify the EDLNF to incorporate more effective STD drugs.

Condition Precedent No. 7: The PACC has approved the 1995 annual work plan for the National Population Council with agreed upon objectives, and has received a commitment

from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Evidence Required

(1) The National Population Council (NPC) 1995 program of work including indicators for specific objectives, training plan and budget as approved by PACC.

(2) The 1995 GOG budget establishing a separate line item for the NPC to cover capital, personnel and other recurrent expenditures of the NPC and its secretariat, including activities of the PACC, or evidence of other financial support.

Condition Precedent No. 8: The Grantee has furnished to USAID specimen signatures of the responsible officers for GHANAPA on behalf of the Ministry of Finance and Economic Planning (MFEP) and the Ministry of Health (MOH) and the names of the banks and numbers of the interest-bearing accounts to be used to transfer U.S. dollars during program implementation.

Evidence Required

(1) A letter indicating approved signatories on behalf of the GOG (MFEP and MOH) and their signatures.

(2) A statement designating an interest-bearing account in a U.S. bank for dollar transfers.

Tranche 2 (1996) Prior to second disbursement under the Grant, in the amount of Three Million United States dollars (US$3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID:

Conditions Precedent No. 1: The Grantee is allocating adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon family planning benchmarks as measured by couple years of protection.

Evidence Required

(1) Analysis of 1995 quarterly service statistics indicating MOH progress toward achieving family planning benchmarks for Couple Years of Protection (CYP) at 118,000 for short-term methods and 99,000 for long-term methods, and an analysis by the MOH of factors affecting achievement of family planning benchmarks.

(2) Analysis of the GOG 1995 expenditure report indicating GOG and MOH expended non-personnel recurrent (items 2-5) levels.

(3) Analysis of the GOG 1996 approved budget indicating GOG and MOH non-personnel recurrent (items 2-5) levels.

(4) The GOG 1996 General Budget Guidelines and MOH Policy and Planning guidelines that family planning is a priority at the national, regional and district levels.

(5) Approved family planning clinical guidelines, a report indicating that the guidelines have been disseminated to all family planning providers, and a report on training programs for presenting the guidelines.

(6) Analysis of the 1996 MOH national family planning work and training plans.

Condition Precedent No. 2: The Grantee has completed the following actions: (a) revised its contraceptive pricing policy upon consideration of a contraceptive pricing study; (b) adopted a schedule of graduated price increases for contraceptives which shall result in the recovery of increasing percentage of annual commodity costs by the year 2000 - based on the study and approved by PACC; and, (c) disseminated the revised pricing policy to all public sector providers and implemented the first stage of price increases.

Evidence Required

(1) Revised contraceptive pricing policy, MOH circular to all providers announcing new pricing policy, and letter indicating that new pricing policy has been disseminated to all providers.

(2) Annual adjusted contraceptive price schedules.

Condition Precedent No. 3: The Grantee is allocating adequate resources, based on an annual program of work to be reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities.

Evidence Required:

(1) The GOG 1996 General Budget Guidelines and MOH Policy and Planning Guidelines indicating that HIV/AIDS/STD a priority at the national, regional and district levels and an analysis by MOH of the factors affecting the HIV/AIDS/STD prevention and control program.

(2) Analysis of the results of 1995 national sero-surveillance system including status of HIV and syphilis, issues/problems, recommendations and implementation plan.

(3) Analysis of the 1995 MOH HIV/AIDS/STD program indicating progress and problem areas.

(4) Analysis of the 1996 MOH HIV/AIDS/STD program of work and training plan, including STD training for CHAG institution personnel at a level approved by PACC.

Condition Precedent No. 4: The Grantee has revised the Essential Drugs List and the National Formulary (EDLNF) to include subdermal contraceptive implants and more effective drugs for the treatment of STDs, and has distributed the revised EDLNF to all Ghanaian health care practitioners.

Evidence Required:

(1) The Essential Drugs List and the National Formulary.

(2) Report of the distribution of the Essential Drugs List and the National Formulary.

(3) Approved clinical guidelines for the treatment of STDs including use of more effective drugs, a report indicating that the guidelines have been disseminated to all health facilities, and a report on training programs presenting the guidelines.

Condition Precedent No. 5: The Grantee has improved its contraceptive forecasting and stocking procedures to reduce the commodity pipeline to an average of 21 months, to ensure that contraceptive commodities are used prior to their expiration date.

Evidence Required

(1) Approved revised contraceptive forecasting and stocking procedures.

(2) Report indicating that revised forecasting and stocking procedures have been disseminated and are being utilized throughout the MOH.

Condition Precedent No. 6: The National Population Council (NPC) has achieved the objectives of the 1995 annual workplan. The PACC has approved the 1996 annual work plan for the NPC with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Evidence Required

(1) Report of the 1995 National Population Council (NPC) activities indicating progress in meeting objectives specified in the program of work.

(2) The NPC 1996 program of work including specific objectives, training plan and budget as approved by PACC.

(3) The 1996 GOG budget establishing a separate line item for the National Population Council (NPC) to cover capital, personnel and other recurrent expenditures of the NPC and its secretariat, including activities of the PACC, or evidence of other financial support.

Tranche 3 (1997) Prior to third disbursement under the Grant, in the amount of Three Million United States dollars (US$3,000,000), or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID:

Conditions Precedent No. 1: The Grantee is allocating adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon family planning benchmarks as measured by couple years of protection.

Evidence Required

(1) Assessment of 1996 quarterly service statistics indicating MOH progress toward achieving family planning benchmarks for Couple Years of Protection (CYP) at 130,000 for short-term methods and 130,000 for long-term methods, and an analysis by the MOH of factors affecting achievement of family planning benchmarks.

(2) Analysis of the GOG 1996 expenditure report indicating GOG and MOH expended non-personnel recurrent (items 2-5) levels.

(3) Analysis of the GOG 1997 approved budget indicating GOG and MOH non-personnel recurrent (items 2-5) levels.

(4) The GOG 1997 General Budget Guidelines and MOH Policy and Planning guidelines that Family planning is a priority at the national, regional and district levels.

(5) Analysis of the 1997 MOH national family planning work and training plans.

Condition Precedent No. 2: The Grantee is implementing a schedule of graduated price increases for contraceptives which shall result in the recovery by public sector family planning service providers of annual commodity costs at a level exceeding that achieved under the second tranche, as approved by the PACC.

Evidence Required

(1) Annual adjusted contraceptive price schedules.

Condition Precedent No. 3: The Grantee has allocated adequate resources, based on an annual program of work reviewed by PACC, to the MOH to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities.

Evidence Required:

(1) The GOG 1997 General Budget Guidelines and MOH Policy and Planning Guidelines indicating that HIV/AIDS/STD is a priority at the national, regional and district levels and an analysis by MOH of the factors affecting the HIV/AIDS/STD prevention and control program.

(2) Analysis of the results of 1996 national sero-surveillance system including status of HIV and syphilis, issues/problems, recommendations and implementation plan.

(3) Analysis of the 1996 MOH HIV/AIDS/STD program indicating progress and problem areas.

(4) Analysis of the 1997 MOH HIV/AIDS/STD program of work and training plan, including STD training for GHAC institution personnel at a level approved by PACC.

Condition Precedent No. 4.: The Grantee has reviewed its contraceptive forecasting and stocking procedures to ensure that the reduced pipeline has resulted in fewer commodity expirations.

Evidence Required

(1) Report indicating that revised forecasting and stocking procedures are reducing the commodity pipeline to an average of 21 months.

(2) Report indicating results of training of MOH staff on the revised forecasting and stocking procedures.

Condition Precedent No. 5: The National Population Council (NPC) has achieved the objectives of the 1996 annual workplan. The PACC has approved the 1997 annual work plan for the NPC with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Evidence Required

(1) Report of the 1996 National Population Council (NPC) activities indicating progress in meeting objectives specified in the program of work.

(2) The NPC 1997 program of work including specific objectives, training plan and budget as approved by PACC.

(3) The 1997 GOG budget establishing a separate line item for the National Population Council (NPC) to cover capital, personnel and other recurrent expenditures of the NPC and its secretariat, including activities of the PACC, or evidence of other financial support.

Tranche 4 (1998) Prior to the fourth disbursement under the Grant, in the amount of Three Million United States dollars (US$3,000,000) or to the issuance by USAID of Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID:

Conditions Precedent No. 1: The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon annual family planning benchmarks as measured by couple years of protection.

Evidence Required

(1) Analysis of 1997 quarterly service statistics indicating MOH progress toward achieving family planning benchmarks for Couple Years of Protection (CYP) at 137,000 for short-term methods and 167,000 for long-term methods, and an analysis by the MOH of the impact on family planning benchmarks.

(2) Analysis of the GOG 1997 expenditure report indicating GOG and MOH expended non-personnel recurrent (items 2-5) levels.

(3) Analysis of the GOG 1998 approved budget indicating GOG and MOH non-personnel recurrent (items 2-5) levels.

(4) The GOG 1988 General Budget Guidelines and MOH policy and budget guidelines that family planning is a priority at the national, regional and district levels.

(5) Analysis of the 1998 MOH national family planning work and training plans at all levels.

Condition Precedent No. 2: The Grantee is implementing a schedule of graduated price increases for contraceptives which shall result in the recovery by public sector family planning service providers of annual commodity costs at level exceeding that achieved under the third tranche, as approved by PACC.

Evidence Required

(1) Annual adjusted contraceptive price schedules.

Condition Precedent No. 3: The Grantee has allocated adequate resources, based on an annual program of work reviewed by PACC, to the MOH to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities.

Evidence Required:

(1) The GOG 1998 General Budget Guidelines and MOH Policy and Planning Guidelines indicating that HIV/AIDS/STDS is a priority at the national, regional and district levels and an analysis by MOH of the factors affecting the HIV/AIDS/STD prevention and control program.

(2) Analysis of the results of 1997 national sero-surveillance system including status of HIV and syphilis, issues/problems, recommendations and implementation plan.

(3) Analysis of the 1997 MOH HIV/AIDS/STD program indicating progress and problem areas.

(4) Analysis of the 1998 MOH HIV/AIDS/STD program of work and training plan, including STD training for CHAG institution personnel at a level approved by PACC.

Condition Precedent No. 4: The National Population Council (NPC) has achieved the objectives of the 1997 annual workplan. The PACC has approved the 1998 annual work plan for the NPC with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Evidence Required

(1) Report of the 1997 National Population Council (NPC) activities indicating progress in meeting objectives specified in the program of work.

(2) The NPC 1998 program of work including specific objectives, training plan and budget as approved by PACC.

(3) The 1998 GOG budget establishing a separate line item for the National Population Council (NPC) to cover capital, personnel and other recurrent expenditures of the NPC and its secretariat, including activities of the PACC, or evidence of other financial support.

Tranche 5 (1999) Prior to fifth disbursement under the Grant, in the amount of Three Million United States dollars (US$3,000,000) or to the issuance by USAID of documentation pursuant to which such disbursement will be made, the Grantee will, except as the Parties may agree otherwise in writing, furnish to USAID, in form and substance satisfactory to USAID:

Conditions Precedent No. 1: The Grantee has allocated adequate resources to the MOH non-personnel recurrent budget (items 2-5) to meet agreed-upon annual family planning benchmarks as measured by couple years of protection.

Evidence Required

(1) Assessment of 1998 quarterly service statistics indicating MOH progress toward achieving family planning benchmarks for Couple Years of Protection (CYP) at 143,000 for short-term methods and 210,000 for long-term methods, and an analysis by the MOH of the impact on family planning benchmarks.

(2) Analysis of the GOG 1998 expenditure report indicating GOG and MOH expended non-personnel recurrent (items 2-5) levels.

(3) Analysis of the GOG 1999 approved broad based budget indicating GOG and MOH non-personnel recurrent (items 2-5) levels.

(4) The GOG 1999 General Budget Guidelines and MOH Policy and Planning guidelines that family planning is a priority at the national, regional and district levels.

(5) Analysis of the 1999 MOH national family planning work and training plans.

Condition Precedent No. 2: The Grantee has implemented a schedule of graduated price increases for contraceptives which shall result in the recovery by public sector family planning service providers, of annual commodity costs at a level exceeding that achieved under the fourth tranche, as approved by the PACC.

Evidence Required

(1) Annual adjusted contraceptive price schedules.

Condition Precedent No. 3: The Grantee has allocated adequate resources, based on annual program of work reviewed by the PACC, to conduct HIV/AIDS and sexually transmitted disease (STD) monitoring, prevention, and control activities.

Evidence Required:

(1) The GOG 1999 General Budget Guidelines and MOH Policy and Planning Guidelines indicating that HIV/AIDS/STDS is a priority at the national, regional and district levels and an analysis by MOH of the factors affecting the HIV/AIDS/STD prevention and control program.

(2) Analysis of the results of 1998 national sero-surveillance system including status of HIV and syphilis, issues/problems, recommendations and implementation plan.

(3) Analysis of the 1998 MOH HIV/AIDS/STD program indicating progress and problem areas.

(4) Analysis of the 1999 MOH HIV/AIDS/STD program of work and training plan, including STD training for CHAG institution personnel at a level approved by PACC.

Condition Precedent No. 4: The National Population Council (NPC) has achieved the objectives of the 1998 annual workplan. The PACC has approved the 1999 annual work plan for the NPC with agreed upon objectives, and has received a commitment from the Ministry of Finance and Economic Planning for provision of adequate resources to carry out these objectives.

Evidence Required

(1) Report of the 1998 National Population Council (NPC) activities indicating progress in meeting objectives specified in the program of work.

(2) The NPC 1999 program of work including specific objectives, training plan and budget as approved by PACC.

(3) The 1999 GOG budget establishing a separate line item for the National Population Council (NPC) to cover capital, personnel and other recurrent expenditures of the NPC and its secretariat, including activities of the PACC, or evidence of other financial support.

2. Tranche Reviews:

Under the cash grant, two types of tranche reviews will be held. An informal pre-tranche review is tentatively scheduled for December of each year to review progress in meeting CPs to current year tranche disbursement. More formal annual tranche reviews will occur two months prior to scheduled disbursement of the respective tranches to identify and develop a strategy for resolving any problems in meeting CPs. USAID will notify the MFEP and MOH

in writing at least seven months prior to the formal tranche review of the specific evidence that will be required to meet the conditionality.

Prior to each pre-trance and tranche review, the MFEP will advise USAID/Ghana in writing of the status of progress towards meeting the CPs. Findings that CPs to disbursement have been met will be documented through the issuance of a PIL when all CPs to disbursement have been met, as determined by the USAID/Ghana Mission Director in accordance with applicable delegations of authority.

3. **Tranche Disbursements:**

The first and subsequent tranches will be disbursed immediately after an approved PIL has been sent to MFEP and MOH confirming that CPs to disbursement of the respective tranches have been met. After issuance of the PIL, USAID will instruct USAID/W (FA/FM/CMPD) by cable to transfer the funds to the GOG designated Bank of Ghana account in New York. The cable will include: (1) certification that all CPs have been met and the date met; (2) any other information which may be required under the terms of the agreement to make the disbursement; (3) the dollar amount to be disbursed; and (4) the Bank of Ghana's U.S. bank address, account name and account number. USAID/W will then effect the transfer from the U.S. Treasury to that account. At this point, all USAID responsibility for tracking will cease.

4. **Dollar Tracking:**

SECTION 537(b) of the 1994 Appropriations Act states that countries receiving cash transfers or cash disbursing non-project sector assistance, whether Development Assistance, Development Fund for Africa or Economic Support Funds, are required to establish separate accounts for receipt of such funds and not to commingle them with other funds. The legislation further requires USAID to submit a Congressional Notification at least 15 days prior to obligation of any such cash transfer or non-project assistance, including details on the planned uses of the dollars to be provided.

GHANAPA will require that the GOG establish and use a separate interest-bearing account in New York for U.S. Dollars. Dollars will be tracked until they are deposited into the separate account. At that point, USAID will cease to track the dollars. Dollars will be used either for adding to the foreign currency reserves of the Bank of Ghana, or for sale to the commercial banking system through the Bank of Ghana's interbank system. Through the years, the GOG has demonstrated competency in programming, utilizing and accounting for funds. Its accounting system is dependable and transparent. Adhering to Section 536(b) requirements for detailing planned uses of dollars provided by GHANAPA would be intrusive to Ghana's foreign exchange allocation system, a system that is open and transparent. Because of this and the level of control that would be required by USAID, which represents more control than the GOG itself requires, USAID has received approval to exempt GHANAPA under Section 537(b)(4) of the Act (see Congressional Notification and expiration cable in Annex N).

5. **GOG Contribution:**

Dollar disbursements will go directly into the coffers of the GOG and no local currency will be generated. The GOG will provide sufficient funding for the local currency needs of GHANAPA through the General Budget. Conditionality under the cash grant has been drafted in such a way that the GOG will be responsible for demonstrating that adequate budgetary resources have been appropriated, committed and disbursed. USAID's role will be to monitor the conditionality and the specific conditions as they relate to specific program and impact indicators. USAID, MFEP and MOH, as part of the tranche review process will discuss and come to agreement on the local currency needs of GHANAPA for each year and discuss any problems and delays in supplying local currency to the MOH or CHAG as part of the tranche review process. The agreement reached by USAID and the GOG will be formalized in a PIL that will be signed by the Minister of Finance and Economic Planning, Minister of Health and USAID.

Under previous cash grants, the GOG has contributed a percentage of local currency generations to the USAID Trust Fund. USAID and the GOG have signed a formal Agreement on the use and reporting of Trust Funds by USAID.

Since no local currency will be generated under GHANAPA, the agreement will require the GOG to make available the cedi equivalent of ten percent (10%) of the dollar value of that year's NPA disbursement from the GOG's General Budget. The exact amount of each year's allocation will be discussed as part of the tranche review and will be incorporated in the Letter of Intent signed by the MFEP.

PN-ABJ 692
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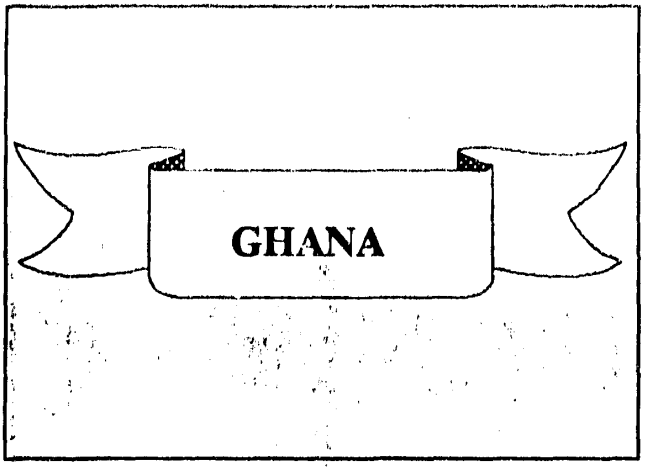

Ghana Population and AIDS (GHANAPA) Program

Nos. 641-0131 and 641-0132

Annexes

Volume 2

September 29, 1994

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ANNEX A

GHANA POPULATION AND AIDS PROGRAM

POLICY MATRIX

Policy/Objective	Tranche 1 (4/95) $2,000,000	Tranche 2 (4/96) $3,000,000	Tranche 3 (4/97) $3,000,000	Tranche 4 (4/98) $3,000,000	Tranche 5 (4/99) $3,000,000	Impact Indicators
1. GOG has met all Conditions Precedent for the FPHP NPA	•USAID FPHP PIL					•FPHP provides strong basis for successful GHANAPA Program
2. GOG establishes a Population and AIDS Coordinating Committee	•GOG letter to NPC •PACC program of work					•PACC established and functioning
3. GOG is allocating resources to meet family planning benchmarks as measured by CYP	•MOH provides 113,000 short-term CYP and 78,000 long-term CYP and analysis of factors affecting family planning •Analysis of 1995 MOH non-personnel recurrent costs budget •GOG general budget & MOH policy and planning guidelines •1995 MOH family planning work and training plans	•MOH provides 118,000 short-term CYP and 99,000 long-term CYP and analysis of factors affecting family planning •1995 Public Expenditure Review •Analysis of 1996 MOH non-personnel recurrent costs budget •GOG & MOH guidelines prioritize family planning •Family planning clinical guidelines •1996 MOH family planning work and training plans	•MOH provides 130,000 short-term CYP and 130,000 long-term CYP and analysis of factors affecting family planning •1996 Public Expenditure Review shows targets met •Analysis of 1997 MOH non-personnel recurrent costs budget •GOG & MOH guidelines prioritize family planning •1997 MOH family planning work and training plans	•MOH provides 137,000 short-term CYP and 147,000 long-term CYP and analysis of factors affecting family planning •1997 Public Expenditure Review shows targets met •Analysis of 1998 MOH non-personnel recurrent costs budget •GOG & MOH guidelines prioritize family planning •1998 MOH family planning work and training plans	•MOH provides 143,000 short-term CYP and 210,000 long-term CYP and analysis of factors affecting family planning •1998 Public Expenditure Review shows targets met •Analysis of 1999 MOH non-personnel recurrent costs budget •GOG & MOH guidelines prioritize family planning •1999 MOH family planning work and training plans	•Public sector family planning objectives
4. Revision of the public sector contraceptive pricing policy	•Contraceptive pricing structure study with recommendations and implementation plan	•Revised contraceptive pricing policy and dissemination report •Adjusted contraceptive price schedules	•Adjusted contraceptive price schedules	•Adjusted contraceptive price schedules	•Adjusted contraceptive price schedules	•Cost recovery from MOH commodity sales increased •Private/public sector price differential reduced

Policy/Objective	Tranche 1 (1995) $2,000,000	Tranche 2 (1996) $3,000,000	Tranche 3 (1997) $3,000,000	Tranche 4 (1998) $3,000,000	Tranche 5 (1999) $3,000,000	Impact Indicators
5. GOG allocates adequate resources and conducts HIV/AIDS/STD monitoring, prevention and control programs	•GOG budget & MOH policy and planning guidelines and analysis by MOH of factors affecting program •Analysis and results of 1994 sero-surveillance system •1995 HIV/AIDS/STD work and training plans including CHAG	•GOG & MOH budget guidelines prioritize HIV/AIDS/STD prevention and control activities and analysis by MOH of factors affecting program •Analysis and results of 1995 sero-surveillance system •1996 HIV/AIDS/STD work and training plans including CHAG	•GOG & MOH budget guidelines prioritize HIV/AIDS/STD prevention and control activities and analysis by MOH of factors affecting program •Analysis and results of 1996 sero-surveillance system •1997 HIV/AIDS/STD work and training plans including CHAG	•GOG & MOH budget guidelines prioritize HIV/AIDS/STD prevention and control activities and analysis by MOH of factors affecting program •Analysis and results of 1997 sero-surveillance system •1998 HIV/AIDS/STD work and training plans including CHAG	•GOG & MOH budget guidelines prioritize HIV/AIDS/STD prevention and control activities and analysis by MOH of factors affecting program •Analysis and results of 1998 sero-surveillance system •1999 HIV/AIDS/STD work and training plans including CHAG	•HIV/AIDS/STD EOPS Indicators
6. Revised Essential Drugs List and National Formulary to include subdermal contraceptive implants and more effective drugs to treat STDs	•Plan of action to include subdermal contraceptive implants and more effective STD drugs to EDLNF	•Revised EDLNF including subdermal contraceptive implants and recommended STD treatment drugs •Report of EDLNF distribution •STD treatment guidelines				•Subdermal implants and recommended STDs drugs available in MOH facilities in each region and STD clinic
7. Signatories assigned and bank account established	•Signatories from MFEP and MOH assigned and bank account established					•Signatories assigned and bank account established
8. National Population Council functioning	•1995 NPC workplan with specific objectives	•1995 NPC workplan objectives reached •1996 NPC workplan with specific objectives	•1996 NPC workplan objectives reached •1997 NPC workplan with specific objectives	•1997 NPC workplan objectives reached •1998 NPC workplan with specific objectives	•1998 NPC workplan objectives reached •1999 NPC workplan with specific objectives	•NPC functioning
8. Improved contraceptive commodity forecasting and stocking procedures.		•New forecasting formula developed and accepted by GOG •Dissemination and utilization report	•Forecasting formula adjusted to reduce pipeline to average of 21 months •staff trained on revised procedures.			•Stockouts and outdated supplies reduced

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GHANA POPULATION AND AIDS PROGRAM
LOGICAL FRAMEWORK[1]

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
GOAL:	**MEASURE OF GOAL ACHIEVEMENT:**		
To lower fertility through family planning activities	Total fertility rate (TFR) reduced from 5.5 to 5.0	DHS 1993, 1998	Political stability and economic growth continue
and			
stabilize the rate of increase of HIV/AIDS	Annual rate of increase of HIV/AIDS incidence stabilized at no more than 1% annually	Annual sero-surveillance reports	
PURPOSE:	**END OF PROJECT STATUS:**		
To increase the use of modern and effective family planning methods	1. Modern contraceptive prevalence rate (CPR) increased from 10% to 20% among women in union.	1. DHS 1993, 1998 and Consumer surveys 1993, 1995, 1997, 1999	Use of modern contraceptive methods remains an important determinant of TFR.
	2. Percent of CPR derived from long term methods (IUDs, injectables, Norplant, voluntary surgical contraception (VSCs) increased from 20% to 40%	2. DHS 1993, 1998 and Consumer surveys 1993, 1995, 1997, 1999	Other donors will continue to support family planning, AIDS and MCH activities that complement the USAID program.
			Men will increasingly support the use of family planning methods.
	3. Percent of total demand satisfied (all contraceptive methods) rises from 26.4% to 50%.	3. DHS 1993, 1998 and Consumer surveys 1993, 1995, 1997, 1999	HIV prevalence will not reach epidemic proportions.
and			
to increase knowledge and practice of HIV/AIDS risk reduction behavior	4. At least 50% of respondents report using a condom during the most recent act of sexual intercourse with a non-regular partner	4. DHS 1998 Consumer surveys 1995, 1997, 1999	
	5. Number of people citing at least two acceptable ways to prevent HIV infection rises from 61% to 75%	5. Consumer survey 1995, 1997, 1999	

[1] Unless otherwise noted, baseline year for indicators is 1993 and target year is 1999.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
OUTPUTS **A. FAMILY PLANNING COMPONENT** **Improved Planning/Policy for FP Activities**	CYP from the MOH rises from 191,000 in 1994 to 353,000 for the year 2000. GOG reviews and revises pricing policy for commodities annually	NPA conditionality documentation NPA conditionality documentation	Political and financial support will continue for FP and MCH in both the public and private sectors Efforts to reform the budgetary process for family planning programs will not be overwhelmed by broader GOG/MOH budget management problems as planning and budgetary management responsibilities are devolved to regional and district administration.
Increased Demand for Family Planning Services	50% of all respondents can name (without prompting) 3 or more contraceptive methods. Percent of women who think their husband/partner approves of couples using a method to avoid pregnancy rises from xx% to xx%	DHS 1993, 1998 Consumer Surveys 1995, 1997, 1999 DHS 1993, 1998 Consumer surveys 1995, 1997, 1999	
Expanded Provision of Family Planning Services	Percent of FP service providers restricting access to FP services on the basis of marital status, or spousal consent decreases from xx to xx. Total couple years protection (CYP) for modern methods rises from 350,000 to 955,000. Total CYP for long term methods rises from 48,000 to 237,000 55 facilities in public/private sector completed for provision of long term methods (VSC, NOORPLANT®) for a total of 115 sites by 2000.	Situation Analysis 1996, 1998 Service statistics from MOH, GSMF, GRMA, PPAG Service statistics from MOH, Semi-annual report from Cooperative Agreement	
Improved Family Planning Program Sustainability	CYP provided through the private sector accounts for 25% of all long-term methods provided and 75% of short-term methods by 2000 Cost recovery from MOH commodity sales rises from 5.5% to at least 15% by 1999	Service statistics from MOH, GSMF, GRMA and PPAG Revisions in MOH commodity pricing policy	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
OUTPUTS **B. AIDS/STD COMPONENT**			
Improved Planning/Policy for AIDS/STD Activities	Annual sero-surveillance system functioning as planned. 15,000 specimens analyzed annually for HIV and syphilis. Standards and procedures for licensing laboratories established by 1996	NPA conditionality documentation NPA conditionality documentation National Record	Political and financial support will continue for AIDS and STD activities in both the public and the private sectors.
Improved Diagnosis and Treatment of STDs	STD case management guidelines revised and disseminated by 1996 At least 60% of STD cases treated according to national guidelines At least 50% of those seeking STD care receive appropriate advice on condoms and partner notification	MOH reports Situation Analysis 1996, 1998 Situation Analysis 1996, 1998	
Improved HIV/STD Surveillance	HIV sero-prevalence monitored through sentinel surveillance system Sero-positivity for syphilis among pregnant women monitored through sentinel surveillance system	Sentinel surveillance results Sentinel surveillance results	

Narrative Summary	Objectively Verifiable Indicators		Means of Verification	Important Assumptions
INPUTS:	(US$000)			
USAID	**USAID**			
Non-Project Assistance	**Non-Project Assistance**	14,000		
AID Project	**Bilateral Grant Agreement**			
1. Family Planning Component	1. Family Planning Component			1. USAID, GOG and private sector resources are available and disbursed in a timely manner.
Technical assistance	Training	1,000	1. Reports	
Training	Commodities	755		
Commodities	M&E and Studies	1,200	2. Surveys	
Operations Research	Audits	150		
Grants	Program Support	1,600	3. Budgets	
Program Support	Subtotal	4,705		
			4. Financial Reports	
2. HIV/AIDS/STD Component	2. HIV/AIDS/STD Component			
Technical Assistance	Technical Assistance	150		
Training	Training	580		
Commodities	Commodities	461		
Operations Research	Special Studies	75		
Program Support				
	Subtotal	1,266		
3. Endowments				
	Total Bilateral Grant	**6,000**		
4. Contraceptives	**Grants to NGOs**			
85,570,000 Condoms	Local NGOs	5,500		
12,483,700 Oral cycles	Cooperative Agreement	3,000		
17,101,380 VFT	Endowments	5,500		
149,070 IUDS				
2,904,790 Depo Provera				
12,695 NORPLANT sets	**Total Grants to NGOs**	**14,000**		
GOG AND PRIVATE SECTOR	**Contraceptives**	**11,000**		
1. Personnel				
2. Health and training facilities, private shops and stores	**Total USAID**	**45,000**		
3. Operational costs	**GOG**			
4. Project Support	25% Counterpart (minimum)	**6,666**		
	Private/NGO Sector			
	25% Counterpart	**4,666**		
	GRAND TOTAL	**$56,332**		

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ANNEX C

ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Ghana

PROJECT TITLE AND NO.: Ghana Population and AIDS Program (GHANAPA 641-0118)

FUNDING: FY 1995-2001 US$14.0mil(NPA) $31.0 mil(PA)

IEE PREPARED BY: Denise Rollins, USAID/Accra

ENVIRONMENTAL ACTION RECOMMENDED:

1. Categorical Exclusion (for healthcare, family planning components)

2. Negative Determination (for distribution and/or use of commodities for STD testing and HIV screening)

CONCURRENCE:

Bureau Environmental Officer:
John J. Gaudet, AFR/ARTS/FARA

APPROVED: ✓
DISAPPROVED: ____
DATE: 7/14/94

CLEARANCE:

GC/AFR: [signature] DATE: 7/14/94

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SUMMARY OF FINDINGS:

The purpose of this activity is to limit the spread of HIV in Ghana. It will raise the awareness of AIDS, HIV and sexually-transmitted disease (STD) control and prevention. It will also expand the delivery of services for sexually-transmitted disease(s). Assistance includes an NPA component which will serve to develop a supportive policy environment for population and family planning activities. The most notable policy reforms include: the creation of the National Population Council as an advisory to government on population issues, the revision of the National Population Policy for improved legal and regulatory framework, the removal of restrictions on the sale and distribution of contraceptives, and the legalization of the advertising of contraceptives.

Program Description:

GHANAPA is a $45 million program that will be administered over a six-year period. The $14 million Non-Project Assistance (NPA) component will be disbursed over a five-year period aimed at promoting sustainability. To accomplish this goal, conditionalities will be required to encourage a reduction in provider practices that now impede service delivery, and to ensure that all family planning methods and drugs for treatment of sexually transmitted diseases (STDS) are contained on the Essential Drug List.

The $31 million in Project Assistance (PA) will be used for technical assistance, training, and the purchase of contraceptives.

The overall strategic objectives of the program are to encourage policy reforms; to increase the demand for family planning, to expand the provision of family planning services, to foster greater sustainability of family planning programs through an endowment to the Ghana Social Marketing Foundation, to promote safe sexual behavior, to encourage proper diagnosis and treatment of STDs, and to improve the surveillance of AIDS/HIV/STDs.

USAID will implement these activities by providing small grants and equipment to the public, private, and the NGO sectors, with technical assistance to be provided by U.S. Contractors.

A categorical exclusion is recommended on the basis that this project is a program involving health care, population, and/or family planning services, under section 216.2(c)2(viii) of USAID's Environmental procedures (Reg 16).

A negative determination is requested for the activities dealing with sexually-transmitted disease case management because this component of the project does not anticipate any activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.) The project may include the provision of HIV/AIDS prevention and control commodities (such as disposable gloves, syringes and other protective materials). These commodities may be distributed to regional hospitals and health centers.

Although blood may be drawn for the purpose of STD diagnosis, or HIV counselling and testing, proper disposal facilities and techniques are already in use. In this regard, it has been determined through discussions with the Ministry of Health, that commodities provided through the project will be used appropriately and will be disposed of safely. USAID/Accra, based on Ghanian government regulations for disposal of contaminated medical commodities, and planned monitoring of how these regulations are followed during the project, is confident that the HIV/AIDS prevention and control commodities supplied under this project will be disposed of in an environmentally safe manner.

Further, following the guidance provided in State 264038(93), copy attached, the Mission Environmental Officer will provide the Bureau Environmental Officer with a more complete report on bio-hazardous waste disposal in Ghana.

AID/AFR/FARA/ARTS:JGAUDET:12AIDS1
08/20/93 7-9029
AID/AFR/FARA/ARTS:CREINSTMA

PRIORITY ADDIS ABABA, PRIORITY DAKAR

ROUTINE NAIROBI, ABIDJAN

AIDAC NAIROBI AND ABIDJAN FOR REDSOS (REGION. ENV. OFF.)

E.O. 12356: N/A

TAGS:

SUBJECT: DISPOSAL OF BIOHAZARDOUS WASTE GENERATED FROM USAID AIDS PROJECTS

REF: BARBIERO/HOFFMAN FAX (8/19/93)

1. SUPPORT TO AIDS CONTROL (663-0010), USAID/ADDIS ABABA AND AIDS CONTROL AND PREVENTION PROJECT (685-0306), USAID/DAKAR HAVE BOTH PREVIOUSLY RECEIVED CATEGORICAL EXCLUSIONS UNDER REG 16. RECENTLY CONCERN HAS BEEN RAISED IN AID/W REGARDING SAFE DISPOSAL OF BIOHAZARDOUS WASTER GENERATED BY AIDS PROJECTS WHERE STD SCREENING AND HIV TESTING ARE BEING IMPLEMENTED.

2. AFR HAS NOT PREVIOUSLY REVIEWED AIDS PROJECTS ESPECIALLY TO DETERMINE IF CONDITIONS AND PROCEDURES IN EXISTENCE IN SUBJECT HOST COUNTRIES ARE ADEQUATE TO ENSURE THAT RISKS ASSOCIATED WITH BIOHAZARDOUS WASTES ARE MITIGATED.

3. BUREAU ENVIRONMENTAL OFFICER HAS PROVIDED THE EXECUTIVE SUMMARY OF AN AIDS PROJECT IN THE ASIA BUREAU WHERE THESE CONCERNS WERE RAISED AND AN ENVIRONMENTAL ASSESSMENT WAS CARRIED OUT. THE RECOMMENDATIONS MADE FROM THAT ENVIRONMENTAL ASSESSMENT ARE INSTRUCTIVE AND WOULD PROVIDE A ROUGH GUIDE TO THE ESSENTIAL POINTS THAT SHOULD BE REVIEWED IN BOTH SUBJECT PROJECTS.

4. AFR WOULD APPRECIATE INFORMATION FROM MEOS IN SUBJECT

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MISSIONS BY RETURN CABLE THAT WOULD ADDRESS SIMILAR CONCERNS IN SUBJECT COUNTRIES, PLEASE USE EXECUTIVE SUMMARY BELOW AS A MODEL FOR YOUR REPLIES.

5. FOR ADDIS ABABA: BEO HAS RECEIVED SUMMARY INFORMATION IN RECENT IEE AMENDMENT, AND ON THAT BASIS A NEGATIVE DETERMINATION HAS BEEN APPROVED FOR THE IEE AMENDMENT, WITH THE PROVISO THAT A MORE DETAILED REPORT ON DISPOSAL OF BIOHAZARDOUS WASTE WILL BE PASSED TO BEO IN THE NEAR FUTURE.

6. EXECUTIVE SUMMARY OF ENVIRONMENTAL ASSESSMENT FOLLOWS:

A.- THE AIDS SURVEILLANCE AND EDUCATION PROJECT (ASEP) IS A JOINT UNDERTAKING OF THE PHILIPPINE DEPARTMENT OF HEALTH AND USAID/MANILA TO ESTABLISH THE INSTITUTIONAL MECHANISMS IN THE PUBLIC AND PRIVATE SECTORS TO: A) DEVELOP A NATIONAL HIV/AIDS SENTINEL SURVEILLANCE SYSTEM AND B) EXPAND INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES, TARGETING INDIVIDUALS AT HIGH RISK OF BECOMING INFECTED WITH HIV/AIDS AND RAISING THE GENERAL PUBLIC'S AWARENESS ABOUT THE IMPORTANCE OF PREVENTING HIV INFECTION. THE SENTINEL SURVEILLANCE SYSTEM WILL REQUIRE OBTAINING BLOOD SAMPLES FROM INDIVIDUALS IN SELECTED SENTINEL GROUPS (I.E., HIGH-RISK GROUPS). AS MANY AS THIRTY SURVEILLANCE SITES ARE PLANNED FOR NATIONAL COVERAGE. APPROXIMATELY ONE THOUSAND BLOOD SAMPLES WILL BE COLLECTED EVERY SIX MONTHS AT THE SITES, PRODUCING A CORRESPONDING AMOUNT OF USED MEDICAL MATERIALS WHICH ARE POTENTIALLY HIV CONTAMINATED.

B.- THE PROPER HANDLING OF THESE MATERIALS SO AS TO ELIMINATE OR SUBSTANTIALLY REDUCE THE RISK OF ACCIDENTAL INFECTION OF INDIVIDUALS WHO MAY COME INTO CONTACT WITH THEM WAS THE MAIN FOCUS OF AN ENVIRONMENTAL ASSESSMENT. THE RISK OF ACCIDENTAL INFECTION IS THE "REASONABLY FORESEEABLE ENVIRONMENTAL EFFECT" OF ASEP.

C.- RECOMMENDATIONS OF THE ENVIRONMENTAL ASSESSMENT FOR MANAGING THESE MATERIALS IN WAYS WHICH REDUCE THIS RISK AND ARE NOT ENVIRONMENTALLY HARMFUL ARE AS FOLLOWS:

- THE GENERAL STRATEGY TO BE FOLLOWED IS TO INITIATE DECONTAMINATION OF MATERIALS BY THE TECHNICAL STAFF

INVOLVED WITH BLOOD COLLECTION AND BY THE MEDICAL TECHNICIANS CONDUCTING THE TESTING PRIOR TO THE RELEASE OF THESE MATERIALS FOR SUBSEQUENT PROCESSING THROUGH THE HOSPITALS ESTABLISHED PROCEDURES.

- NEEDLES USED WITH VACUTAINERS WILL BE DEPOSITED IN A PUNCTUREPROOF CONTAINER (E.G., POWDERED MILK CONTAINERS) WHICH CONTAINS A FRESH SOLUTION OF SODIUM HYPOCHLORITE. THESE CONTAINERS WILL HAVE A SMALL SLIT OR OPENING CUT IN THEM LARGE ENOUGH TO ALLOW DEPOSITING OF THE NEEDLE IMMEDIATELY AFTER USE. THE MEDICAL TECHNICIAN COLLECTING THE BLOOD SAMPLES WILL BRING A CAN CONTAINING THE SOLUTION TO THE COLLECTION SITE. THESE CANS WILL BE DELIVERED TO THE REGIONAL HOSPITAL/LABORATORY WHERE THEY WILL BE BURIED IN THE HOSPITAL GROUNDS AT A "DEDICATED SITE" FOR THIS PURPOSE TO PREVENT SCAVENGING FOR SALE OR REUSE. SURVEILLANCE WILL BE UNDERTAKEN IN 30 DIFFERENT SITES AND EACH SITE WILL DISPOSE OF ITS OWN WASTE. THE VOLUME OF SODIUM HYPOCHLORITE THAT WILL BE BURIED DURING THE ENTIRE PERIOD OF THE SURVEILLANCE PROGRAM WILL NOT CAUSE A SIGNIFICANT NEGATIVE IMPACT ON THE ENVIRONMENT.

- THE VACUTAINER SYSTEM THAT WILL BE USED TO COLLECT BLOOD SAMPLES WILL BE HELD IN STURDY RACKS PLACED INSIDE LEAK-PROOF CONTAINERS LINED BY AN ABSORBENT PAD. IF SPILLS OCCUR, SODIUM HYPOCHLORITE SHOULD BE USED TO CLEAN CONTAMINATED SURFACES AND MATERIALS. THE CONTAINERS ARE SAFE AND EASY TO USE BY EXPERIENCED LABORATORY TECHNICIANS. BLOOD SAMPLES, I.E., THE BLOOD CLOTS RESULTING FROM TESTING, CAN BE SAFELY DISPOSED OF BY POURING THEM DOWN THE SINK AND DECONTAMINATING THE SINK WITH SODIUM HYPOCHLORITE.

- RUBBER GLOVES WHICH CAN BE REUSED WILL BE WASHED, AND THEN AUTOCLAVED. CONTAMINATED PAPER AND GLOVES WHICH ARE PUNCTURED, TORN OR IN SOME WAY UNUSABLE WILL BE DEPOSITED IN A COLOR-CODED BIOHAZARD BAG AND THEN DISPOSED OF ALONG WITH OTHER THE HOSPITAL WASTES (I.E., BURNING).

- TEST TUBES, PIPETTES AND OTHER GLASSWARE WHICH CAN BE REUSED WILL BE WASHED, DECONTAMINATED WITH SODIUM HYPOCHLORITE AND THEN AUTOCLAVED IF STERILIZATION IS NECESSARY. BROKEN GLASSWARE WILL BE DEPOSITED IN A COLOR-CODED BIOHAZARD BAG, PLACED IN HARD-SIDED CONTAINERS, AUTOCLAVED OR DECONTAMINATED WITH SODIUM HYPOCHLORITE,

AND THEN DISPOSED OF WITH OTHER HOSPITAL WASTES (E.G., TRASH PLACED IN HARD-SIDED CONTAINERS TAKEN TO A DUMP SITE).

D.- TO INCORPORATE THESE PROCEDURES INTO THE OPERATIONAL PLAN FOR HIV SURVEILLANCE, THE FOLLOWING RECOMMENDATIONS ARE MADE:

- AS PART OF THE PREPARATORY TRAINING SESSIONS CONDUCTED PRIOR TO FIELD WORK, THESE PROCEDURES WILL BE REVIEWED WITH TECHNICIANS INVOLVED WITH BLOOD SAMPLE COLLECTION AND HIV TESTING.
ADDITIONAL OR SPECIAL TRAINING OR LABORATORY PROCEDURES ARE NOT NECESSARY FOR THE FOLLOWING REASONS: A) THE INDIVIDUALS INVOLVED WITH THE SURVEILLANCE SYSTEM ARE WELL TRAINED AND EXPERIENCED LABORATORY TECHNICIANS, B) THE MEDICAL MATERIALS POTENTIALLY CONTAMINATED WITH HIV ARE HANDLED THE SAME WAY AS THOSE USED FOR OTHER MEDICAL PURPOSES AND C) THE EXISTING PROCEDURES REGIONAL LABORATORIES FOLLOW FOR HANDLING BIOHAZARDOUS, INFECTIOUS OR TOXIC MATERIALS ARE ADEQUATE FOR HIV.

- RESPONSIBILITY FOR ASSURING THESE PROCEDURES ARE FOLLOWED WILL BE ASSIGNED TO THE SURVEILLANCE SITE MANAGERS, TYPICALLY A PATHOLOGIST FROM THE TESTING LABORATORY OR SENIOR MEDICAL TECHNICIAN. THE SITE MANAGER, THEREFORE, WILL BE THE PRINCIPAL MONITOR OF PROPER HANDLING OF USED MATERIALS. THIS INCLUDES ASSURING THAT THE TECHNICIANS HAVE PROPER CONTAINERS FOR NEEDLES, THAT A FRESH SODIUM HYPOCHLORITE SOLUTION HAS BEEN PREPARED AND THAT CANS CONTAINING USED NEEDLES ARE PROPERLY BURIED ON HOSPITAL GROUNDS. BRL AND RITM STAFF RESPONSIBLE FOR THE NATIONAL SURVEILLANCE SYSTEM WILL PERIODICALLY CHECK ON ADHERENCE TO THESE PROCEDURES AS PART OF THEIR REGULAR SITE VISITS (E.G., INSPECTING THE "DEDICATED" BURIAL SITE, CHECKING IN TRASH CANS AT THE LABORATORY, SPOT CHECKS AT BLOOD COLLECTION SITES).

- THESE PROCEDURES AND RESPONSIBILITIES WILL BE SPECIFIED IN THE OPERATIONAL PLAN FOR THE NATIONAL HIV SURVEILLANCE SYSTEM.

- THE COSTS OF THESE PROCEDURES ARE NEGLIGIBLE AND CAN BE ABSORBED BY THE BUDGETS OF THE LABORATORIES (E.G., ONE LITER POWDERED MILK CANS WITH SODIUM HYPOCHLORITE SOLUTION).

ASEP FUNDING WILL COVER ALL OTHER SUPPLIES (I.E., VACUTAINERS, ADDITIONAL GLOVES AND SODIUM HYPOCHLORITE SOLUTION, HARD-SIDED CONTAINERS, LEAK-PROOF CONTAINERS LINED WITH ABSORBENT PADS,THE PARTICLE AGGLUTINATION TEST KITS). YY

ANNEX D

In case of reply the number and date of this letter should be quoted

Our Ref. No....USA/G/19.5

Your Ref. No.....

Tel. No.....

REPUBLIC OF GHANA

MINISTRY OF FINANCE AND ECONOMIC PLANNING
P.O. BOX M 40
ACCRA

26th September.....19.94.

Dear Ms. Sandoval,

REQUEST FOR FINANCIAL ASSISTANCE TO IMPLEMENT AIDS PROGRAMME (GHANAPA)

I wish to request for a grant of approximately US$20 Million to increase the use of effective family planning mothods, and increase awareness and practice of HIV/AIDS risk reduction behaviour in Ghana. The Programme will assist in improving the health of mothers and children by ensuring that critical family planning supplies are available on a sustainable basis in Ghana.

A portion of the grant requested for (approximately US$6 Million) would be used to increase the capacity of health care providers to deliver family planning and AIDS/HIV/STD prevention and control service, provide for monitoring, evaluations, audits and studies, participant training, commodities and equipment.

The remaining portion of the grant (approximately US$14 Million) would be provided as a cash grant to government to be released in tranches upon the achievement of policy and regulatory reforms related to population and HIV/AIDS prevention and control activities.

As its contribution towards the implementation of the Programme, Government would provide the necessary staff, facilities, administration, equipment and supplies to be deployed on the Programme.

The implementation of the GHANAPA Programme would enhance our national health and population goals. In the light of this, we look forward to negotiating and collaborating with USAID in the implementation of the Programme.

Yours Sincerely,

(K. B. AMISSAH-ARTHUR)
DEPUTY MINISTER OF FINANCE

MS. BARBARA SANDOVAL
DIRECTOR,
USAID,
ACCRA.

cc: **The Hon. Minister**
Min./Health,
Accra.

The Chairman,
National Population Council,
Accra.

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ANNEX E

USAID/GHANA

SOCIAL SOUNDNESS ANALYSIS

FOR THE

GHANA POPULATION AND AIDS PROGRAM

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1.0 EXECUTIVE SUMMARY

1.1 CONCLUSIONS

1.1.1 FAMILY PLANNING

The analysis points to the fact that the socio-cultural terrain and the political climate make GHANAPA a feasible program. At the individual and national levels, there is now awareness of the impact of uncontrolled population growth on the development and welfare of both the individual and society. Thus various structures and programs have been put in place. However, in a pronatalist and largely gemeinschaft society like Ghana, the pay-off of these cannot be felt immediately. Nevertheless, it may be quickened when the fears and aspirations of the people are given due cognisance in any interventionist measures.

1.1.2 AIDS

The analysis of the awareness/knowledge and attitudes of adolescents, the focal target group, about AIDS show clearly that there is a lot to do to save our adolescents from the scourge of HIV/AIDS infection. Barred by the larger society from procuring contraceptive devices (we may recall the provider eligibility restrictions whereby some providers simply refuse contraceptive services to certain categories of people including adolescents) the schools cannot help either because AIDS and Contraception are not included in the syllabus. Thus both teachers and students are ignorant of modes of transmission and prevention of HIV infection.

1.2 RECOMMENDATIONS

1.2.1 FAMILY PLANNING

I MALE PARTICIPATION

The role of men in the joint-decision making on family planning practices is going to be crucial in promoting the use of family planning methods. It is therefore suggested that one way of bringing partners together is to motivate men through targeted and sustained IEC.

Also efforts must be made to interact with men through male's social clubs and organizations in both the urban and the rural sectors.

As a beginning, however, attention must be focused on policy makers most of whom are men, while at the same time measures to improve the material conditions of women are instituted. In our situation, it has been found that one significant way of achieving these objectives is to make formal education as socially accessible as possible. In a society where for cultural reasons, female education is generally not valued, a special program would have to be instituted, especially in the rural north, whereby, not only parents are motivated

to send their daughters to school, but also girls' interest in formal education is sustained to the highest level possible. This is going to be a very slow process but ultimately some changes may occur.

II RURAL TARGETING

Whilst, it has been identified that the rural areas are lagging behind in the knowledge and use of modern contraceptives, it is also obvious that appropriate interventions can correct this imbalance. There is therefore the need for the intensification of IEC campaigns that address misinformation, misconception and perceived method constraints.

Evaluation studies undertaken by some sociology students in the University of Ghana have shown that the frequency modu-lation station in Bolgatanga in the Upper East Region of Ghana, has played significant role in informing, educating and changing the negative attitudes of the people with regards to family planning and maternal and child health. Perhaps, more of such stations would be required in the rural areas. This presupposes, however, that, villagers have the means to procure wireless sets.

Also, efforts must be made to ensure on sustainable bases the availability of and accessibility to contraceptives possibly within every 10 miles but, at best, within the community itself. And finally, service delivery must have some degree of confidentiality.

III URBAN

In the urban areas, however, it appears that there is now the need to refocus IEC campaigns onto long term contraceptive methods including sterilization. In other words, in the urban areas, method-specific messages must now be emphasized.

IV DELIVERY

Another crucial point to consider about service delivery is how this is done and who does it. Most clients want to obtain contraceptives in secret, but services are often not designed for that. In some government clinics, separate waiting areas and consultation rooms are used for family planning service provisions. However, as reported, most clients refuse to sit on the "family planning bench" to wait for their turn while being exposed to the looks of others. The desire for secrecy is also not assured by chemical sellers who have been trained to distribute contraceptives. They are reported to have observed that most of their contraceptive clients do not enter the shop if there are other customers inside but wait till the shop is empty. Thus, in the rural setting, the profile of an ideal service provider include:

i. the ability to keep secrets (he/she should have "no slippery mouth");

ii. the ability to read and write;

iii. must be of the same gender as the client;

iv. the ability to sell other products in addition to contraceptives (MOH 1992).

1.2.2 AIDS

Having identified adolescents as the core target group the NACP would find it most beneficial to team up with the Ghana Education Service to develop appropriate teaching materials on all aspects of HIV/AIDS infection not only for primary and secondary schools but also for all teacher education institutions.

It is known that the junior secondary school curriculum has sex education as a component of the family live education program. It is suggested that this program be widened to include all aspects of HIV/AIDS infection and must be tailored to the situational needs of students.

In the case of the universities and other tertiary institutions however, social clubs and festive occasions such as "hall week", celebrations must be used to disseminate information on HIV/AIDS infection.

The analysis has established the need for the National AIDS Control Program and the Health Education Division of the Ministry of Health, to undertake a thorough pre-testing of IEC materials especially among the targeted population before these are circulated.

Also, since the literacy rate is low in Ghana, efforts must be made to produce some of the poster messages in the vernacular, at least for the benefit of the many in the rural areas who have graduated from the Non-formal Education sector. In this regard, technical assistance may be sought from institutions such as the Ghana Bureau of Languages, the School of Ghanaian Languages of the University College of Winneba, the Non-formal Education Division of the Ministry of Education, the Sudan Interior Mission, and the Ghana Institute of Literacy Literature and Bible Translation, all of which are involved in the production of vernacular literacy materials for the various ethnic groups in Ghana.

2.0 BACKGROUND

Following the economic difficulties which plaqued the country from the mid-1960's the Government of Ghana was compelled to revisit the population issue which Nkrumah's government had rejected earlier. In 1969, therefore,a comprehensive population policy was adopted. This policy included a clear fertility reduction goals and the establishment of institutional structures for the propagation of the policy. Thus the Ghana National Family Planing Program (GNFPP) was established in 1970 to serve as a coordinating department for the planning program within the Ministry of Finance and Economic Planning. However, for almost 2 decades the policy made little impact on fertility. A 1989 National Population Conference that deliberated on the 'failure' of the population policy listed a number of factors to account for the problem. These include:

- Lack of a comprehensive national strategy for policy implementation;
- poor coordination among agencies;
- low public awareness of population pressures and of health risks of high fertility;
- the lack of popular involvement in the development of the policy and related programs.

Very interestingly the Conference omitted the issue of general lack of understanding of the socio-cultural terrain in which the policy was to operate. As characteristic of policy makers of Ghana, perhaps the concerns of beneficiaries were not deemed necessary for policy consideration.

The period following the "lost decades" has seen a sudden resurgence of interest in the promotion of family planning activities. A series of conferences and workshops dealing with population issues and awareness raising efforts led by the Population Impact Project (PIP) of the University of Ghana, has contributed to high level political concern for demographic issues. The climax of this political concern is evinced by the recent establishment of a National Population Council to among others, advise Government and coordinate all population related activities in Ghana.

In support of this renewed interest, a number of external donors and NGO's have contributed or pledged massive financial assistance.

USAID/GHANA is planning to design the new $45 million Ghana Population and AIDS Program (GHANAPA) which has as its major purpose: to increase the use of modern and effective family planning methods and to reduce the rate of increase of HIV prevalence. Successful accomplishment of this purpose will be measured by:

1. increasing the Contraceptive Prevalence Rate (CPR) from approximately 15% to 25%;
2. increasing the percentage of CPR derived from longer lasting family planning methods from 20% to 40%;
3. limiting the increase of HIV prevalence to 8 percentage points over the 1994 level.

GHANAPA consists of Non-Project Assistance (NPA) and project assistance components. The NPA component totals $13 million in cash transfer assistance which will support GOG policy reforms to:

1. enhance the sustainability of family planning AIDS/HIV/ STD programs by increasing budgetary support, improving contra-captive price, forecasting and stocking procedures and changing customary practices that impede family planning service delivery;

2. improve services by increasing the availability of all contraceptive methods and selected drugs for treatment of STDs.

Project assistance includes a $20 million bilateral grant and $12 million in contraceptive commodities. This component finances technical assistance, training, commodities and the establishment of an endowment for the Ghana Social Marketing Foundation to:

1. support policy reform efforts;
2. increase demand for family planning;
3. expand provision of family planning services;
4. foster greater sustainability of family planning programs;
5. promote safe sexual behavior;
6. encourage proper diagnosis and treatment of STDs;
7. improve the surveillance of AIDS/HIV/STDs.

Marketing and Social Research Institute Ltd (MSRI) was commissioned to undertake a social soundness analysis following the acceptance by USAID/GHANA of proposal submitted by MSRI in response to a request by Mr. Floyd R. Spears, Executive officer, USAID/GHANA in a letter dated March 8, 1994 together with a Scope of Work for the project and received by MSRI on March 23, 1994.

3.0 OBJECTIVES

The overall objective of GHANAPA will be to focus on changing individual behavior/practices to increase the use of family planning methods, thereby reducing fertility and reduce sexually risky behavior, to slow the transmission of HIV/AIDS virus.

4.0 RESEARCH DESIGN

4.1 THE SCOPE OF ANALYSIS

The literature on western technology diffusion in non-western cultures is replete with cases of failure or non-sustainability inspite of grounds well of political goodwill. This is because, in the main, the cosmological notions of beneficiaries of such diffusion exercises were not given due attention. As a logical step therefore, the core question which this analysis must answer is this: Is the proposed expansion of family planning services and the intended increase in the consumption of modern contraceptive methods socio-culturally feasible. In other words, how can this program be carried out and sustained without unduly hurting the socio-cultural sensibilities of the people?

A number of issues may be raised from these questions but for the purposes of this analysis, the following tasks will be undertaken:

i. to assess the socio-cultural context with regard to beliefs, values and practices regarding fertility regulation focusing on women as participants and as beneficiaries;

ii. to determine the structure and pattern of decision-making with respect to family planning including the role of men;

iii. to assess the implication of rural-urban differences with regard to the use of modern family planning methods; and

iii. to assess the level of knowledge of the community about AIDS/STDs control and prevention in relation to sexual behavior change with a focus on adolescents.

4.2 MODE OF ANALYSIS

This analysis is based essentially on the review of secondary data and on the study of a number of project documents. However, where possible, the analysis has been reinforced with impressions gathered from informal discussions with students of the University of Ghana and commercial sex-workers who operate nocturnally around the abandoned site of the former Star Hotel in Accra.

4.3 METHODOLOGICAL AND CONCEPTUAL PROBLEMS

A few methodological difficulties are noted with this kind of analysis. The most significant of these is the degree to which generalizations can be made, especially from limited researched works some of whose sampling techniques may be biased. This difficulty is compounded by the fact that Ghana is an amalgam of varying social, economic, and cultural configurations. Thus generalizations may not easily apply to some social and cultural situations. These problems not withstanding, research data available do indicate at least the general trend of affairs with regard to fertility regulation in this country. Also as Assimeng (1981) has argued, Ghana constitute a social structure, given the similarity of cultural beliefs and practices of the various ethnic groups.

Conceptually, in discussing phenomena that have both "traditional" and "modern" aspects, social scientists and lay social commentators often tend to create a dichotomous society - one which is characterized by traditionalism and the other by modern ethos. For the social scientist, this categorization is done for ease of theoretical discourse. In reality, however, this categorization does not exist. In Ghana for instance, as a result of our colonial past and the forces unleashed by social change, even in the remotest parts of the country, it is not easy to tell where traditionalism and modernism begin and end. What obtains is essentially a syncretism of norms and values in which Western ethos have been indigenised in order to harmonize with existing traditional value systems. Thus whenever a distinction is made between traditional and modern societies, it is done with a great deal of circumspection, for convenience. It is against this background the fertility regulation within the socio-cultural context of Ghana is examined.

5.0 MAIN FINDINGS

5.1 FAMILY PLANNING

5.1.1 THE SOCIO - CULTURAL CONTEXT OF FERTILITY REGULATION

Fertility is a behavioral phenomenon involving human decisions. These decisions are taken in pursuit of goals which have personal and societal consequences; like all human decisions they are taken under a complex set of conditions and are influenced by a myriad of factors. Among the various ethnic groups in Ghana, the issue of fertility regulation is tied to the issues of sex, marriage, pregnancy, child-birth, and child-caring, all of which have deep-seated moral connotations.

In the traditional system, sex and marriage were meant essentially for procreation. Thus coition was meant for married couples only. Traditionally, the onset of menarche for females signified biological maturation and rites of passage were performed. The management of fertility was viewed as one of the most important features of adulthood and after puberty rites a girl was considered old enough to marry. Premarital sexual relation was a taboo, a public offence for which culprits especially females were sanctioned. In this system also matters relating to sex were not for public consumption. However, whenever they must be publicly discussed, they were couched in proverbs and euphemisms quite unintelligible to the young and untutored ear.

A number of studies have reported that Ghanaians are essentially pronatalists. Children form the bedrock of marriage and a childless couple (especially the woman) is looked upon with malicious pity. She is often regarded as a witch or a victim of witchcraft or as paying for past misdeeds. Parenthood enhances a persons social status and guarantees some form of security in times of ill-health and old age. In the traditional realm, children are seen also as a source of labour and as the medium through which the "living -dead" ancestors return to visit the living members of the kingroup (Mbiti 1969). Not unexpectedly therefore, the prayer or libation which accompanies every newly contracted marriage includes a plea for increased fecundity. The Ga of Accra go further to admonish the bride to "give birth to ten children so as enjoy the honour of sleeping on ten mats" (Fo nyoma ni owo nyoma saa no). The Akan rite of "Bedu gwan" is similar in orientation.

5.1.2 FERTILITY REGULATION

Although Ghanaian traditional societies stress the importance of fecundity, this is not left without its checks and controls (Kumekpor and Twum-Baah 1972). There usually exists an institutionally prescribed framework within which reproduction takes place. Thus over

fecundity and uncontrolled child-bearing is ridiculed and disapproved of. Often it is the woman who is at the receiving end of such unorganized sanction. She may be referred to as one who brings forth like a pig or rabbit, as a mother of improperly spaced children, as one who is unnecessarily sexy, etc.

Traditional methods of birth-spacing are few. Essentially, these include sexual abstinence, the use of charms and various herbal preparations and abortifacients, and coitus interruptus. Sexual abstinence is practiced when on delivery, a woman leaves her marital home to take up residence with her parents or parents - in - law till the child is weaned. In some ethnic groups in Ghana, this practice is reinforced by the medico-religious belief that coition with a nursing mother portends undesirable spiritual and health consequences for the mother and child. Thus to promote post-partum sexual abstinence, a man may resort to polygyny or take a mistress. Traditionally, therefore a period of two to three years is required for child-spacing.

As regards traditional abortifacients, field studies undertaken by Ampofo (1971), Mensah-Agbokpor (1973 - 1974), Warren (1974), Bleek (1969) and Kumekpor and Kumekpor (1977) provide useful insights into the products used. The latter include nkrangyedua (Jahropa Curcas), "milkbush" (Thevetia Peruviana) nyanya (Passiflora foetida), mango (Magnifera Inidca), pawpaw (Carica Papaya), pine apple (Ananas Sativus), sugar cane (Sacharium officinale) and akpeteshie, a locally distilled gin. However, given its illegal nature and the secrecy which characterizes abortion, it is not easy to appreciate the exact dimension of the practice in Ghana, though anecdotes indicate that the practice is widespread (Bleek 1976a)

If these traditional modes to limit fertility exist, then why the need for modern family planning? In a large measure, this need has arisen because as one study (MOH 1992) has shown factors and consequences of social change - urbanization, migration Western education, religion, and medicine, money based economy, etc - have rendered some of these modes of fertility regulation unacceptable. For instance induced abortion is a criminal act punishable by a term of imprisonment, while the use of charms and herbal preparations especially in the urban areas is often regarded as primitivism. Coitus interrupts is associated with stroke among men (Ampofo et al. 1993). Also, prolonged physical separation and polygyny can be maintained at great financial cost to the man. However, traditional societies have their own reasons besides financial cost.

A study (MOH 1992:7) quotes two respondents in this regard thus:

- "If you stop sleeping with your wife and she does not get the thing (sperms) she will grow lean. If you continue this for let's say, 5 years and there are still deliveries in her stomach, she might later not become pregnant any more because the womb seals up". (41 year old man - Bolgatanga)

- "We ourselves would have liked to sleep with our women always but because we have no other meth[illegible] are forced to abstain". (Man 60 years - Bolgatanga)

5.1.3 BENEFICIARIES:

Who are the beneficiaries of traditional fertility regulation? As a study (MOH 1992) reports, in rural Ghana, the most important reason for limiting the number of children is the desire for good health and not necessarily for the good of the entire country. The concept of the modern nation-state is far from everyday discourse. Thus there is no linkage between fertility regulation and aggregate welfare. Rather, often a relationship is made between the number of children and the health of the mother and child. Two respondents are quoted thus:

- "The women who don't space their children lose a lot of blood during delivery and will age and weaken faster. They will lose their beauty".

- The unspaced child will be forced to eat staple food instead of breast milk. Since the stomach is not strong enough, it will get malnourished."

Indeed in most Ghanaian communities, Kwashiorkor is associated with lack of child-spacing. As the report quotes one respondent in this regard:

- "If they (children) are so close, they get that red hair".

In sum, then the cultural landscape provides the need for more convenient contraceptive methods in Ghana. There seem to be at least some dissatisfaction with traditional modes of contraception while for economic and health reasons, the need for contraception is appreciated. Herein lies the need for modern contraceptive services.

5.1.4 CONSTRAINTS TO MODERN CONTRACEPTION

Over two decades of exposure to family planning and to modern contraceptive devices has created a high awareness of contraceptive methods among Ghanaians. According to the GDHS (1988) 76% of all women and 79% of currently married women know about contraceptive methods. In spite of this, the Contraceptive Prevalence Rate (CPR) remains relatively low. In 1988 the CPR was estimated to be 5.2% percent. A number of reasons have been given for this. These range from problems of program management to political inertia. However, 5 years later, the most recent survey data from the Consumer Baseline Survey (1993) indicates that Ghana has reached the "launch phase" of modern CPR of 14.8%, thanks in part to the efforts of the Ghana Social Marketing Foundation which operated under the auspices of the Family Planning and Health Program (FPHP). If this momentum is to be sustained or increased, then a number of socio-culturally related problems must be addressed. And one of these is the role of men in women's decision to avail themselves of contraceptive services.

5.1.5 ROLE OF MEN

A number of local studies on contraceptives use have identified the "male factor" as one important determinant in women's desire to use or not to use contraceptives. In 1974, in a study on receptivity to post-partum family planning advice, Chew found what he termed a "surprising few (20% of post-partum women)" who wanted "to consult their husband" on the issue. He also found another 50% who were "thinking over it", apparently meaning they were still awaiting spousal assent. Discussion of family planning between husband and wife is thought to be instrumental in the decision to take joint action to control fertility. However, such discussions are stifled by cultural norms.

As the GDHS (1988) report indicates, more than half of husbands who knew at least one contraceptive method have never talked with their wives about family planning. In the Consumer Baseline Survey (1993) report, 7 percent of 'never users' and 13 percent of 'former users' indicated 'partner disapproval' as an explanation for their contraceptive status. Also, as the GHANAPA report indicates, many service providers do not offer family planning services to categories of women, including those without spousal consent.

It appears to be the general belief of providers - just as of many Ghanaians - that a woman's decision to contraception is serious enough to merit spousal attention. Local newspapers sometimes report of cases where angry husbands have harassed service providers for contracepting their wives without their (husband's) consent. Again, it is the belief of service providers that a man or woman must have at least three children before availing himself or herself of say, sterilization. Indeed, as one top official of the Accra Voluntary Vasectomy Unit disclosed at a workshop recently, "Many men report to the unit to avail themselves of the service. Unfortunately, most of them are too young; besides, some have no children" It is clear from these instances that service providers like their compatriots, are heavily influenced by the pronatalistic and viricentric ideology of the society. The need for serious re-education of providers is clearly underscored.

The negative or indifferent attribute of men to women's use of contraceptive stems from community attitude towards modern contraceptives. There is for instance a direct association of between contraceptive use and promiscuity or love for frequent sex. Thus men see family planning as a threat, a potential license for women to engage in multiple sexual relationships without the "punishment" of becoming pregnant. In this regard, among the Kasena and Nankana of Upper East Region, a man who accompanies his wife to a family planning clinic or allows his wife to avail herself of family planning services is said to have been 'bought' by the wife. This fear among men is captured by a quotation obtained from a MOH focus group discussion. A woman was said to have observed thus: "They (men) think that if you use family planning and a man says open (your legs), then you open". (MOH. 1992:13)

The pattern of decision - making in a family - whether nuclear or extended - is often shaped by the larger community. The position of a woman in the family is often dependent on whether she is married, single, widowed, young or old, and literate or illiterate. She is valued because of her reproductive abilities (as the guarantor of the family line) and her role in providing food, fetching water and firewood, washing, taking care of children, the sick and the aged, and promoting the health and well-being of other family members. Oppong (1984) has classified these into seven conflicting roles that women perform for their own families and for the extended kingroup. In spite of these, there exists a situation of gender inequality and men enjoy a dominant position within the family or the household compared to women. This is reinforced by social, cultural, and religious beliefs and practices which demanded for instance that men have the last say. An Akan proverb captures this point aptly. "If a woman buys a gun, she keeps it in a man's room." Thus even when women are household heads as is increasingly becoming the case in Ghana (GLSS 1989 shows that 29.1% households in Ghana are headed by females, a slight increase over the 28.76% recorded by the 1984 census) they do not always enjoy the same authority as men and may have to refer issues relating to children to male kins.

Although men's dominant position is generally acknowledged, the degree of authority they exercise within marriage varies with the type of marriage and the system of descent that the marriage subscribes to. Clearly in patrilineal system of descent a man has greater authority as he exercises his uxorial and genetrical rights; in the matrilineal system as exhibited by the Ashanti, the husband's power is considerably less as his is generally restricted to uxorial rights. Women here have greater say in matters concerning the welfare of their children and to a limited extent in matters concerning their reproductive life. However, serious studies have been undertaken to determine how women in the matrilineal system use their genetricial power to regulate fertility.

It appears also that the degree of dominance a man exercises in marriage may be determined by the amount of dowry he pays to marry the wife. In the northern savannah regions of this country where dowry payment is heavier than in the southern regions, there is total male dominance in marriage. For instance, among the Nankana of Upper East Region, marriages are not recognized until a prospective husband has paid in addition to other things, seven cows or twenty-eight sheep. Consequently, a woman's domestic and sexual services are exploited to the fullest possible extent.

It is clear, however, that the forces of modernization have made some in-roads into the hitherto dominant position of men. Women who are educated and or earn stable income no longer subscribe to the status quo (Greenstreet 1988); they demand a share in decisions that affect their welfare and that of their children. Clearly then, couples with low educational background are most likely to have the customary autonomic or selective pattern of decision - making whereas men whose wives make little or no contribution to household expenses usually make decisions autocratically. As Bleek (1987) found among the Kwahu, a husband because of his solid economic position is able to wield considerably more power over his wife, whose material position is thus improved while her conjugal autonomy is reduced. This

phenomenon can be explained by the exchange theory: those who contribute resources or have alternative sources of the things they need can be independent whereas those who are dependent on others for benefit and or services must be subservient to their power (Mauss 1925).

5.1. 6 RURAL - URBAN DIFFERENTIALS

A proper analysis of this issue would call for statistics on the level of availability of and accessibility to, contraceptive devices and related services. In the absence of these data however, some impressions may be gathered from the documents available.

The GDHS (1988) found that the variation in knowledge of method and source of modern contraceptive between the urban and rural areas of Ghana, was significant. According to the report, for urban women knowledge about method and source were 88% and 82%, respectively while for rural women these percentages were 71 and 64.

Also regional differentials reinforced rural - urban differences. Thus as the report revealed apart from the more rural regions of Northern, Upper East and Upper West where only 40 percent know a method and only 32% knew a source, more than 70 percent of married women knew a method and more than two - thirds knew a source in each of the other regions.

As regards the use of modern contraceptives again the rural areas were in an inferior position. The GDHS infact established a strong relationship between contraceptive use by women and place of residence. In comparing urban and rural dwellers, the report found that a greater proportion of married women in the urban areas were then using a method of contraceptive than their rural counterparts. Specifically, the proportion using any method was almost 20% among urban women and about half that among rural women. Also at the regional level, Greater Accra Region which at the aggregate level is the most urbanized had the highest proportion of usage for any method (11%).

These statistics say nothing new: the urban areas of this country have always had the best share of whatever the nation can offer. With heavier concentration of health facilities and personnel, good communication network, and high population density the urban population is logically the more attractive choice. However, the rural sector must not be left out because this sector has the greater proportion of the population and contributes more to the high population growth rate of Ghana.

Against this background, it is important to revisit the Family Planning and Health Programs (FPHP) mission's strategic objective: to reduce Ghana's fertility rate from 6.4 to 6.1 by 1995 and slow down the annual rate of population growth from 3.4% to 3% by the year 2,000. This is to be achieved by increasing contraceptive prevalence of modern methods from 5% to 15% by 1995.

Clearly, this objective envisages easy availability of and accessibility to contraceptives throughout the country. Indeed between 1986 and 1992 under the auspices of the FPHP, the Ghana Social Marketing Foundation considerably increased the sale of its products by 398% merely by increasing the number of service delivery points covered from 3,000 in 1992 to 5,000 in 1993 (USAID 1993)

In the rural communities, however, some consideration must be given to service delivery. Low availability and inaccessibility are arguments frequently used by villagers to explain their low use of contraceptives. Indeed, the Danfa research project concluded after a decade of intervention studies that villagers are not prepared to travel further than 10 miles to obtain family planning services (UGMS/UCLA 1979). This conclusion is more relevant to the northern sector of the country where settlements are often far away from most service delivery points. A community based service delivery is thus advocated for.

5.2 AIDS AND SEXUALLY TRANSMITTED DISEASES

Since the first AIDS cases in Ghana were confirmed in 1986, the Government with support from external donors, has instituted a number of measures to control the HIV/AIDS epidemic. As one of the important measures, the Government established the National AIDS Control Program (NACP) in 1988 and finalized a Medium - Term Plan in 1989. The objective of the plan include, among others, determining the extent and pattern of HIV infection and providing information to the public concerning the epidemic and to promote condom use for prevention.

In spite of these, HIV/AIDS cases continue to increase every year. According to the NACP as at the end of August 1993, a total of 11,625 HIV seropositives had been diagnosed. And as at April 1993, a total of 11,044 AIDS cases had been reported. The later is made up of 29.2 percent males and 70.8 percent female. For both genders very high incidence rates are concentrated in the 15-49 age cohort, consisting of mostly the sexually and economically active persons. Thus with a characteristically young population (22.7% within 10-29 years age group) the social, economic and political life of this country is ruined if serious steps are not taken to intervene in the spread of the epidemic. The control and prevention program must thus focus on the high-risk groups. This analysis thus focuses on adolescents.

In order to change (or maintain) any behavior, it is important to understand the determinants of the behavior. As has been pointed out by Fishbein and Middletadt (1989) the more that is known about the factors underlying the performance of a given behavior, the higher the chance that successful interventions can be developed to influence it. Sexual behavior is indeed complex; it is determined by a wide range of biological, psychological, and social factors (Reiss, 1984, 1986). However, in our context, biological explanation of sexual behavior are perhaps not well designed to answer questions concerning adolescent sexual behavior. Consequently, psychosocial explanation are necessary. (Ford and Ankomah 1993)

Adomako (1993) has observed that among secondary school students sexual encounter begins

at very early ages. In her study 50% of respondents had their first sex between the ages of 14 and 17; 25% between 8 and 13 years; 24% between 18 and 20 years and 4% after 21 years. Watzeels (1993) found similar situation in her study among students in Ashanti Akim North District. Clearly the rising incidence of teenage pregnancy is an indication of this situation.

As regards reasons for early sex, Adomako's study identified the following: peer pressure and or deception by partner (28%); experimentation (25%); and sexual desire (16%); 9% felt that "something would happen" if one did not have sex by a certain age; 5% had sex for the fun of it and 3% because they were in love.

As regards contraceptives Adomako observed that the most commonly known and used is the condom, followed by the spermicides and the rhythm method. Most procured their contraceptives from drug stores (68%) or from friends (16%). However, as Adomako observed, "Generally, knowledge of contraception among adolescents is fragmentary and inaccurate. Even when contraceptives are readily available, and adolescent use them, they tend to use them improperly. Of greater danger than the non-use of contraceptives is the over-confidence to engage in sex as a result of reliance on ineffective methods of birth control such as a variety of questionable pills, herbs and reliance on 'safe period' whose exact timing adolescents generally seem to be ignorant of (ibid:30). In support of this, Bleek (1976) discovered in his Kwahu study that among adolescents few knew of the ordinary contraception pill while most of them talked of a variety of pills which rarely had any connection with birth control.

When it comes to STD, 78% of Adomako's respondents said they were aware of their existence and by far the most well-known was AIDS (82%) followed by gonorrhoea (14%) and syphilis (3%). It is evident that the massive educational campaigns on AIDS have been effective in creating this awareness.

However as Watzeels found with regard to AIDS there exist a lot of dangerous misconceptions among students. Indeed most of her respondents (92.3%) were convinced that they could not get AIDS although many of them engaged in unprotected sex. "At the same time more than half of the students do not know how AIDS can be passed on and three quarters do not know how they effectively can protect themselves against AIDS. Almost half of the students think of women as the only people most likely to get AIDS ..." Incidentally, secondary school students are not the only ones with defective knowledge on AIDS transmission. In the author's interaction with a number of students of the University of Ghana and commercial sex workers in Accra, it was appreciated that a good number of them had a false sense of security. Indeed, while university students claim they stick to their regular partners and therefore are insulated from HIV infection, some commercial sex workers claim they can tell at a glance prospective customers with HIV infection. As an indication of their false sense of security, therefore, commercial sex workers charge ¢5,000 per hour for customers who desire to use condoms and ¢10,000 for those who do not want to. In addition, there are many who live under the "AIDS is not here Syndrome". These situations call for the intensification of IEC on AIDS.

Using the AIDS posters to test students' comprehension of the messages carried by these posters, Watzeels concluded that the students' English language was too bad to make some of the poster slogans sensible. It appears also that the visual import of the posters did not make the expected impression on the students. This is what she wrote about the poster with the slogan "AVOID CASUAL SEX":

"The students at the Junior Secondary School (11 - 15 years of age) do not know whether this poster is about students, young people or adults. According to a boy in Akutuase, the woman gets annoyed with the man who wants to do something with her. One student in Konongo thinks that the boy touches the girl because he loves her. She does not want to have sex with him because she is afraid of AIDS. No one understands the text because they do not know the term casual sex, even most of the teachers do not know what it means".

ANNEX F

TECHNICAL ANALYSIS

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TECHNICAL ANALYSIS

I. DEMOGRAPHIC AND ECONOMIC SETTING

At independence in 1957, Ghana had a population of about 5 million and one of the highest levels of income as well as social and economic infrastructure, in sub-Saharan Africa. However, by the early 1980's, the relatively high standard of living of Ghanaians had been eroded by inappropriate development policies and strategies and high population growth. Real per capita GDP declined by an average of almost 2 percent per year between 1965 and the early 1980's.

Ghana initiated a far-reaching Economic Recovery Program (ERP) in 1983. Initially, the program focussed on the short-term objectives of macro-economic stabilization. As these objectives were realized, the Government, with substantial donor support, turned its attention to stimulating economic growth. The results have been impressive, with real GDP growing at an average of 5 percent per year over the past five years. However, Ghana's population growth rate has remained high, and net per capita GDP has increased less than 2 percent per year to about $400 in 1993. At this rate, it will take 36 years for per capita income to double.

Life expectancy in Ghana has increased only gradually, from approximately 50 in the 1970s to the current estimate of about 56 years. While it is among the highest in West Africa, in common with Africa as a whole, life expectancy lags significantly behind other developing countries:

Africa	55
West Africa	52
Latin America	64
Asia	68

The 1994 mid-year population of Ghana is estimated to be 16.9 million, with an annual growth rate of 3.0 percent. This implies a doubling of population in twenty three years, putting tremendous pressure on already overstretched social and economic infrastructure and services. Currently, a Ghanaian woman will have an average of six children by the time she reaches her forty-fifth birthday. Factors contributing to this high rate of fertility include early age at marriage, a youthful age structure, low contraceptive prevalence, and falling mortality rates.

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II. HISTORY OF USAID ASSISTANCE TO POPULATION AND FAMILY PLANNING ACTIVITIES IN GHANA

Assistance from the United States Agency for International Development (A.I.D.) to the Government of Ghana's (GOG) health and population sector dates to 1968. Between 1968 and 1992, an estimated total of $30 million was obligated to support population and family planning activities in Ghana. This support was carried out under eight bilateral and regional projects and 43 centrally funded projects. This assistance can be divided into three time frames: (1) 1968-1981 when approximately $15 million was provided to initiate population programs, resulting in an increase in the modern CPR from 0 to 5.4 percent; (2) 1981-1985 when severe economic and political constraints caused USAID and other donors to cease assistance, resulting in contraceptive prevalence dropping to virtually zero; and (3) 1986-1992 when approximately $18 million was provided, not including the current project, to rebuild Ghana's population program, during which time the CPR rebounded from 0 to 5 percent in 1988 to approximately 9 percent in 1992.

High growth rates coupled with relatively low levels of contraceptive prevalence, led USAID in 1992, as part of its Country Program Strategic Plan (CPSP), to identify reduction of fertility as one of its three strategic objectives. USAID targets a reduction in total fertility rate from 6.4 in 1988 to 5.3 by the year 2000. This reduction in fertility would reduce the population growth rate, which would lessen the burden on infrastructure and services and would increase net per capita income growth.

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

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

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

Support to the American College of Nurse Midwives (ACNM) is provided to help strengthen the Ghana Registered Midwives Association (GRMA) and to provide family planning training

to its members. ACNM also works with the MOH to strengthen its training program in maternal and child health and family planning for traditional birth attendants (TBAs). In addition, the original project design included buy-ins to selected centrally-funded projects: support for long-term contraceptive methods from the Association for Voluntary Surgical Contraception (AVSC), and assistance with population policy activities under the OPTIONS II project.

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

III. ANALYTIC FRAMEWORK FOR THE TECHNICAL ANALYSIS

To guide the technical analysis of the population/family planning sector, the typology developed by the Family Planning Services Division of the Office of Population, USAID/ Washington, that classifies national family planning programs according to level of use of modern methods of contraception was adopted as the analytic framework. A strong association has been found between national family planning policies and program environments and degree of modern contraceptive prevalence, resulting in distinct general patterns of family planning knowledge, supply and method mix at each level. This framework considers five phases through which family planning programs can progress:

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

. launch (8 to 15 percent)

. growth (16 to 34 percent)

. consolidation (35 to 49 percent)

. mature (50 percent or higher)

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

The FPHP was designed to assist Ghana to move the program from the "emergent" phase through the "launch" phase by increasing the modern CPR from 5.2 percent in 1988 to 15 percent by 1996. A Consumer Baseline Study conducted in April 1993 suggests that Ghana has already reached a modern CPR rate of 14.8 percent among married women. The 1993 DHS shows a more modest rise to 10.1 percent. Nevertheless, the DHS suggests a substantial decline in fertility from a TFR of 6.4 in 1988 to 5.5 in 1993. This is a remarkable achievement in a period of five years compared to other family planning programs worldwide, and an **outstanding** accomplishment for sub-Saharan Africa. Average contraceptive prevalence increase worldwide is slightly over 1 percent. This is equivalent to a reduction in fertility from an average of six and a half children per woman in 1988 to an average of five and one half children children in 1993.

This achievement was accomplished by concentrating on the provision of short-term contraceptive methods such as condoms, pills and vaginal foaming tablets, through the Ghana Social Marketing Program (GSMP) (low cost, private sector promotion and distribution), and initiation of long-term contraceptive methods such as IUDs, injectables and sterilizations.

These efforts have been coupled with strong information, education and communication (IEC) campaigns in the public, private and NGO sectors.

The following is a brief sketch of the emergent phase (where Ghana was at the time of the 31988 Demographic and Health Survey), the launch phase, through which the program has moved at an extraordinary pace, and the growth phase which the Ghana program is about to enter:

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

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

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

IV. POPULATION POLICY AND THE POLICY ENVIRONMENT IN GHANA

A. Current Status

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

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

Both the 1986 Legon Conference on Population and National Reconstruction and the 1989 National Population Conference of the University of Ghana (Legon) revitalized the population policy development process by identifying several problems which had hampered the successful implementation of the 1969 policy (as noted above), and by drafting a set of recommendations for a new approach to policy implementation. The "Legon Plan of Action on Population" and the 1989 Conference called for the establishment of a Population Policy Implementation Assessment Committee (PPIAC) to review population activities and to design an institutional structure for policy implementation. In 1991, the PPIAC held a high-level seminar to stimulate debate and begin consensus building for the formation of a National Population Council (NPC).

FPHP has effectively utilized non-project assistance (NPA) for policy reform to sustain a supportive policy environment for population and family planning activities, as evidenced by the frequent public statements of top government officials, especially the President and First Lady. The most notable policy reforms are: (1) the creation of the National Population Council (NPC), the highest advisory body to government on population issues, which helps to ensure the participation of the private sector, coordinates and monitors all population activities and represents the Government to donors and the international community; (2) revision of the

National Population Policy, which establishes the legal and regulatory framework, to include responsibility for implementation of the population program; (3) removal of restrictions on the sale and distribution of contraceptives, which greatly expands availability of services; and (4) legalizing the advertising of contraceptives, which increases overall awareness and knowledge of family planning.

The NPC was established and formally inaugurated by the GOG in November 1992. The Social Sector Policy Unit (SSPU), Ministry of Finance and Economic Planning is currently serving as the interim secretariat for the NPC until a permanent secretariat is created and is leading the policy revision process as well as organizing the plan of implementation to support the policy. The GNFPP and the district "population" officers who are in the field, will be absorbed into the NPC secretariat structure.

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

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

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

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

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

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

In its capacity as interim Secretariat, the SSPU is currently conducting a number of activities. One "stream" of activities is organized around reviewing and revising the population policy, with financial and technical assistance from the UNFPA. The draft revised policy, which is currently being reviewed in a series of regional and national meetings and workshops, contains many of the components of the previous policy, including targets for fertility decline. However, it differs from the previous policy in that it sets up a stronger policy implementation framework to support not only fertility decline but also broader demographic and social objectives.

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

B. Analysis of the Policy Environment

Strong political support often has been a key issue for development of national family planning programs. As noted, the policy climate in Ghana for population programs has significantly improved over the past five years. Continuing improvement in the policy environment, which will greatly facilitate program success, will include a strengthening of the political commitment to the population policy objectives (at all levels), and augmenting the capacities of the NPC Secretariat.

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

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

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

Financial decentralization details remain under negotiation, but ultimately, each district is mandated to raise its own revenues, recruit and pay its own staff, and finance its activities with marginal support from the central government. To date, control over provision of services such as health care and education remains vested in the central ministries which delegate to personnel at the lower levels. Nevertheless, the Ministry of Health seems to be in the vanguard of the decentralization process with the institution of Primary Health Care (PHC) program as the basis for delivery of health services. The MOH was restructured in July 1992 to place responsibility for service delivery at the regional and district levels, retaining policy development and technical assistance functions at the central level. In addition, the MOH has adopted its own plan to build up the capacities at the district level. District Health Management Teams have been established to assume greater district autonomy in setting priorities and delivering services, but the financing of programs has not devolved yet.

C. Current Issues and Constraints

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

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

Policy Implementation: NPC Institutional Development: Effective policy implementation will require a technically capable NPC Secretariat that can provide leadership for the overall program and facilitate and coordinate program efforts. As noted above, the NPC Secretariat has been given the mandate to conduct a very ambitious program over the next few years.

These activities will require a large pool of analytic and technical skills which must be identified or developed as well as sustained technical assistance until this capacity is built.

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

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

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

D. Recommendations

There are a number of ways in which the policy environment for population programs needs to be strengthened at present in Ghana, through the NPC and through activities with key agencies and organizations in both the public and private sectors.

Political commitment: It is critical for long range program success that there be broad participation in, and consensus about the revision of the national population policy so that it is not perceived as imposed from above or unrelated to the experience and concerns of people in the districts. Activities are needed to raise awareness of population issues among the general public and special target groups (religious groups, parliamentarians, line ministry staff, etc.) in order to strengthen the policy consensus.

In particular, as the district assemblies will be more responsible for setting program and budget priorities in the future, local leaders, interest groups, and planners (and the public) must be educated about the importance of population programs so that they can make informed decisions regarding program support and administration. IEC programs, both

general population awareness and for family planning are needed, tailored to local conditions (and in local languages) in order to improve their effectiveness.

NPC Institution-Building : A professionally respected, politically influential Secretariat will be able to motivate all other aspects of the program, facilitate the work of the involved ministries and agencies at all levels, and coordinate activities so that efforts achieve synergy. Technical assistance provided from USAID centrally funded projects, and UNFPA, intensive in the early stages, can gradually be phased out as the Secretariat develops capacity--thus achieving a measure of technical sustainability prior to other program components.

V. DEMAND FOR MODERN CONTRACEPTION

In 1988, the Demographic and Health Survey (DHS) found that use of contraceptive methods overall in Ghana was very low at less than 13 percent; use of modern contraceptives was only 5.2 percent. The 1993 CBS, however, suggests that considerable gains have been made during the past five years. The CBS found current use of modern contraceptives among married women had increased significantly to 14.8 percent. This prevalence was strongly weighted towards temporary methods. Among currently married family planning users 5.9 percent use the condom and 5 percent use the pill. Vaginal foaming tablets are used by only 1.9 percent, injections by 1.8 percent, IUDs by 0.8 percent, and female sterilization by 0.3 percent of married women. Moreover, the study found that 14 percent of all women were currently using modern contraception and that 12 percent of them had used modern contraceptives for over three months and 9 percent had used them for over a year.

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

In order to increase demand and thus expand the use of effective contraception, potential users must move along a continuum from awareness and knowledge, through interest/motivation, trial and assessment to retrial/commitment. The 1993 data indicate a significant improvement in the pattern of contraceptive use, essentially achieving the FPHP target of 15 percent for married women, as well as a notable shift in attitudes towards further childbearing. Nevertheless, contraceptive prevalence in Ghana remains relatively low, raising the question of how far along this continuum Ghanaian women are willing to move.

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

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

The strategy for the communication campaigns under FPHP is to specifically address the low level of knowledge of all the methods. IEC efforts focus on community mobilization and interpersonal communication supported by public relations and media campaigns. Public

sector IEC campaigns providing method specific information will be supported by brand specific campaigns addressing the benefits of the social marketing products.

In order to support this information base and encourage successful trial, the FPHP is also continuing to train health personnel about the methods and their contraindications as well as in family planning counseling techniques. Through this training, health personnel are encouraged to realize that their responsibilities include the creation and support of demand, as well as the delivery of services, and they are trained in outreach and interpersonal communication techniques.

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

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

A. Constraints to Demand for Non-Clinical Methods

Lack of awareness and knowledge of individual methods continue to be major barriers to use. Thirty-five percent of never users state that they are not using contraceptives due to lack of knowledge; 14 percent cited fear of side effects as a reason for non-use.
In more urban settings, especially in the south, where women are more educated and there is greater acceptance of modern contraceptives, evidence suggests that improving knowledge of products and increasing awareness of sources has a positive impact on prevalence. Service statistics in districts that had information campaigns indicate an increase in awareness and trial of modern contraceptives as a result of the campaign. These results highlight the importance of providing proactive outreach, where women are sought out to be given information, support and access rather than waiting for women to seek out the information, products and services.

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

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

The difference found in the baseline between trial and current use also indicates that there is substantial discontinuation. Former users report that they are not contracepting because of lack of knowledge, as well as because of fear of side effects and partner disapproval. This finding underscores the need for more information and support for women to increase their knowledge about specific methods and reduce their health concerns as well as a need to educate men about the benefits of contraception in order to foster greater levels of continuation.

Once women have a positive attitude toward family planning, and are aware and knowledgeable about methods and their sources, they can proceed to try the methods, evaluate that trial, and, if the trial is successful, continue to use the method. This process is greatly facilitated by the involvement and approval of their partners. In Ghana, as a result of the low levels of awareness and knowledge, trial of modern methods (ever use) has been limited. According to the 1993 CBS, for all women, trial of any modern method is 32 percent, ranging from 1 percent for IUD, and 3 percent for injection to 5 percent for vaginal foaming tablets, 12 percent for the pill and 18 percent for condoms.

At present the FPHP does not include a well-developed system of CBD workers who could provide information and thus expand the demand for Contraceptives. Through the American College of Nurse Midwives (ACNM), FPHP currently supports MCH training for Traditional Birth Attendants (TBAs) that includes family planning. This training is intended to enable TBAs to provide information and serve as CBDs. Educating TBAs about family planning can provide important access, especially to more rural women. It is unclear whether TBAs are the most appropriate group as a whole to serve as CBD workers, although individual TBAs may serve successfully in this role.

B. Constraints to Demand for Long-Term Methods

Demand is even lower and the supply infrastructure is much less developed for the long-term clinical than for the non-clinical methods. The 1993 FPHP baseline also clearly demonstrates the demand situation for long-term and permanent methods: among all women, awareness of injectables was 50 percent, IUDs was only 34 percent, female sterilization was 35 percent, and male sterilization was only 10 percent. Moreover, only 23 percent of women were aware of that MOH clinics were a source for IUDs; only 5 percent were aware that PPAG was a potential source.

Very few women possess basic knowledge about long-term methods. Only 26 percent of women know how to use injectables; and only 22 percent of women have a basic knowledge

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about IUDs. No data were available about knowledge of sterilization or NORPLANT®.

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

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

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

Demand generation for long-term methods must be coordinated with and targeted to the development of the delivery infrastructure. Once an area has a critical mass of providers who are trained in the techniques and who have the time and access to the facility to perform them, specific demand generation activities can be targeted to that area. Women must be given specific information about the methods and the sources for obtaining them.

Referral systems are needed to stimulate demand and trial of clinical methods. Because there far fewer potential service sites for long term methods, community outreach, CBD, pharmacists, and others need to be trained to refer potential clients to an appropriate source.

Finally, at present, there is no country-wide strategy for the continued provision of NORPLANT®. Such a strategy must consider whether NORPLANT® will be maintained in the public sector or private sector and whether there is donor support for the purchase of the sets. Additionally, it should explore if and how the product can be marketed in the private sector. There has been social marketing of NORPLANT® in Mexico, where the product is brought in through the FPA at donor prices, but marketed through the private sector. However, even these prices are vastly outside the grasp of most consumers in Ghana, and would have to be subsidized.

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

VI. DELIVERY OF SERVICES

A. Current Status

In the public sector at present, motivation for family planning counselling and contraceptive methods are available at all MCH/FP service delivery points (SDPs). However, surgical contraception is available only at seven regional hospitals, while NORPLANT® can be obtained only at two sites. At present, there are over 6,000 service delivery points in Ghana, and an additional 12,000 individuals such as traditional birth attendants, outreach workers and community based distributors who provide family planning services and commodities. Under FPHP, the number of service delivery points covered by the Ghana Social Marketing Foundation (GSMF) has risen substantially from 3,000 in 1992 to 5,000 in 1993 with an expected increase of 2,000 per year.

With respect to deployment of staff, MCH/FP manpower policy has not been successful. Despite decentralization efforts, as of 1992 Greater Accra had 70 MCH/FP professionals above that required to meet the national average staff to population ratio of 1:41,348. Similarly, disparity in the distribution of Community Health Nurse Midwives persisted, with disproportionate concentrations in Eastern, Greater Accra and Volta regions.

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

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

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

B. Analysis of Service Delivery

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

A program in the "growth" phase, which will be the target of GHANAPA, concentrates on expansion of services and quality of care, while integrating these services into already existing programs. The emphasis is on a method mix with a greater proportion of more effective methods (IUDs, injectables, NORPLANT® and surgical contraception) and expansion of the availability of non-clinical methods to low income consumers and hard to reach clients in the rural areas. To accomplish this shift, the established target is to have the more effective methods comprise 40 percent of the method mix. The following shows the projected method mix for the year 2000.

METHOD	PERCENT
Condoms	5.40
Injectables	5.00
IUD	1.80
Oral Contraceptives	5.40
Vaginal Foaming Tablets	1.20
NORPLANT®	0.20
Female Sterilization	1.00
TOTAL	20.0

Details of the TARGET MODEL from which these figures were derived are given in Attachment _____.

1. Short-Term Methods

Short-term methods are provided through the public sector and a variety of private sector/NGO channels including the Ghana Social Marketing Foundation (GSMF), Ghana Registered Midwives' Association (GRMA) and Planned Parenthood Association of Ghana (PPAG). Of the sixty-five percent of short-term methods supplied by the private sector,

GSMF provides nearly 84 percent, the remainder being provided by PPAG, GRMA and other NGOs. Following is a brief description of the three major private sector/NGO organizations involved in the Mission's family planning activities, as well as information on other NGOs that receive assistance under FPHP and are expected to continue under GHANAPA.

o **Ghana Social Marketing Foundation**

The Ghana Social Marketing Foundation, established as the Ghana Social Marketing Program in 1985, is a non-profit, incorporated, private sector organization dedicated to improving the quality of life of individuals and families through the provision of affordable and accessible family planning and maternal and child health products and services. The organization became a private company in 1993, governed by a board of directors, and is now the largest provider of private sector contraceptives in Ghana.

GSMF has been receiving financial support and donated contraceptive commodities from USAID/Ghana since 1985 (?) under both the Contraceptive Supplies Project and the FPHP. Under FPHP, GSMF has received significant training and technical assistance which has strengthened the organization's financial management and administrative capabilities, established procurement procedures, and improved overall accountability.

GSMF capitalizes on the efficiency of the private sector to improve existing distribution channels to extend access to family planning products and services, and now supplies 5000 pharmacy and chemical retail shops throughout Ghana. GSMF currently sells two brands of condoms and one brand each of oral contraceptives, vaginal foaming tablets and oral rehydration salts.

By using three different distributors for their products (discussed in section 9 on Commodities), GSMF has now expanded its client base to include private midwives, supermarkets, gas stations, packaged goods stores, local markets and hairdressers with a goal of reaching 10,000 retail outlets by 1996. Plans call for injectables and IUDs to be sold to private doctors and clinics as the program emphasis shifts to long-term methods. GSMF engages in extensive product promotion to increase awareness and knowledge about the benefits of the products, and training to ensure that retailers can provide correct information about the products.

As indicated in Table 1, GSMF has almost **quadrupled** its total sales since 1986. Such a significant increase demonstrates that consumers are willing to pay for contraceptive supplies and speaks to the future sustainability of the program. GSMF currently recovers 15 percent of its recurrent costs through sale of products. FPHP project assistance covers the remaining 85 percent. By the year 2000, GSMF projects increasing its share of recurrent costs to 54 percent.

Table 1: GSMF Commodity Sales According to Method by Year

	CONDOMS	FOAMING TABLETS	ORALS	TOTAL
1986	1,323,600	-	-	1,323,600
1987	2,519,100	544,200	284,900	3,348,200
1988	3,501,100	614,500	350,000	4,465,600
1989	3,214,300	724,700	431,300	4,370,300
1990	3,586,500	1,602,172	451,082	5,639,754
1991	3,748,300	1,911,332	453,839	6,113,471
1992	4,026,651	2,190,392	379,097*	6,596,140
PERCENT INCREASE	204 percent	302 percent	33 percent	398 percent

*The decline in oral sales noted in 1992 is a result of (1) supply problems due to start-up of new USAID/W contract for procurement of contraceptives; (2) difficulties with the local distributor. The worldwide contract is now in place and distribution has been expanded to include three local distributors.

Source: GSMF Quarterly Returns, 1986-1992.

As elaborated upon in section____and Annex____ of this document, GHANAPA will establish an endowment or trust fund for the GSMF to allow the Foundation to develop an investment strategy for self-sufficiency. It is anticipated that by utilizing such an investment mechanism in conjunction with income generated from sales, GSMF will be able to cover all recurrent costs and generate enough income to begin purchasing a portion of contraceptives with ten years.

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

PPAG is a private NGO and is the local affiliate of the International Planned Parenthood Federation (IPPF). PPAG is the largest NGO provider of family planning services in Ghana, and currently provides 14 percent of the total short-term methods in the private/NGO sector. PPAG receives the majority of its commodities through IPPF and funding from the World Bank, and delivers them through its family planning system, as well as through a system of community-based distribution (CBD). At times, PPAG has experienced commodity shortages or outages due to delays in the provision of these goods. However, under the new centrally-funded agreement between AID/Washington and IPPF/London, adequate supplies of all contraceptives should be readily available.

PPAG has developed strategic plan for 1995-2000 which calls for the expansion of delivery of short-term methods, particularly through its CBD program, as well as an increase in the delivery of long-term methods through its family planning clinics. PPAG places a particular emphasis on target groups such as adolescents and men. The GHANAPA program plans to provide a grant to PPAG to expand its family planning programs, particularly with regard to long-term methods, and to reach underserved populations through its CBD program and programs for adolescent. In the event of occasional shortages, GHANAPA will also provide commodities as needed through the GSMF to supplement those received from IPPF, thereby assuring PPAG of a constant supply of short-term methods, and further increasing the commercial distribution of short-term commodities.

- **Ghana Registered Midwives Association (GRMA)**

GRMA is a non-governmental organization which consists of approximately 500 registered nurse midwives, who serve as private practitioners and provide pre-natal, delivery and family planning services to women throughout the country. Under the FPHP, USAID/Ghana has provided funding to GRMA for the training of its members in general family planning information, and the provision of short and long-term methods. To date, 275 members have received training in family planning and receive commodities through the MOH and GSMF; 45 have been trained in IUD insertion. USAID funding to GRMA began in 1987 through a grant from REDSO/ WCA to establish the organization, while USAID/Ghana funding under FPHP began in 1992 to help establish appropriate administrative and financial management structures. While thus far GRMA accounts for only a small percentage of the overall NGO provision of family planning services, it provided nearly 5000 couple years of protection in 1993 and is an important channel for provision of family planning and other reproductive health services in the private sector. GHANAPA will continue to provide training support to GRMA in long-term methods, particularly the IUD, as well as supply short-term methods through GSMF. Over time GRMA will increase its overall share of family planning, further shifting provision of these services to the private sector and thereby increasing program sustainability.

- **Other NGOs**

Under FPHP, USAID/Ghana provides funding for training in counselling and referral, IEC materials, and contraceptives through the GSMF to 10 local NGOs as part of the community-based distribution program. The NGOs are selected based on their involvement in providing family planning services and referrals and on their ability to utilize messages developed under the IEC activities of FPHP. Linkages between the GSMF and other project activities, including IEC, and the NGOs will continue and perhaps be expanded under GHANAPA.

It will be a major accomplishment if, at project's end, a substantial portion of the procurement and distribution of short-term methods is financially self-sufficient.

2. Long-Term Methods

In order to achieve a significant decline in fertility, a shift to long-term methods must take place during the growth phase of Ghana's population program. This requires increasing the current number of users of long-term methods from 48,000 in 1993 to approximately 236,000 by the year 2000, which corresponds to 20 and 40 percent of all users in 1993 and 2000 respectively (Table 2).

Table 2: Current and Projected Number of Users of Long-Term Methods

	1993		2000	
METHOD	Percent	Number (000's)	Percent	Number (000's)
IUD	5	13	9	53
NORPLANT®	0	0	1	6
Injectable	12	30	25	147
Female Sterilization	2	5	5	30
TOTAL USERS	19	48	40	236
TOTAL CYP[1]	95,000		281,000	

SOURCE: TARGET Model (Annex) an d Consumer Baseline Survey, The Futures Group, 1993.

Table 3 shows the annual numbers of long-term procedures projected to meet these targets. While these numbers project a rapid growth, they are consistent with the demand analysis presented earlier. For these targets to be met, there must be a significant increase in the number of service delivery points for long-term methods and numbers of personnel trained in counselling and performing these procedures.

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[1]Couple Years of Protection -- contraceptive protection for a couple for one year. For example, four doses of the injectable, Depo Provera, annual yield one CYP. There are standard values used for each method which account for various factors which permit comparison of programs, although country- or region-specific values need to be incorporated to reflect local circumstances. For example, if women are sterilized on average at age 38, as they are in Ghana, they will not benefit from the full 12.5 average years of protection associated with sterilization. In this analysis, the following values were used: IUDs - 2.5 CYP; NORPLANT® - 3.5 CYP; Injectables - 4/CYP; Sterilization - 8 CYP.

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Table 3. Numbers of Procedures Projected Annually by Type of Procedure

	VSC	NORPLANT*	IUD
1994	1,049	781	10,700
1995	3,394	767	15,590
1996	4,108	1,431	16,330
1997	4,872	1,423	18,470
1998	5,678	2,271	21,570
1999	7,803	2,776	24,050
2000	7,412	2,267	26,530

Source: TARGET Model (see Annex E)

* In some years, TARGET requires fewer NORPLANT insertions because the denominator (women of reproductive age) is increasing at a faster pace than the numerator (percent of method mix).

There are currently fifteen sites providing sterilization procedures throughout the country. In 1993, the Association for Voluntary Surgical Contraception (AVSC) conducted an assessment of 100 additional service delivery points to determine their suitability as sites where long-term (clinical methods) could be offered. These sites consisted of university teaching hospitals, 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, and concluded that of the 100 sites, 35 require major renovation (> 3.5 million cedis; approximately $3,750 at the rate of C935 = $US1) and 20 require minor renovation (< 3.5 million cedis). The remaining sites require equipment only, no assistance at all, or renovation is not possible because the space is rented.

The analysis indicates that once renovated and equipped, these 100 sites plus the existing fifteen will be adequate for providing the required number of procedures. However, these facilities are also utilized for other types of surgery and operating room access for family planning procedures has been cited as a constraint by providers. This issue will be addressed by reaching agreements with each facility regarding availability for provision of long-term family planning methods.

An analysis of training requirements to perform the number of clinical procedures necessary indicates that an additional 340 doctor/nurse teams are needed for sterilization, 40 doctors and 200 nurse midwives for NORPLANT® procedures, approximately 600 trained and practicing nurse-midwives for IUD insertion, and a minimum of 900 personnel for counselling and

referral. Since 1991, pre-service training in IUD insertion has been included for all nurse-midwives and public health nurses, of which there are approximately 300 graduates each year. However, not all of the nurse-midwives assigned to the public sector are given IUD kits and not all are put in clinical service units where they can practice. In the private sector, 275 of the approximate 500 registered nurse-midwives have been trained in general family planning, and forty-five of those have received clinical training and are currently performing IUD insertion.

C. Constraints

Overall, there are several service delivery gaps in the current program which would benefit from additional resources. The first is the lack of programs for adolescents which would provide **services** in addition to information and counseling. These services are needed in a setting which is outside the usual MCH/FP context, providing maximum privacy to the teen.

Post-abortion/post-partum services also receive little emphasis at present. There are many missed opportunities to educate women about family planning during this period. The situation analysis found that 47 percent of family planning clients have had an unwanted pregnancy and 50 percent of these women have had an abortion. Of 1,397 women visiting MCH facilities and interviewed, 62 percent have never used a family planning method. Of those who are currently using a method, many were not aware that family planning was available in the **same service delivery site** where they were receiving MCH services. Training for post-partum IUD insertion for nurse midwives and private physicians, as well as training in counselling and referral for post-abortion patients would begin to address this overlooked population.

Third, the rural areas are underserved. CBD programs are needed which can get the services out to the remote areas.

In assessing the constraints to the delivery of services, it is useful to consider clinical (surgical contraception, IUDs, injectables and NORPLANT®) and non-clinical (pills, condoms, VFTs) methods separately, as the level of demand and the supply infrastructure vary for the different types of methods. For example, the distribution systems are more developed for non-clinical methods than for clinical methods because the previous USAID family planning projects focused on building demand and delivery mechanisms for non-clinical (supply) methods.

1. Constraints to the Supply and Delivery of Non-Clinical Methods

Public Sector: In the past, the public sector has experienced considerable disruption in the supply of non-clinical contraceptives. Stock outages have occurred for almost all the methods at different times due to problems with ordering, shipment, clearance and inventory levels. A recent (February 1993) Family Planning Logistics Management (FPLM) assessment reported improved stock management in the public sector. However, the 1993 Situation Analysis

indicated that there continue to be moderate levels of stock outs. Thirty-three percent of service delivery points providing the progestin-only pill reported a stockout in the past six months. This figure is 18 percent for VFTs, 11 percent for condoms, 8 percent for combined oral contraceptives, 8 percent for IUDs and 4 percent for injectables.

NGO Sector: Members of the Ghana Registered Midwives Association (GRMA) provide contraceptives through their private maternities, which currently serve an average of 47 new family planning clients per year per maternity. Only 250 of their 500 members have been trained in general family planning services thus far, which limits their contribution to the national program.

One major constraint to developing the NGO delivery network is the lack of funds to support NGO activities. Though training has been offered to NGOs under the current project, the reality is that the participation of these organizations requires financial and logistical support.

Private Sector: Many of the constraints to the supply and delivery of non-clinical methods in the private sector have been addressed under FPHP. However, there are still rural areas in which these products are not available. Training, including refresher training, for pharmacists and chemical sellers will have to be conducted to maintain the momentum of the current program. Most private physicians are not trained to counsel, refer or provide family planning services.

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

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

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

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

The training that has been done has also not been well orchestrated and documented. Some providers have been trained in general family planning, others in IUD insertion, others in sterilization. There is no clear record of IUD trainees, where they are, whether they are

currently practicing and so forth. Since future efforts require the development of demand concurrently with the development of a service delivery capacity, it is critical to be able to identify and locate past and present trainees.

Public Sector: In the short term, the lack of an adequate service delivery infrastructure for clinical methods remains a major constraint to meeting prevalence targets. The IUD has the greatest acceptance and the greatest potential for increasing prevalence but the number of trained service providers is very limited. Training is also limited by the number of sites where those receiving theoretical training in long term or permanent methods can receive practical training. The development of training sites must be done in a coordinated fashion, rather than separately for VSC and IUD insertion.

Private Sector: The private sector clinical service delivery infrastructure is the most underdeveloped of all the sectors. Only 64 private physicians (out of only 300) have been trained in IUD insertion techniques.

D. Recommendations

NGOs not only can play an important role in creating a supportive environment for the use of family planning by providing a forum for reaching women and men to increase knowledge and trial, they can also provide a network for distribution of non-clinical family planning methods. NGOs should be used to provide support and distribution to areas of low prevalence that are unserved by either the public or the commercial sectors, or where more intensive proactive support is required.

Private midwives furnish an excellent network to promote and support family planning services, given their role in providing reproductive health care to their clients. In addition to training in basic family planning, greater numbers should be trained in IUD insertion. In addition, they should be utilized to provide injectables, as well as NORPLANT®.

In the longer term, to increase the sustainability of family planning service delivery in Ghana, the private sector must play an even greater role in the provision of services. The GSMF currently is investigating the addition of injectables and IUDs to its product line. Distribution would be through the network of midwives and doctors.

The Society for General Medical and Dental Practitioners represents private medical practitioners. Currently, private practitioners have no formal distribution network which supplies them with either non-clinical or clinical methods. Linkages should be established between the Society and the GSMF to ensure participation of its members in training programs, and to provide access to contraceptive supplies. After an initial test of the private provision of non-clinical family planning services, a more extensive social marketing of long term methods should be initiated. In this scheme private providers can be trained in a range of family planning methods, can receive their products from the GSMF and their network can be

promoted through GSMF. Providers can be trained to be more consumer driven and improve their quality of care, as well as to promote their services. Extensive support for longer term methods and private providers can be provided by public relations activities and referral networks. Family planning counseling training should be expanded to include the staff of private providers.

VII. Quality of Care

The 1992 Annual Report of the MCH/FP unit reports that, despite increases in the number of SDPs there continue to be problems with poor continuity and underutilization of services. A major factor is the quality of care. Factors such as availability of services, provider attitudes, and lack of skill may play a role in mitigating the significant improvements in family planning service coverage that have been achieved in Ghana. Many of these issues can be examined using data from the Situation Analysis. Selected findings are presented below:

Counselling skills:

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

Technical competence:

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

Acceptability of services:

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

Mechanisms to encourage continuity:

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

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

Method choice

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

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

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

Clearly, training in counselling, referral and clinical skills will improve the quality of services provided in all sectors.

VIII. PROVIDER PRACTICES

A. Status

In Ghana, as in most countries, increasing attention is being given to the quality of services provided (see Section 7 above). Nevertheless, certain restrictions or provider practices designed or intended to ensure high quality have the effect of limiting access to family planning services without necessarily improving quality. Such restrictions have come to be referred to as "medical barriers." These restrictions are imposed on the individual in the name of quality of care, because of a "perceived" medical risk, or more typically because of lack of knowledge about the latest contraceptive technology. These restrictions can appear as inappropriate eligibility criteria, misinterpretation or overstatement of a medical contra-indication, restrictions on who can provide certain methods, process hurdles such as repeat medical examinations or laboratory tests, and provider biases to name a few. Taken together, these restrictions can prevent women who choose to plan their families from receiving the care they seek. Currently, there are no regulatory constraints which prohibit dispensing of contraceptives according to age, marital status, or partner's consent. However, clinical guidelines suggest that family planning is for married couples.

B. Constraints

To date, some attention has been given to provider practices, as well as to customs that constrain wider access to services. Nevertheless, additional work is required. Results from the Family Planning Situation Analysis suggest the presence of provider bias in service delivery in Ghana, a phenomenon whereby practitioners will not provide certain methods at all or not provide them to certain categories of clients because they are misinformed about the safety or efficacy of the method.[2] While taking medical history and blood pressure are certainly in order, urine and blood tests are considered unnecessary prior to providing hormonal methods. Not only does this practice increase the cost of service delivery to both the provider and the client, it creates a process hurdle for the potential client. Table 4 shows the percent of providers interviewed in the Ghana Situation Analysis who reported that they conducted certain tests prior to administering a particular method. Nearly half of all clients wishing to use oral contraceptives or injectables are given blood and/or urine tests. Similarly, pelvic exams, unless warranted by a condition noted in the medical history, should not be required for pill or injectable use.

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

Table 4: Percent of Staff Conducting Medical Tests by Contraceptive Method Type

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

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

Table 5 shows provider biases regarding eligibility for method use. Nearly 90 percent of the providers interviewed would not provide **any method** to a woman with fewer than three children. Many providers would not provide family planning to unmarried clients or without the spousal consent of the married clients.

Table 5: Provider Eligibility Restrictions on Method Use by Method and Restriction

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

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

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

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

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

Process hurdles are medical procedures which actually result in denied access or high discontinuation rates. Provision of one cycle of oral contraceptives per visit or requiring a brief medical exam, even if the client is a continuing user with no adverse side effects or complaints, can result in a client suspending use of the method. Similarly, restrictions on who can provide certain methods may result in fewer users.

Inappropriate eligibility criteria can also severely restrict clients from obtaining services. It was noted that some providers are more willing to provide services to unmarried clients than to married clients without spousal consent, while other providers were reluctant to provide services to young or unmarried women at all. Some of these practices relating to eligibility criteria arise from rumors and misconceptions e.g. the delayed return to fertility thought to be associated with injectable use.

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

C. Recommendations

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

- Review legal and regulatory constraints to policy implementation and development of a reform strategy
- Assess appropriateness of provider certification criteria
- Improve the knowledge of providers through in-service training and workshops
- Conduct research to validate safety and efficacy for providers and policy-makers of proposed changes in regulations
- Develop service delivery/training guidelines
- Conduct contraceptive technology updates for service providers, policy makers, the media and pre-service faculty

IX. COMMODITIES

At present, almost all commodities in Ghana are distributed by three major players: the Ministry of Health's Maternal and Child Health/Family Planning (MCH/FP) Division, the Ghana Social Marketing Foundation (GSMF), and the Planned Parenthood Association of Ghana (PPAG). There is little purely private contraceptive distribution, though of course GSMF products (and in many cases MCH/FP and PPAG products) are distributed through commercial networks.

The in-country distribution systems of the three organizations are generally adequate for the quantities of contraceptive commodities currently flowing through them, though there are supply imbalances in some places. Stockouts experienced in recent years have been due primarily to problems in obtaining products from abroad and to difficulties in port clearance once commodities arrived in Ghana. These issues are largely resolved, though there are still periodic shortages of several items provided by UNFPA and IPPF.

A. Status of Current Logistics Systems

This section briefly describes the current status of logistics systems in MCH/FP, GSMF, PPAG, and the private sector.

1. The Ministry of Health

MOH services are provided through a network of some 900 service delivery points (SDPs) including hospitals, clinics, health posts, and villages served through outreach activities. All SDPs provide some level of MCH/FP services, ranging from the full gamut of clinical services to only motivational outreach efforts. These sub-district level services are managed by multi-disciplinary District Health Management Teams (DHMTs). The 110 districts are in turn supervised by ten Regional Health Management Teams (RHMTs) under the direction of the Regional Medical Officers (RMOs) and Principal Nursing Officers (PNOs). PNOs also report to the central MCH/FP Division in Accra for family planning and MCH activities.

MOH contraceptives have to date been provided exclusively by donor organizations. However, the MOH has agreed to begin procurement of contraceptives through its own funding, and funds for an initial international tender are included in the current budget.

Contraceptive distribution is accomplished through a requisition or "pull" system at all levels. Sub-district facilities request enough stock each month to bring their balances up to four months of supply of each commodity, based on quantities dispensed in the month just ended. Similar procedures are followed at the district level, but on a quarterly basis. A request is prepared to bring stocks up to four months of supply in the SDPs, and to six months of supply in the district store.

At the regional level, sufficient quantities are requested to ensure a nine-month supply, plus the quantities necessary to completely resupply all district and sub-district facilities. Requests are discussed and approved at MCH/FP Division headquarters in Accra before commodities can be collected from the Central Medical Stores (CMS) in Tema. Coordinating the approval and issue process between Accra and Tema is often difficult, which can hamper transport. At all levels, transport is generally available, but MCH/FP receives low priority.

The central desired stock level is set by policy at twelve months. Thus the theoretical length of the in-country MCH/FP pipeline is 31 months (4 at the sub-district plus 6 at the district plus 9 at the region plus 12 at the central level). In practice these quantities of stock are rarely available, and logistics managers at all levels allocate lesser quantities based on availability and actual need.

At the central level, MCH/FP commodities are stored in a separate section of the CMS, and managed by the same system used for drugs and other MOH commodities, but with decision-making responsibilities shared by the MCH/FP Division and the Supply and Procurement Division. This same strategy is followed at the Regional Medical Stores (RMSs) with the Regional Pharmacist managing the physical stocks and the PNOs responsible for distribution decisions. Storage capacity for MCH/FP commodities is generally adequate for current volumes. Storage conditions are typically good, though better insulation, ventilation or air-conditioning would improve most sites. At the district and sub-district level, storage capacity and storage conditions are more variable, but were found to be adequate for current volumes in sites visited.

Good storekeeping practices are generally observed at all levels. Products are separated by brand and date, usually stacked and labelled neatly, and usually protected from environmental hazards. Stock records (tally cards) are up to date and generally accurate; first-expiry, first-out stock rotation procedures are generally observed.

Forecasting at the national level is done annually by MCH/FP staff, with some external technical assistance provided by A.I.D. and, until recently, by UNFPA. The national commodity situation is monitored quarterly by MCH/FP and donor staff. All of these forecasts are based on quantities dispensed to clients at the sub-district level.

The MCH/FP Logistics Management Information System (LMIS) is separate from the national health MIS now under development, though it is consistent with the requirements of the larger system. Dispensed-to-client data are reported in aggregate form all the way up the system to Accra. These reports are usually timely, and are believed to be accurate. Logistics data are tracked centrally by MCH/FP staff using a complex array of LOTUS spreadsheets on a personal computer. The LMIS reporting format has been recently revised with technical assistance from UNFPA, though implementation of the new format is not complete.

2. The Ghana Social Marketing Foundation

Contraceptives supplied by USAID to the Ghana Social Marketing Foundation (GSMF) are cleared from port by the local agent of USAID's U.S. freight forwarder and delivered to GIHOC Pharmaceuticals' warehouse. GIHOC is responsible for central level warehousing and repackaging, and has adequate space to allow for program expansion well into the future.

The FPHP technical assistance contractor contracts with local firms to supply sufficient quantities of repackaging materials to GIHOC. Repackaging is done in the same GIHOC facility where the product is warehoused.

GIHOC then releases quantities to three distributors: DANAFCO (distributing primarily to pharmacies), STARWIN (distributing to pharmacies and other chemical sellers) and Johnson's Wax (distributing to sellers of other Johnson's wax household products). Each maintains a central warehouse in Accra from which products are transported to the regions. Each distributor also has some regional representatives, as well as a network of salespeople, stockpeople and retail outlets. The total number of retail outlets of the three distributors combined is now over 4,000.

Competition among the distributors to enlist pharmacists and chemical sellers into their networks has lead to improved performance by each distributor's regional representatives. Pricing is more competitive and increased efforts are made to ensure that the individual sellers are resupplied on a timely basis.

Sales data pass through each distributor's network from the field up to the central office. Data are then centralized at GIHOC, and regularly transmitted to the contractor. Product requirements are derived from projected sales which in turn are based on historical sales patterns and future program plans. Estimates of future GSMF commodity requirements are submitted to USAID to facilitate preparation of the annual Contraceptive Procurement Tables.

Funds generated by the sales of GSMF products are also passed back up through the networks after the appropriate profit margins are retained. These funds are then deposited into a bank account in Accra under the FPHP contractor's responsibility.

Previously, the GSMF distributor's management system did not make regional breakdowns of sales by product readily available. This refinement of the GSMF's information system is currently being introduced by GIHOC, and will be a valuable asset in strategic program planning. GIHOC also provides the contractor with monthly reports of stocks on hand of repackaged product, unrepackaged product and the various repackaging materials.

3. The Planned Parenthood Association of Ghana

PPAG operates in seven regions, with some 25 clinic sites and 447 CBD workers. Program operations are controlled by the PPAG central office in Accra, and supervised through

regional offices in seven of the ten regions. PPAG family planning nurses in six of these seven regions perform IUD insertions, both in the clinics located in the regional capitals, and during their monthly or bi-weekly rounds to the 18 district MOH facilities where PPAG has established representation. PPAG's CBD agents refer prospective IUD clients to these facilities, and arrange appointments to coincide with the regional nurse's scheduled rounds. They also arrange appointments for first time orals clients, and clients requiring clinical back up visits.

USAID has identified two sites (Koforidua and Takoradi) for renovation and training in order to give PPAG voluntary surgical contraception (VSC) capability.

Contraceptives are provided both by IPPF and most recently by the World Bank. In addition, PPAG occasionally purchases from the MOH when stocks from other sources run low.

PPAG's forecasting for commodities follows IPPF standard annual planning procedures. Requirements estimates are based on historical usage rates adjusted for annual program plans. Once the IPPF annual workplan is approved, PPAG knows the quantities of each commodity it will receive in the coming year, but each product is shipped directly from the manufacturer to PPAG, and may arrive at any time during the year. IPPF has some ability to change the manufacturers' shipping schedules where stockouts are anticipated. Total budgets for IPPF commodities are limited. However, under the terms of the centrally-funded agreement with IPPF/London, USAID-funded contraceptives should be available to PPAG in future without such constraints.

The World Bank agreement to procure contraceptives for PPAG has been in place for some time, but there have been extended delays in establishing this new procurement channel. UNFPA now acts as procurement agent for contraceptives obtained with these funds. The current agreement extends only to 1996, but the Bank has indicated willingness to consider supplying commodities beyond that time period, given delays in the process to date.

The delay in Bank procurement and variability of IPPF schedules have historically caused significant stock shortages. PPAG often has had to purchase substantial quantities of contraceptives at the central, regional, district, as well as local levels to avoid stockouts. Where MCH/FP staff have believed that their own stocks were insufficient for MOH needs, PPAG's requests have been refused.

Storage capacity at the PPAG central facility is sufficient for current needs, but there is little room for expansion. PPAG staff allocate commodities to regional stores as soon as they are received, due to the overall shortage of supplies, and retain only small quantities of emergency stocks centrally. Storekeeping practices are good. Stock records are kept up to date and are reasonably accurate. The storage situation at the regional level varies from place to place.

For the MOH district facilities where PPAG has representation, the PPAG regional family planning nurse delivers contraceptives while making her monthly or bi-weekly rounds, based

on her knowledge of each facility's distribution rates. When she delivers products, the district PPAG representatives provide her with data on use of quantities of products previously supplied and quantities of stock on hand. Since these rounds are scheduled in advance so that the nurse can perform IUD insertions and clinical backup visits for orals and injectables clients, district PPAG representatives can contact the regional office prior to the nurse's visit to communicate any particular supply needs.

For the PPAG CBD agents, either the agents come to the Regional office for resupply, or they are resupplied by the regional nurse when she makes her rounds.

PPAG follows standard IPPF reporting and monitoring procedures for stocks and other program activities. These administrative systems and the PPAG MIS appear to function well.

4. The Private Sector

Little purely private sector contraceptive distribution is evident in Ghana at present, though the subsidized social marketing products of GSMF do move though private sector distribution channels. Prices for these products vary from place to place, usually within the following ranges:

Panther condoms	30 - 50 cedis (each)
Protector condoms	150 - 200 cedis (3 pack)
Kamal VFTs	135 - 200 cedis (8 pack)
Secure orals	150 cedis (cycle)

It is also common to find MOH and sometimes PPAG products available through chemical sellers and pharmacists. In some cases Ministry staff will sell product to such retailers only when they know that there is no other readily available source of supply. In other cases, MOH staff have recruited chemical sellers and pharmacists to provide additional outlets, providing them with training and gathering and reporting data on the service they provide. Again, prices vary considerably, usually within the following ranges:

Condoms (plain)	20 - 50 cedis (each)
NeoSampoon condoms	200 cedis (4 pack)
Lo Femenal	200 cedis (cycle)

This practice effectively creates another subsidized distribution channel, with prices at the low end of the range.

B. Constraints

While the three main distribution systems are generally working well, some weaknesses remain. In terms of the public sector, issues requiring attention include the following:

- Contraceptive requisitions based on dispensed-to-user data for the time period just ended result in extreme fluctuations in quantities requested;

- Current desired stock level policy that results in an in-country pipeline 31 months long drastically increases the chance of product expiry or damage in storage;

- The policy of ordering enough product at each level to fully stock the entire pipeline every quarter needlessly strains and frequently exceeds both storage and transport capacity throughout the system;

- Quantities of most products supplied through UNFPA are insufficient to meet total demand, resulting in stockouts, rationing, and shortages, and leading to frequent brand switching by MOH clients;

- Transport procedures are not systematized at any level, resulting in ad hoc transport schemes which will be severely strained if commodity volume increases as expected;

- Financial resources at lower levels are insufficient for program operating expenses, including transportation of products, supervision activities and program services such as outreach.

The main constraints for the GSMF are that some perceive their products to be too expensive, at least for some portion of the target population. Further, the existence of lower prices at MOH and PPAG outlets, and the availability of MOH and PPAG products to private outlets, are currently limiting GSMF's ability to increase its market share.

The IPPF and World Bank procurement issues make commodity planning difficult for PPAG, although it is anticipated that some relief will come through the new arrangement with USAID/
Washington.

Limiting factors concerning the private sector as a whole include the lack of any history of large scale importation of purely private family planning commodities into Ghana. Also, subsidization of products from GSMP and PPAG the market share available for the purely private sector.

C. Recommendations

In anticipation of continued dramatic program growth, both the service providers and the donor agencies have questioned whether existing distribution systems will be able to handle vastly increased quantities of contraceptive products, as well as what those quantities are likely to be. The recent analysis of the commodity distribution and management capacity in

the public and private sectors suggests that the MOH, GOG and PPAG will be able to meet projected demand under several scenarios of continued rapid growth, presuming that

- distribution systems are modified and strengthened;
- commodity pricing policies are rationalized to encourage the flow of commodities through GSMF and pure private sector commercial outlets; and
- necessary commodities can be procured through a combination of donor funds and Government of Ghana (GOG) resources.

Since donor and GOG resources are limited and will eventually become insufficient, some changes in public sector programs are needed which will foster growth of an unsubsidized private sector market for contraceptive commodities.

As the family planning programs in Ghana mature, there will be a natural shift in method mix, from traditional, less effective and temporary supply methods toward modern, more effective and permanent methods. In addition to programmatic implications, such changes have large consequences for logistics management; for example, providing five Couple-Years of Protection (CYP) with condoms requires much more storage capacity, transport capacity, and service delivery capacity than providing five CYP with two IUDs.

Strategic approaches for meeting these commodity needs include the following:

- Use the comparative advantages of each distribution system (MOH, GSMF, PPAG, private sector) so that each is providing the types of services for which it is best suited and none are overwhelmed as volumes increase;
- Concentrate service expansion efforts on accessible populations to encourage continued rapid program growth;
- Encourage use of the most effective methods (which also require a smaller storage and transport capacity) through changes in counselling and service delivery patterns;
- Rationalize public sector pricing policies to encourage commodity movement through the social marketing system and to foster growth of private sector distribution channels, while ensuring that price does not become a barrier to contraceptive use;
- Decentralize resources needed for program operations in the MCH/FP service delivery system;
- Continue to integrate specific MOH family planning logistics functions with essential drug distribution functions where appropriate;
- Move cautiously toward self-sufficiency in contraceptive procurement in the government program; and
- Strengthen the MOH, GSMF, and PPAG in-country distribution systems.

X. SUSTAINABILITY

A. Financial Sustainability

The issue of program sustainability has received increasing attention from USAID and other international donors in recent years. As discussed here, a fully sustainable program or project is one that generates sufficient revenue to cover its recurrent costs. In the area of family planning, the success of programs has resulted in dramatic increases in the demand for contraceptives. Even if global resources from donors and host country governments increase, however, they will not rise fast enough to cover this rising demand. It has been estimated that resources may fall short by as much as $1.4 billion by the year 2000 (USAID, 1989). Thus, generating more-sustainable programs has been identified as a way to stretch scarce dollars.[3]

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

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

1. Current Budgetary Support

Between 1988 and 1993, gross budget allocations by the GOG to the Ministry of Health rose dramatically, but the MOH share of total budget resources has been maintained at about 6 percent of total government allocations. Nevertheless, persistent, rapid inflation has reduced the value of allocations with the result that there has been little or no increase in funds available to the MOH. About 90 percent of the 1993 capital budget will be financed by GOG and 10 percent by donors. Compared to other West African countries, the contribution by donors to Ghana's capital health budget is quite low which might suggest sustainability in the long-run.

However, the percent of the capital budget devoted to MCH/FP is negligible. The total estimated 1993 recurrent budget for the MOH as a whole is 46.7 billion cedis ($70.2 million at $1 = 665 cedis), representing 11 percent of the total GOG recurrent budget.

According to Save the Children Fund (UK), donor contributions currently represent 15 percent of the total MOH budget (recurrent plus capital costs). From 1984 to 1991, over $85 million

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

was committed by donors for Ghana's health care system, including family planning. For the 1991-1996 period, external assistance is estimated at $162.8 million. As shown in Table 6, during this period the African Development Bank (23 percent of total), USAID (21 percent) and the World Bank (16 percent) will be taking the lead in health sector financing; USAID will continue to take the lead in the financing of family planning activities:

Table 6: External Assistance 1991-1996 in Health/FP

(in $ Million)

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

With respect to family planning and maternal and child health alone, the Ministry of Health has examined the issue of sustainability by developing estimates of the resources required to attain all MCH/FP targets concerning safe motherhood, family planning and child survival in relation to an annual average of donor support, the GOG share of the recurrent budget, and rough estimates of maximum community contributions through hypothetical "user fees". The

results suggest that in 1992 the MCH/FP program operated with only 37 percent of their required budget needs being met of which 8 percent was provided by the GOG, 24 percent by donors, and a potential maximum of 5 percent from user fees.

The budgetary situation is even bleaker at the regional and district levels. In 1992, the Ministry of Health was restructured to make services more effective and efficient. This new structure assigns to the central level the role of policy formation, technical guidance and central procurement, while direct responsibility for management of health services is to shift to the regions. In line with overall GOG policy on decentralization, the Regional Medical Directors in turn are to delegate increasing responsibility for service delivery to the District Health Management Teams. Nevertheless, while efforts are ongoing to strengthen the management capacity at regional and district levels, the MOH budget process does not currently allow resources to reach these levels. For example, the draft of a 1993 study by Save the Children (U.K.) shows that other than salaries and supplies, only about 5 percent of the MOH budget is allocated to the district level and 0 percent to the level B or sub-district level, the majority of the budget being reserved for the central level and teaching hospitals (about 50 percent). Level B facilities are apparently operating exclusively from funds generated from the sales of drugs and collection of service fees.

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

2. Cost Recovery

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

On the other hand, a study conducted in the Ashanti-Akim District raises questions about equity under cost recovery schemes. Introduction of cost recovery led to substantial declines in utilization levels, although urban sites gradually regained pre-cost recovery utilization rates

and eventually surpassed them. There were also significant decreases in the proportion of females using both the rural and the urban health centers.

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

Typically, countries with family planning programs at the launch stage of the family planning typology such as Ghana initiate social marketing of contraceptives to upper income groups in urban areas to begin some effort at cost recovery. Under both the previous Contraceptive Supplies Project and the current FPHP, USAID has supported social marketing activities, with prices kept relatively low. Nevertheless, there is now a movement toward raising the prices of commodities in both the public and private sectors to enhance sustainability. Further, establishment of an endowment for the GSMF will enable that group to nearly cover its recurrent costs out of sales plus the return on investment after the year 2000.

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

Operations Research is needed to test approaches to improving the financial sustainability of family planning in Ghana, including the commercial feasibility of setting up private practices in rural and under-served areas. Studies are also needed on the ability of clients to pay for services, with attention to pricing of commodities and services. Thus, OR should be undertaken that includes cost effectiveness and cost efficiency studies of various service delivery approaches, as well as cost-analyses directed at comparing the costs of hospital stay for delivery or for treatment for abortion complications with family planning costs, and examining the opportunity costs of the social sectors (e.g., health and education) to show the potential impact of family planning (cost-benefits) on reducing public expenditures in these sectors are recommended.

B. Technical Sustainability

Attention to the financing of programs alone is not sufficient to ensure sustainability; it is critically important to also focus on transferring technical skills. A recent analysis of several

health and population projects suggests that the prospects for sustainability were stronger in projects that included a strong training component. Such training may encompass long term professional training, often at overseas institutions, as well as in-country training for professionals and para-professionals, both in-service and pre-service, and long and short-term.

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

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

Human resource constraints in Ghana encompass both the lack of skilled personnel, and the inadequate deployment of those who are trained. There is a continuing need for training service providers, especially those who can provide long-term and permanent methods. Consideration might be given to experimentation with an incentive package to encourage service providers (in the public sector as well as the private sector) to locate in the under-served regions.

For the public sector, a human resources needs assessment is required to form the basis for a training plan that will include short and long term training, as well as technical assistance. Other recommended training includes management and financial skills training for relevant staff at regional and district levels. In addition, it is recommended that members of the GRMA, along with other private providers, receive training in business skills, to facilitate their setting up and operating private maternities and clinics.

XI. OTHER DONOR SUPPORT

The World Bank

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

United Nations Fund for Population Activities (UNFPA)

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

United Nations Childrens Fund (UNICEF)

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

Overseas Development Assistance (ODA)

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

The World Health Organization (WHO)

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

Save the Children Fund (SCF)

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

Danish International Development Agency (DANIDA)

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

Canadian International Development Agency (CIDA)

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

Germany's Gesellshaft fur Techische Zusammernarbeit (GTZ)

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

European Economic Community (EEC)

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

African Development Bank (ADB)

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

Saudi Fund for Development

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

Government of Japan

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

XII IMPLICATIONS OF THE RESULTS OF THE 1993 DEMOGRAPHIC AND HEALTH SURVEY

When the PID for the GHANAPA project was written, and the preliminary log frame developed, three primary data sources were available:

- 1988 Demographic and Health Survey
- Quarterly service statistics from the Ministry of Health the Ghana Social Marketing Program (now Foundation), and PPAG; and
- 1993 Consumer Baseline Survey, conducted by the Futures Group

The Consumer Baseline Survey (CBS), conducted in April, was designed to provide data that would be comparable to the 1993 DHS, which was carried out from October through December, 1993. The CBS used the DHS sampling frame and was household-based; sample size was 1,069 females between the ages of 15 and 49.

Data from these sources showed that modern method prevalence among currently married women had increased from 5.2 percent in 1988 to aproximately 9 to 10 percent by 1991 (based on service statistics); by the time of the baseline in 1993, the figure was 14.9 percent. Based on this information, and on trends in contraceptive use from the quarterly service statistics, the project development team in consultation with the NPC Secretariat established as a target an increase in modern method prevalence from 15 to 25 percent of women in union over the life of the project. This is in accordance with the goals established in the Ghanaian National Population Policy (1993). Further, in addressing the Project goal of lowering fertility, the target established was a reduction in the TFR from 6.1 (estimate for 1993) to 5.3 by the end of the project. It was expected that only minor revisions to these targets would be necessary once the 1993 DHS was completed.

Preliminary results of the 1993 DHS are now available, which indicate that modern contraceptive method prevalence in Ghana is currently 9.3 among all women (10.1 percent among married women), and the TFR is 5.5 for all women ages 15-49. These results suggest that, while modern method prevalence rose by 5 percentage points[4] during the past five years, the TFR dropped by nearly one child from 6.4 in 1988. These results raise two questions:

- Are the data in the 1993 DHS internally consistent? If not, what is the source of the inconsistency?

- What accounts for the substantial difference in method prevalence between the CBS and the DHS?

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[4]Although an increase of 5 percentage points is rather modest, it does represent a doubling of prevalence, which is not an insignificant achievement in a low-prevalence context such as Ghana.

Internal Consistency of DHS Data

As noted, between 1988 and 1993, according to the DHS, fertility declined from 6.4 to 5.5, while modern contraceptive prevalence increased from 4.7 to 9.3 percent. Worldwide data on contraceptive prevalence and fertility suggest that, on average, an increase of 15 percentage points in contraceptive prevalence is associated with a decline in the TFR of about one child. **Total** contraceptive prevalence in the 1988 DHS was reported at 12.3 percent for all women; results from 1993 DHS show that proportion increasing to 18.9 percent (Table 1). At that prevalence, the expected TFR, estimated with the regression equation describing the relationship between prevalence and fertility (based on worldwide data[5]) is 5.97. Similarly, a TFR of 5.5 would be associated with contraceptive prevalence of 25.6 percent.

If we expect Ghana's experience to follow the typical pattern that seems to be true for other countries, then we may question whether the data overestimate the decline in fertility, or underestimate the level of contraceptive prevalence. If neither is the case, then we must look for other explanations for this unusual pattern of a substantial fall in fertility accompanied by a modest increase in contraceptive prevalence.

According to the results of the two Demographic and Health Surveys, Ghana has experienced a substantial decline in fertility during the past five years. The birth history section of the questionnaire is standard, and has been tested and used in many countries. It includes several probes and interviewer check-points to ensure data quality. Analysis of the 1993 DHS birth history data shows that there is clear age heaping at age 4 (i.e., transfers of birth dates from 1990 to 1989 to avoid eligibility for the longer sequence of questions on child health for those born since January 1990). However, there is no evidence that births were omitted entirely from the birth history and no downward bias evident in the calculated 5-year total fertility rate of 5.5.

Thus, there seem to be no grounds for further questioning the fertility data. However, it still is important to understand the factors influencing the fertility decline, to determine whether the data on contraceptive prevalence are flawed, and to consider what additional circumstances exist that make Ghana's experience so unusual. The following are factors that have been proposed as contributing to the unexpected results:

- **Abortion**: Abortion is apparently fairly widespread in Ghana, and could have a major impact on fertility without having a similar effect on contraceptive use. Little data is available, but nearly one-quarter of family planning clients interviewed for the Situation Analysis had had an abortion.

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[5] Ross, John A. and Elizabeth Frankenberg. 1993. **Findings from Two Decades of Family Planning Research**. New York: The Population Council.

- **Desire for Children**: The 1993 DHS shows a dramatic increase in the proportion of women who reportedly want no more children, rising to 33 percent from 23 percent in 1988 (Table 4). (This is line with the sizeable decline observed in the TFR.)

- **Periodic Abstinence**: This is a very popular method, especially among Catholics. The DHS shows that 7.5 percent of currently married women use periodic abstinence, representing more than one third (37 percent) of all current users. (This compares with 6.2 percent in the 1988 DHS.) However, it is suggested that abstinence is typically used in conjunction with other methods, e.g., condoms. Since it was not possible to list more than one current method, this might have resulted in underreporting of "modern" methods.

- **Marital/childbearing patterns**: Ghana Statistical Service reports that there have been increases in both the age at marriage and the age at first birth. (It isn't clear whether this is from the DHS or other data sources.)

- **Household Composition**: Analysis of the households in the DHS shows a decline in the average number of household members (de facto) from 4.83 in 1988 to 3.68 in 1993, relfected in the growth of single person headed households from 22 percent in 1988 to 43 percent in 1993. However, the percentage of the overall household population represented by women of childbearing age was about 22 percent in both 1988 and 1993. The GLSS also has found a large increase in the percentage of female-headed households. Absence of husbands/partners could have a major impact on fertility, although this would depend on the level of sexual activity outside of marriage or union.

- **Post-partum Abstinence and Breastfeeding**: Changes in the extent and duration of both post-partum abstinence and breastfeeding could have had an impact on fertility without necessarily affecting contraception, but we do not yet have data from the DHS on these issues. However, it is more usually the case that these traditional restraints on high fertility decrease rather than increase with modernization.

- **Fecundity**: A major change in the overall fecundity status of the population could be responsible for changes in fertility. Nevertheless, the proportion of currently married women declared infecund is virtually the same in 1993 (3.7 percent) as in 1988 (3.5 percent) (Table 4).

- **Questionnaire Wording**: The questions pertaining to contraceptive prevalence ask whether a woman (or her partner) is currently using a method, and then asks: "what are you doing to prevent a pregnancy?" It appears that "you" is translated as singular, rather than plural, which is the intended meaning in English. This could have resulted in underreporting of contraception, especially

of condom use. Indeed, the percentage of males who report current use of condoms is substantially greater than that among women: 10.8 percent compared with 2.6 percent.

- **Education**: It has been suggested that the recent increase in the percentage of females in secondary (?) school from 60 to 65 percent could have had an impact on fertility (but also presumably on contraceptive use).

- **Economic Conditions**: Although no particular evidence was presented, it has been suggested that recent economic reversals have served to reduce fertility.

- **Sampling error:** Reportedly, the sampling error for TFR is typically .2 to .3 child. Thus the observed TFR of 5.5 could actually be as high as 5.8. However, this would still be a decrease of .6 child in five years, with an increase in modern contraceptive prevalence of only 5 percentage points.

Of the factors discussed that may have influenced fertility in Ghana during the past five years, only increased recourse to abortion to terminate unwanted pregnancies, and changes in marriage behavior that reduce exposure to the risk of pregnancy (e.g., increase in age at marriage, marital dissolution or absence of partner) would not have also served to increase contraceptive prevalence. It is unknown, however, whether the level of abortion and changes in marriage behavior are great enough to have reduced fertility by such a large amount in the absence of a greater increase in contraception. This is particularly so because we have numerous examples of other, similar countries in Africa where abortion is high and changes in household structure and marriage are occurring where we do not find large reductions in fertility accompanied by modest increases in contraception.

Comparison of Consumer Baseline Survey and the Demographic and Health Survey

The results of the CBS suggested that modern contraceptive method prevalence had tripled since 1988, a significant achievement for any developing country but an outstanding one for Sub-Saharan Africa. While this indicated unusual success, analysis of service statistics on contraceptive sales and commodities distributed suggested that the results were plausible (Table 5). (****PAM: Please put in table of CYPs for past several years from service statistics)**** The rather large difference found between the CBS and the 1993 DHS requires that we examine both sets of data more carefully, as we consider revisions to the targets for GHANAPA.

As a first step in examining the differences between the results in the two studies, Table 1 to 4 display data on contraceptive use and knowledge as a means of investigating whether the differences are systematic, or whether it is prevalence alone that seems out of line. Data from the 1988 DHS are also presented for purposes of comparison.

Ever Use

Both the 1993 CBS and the 1993 DHS show strong increases in ever use of contraception, as shown in Table 1; this is particularly true when the CBS is compared to the 1988 DHS, which show ever use of all methods at 49 percent and 34 percent, respectively. Comparisons of the two DHS data sets shows a somewhat stronger increase in modern prevalence, from 21 percent in 1988 to 30 percent in 1993, than is found for traditional methods, which rose from 23 percent to 30 percent.

The major difference in ever use of modern methods between 1988 and the two 1993 surveys is the substantial increase in use of condoms. This result was expected, in light of the strong social marketing program, and the emphasis on the use of condoms as protection against HIV/AIDS, as well as for family planning. With respect to traditional methods, the CBS suggests substantially lower percentages ever using such methods in comparison with both DHSs, suggesting a methodological difference.

Current Use

Data on current use are shown for the three surveys in Table 2. Both of the 1993 surveys again show substantial increases in contraceptive prevalence since 1988, with 21 percent of all women in the 1993 CBS and 19 percent in the DHS reporting current use of all methods.

There are some interesting differences when the two 1993 surveys are compared.[6] For example, the 1993 CBS shows that modern method prevalence has tripled, while the 1993 DHS shows a doubling in prevalence. While the DHS thus indicates more modest progress, it is still an important achievement for a country in Sub-Saharan Africa. It appears that differences in reported use of the pill and condom, both lower in the DHS compared to the CBS, are the primary factors responsible. At least some of this may be the result of under-reporting of condom use in the DHS because of the wording of the question (discussed above). Conversely, reported use of traditional methods is nearly the same when the 1988 DHS and the 1993 CBS are compared, while the 1993 DHS shows an increase, particularly noticeable for periodic abstinence. The 1993 CBS may be underestimating current use of traditional methods since the survey was designed to look at consumer preferences, brand recognition and so forth, which would not be relevant in the case of traditional methods. In fact, greater popularity of periodic abstinence was mentioned as a potential factor in the observed decline in fertility.

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[6]Because the percentages are small, it is not certain whether any of these differences is large enough to exceed sampling variability.

Knowledge of Contraceptive Methods

Table 3 shows the percentage of respondents in the three surveys who "know of" each contraceptive method, including both those who spontaneously named a method and those who acknowledged that they "knew" the method, when asked. Between 1998 and 1993, the DHS data show strong increases in knowledge of all methods, with even the percentage who know about male sterilization doubling during the five year period. When we examine the data from the 1993 CBS, however, the pattern is less clear. The data generally reflect an increase in knowledge, although the magnitude of the change in comparison with the 1988 DHS is smaller in all cases. Further, in the case of the IUD and sterilization (both male and female), the percentage is lower. This may well be due to differences in questionnaire wording and instructions to interviewers concerning probing unclear responses.

Desire for Children

The last topic on which we have compared the DHS and CBS data is the desire for children, shown in Table 4.

Conclusions

Based on this brief consideration of the results of the 1993 DHS in relation to the 1988 DHS and the 1993 CBS, there is no obvious explanation for the seeming inconsistency between a substantial decline in fertility and a modest rise in modern contraceptive prevalence. No evidence has been found to doubt the validity of the reported TFR. In fact, the substantial decline is quite plausible when considered in conjunction with the large rise in the proportion who want no more children.

With respect to the differences in contraceptive prevalence reported in the two 1993 surveys, again there is no obvious flaw in either survey, with the possible exception of the wording of the 1993 DHS question concerning current use. In both, contraceptive prevalence has clearly increased strongly--the main difference is in the magnitude of change. With the change in attitude towards childbearing and family size observed in both surveys, there is clearly a need to expand family planning services with increases in accessibility, availability and quality in mind. Thus, in terms of the design of the GHANAPA project, there is no reason to alter the general approach. Family planning has caught on, and the program is moving rapidly through the "launch" phase. The tasks with respect to policy, demand generation, improvements in service delivery--especially the expansion of the capacity for delivering long term and permanent methods, and sustainability remain the same.

What should be altered, however, are the targets. The program is directed towards fertility reduction. Based on the new information from the DHS, then, the goal of the project is a reduction in TFR from 5.5 to 5.0 by the end of GHANAPA. Change in contraceptive prevalence should be retained as a target, but revised to take the lower 1993 DHS estimate

into account. Thus, the target should be an increase in modern contraceptive prevalence from 10 to 20 percent by the project's end. Other targets, such as that relating to the change in the relative proportions of prevalence due to short-term and to permanent and long-term methods should remain the same.

This analysis suggests, however, that there is a need for further investigation to better understand the pattern of fertility decline that Ghana is currently experiencing. If contraception is not responsible, we need to investigate other factors. The first section highlighted both abortion, and changes in marriage behavior as likely influences. Thus, studies will be designed to address these issues. In addition, further study of the contraceptive prevalence data, and comparison of the results of the three surveys, as well as examination of differences in methodology will proceed.

Table 1: Ever Use of Contraception by Method: 1988 DHS, 1993 Consumer Baseline Study, 1993 DHS, All women

Contraceptive Method	Ever Used Method		
	1988 DHS	1993 CBS	1993 DHS
Any Method	33.9	39.5	43.1
Any Modern Method	**20.5**	**31.9**	**29.5**
Pill	12.8	11.6	15.1
IUD	1.2	1.3	2.2
Injectable	0.9	2.6	3.7
Vaginal Methods	7.9	5.0	8.8
Condom	4.5	18.2	13.0
Female Sterilization	0.8	0.1	0.8
NORPLANT®	----	0.0	0.0
Male Sterilization	----	0.0	0.0
Traditional	**23.1**	**9.7**	**29.9**
Periodic Abstinence	18.3	8.2	21.6
Withdrawal	7.8	0.7	16.4
Other	2.7	1.3	2.7
Respondents	4,488	1069	4,562

Table 2: Current Use of Contraception by Method: 1988 DHS, 1993 Consumer Baseline Study, 1993 DHS, All women

Contraceptive Method	Currently Use Method		
	1988 DHS	1993 CBS	1993 DHS
Any Method	12.3	21.1	18.9
Any Modern Method	**4.7**	**13.2**	**9.3**
Pill	1.6	4.0	2.8
IUD	0.5	0.7	0.7
Injectable	0.2	1.4	1.2
Vaginal Methods	1.2	0.8	1.1
Condom	0.3	6.0	2.6
Female Sterilization	0.9	0.2	0.8
NORPLANT®	----	---	0.0
Male Sterilization	----	0.1	0.0
Traditional	**7.6**	**7.9**	**9.6**
Periodic Abstinence	6.1	6.3	7.3
Withdrawal	0.8	0.2	1.9
Other	0.6	1.4	0.5
Respondents	4,488	1,069	4,562

Table 3: Knowledge of Contraceptive Methods, 1988 DHS, 1993 Consumer Baseline Survey, 1993 DHS, All women.

Contraceptive Method	Knows Method		
	1988 DHS	1993 CBS	1993 DHS
Any Method	76.2	87.9	91.1
Any Modern Method	73.8	80.5	90.6
Pill	59.7	65	79.4
IUD	36.7	34	44.5
Injectable	42.6	49.6	74.8
Vaginal Methods	36.6	39	53.5
Condom	48.5	69.7	79.5
Female Sterilization	54.1	35.4	67.3
NORPLANT®	----	3.5	4.4
Male Sterilization	11	10.1	21.4
Traditional	49.2	57.1	67.9
Periodic Abstinence	39.0	22.2	57.1
Withdrawal	31.0	25.9	52.3
Other	8.6	--	6.8
Respondents	4,488	1,069	4,562

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Table 4: Percent Distribution of Currently Married Women by Desire for Children

Variable and Category	1988 DHS	1993 CBS	1993 DHS
Desire for Children:			
Want more children	---	46.5*	---
Want within 2 years	19.5	--	16.3
Want after 2 years	44.9	--	39.3
Want, unsure timing	4.1	--	0.7
Undecided	5.1	27.6	5.4
Want no more	22.8	22.7	33.0
Sterilized		---	0.9
Declare infecund	3.5	3.2	3.7
Missing	0.1	--	0.6
Number	3,156	1069	3,204

Questions pertaining to spacing were not asked on the CBS

TARGET MODEL (1993-2000)

METHOD MIX

	1993	1994	1995	1996
Condom	39.9%	38.5%	37.1%	34.4%
Female Sterilization	2.0%	2.0%	2.0%	2.6%
Injectable	12.2%	14.0%	15.9%	17.7%
IUD	5.4%	5.9%	6.4%	7.6%
Norplant	0.0%	0.1%	0.3%	0.4%
Oral	33.8%	32.8%	31.9%	30.9%
Vaginal Tablets	6.7%	6.6%	6.5%	6.4%

	1997	1998	1999	2000
Condom	32.5%	30.7%	28.8%	27.0%
Female Sterilization	3.2%	3.8%	4.4%	5.0%
Injectable	19.5%	21.3%	23.2%	25.0%
IUD	8.0%	8.3%	8.7%	9.0%
Norplant	0.6%	0.7%	0.9%	1.0%
Oral	29.9%	28.9%	28.0%	27.0%
Vaginal Tablets	6.3%	6.2%	6.1%	6.0%

PROXIMATE DETERMINANTS OF FERTILITY

	1993	1994	1995	1996
Number of WRA	3,543,571	3,684,489	3,825,408	3,966,326
% WRA Married	68.1%	67.7%	67.3%	66.9%
Post Partum	13.1 mths	12.9 mths	12.7 mths	12.5 mths
Total Abortion Rate	0.0	0.0	0.0	0.0
Sterility	3.0%	3.0%	3.0%	3.0%
TFR	5.5	5.4	5.3	5.2
Prevalence	10.1%	11.5%	12.9%	14.3%

	1997	1998	1999	2000
Number of WRA	4,107,245	4,248,163	4,389,082	4,530,000
% WRA Married	66.4%	66.0%	65.6%	65.2%
Post Partum	12.4 mths	12.2 mths	12.0 mths	11.8 mths
Total Abortion Rate	0.0	0.0	0.0	0.0
Sterility	3.0%	3.0%	3.0%	3.0%
TFR	5.2	5.1	5.0	4.9
Prevalence	15.8%	17.2%	18.6%	20.0%

Number of users by Method

	Con Thousands	FSt Thousands	Inj Thousands	IUD Thousands	NPl
1993	97.25	4.88	29.74	13.16	0.00
1994	110.55	5.74	40.20	16.94	287.00
1995	123.44	6.65	52.90	21.29	998.00
1996	130.73	9.89	67.32	28.91	1521.00
1997	139.88	13.76	83.85	34.40	2580.00
1998	147.80	18.30	102.59	39.98	3372.00
1999	154.38	23.55	124.18	46.57	4817.00
2000	159.49	29.54	147.68	53.16	5907.00

	Orl Thousands	VTab Thousands	Total Thousands
1993	82.38	16.33	243.73
1994	94.18	18.95	286.86
1995	106.14	21.63	333.05
1996	117.53	24.34	380.23
1997	128.57	27.09	430.13
1998	139.20	29.86	481.10
1999	149.87	32.65	536.02
2000	159.49	35.44	590.71

Contraceptive Consumption for each Method

	Con Millions	FSt	Inj Thousands	IUD Thousands	NPl
1993	9.72	985.00	118.94	8.71	287.00
1994	11.06	1049.00	160.80	10.70	781.00
1995	12.34	3394.00	211.61	15.59	767.00
1996	13.07	4108.00	269.28	16.33	1431.00
1997	13.99	4872.00	335.40	18.47	1423.00
1998	14.78	5687.00	410.37	21.57	2271.00
1999	15.44	6549.00	496.71	24.05	2269.00
2000	15.95	7412.00	590.71	26.53	2267.00

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	Orl Thousands	VTab Thousands
1993	1070.95	1632.99
1994	1224.39	1895.16
1995	1379.76	2162.64
1996	1527.84	2434.19
1997	1671.43	2709.03
1998	1809.56	2986.23
1999	1948.31	3265.02
2000	2073.40	3544.27

Number of Acceptors by Method

	Con Thousands	FSt	Inj Thousands	IUD Thousands	NPl
1993	49.77	985.30	17.12	8.71	287.15
1994	54.34	1049.19	21.69	10.70	781.32
1995	53.57	3394.35	26.25	15.59	767.68
1996	58.17	4108.57	31.59	16.33	1431.25
1997	60.37	4872.79	37.50	18.47	1423.38
1998	62.00	5687.54	44.54	21.57	2271.40
1999	63.00	6549.85	51.28	24.05	2269.64
2000	63.99	7412.17	58.02	26.53	2267.88

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	Orl Thousands	VTab Thousands	Total Thousands
1993	41.27	12.45	130.59
1994	45.64	14.08	148.28
1995	49.35	15.73	164.67
1996	53.08	17.40	182.10
1997	56.61	19.07	198.32
1998	60.46	20.76	217.29
1999	63.23	22.44	232.82
2000	65.99	24.12	248.34

TECHNICAL ANALYSIS

I. Acquired Immunodeficiency Syndrome (AIDS): An Overview

Since its discovery in 1981, AIDS has spread rapidly throughout the world, and has become a public health problem of extraordinary scope and unprecedented urgency. It is a deadly and still incurable disease. Due to the extended incubation period, half of those infected with HIV will develop AIDS within ten years. There is still no vaccine available, and proposed treatments are toxic, expensive and of uncertain efficacy. It is believed that all who are infected with the Human Immunodeficiency Virus (HIV) will ultimately develop AIDS, and will die shortly thereafter. However, this opinion is being challenged by the "long-term Survivors", those individuals who carried HIV more than ten years, yet remain well. Intensive research on these "Survivors" is underway and generates a lot of hope since it could yield to develop a vaccine that could at least contain the infection.

At the same time, much progress is being accomplished in vaccine development and about seven vaccine candidates are ready for field trials. However, the preliminary results of the planned trials are not expected within the next five to ten years. International trials performed in cooperation with countries with high rates of new HIV infections will yield answers within the shortest possible time. The existence of different HIV strains dictates that trials be performed in several different countries. Controlled trials require thousands of people. The developing countries where new infections are occurring most rapidly, and which would benefit most from an effective vaccine, are also those countries where the health and research infrastructures are least developed.

In December 1993, the World Health Organization's Global Program on AIDS (WHO/GPA) estimated that about 15 million adults and close to two million children under five throughout the world have been infected with the HIV virus. Sub-Saharan Africa, with less than 10% of the world's population, accounts for about 58% of total HIV infections, two-thirds of adult AIDS cases and 90% percent of pediatric AIDS cases worldwide. The cumulative of HIV infections in Africa was close to 10 million, an increase of 1.5 million over the past year.

Although central and east Africa remain hardest hit, the virus continue to spread dramatically. AIDS has become a leading cause of death in many East African cities and lately in the West African city of Abidjan, Côte d'Ivoire. Prevalence rates in Nigeria have reached as high as 22 per cent among men attending STD clinics, and already more than one in three women seeking antenatal care in Francistown, Botswana, are infected. Sixty per cent of new infections are among 15-24 year old. By the year 2000, some 7.5 million African women will have been infected.

The demographic Impact

According to WHO/GPA, WHO has estimated that between 1985 and 1990, AIDS added 10 percent to annual death increase for adults aged 15-49. For some age groups, mortality rates could double or even triple by the mid-1990s. Infant mortality is expected to be 4% higher than it would be in the absence of AIDS. Furthermore, it is estimated than 10% or greater of the under-15 year old population in many African countries will be orphaned by the year 2000.
Contrary to negative growth predictions by some demographic models, AIDS is not expected to lead to a shrinking population in Sub-Saharan Africa where underlying growth rates remain high, although the population structure may be altered.

The economic Impact

Unlike other communicable diseases, AIDS increases deaths among young adults between the ages of 14 and 45. This leads to excessive loss of individuals in the most productive years of life, and often leaves children orphaned due to HIV-related deaths in the family. HIV/AIDS disrupts the course of economic, social and political development, and many development gains achieved within the last decade may be negated as a result of this epidemic.

The World Bank's simulations indicate "a slowing of growth of income per capita by an average 0.6 percentage point a year in the ten worst-affected countries in sub-Saharan Africa." In Tanzania, a World Bank study showed that affected rural households in 1991 spent $60 - roughly the equivalent of annual rural income per capita - on treatment and funerals. The study also demonstrated that the effects of losing an adult in the family persist into the next generation as children are withdrawn from school to help at home. School attendance in the 15-20 age group was reduced by half if the household had lost an adult female member in the previous year (World Development Report 1993).

The HIV-STDs link

Most available data suggest that both the susceptibility to HIV infection and the infectiousness of an HIV-infected individual are increased several fold by the presence of other STDs (Piot et al. 1988; Pepin et al. 1989). The clearest evidence of the STD-HIV link involves genital ulcer diseases (GUDs), a group of STDs such as syphilis, chancroid and genital herpes. The interaction between GUDs and HIV appears to be bi-directional: GUDs facilitate HIV transmission by increasing the susceptibility to HIV infection of non HIV-infected persons. At the same time, HIV may prolong and augment the infectiousness of individuals with GUDs, by altering the natural course of STDs, including their response to treatment.

While evidence for the role of other STDs is more preliminary, recent studies in Africa have suggested that non-ulcerative STDs such as gonorrhea, chlamydia and trichomoniasis may also enhance susceptibility to HIV infection. This could have profound implications since these non-ulcerative STDs are far more common that GUDs, <u>and are often asymptomatic in women</u>

and are thus unrecognized. For example, in Africa, prevalence rates of gonorrhea range from 1 to 15 percent in pregnant women and from 20 to 60 percent in commercial sex workers (CSWs), while GUD prevalence range from 1 to 15 percent in pregnant women and from 5 to 15 percent in CSWs (Goeman, Meheus and PIOT, 1991). Table 1 shows the degree to which STDs facilitate transmission of HIV.

Table 1: Role of STDs in HIV Transmission

SYNDROME	RISK ESTIMATE	
	MEDIAN	RANGE
Genital ulcers	4.7	3.3-18.2
Syphilis	3.0	2.0-18.2
Genital herpes	3.3	1.9-8.5
Chlamydia infection	4.5	3.2-5.7
Gonorrhea	4.7	3.5-8.9
Trichomoniasis	2.7	?
Anogenital warts	3.7	?

The HIV-TB link

The HIV-tuberculosis link is already having a dramatic impact in developing countries where 95 percent of people with dual tuberculosis and HIV infection live (AIDS in the World, 1992). The relationship between HIV and tuberculosis is bi-directional: HIV increases the infectiousness as well as the severity of clinical tuberculosis while tuberculosis complicates the course and management of HIV infection. HIV-infected people have a six to thirty times greater risk of tuberculosis (AIDS in the World 1992) and clinical tuberculosis often precedes the diagnosis of clinical AIDS. In Abidjan, a CDC supported study in people with newly diagnosed tuberculosis found that 42 percent of TB cases were in people infected with HIV-1.

Evidence also exists that HIV-infected persons with tuberculosis infection develop active (clinical) tuberculosis more frequently than those without HIV. Thus, in areas where TB is already endemic, reactivation of dormant TB in HIV-infected people has led to dramatic increases in TB rates. For example, in Zaire, the number of hospital admissions for clinical

TB doubled between 1990 and 1992 and among them, one-half were found to have HIV as well. Clinical tuberculosis is a very common opportunistic infection occurring in HIV-infected people, and since active TB is more easily transmitted to household members and the community, it is already creating a new problem for the African health care system already strained and over-burdened by inadequate resources and management.

In Africa, tuberculosis is fast becoming the prime cause of death in HIV-infected adults. For example, the TB mortality rate was 4 percent before the AIDS pandemic; now, the mortality rate has nearly tripled (11 percent) among HIV-infected persons in urban Tanzania.

II. EPIDEMIOLOGY OF HIV/AIDS IN GHANA

The first reported AIDS case in Ghana was diagnosed in March 1986. Since then the total number of cases reported by the National AIDS Control Program (NACP) has reached a total of 11,853. The prevalence of HIV infection appears to be rising in Ghana. Limited HIV seroprevalence data from antenatal sentinel sites indicate that HIV positive rates in 1992 among pregnant women ranged between 1.0% and 4.6% in most parts of the country, although some pockets were as high as 18%. Until recently, such high prevalence rates were unknown.

Eighty-six percent of all cumulative 11,853 AIDS cases identified were in the 20-49 age group, with those aged 20-29 being the most seriously affected.

The HIV epidemic in Ghana has certain important peculiarities. Unlike most other countries, HIV/AIDS in Ghana affects more people in the semi-urban and rural areas than the urban core. Ghana has an "AIDS belt,", which runs across the middle of the country, but does not include Accra, the capital city, or the second largest port, Sekondi-Takoradi. As of September 1993, the Ashanti and Eastern regions accounted for the highest number of reported cases, 3793 and 30006 respectively, followed by the Greater Accra (1361) and Brong Ahafo (1179) Regions.

In other African countries, the disease is initially more widespread among females or males (males in Cote d"Ivoire), but rapidly equalizes. However, in Ghana, women remain disproportionately affected. As of September 1993, reported AIDS cases among females accounted for 70% of the cumulative cases.

One of the important risk groups in many countries has been the Armed Forces. A careful study in Ghana revealed that the rates among soldiers were approximately the same as those found in the general population.

III. EPIDEMIOLOGY OF STDS IN GHANA

Limited data are available on the prevalence of STDs in Ghana. In 1992, there were 15,000 cases of gonorrhea reported to the government. This figure probably represents only a small fraction of the actual number of new cases, as there are limited diagnostic capabilities, and many persons seek treatment for STDs from pharmacists, chemical sellers, or traditional healers, who are unlikely to report cases.

A study done at Korle Bu Hospital in Accra and published in 1985 indicated that gonorrhea and chlamydia infections were common among women. The study isolated Neisseria gonorrhoea from five (3.4%) of 148 postpartum women and five (3.1%) of 162 randomly selected women attending the gynecology outpatient clinic. Chlamydia trachomatis was isolated from three (7.7%) of 39 postpartum women and eight (4.9%) of 162 women attending the gynecology clinic. Hence, 11.1% of postpartum women were infected with either N. gonorrhoea or C. trachomatis. A study now being conducted in Accra will provide current data on the prevalence of gonorrhea, chlamydia infection, trichomoniasis, and candidiasis. The study will include 150 male STD patients, 150 female STD patients, and 300 pregnant women. Of 131 pregnant women examined thus far, 15% had intracellular gram-negative diplococci in endocervical secretions (a finding strongly suggestive of gonorrhea); 2.3% had C. trachomatis antigen in endocervical secretions; 6% had Trichomonas vaginalis detected via wet smear microscopy; and 13% had Candida albicans detected via wet smear.

Available data indicate that gonorrhea and non-specific urethritis are the predominant STDs in Ghana, and that genital ulcer disease is uncommon in Accra and relatively more common in Kumasi. The public STD clinic in Adabraka (Accra) in 1992 recorded 51 cases of gonorrhea and non-specific urethritis, one of syphilis, and none of chancroid. In 1993, the clinic recorded 73 cases of gonorrhea and non-specific urethritis, none of syphilis, and none of chancroid. The public STD clinic at Komfo Anokye Teaching Hospital in Kumasi in 1992 recorded 165 cases of gonorrhea and non-specific urethritis, 28 cases of syphilis, and 42 cases of chancroid. These data also indicate that despite the probably large number of persons with STDs in Accra and Kumasi, relatively few are being seen in the public STD clinics in those cities.

The relatively small percentage of STD cases in Accra with syphilis might be due to a high prevalence of yaws among children. Immunity to Treponema pertenue, the causative agent of yaws, confers some protection against Treponema pallidum, the causative agent of syphilis. The possibly high prevalence of yaws also poses a problem with the use of serologic tests to assess the prevalence of syphilis, as yaws can cause seroreactivity to the nontreponemal tests for syphilis, such as the VDRL and RPR tests. However, other specific tests exist to differentiate syphilis from yaws.

Antibiotic-resistant N. gonorrhoea is a major problem in Ghana. A study done at Komfo Anokye Teaching Hospital in Kumasi tested 356 isolates of N. gonorrhoea for sensitivity to nine antibiotics, using disc diffusion methodology. The isolates were from the urethra (121 isolates), endocervix (96 isolates), high vaginal area (87 isolates), and conjunctiva (52

isolates). It is not known what percentage of the isolates were from patients who previously had been treated unsuccessfully with antibiotics. The percentage of isolates found susceptible to antibiotics were: penicillin, 8%; tetracycline, 3%; co-trimoxazole (trimethoprim/ sulfamethoxazole), 3%; chloramphenicol, 10%; erythromycin, 8%; spectinomycin, 78%; norfloxacin, 97%; cefuroxime, 95%; ceftriaxone, 100%. These results indicate that in Ghana the inexpensive antibiotics (penicillin, tetracycline, co-trimoxazole) are no longer effective in treating gonorrhea, and those antibiotics that are effective are expensive (norfloxacin, cefuroxime, ceftriaxone).

The finding that only a small percentage of N. gonorrhoea isolates in Kumasi were sensitive to penicillin and tetracycline is consistent with results from other parts of sub-Saharan Africa. However, the finding that only 78% of isolates were sensitive to spectinomycin appears atypical. In Abidjan, Cote D"Ivoire, the percentage of isolates susceptible to antibiotics were: penicillin, 30%; tetracycline, 43%; spectinomycin, 100%; ceftriaxone, 100%; and ciprofloxacin, 100%. In Dar es Salaam, Tanzania, the percentage susceptible were: penicillin, 29%; tetracycline, 14%; spectinomycin, 93%; and ceftriaxone, 92%.

A recent commissioned study by USAID[1] indicated that most of the STD cases are seen in the private health facilities, as expected. Using a random sample in five regions of Ghana, the study team interviewed Doctors (30), Midwives (29), Mission hospitals (5) Pharmacists (29), Chemical Sellers (30), and Private laboratories (19) and found the following:

- In the three health care practices of private doctors, midwives and mission hospital, patients with possible STD accounted for over four percent of all outpatient visits. This contrasts with less than one percent of all outpatient visits in the public health centers. Vaginal discharge and male dysuria were the most common presenting symptoms.

- The mission hospitals saw the most patients (mean = 98 patients per hospital in four weeks) followed by doctors (mean = 23 patients per practice in four weeks) and midwives (mean = 10 patients per practice in four weeks).

- Drug Vendors (Pharmacists and Chemical Sellers) also see substantial numbers of patients with possible STD. Pharmacists saw a mean of sixty-eight possible STD patients per shop in four weeks. The mean for chemical sellers was 33. This represents 4.4 percent of all customers for pharmacists and 3.8 for chemical sellers. Only thirty-four percent of all potential STD customers had seen a health care provider before coming to the drug vendor. It was assumed then that sixty-six percent of the possible STD patients were seeking primary STD care from the drug vendors.

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[1] Assessment of Private Sector Sexually Transmitted Disease Diagnosis and Treatment. Stanton David et al. Draft report. April 22, 1994.

Based on the average cases diagnosed in the mission hospitals and private practices of doctors and midwifes, it is estimated that a minimum of 400,000 STDs cases are treated in the public and private facilities. This represents an incidence of about 2000 cases per 100,000 population.

IV. EFFECTIVE INTERVENTIONS AVAILABLE TO COMBAT THE SPREAD OF HIV/AIDS

A number of interventions can halt or decrease the spread of HIV. Various data from developing as well as developed countries have shown that IEC programs that promote behavioral changes and increased condom use are important tools in the control of HIV spread. In vitro and solid epidemiological studies among prostitutes and discordant couples have shown that condoms are efficient barriers to HIV if used properly.

On the medical side, blood screening, including reduction of inappropriate blood transfusion, and the control of other STDs can also help prevent the spread of HIV infection. As indicated earlier, the latter intervention has recently emerged as a critical element in the fight against HIV/AIDS. Programs that reduce the frequency and duration of STDs may reduce the incidence of HIV/AIDS by 50%. For women, STD control is one of the few relevant strategies since they can avail themselves of this means of protection if diagnosis and treatment of STDs can be combined with other consultations requiring an internal examination. Condom usage, abstinence and faithfulness of both partners in a relationship are usually not under the woman"s control.

With the recent development of an HIV/AIDS mathematical model by the Interagency Working Group on AIDS Models and Methods (chaired by the U.S. Department of State), researchers[2] have examined the potential effects of the HIV epidemic on a population, given a particular set of inputs to demographic processes, behavior and disease parameters.

The inputs were chosen to represent processes and behavior similar to those in the sub-Saharan Africa region. The following is a description of four possible interventions which could be implemented in the 1990-1995 period to stop or decrease the spread of HIV. They are:

1. the promotion of condom use that results in the participation of a certain percentage (5 to 25%) of urban women by 1995;

2. a STD control program that reduces the duration of STDs by 5 to 25% in the urban population by 1995;

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[2] Peter Way and Karen Stanecki; The Demographic Impact of an AIDS Epidemic on an African Country: Application of the IWGAIDS Model. Center for International Research, U.S. Bureau of the Census.

3. an IEC program that reduces casual sex in the urban population (to 25%); and

4. a 100% blood screening program in operation by 1995.

1. Condom Use

A model of a five year program of condom promotion, beginning in 1990 and fully operational by 1995, was developed, using the assumption that 0.4% of urban women and men are using condoms in 1990. With no condom intervention, the model projects the prevalence rate of HIV infection by the year 2015 to be about 17% in the urban areas. With an intervention program resulting in the use of condoms by 5% of urban couples, the model projects an overall prevalence rate of less than 13% in the urban areas. According to the model, an intervention that results in condom use by 25% of urban couples will result in a declining epidemic with an urban prevalence rate of 0.6% by the year 2015.

2. Reduction of Casual Sex (the number of sexual contacts outside marital sex)

Under the assumptions of the model, a reduction of casual sex by 15% would be required in order to see a decline in the epidemic.

3. STD Control

A 5% reduction in the duration of STDs in urban areas would result in a 2 percentage point drop in urban sero-prevalence levels in 2015 - from 17% to 15%. Lengthier reductions in STD duration would result in progressively larger decreases in sero-prevalence levels in 2015.

3. Blood Screening

The model predicts little impact on the epidemic due to blood screening. With a 100% blood screening program in place by year 1995, the urban prevalence rate for the year 2015 would be reduced by less than 1 percentage point. Concentrating all available health funds on the establishment of a 100% screening program might not be as cost effective as other types of interventions.

EEC, which has the most extensive experience among donors in supporting blood screening services experts recently estimated that blood screening may only be cost effective with a seroprevalence rate of 20% among blood donors.

However, at this time, blood screening is the only technology available which is effective within a short time period in stopping HIV/AIDS transmission through blood. Also, in many African countries, children are at great risk of acquiring HIV infection because they receive large numbers of transfusions (some of which may be HIV-contaminated) for treatment of malaria and other related anemia symptoms.

In any case, blood screening programs should complement other interventions and not be considered in lieu of IEC and STD control activities. Alternative interventions to screening blood for HIV also should be explored. These should include the review of blood transfusion practices to decrease unnecessary transfusions and the strengthening of blood donor screening in order to discourage those practicing high risk behavior from donating blood.

The HIV/AIDS model also shows that greater impact might be achieved with large-scale programs which include all four of the above-listed interventions.

Although these projections should be interpreted cautiously, recent data from a WHO review of effective interventions to AIDS Prevention indicated encouraging trends. Selected interventions have been successful in assisting people to change their behavior and in improving community response to the epidemic. Studies have demonstrated improvement in consistent condom use from less than 10 percent to over 70 percent; decrease in STD monthly incidence rate from 13 percent to 0.5 percent; decreases in annualized rates of HIV from 15 percent to 3 percent.[3]

V. COMPONENTS OF THE HIV/AIDS AND STD PREVENTION AND CONTROL PROGRAM

A. Health Information Systems

The establishment of measurable indicators is critical for effective program management and evaluation. The most reliable indicator for the effectiveness of an HIV/AIDS prevention program would be changes in the sero-incidence (i.e., the number of new HIV infections acquired in a defined population for a specified unit of time) of HIV infection among selected populations. Sero-incidence should decline as the effectiveness of the prevention messages results in fewer new infections.

Tracking sero-incidence, however, is presently a difficult task because of the problems associated with HIV testing. Collecting sera from a representative sample of the population for laboratory testing is not easy, especially when informed consent is required. In addition, large samples may be required in order to detect any significant difference between two surveys. Thus, a program can not rely exclusively on population-based incidence rates to indicate effectiveness.

Other measures can be representative of changes in HIV sero-incidence, including incidence rates from anonymous, sentinel sero-surveys using convenient, non-representative, sampling methods as well as the use of reductions in STD incidence, syphilis and gonorrhea. As

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Gary Slutkin, Effective Interventions for Prevention: Key Elements of Success, World Health Organization Global Program on AIDS, 1993.

mentioned earlier, a significant constraint in the control of STDs is the lack of good baseline epidemiological data, not much information is currently available on the prevalence of HIV, or other STDs, nor on patterns of resistance to antibiotics by STDs.

With regard to HIV testing, the presence of HIV-2 in west Africa and Ghana in particular requires the use of tests or assays capable of detecting HIV-1 and HIV-2 sero-prevalence. Reliable assays such as ELISA and Western blot are available for this purpose. The development of rapid or simple/rapid assays such as HIVSPOT, which is currently use by the NACP, provides excellent opportunities for developing countries to establish viable facilities for HIV testing without the equipment and maintenance required for ELISA and Western blot assays.

In this regard, the USAID/Ghana funded Family Planning and Health project (FPHP) has been funding the construction of four reference laboratories and is developing an epidemiological surveillance system to provide high quality HIV and STD epidemiologic data. Also, long term technical assistance in laboratory is also being provided.

While WHO and the Dutch, British and German governments have assisted in the procurement of the HIV test kits and reagents for clinical diagnosis, the epidemiology serosurveillance system is dependent on the USAID/FPHP for laboratories supplies and other recurrent costs. The system will require approximately 500 samples from each of the three above mentioned groups in each of the ten health regions to be tested yearly, enabling the NACP to generate adequate epidemiological data.

With the assistance of the FPHP project, Ghana has established a viable, less expensive HIV testing framework. The current Ghana HIV testing algorithm no longer requires confirmation of HIV seropositivity by immunoblot procedures. HIV screening is conducted with rapid assays such as HIVSPOT and confirmation with the ELISA method. A synthetic peptide assay (Innolia) is used in case of discrepant results.

GHANAPA will continue to support the MOH"s efforts to track the HIV/AIDS epidemic though the epidemiological serosurveillance system. NPA conditionality will support adequate GOG budgetary contribution for the recurrent costs of the laboratories, while project funds will finance the HIV reagents needed for the surveillance system.

Currently, with the exception of the head of the Health Laboratory Services (HLS), no one has academic credential at the university level. None of the current HLS personnel has any laboratory management expertise.

Under FPHP the PHRL has begun to build expertise and experience on the management of a continuing education program including infection control, quality assurance, laboratory management and exodus waste management for public and private laboratory personnel. Todate 172 laboratory personnel were formally trained including 40 from the private sector.

By the end of FPHP, all four USAID supported reference and zonal laboratories will be fully equipped. The effective management of the laboratory network continue to be of great concern in view of the limited available expertise. With the exception of the current Head of the Health Laboratory Services, no one within the laboratory services has academic credentials at the university levels. By the termination of the long-term technical assistance in laboratory next year, the management of the PHRL and the zonal laboratories will still be at the initial stages and on-site stimulation and guidance will be required. It should also be noted that FPHP is the first attempt to build laboratory infrastructure and capacity in Ghana. Therefore, it is proposed a six to one-year extension of the LTTA contract and a total of eight-person months of external technical assistance on laboratory management, strategic planning and quality control in order to further improve the management and viability of the laboratory network, which is currently being strengthened by FPHP.

Without an effective vaccine or preventive/curative therapy, education is the primary intervention. Therefore, evaluation of a program"s effectiveness must focus also on this intervention utilizing currently available tools such as research-focused knowledge, attitudes, beliefs, and practices (KABP) studies. Fortunately, the FPHP has conducted several studies concerning HIV/AIDS in Ghana including:

- Consumer Baseline Study, (CBS) 1993[4]. A national household based survey of 1069 female and 1047 male respondents to determine knowledge attitudes and practices concerning family planning and AIDS.

- Qualitative Formative Study on AIDS in Ghana, (QFSAG) 1993[5]. Focus group discussions and individual in-depth interviews on male and female respondents in the Ashanti and Northern Regions were held to understand regional differences in Knowledge, Attitudes and Practices (KAP) and needs for IE&C messages.

- Contraceptives, AIDS, Anti-malarial, and Control of Diarrheal Diseases (CDD) Knowledge Attitudes and Practices among Doctors, Pharmacists and Chemical Sellers, 1993[6]. A survey of 86 physicians, 118 Pharmacists and 263 Chemical Sellers in Accra and Kumasi and adjoining district towns to determine provider information.

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[4] Consumer Baseline Study Ghana , 1993. Marketing and Social Research Institute Limited, Accra.

[5] Adjei, Sam, G. Owusu, M. Ablordey, Qualitative Formative Study on AIDS in Ghana, National AIDS Control Program, Health Education Unit, and Health Research Unit, Ministry of Health, Accra, 1993.

[6] Ghana Family Planning and Health Project Contraceptives, AIDS, Anti-malarial, and CDD Knowledge, Attitude and Practices among Private Service Providers. Marketing and Social Research Institute Limited, Accra, Ghana 1993.

- Ghana Demographic and Health Survey (DHS) 1993. Data was collected in November and December 1993. Preliminary analyses indicate, for example, level of condom use among the sexually active population.

These surveys, together with the Situation Analysis funded by the Population Council and the Ghana Statistical Service, provide considerable information on Knowledge, Attitudes and Practices (KAP) of Ghanaians concerning AIDS. GHANAPA will continue to support these important surveys.

B. Program Management, Coordination and Policy Development

In recognition of the compelling data from other African countries and the opportunity to limit the spread of HIV/AIDS while the rates are comparatively low, the Government of Ghana established the NACP in 1988 and finalized the Medium-Term Plan for HIV/AIDS the following year. The objectives of the medium-term plan include:

- determining the extent and pattern of HIV infection.
- providing information to the public concerning the epidemic and to promote condom use for prevention.
- developing a national program for the control of sexually transmitted diseases (STDs) which are a cofactor for infection with HIV.
- providing adequate clinical management and social support to affected individuals.
- providing adequate laboratory services for the diagnosis of HIV infection.
- ensuring safety of blood transfusions.
- establishing a monitoring and evaluation system for the AIDS prevention and control program.

The MOH"s Program management unit (PMU) of NACP coordinates the HIV/AIDS control activities of the MOH and other government ministries and NGOs. According to the NACP, approximately 80 percent of MOH non-personnel expenditures for AIDS/STD control activities are funded by external donors, including WHO/UNDP, EEC, the Dutch, German and British governments with USAID being the largest contributor. The remainder of these expenditures is covered by the MOH. The MOH projects a total 1994 recurrent and capital budget of $6.7 million for AIDS/STD control. Of this amount, $4.9 million represents donor financing, and the remaining $1.8 million, MOH expenditures.

USAID provides $4 million, roughly 91 percent of total donor resources in AIDS/STD control, but that figure includes approximately $3 million in capital expenditures and technical assistance for the laboratories. Total recurrent AIDS/STD expenditures for 1994 are estimated at $3.7 million. This level is expected to increase slightly over the next few years.

Since the establishment of the NACP, effective program management and coordination have been limited by the following reasons:

* the urgency of dealing with the HIV/AIDS epidemic and the massive resources required for AIDS prevention have led to the establishment of a vertical program causing minimal utilization of existing MOH and other sector infrastructure and resources and a low absorptive capacity for donor funds.

* the seven full time professional staff members have been absorbed by program implementation activities instead of program planning, policy formulation, coordination and advocacy. Consequently, the lines of authority and communication between the PMU and the various MOH Directorates, regions and districts were unclear and remain to be better defined. The same situation prevails within the PMU and between the Regional and District AIDS Committees and Regional and District Management Teams.

* Currently, there is a movement towards decentralization of MOH activities including AIDS and STDs activities. This movement has re-vitalized the regional and district AIDS Control Committees. However, the decentralization process has been hampered by shortages of resources and adequately trained personnel, as well as by problems in logistics and the flow of information to the regional and district levels;

* sectors other than health have not yet assumed a meaningful role in STD/AIDS prevention and control. This situation is related to the lack of financial resources, technical assistance, meaningful policy dialogue, and commitment to encouraging other sectors to participate in the fight against AIDS. The multi-sectoral implications of the HIV/AIDS epidemic dictate that special attention be given to HIV/AIDS prevention and control by the other sectors. The massive resources needed, as well as the social pressures required, to adequately address the HIV/AIDS problem cannot be generated or absorbed by any single sector.

* The use of NGOs to decentralize activities has also been problematic, since NGOs/PVOs which add AIDS prevention to their priority objectives are often understaffed, already over-committed to other areas, and technically unprepared to meet the new challenges posed by human resource intensive AIDS prevention programs.

GHANAPA will use a combination of non-project assistance supported policy reform and project supplied financial resources to assist the MOH address the above mentioned issues. GHANAPA will no longer provide off budget financing of MOH"s FP and AIDS activities, but will encourage the GOG to increase MOH"s budget. This important decision should greatly facilitate the planning process and improve a better utilization of the MOH"s resources at the central, regional and district level.

Given the limited number of NACP staff and experience and expertise of the regions and other sectors in AIDS and STDs related program planning, coordination and policy development, project funded short-term technical assistance will also be provided to improve the capacity of NACP"s PMU in program planning, coordination and policy development. With respect to the involvement of other sectors in AIDS prevention and control, GHANAPA will also support the provision of technical assistance to the Ministry of Education as well as the training of selected NGOs and private companies.

Effective tools have been developed by A.I.D. to facilitate policy dialogue with senior leadership and decision-makers. The AIDS Impact Model (A.I.M.) which has been developed after the highly successful RAPID population presentation model is already being used by the NACP"s PMU. GHANAPA will assist in generating pertinent data on the socio-economic and demographic impact of AIDS in Ghana, and will continue to utilize the AIM to increase commitment of the country"s leadership to HIV prevention and control. The project also will fund observation tours to other countries for community leaders, policy-makers, and professionals to observe policies, programs and strategies in other countries with successful programs.

C. Safer Behavior Change Interventions

The sexual behavior change required to reduce risk of infection of HIV (and other STDs) will take place only if individuals: are aware of HIV/AIDS and understand its transmission; consider themselves personally at risk for contracting HIV; understand which specific behaviors they should modify such as using condoms, reducing the number of sexual contacts and preventing and treating STDs; perceive that the benefits outweigh the social and cultural costs of undertaking these changes; and, have access to the condoms and drugs for treating STDs.

Awareness: The CBS showed that almost all Ghanaians are currently aware of the disease AIDS. Most Ghanaian men (92 percent) and women (86 percent) know that having sex with someone who has the AIDS virus is a transmission route, although misconceptions about transmission still exist. The CBS concluded that although most Ghanaians are aware of AIDS and know it is transmitted sexually, many misconceptions remain concerning HIV/AIDS. Over a third of respondents believe that it can be transmitted by mosquitos.

Health Care Providers Attitudes: The CBS also reported that health care providers were considered by the general public to be the most reliable source of information concerning

HIV/AIDS. However, the 1993 Situation Analysis reported that 44 percent of health care providers would not provide information and counselling on AIDS to family planning clients. It was not clear if this was prompted by unwillingness to discuss HIV/AIDS, or by a perception that they did not have adequate skills and knowledge to counsel on AIDS. Given such a high percentage of failure to provide this information, more research and training are required to change the behavior of providers.

Perceived Risk: AIDS is perceived by many Ghanaians as a disease which occurs only in prostitutes or people who have been out of the country. Very negative attitudes about people with AIDS reduce an individual"s perception of their own vulnerability from continuing practices that expose them to the virus. Seventy seven percent of men and 68 percent of women felt that AIDS patients should be quarantined, to protect the rest of society. Even individuals who were labeled "high risk" of contracting AIDS in the QFSAG survey felt that AIDS patients should be quarantined. The CBS reported that only half of men and women say that anyone can get AIDS, and slightly more than a third of women say that people who have many sex partners can get AIDS. These data confirm that many Ghanaians do not feel personally threatened by AIDS.

Many AIDS control programs have focused on "core" groups of high risk individuals (prostitutes, truck drivers, those with multiple partners, those who have intercourse with individuals who have multiple partners) rather than trying to prevent cases in the general population. Focusing on "very high risk" groups often reinforces the general public"s view that HIV/AIDS only happens to others, thus compounding the problem. In Ghana, the percentage of the population that practices "high risk" behavior, which includes people with multiple sexual partners, is so large, it is difficult to differentiate from the general population. While certain groups can be targeted for specialized messages and interventions, the general population must also understand that anyone can get AIDS.

Behavior Modification: The FPHP 1993 CBS indicated that the use of condoms is increasing. Current condom use among females and males has reached 6.1% and 19.7%, respectively. Men use condoms for both STDs/AIDS prevention and family planning (96%). Even though awareness is high, knowledge is improving, and condom use is increasing, high risk sexual behaviors remain common. The 1993 CBS also reported that 80 percent of the population aged 15-30 is sexually active with approximately 25 percent having multiple partners. Only 25 percent of men who have ever used a condom report that they use it **every time** they have sex. The CBS also reported that 83 percent of Ghanaians know that sexual fidelity is the best way to prevent AIDS, but only 56 percent of men and 29 percent of women felt that using condoms would prevent AIDS.

To date, mass media interventions and social marketing activities have made the greatest contribution to the limited, but encouraging behavior modification. Approximately 8.9 million condoms were sold in Ghana in 1993, up from 4.4 million in 1990. If condom use behavior changes, these amounts must continue to be increased dramatically over the next six years. While it is not known how many condoms are used primarily for AIDS/STD

prevention as opposed to contraception, the CBS reported that condoms are used with other partners more than with wives.

Sufficient condoms will be available through the Family Planning Component of GHANAPA through GSMF to meet the increased demand for condoms. At the same time, the GHANAPA will build on the community-based interventions of the GSMF, PPAG, GRMA, SGMDP and the MOH to also strengthen interpersonal communication interventions which are believed to be critical to behavior modification, once the awareness level of a given population is very high. Training on AIDS and STD will be provided to the health care providers and community-based resource persons. GHANAPA will also continue to support behavioral operations research in order to better refine the IEC interventions.

D. Voluntary testing and Counseling

Voluntary counseling and testing has been shown to induce behavior change in Rwanda and Uganda. An evaluation study conducted in Uganda by CDC at the AIDS Information Center, showed that the program was able to induce behavior change among its clients.
Clients reported substantial changes in certain risk-reducing behaviors, including monogamy and condom use. These changes were reported by both sero-positive and sero-negative individuals.

Counseling centered on HIV testing is a problem, especially since confirmation of HIV sero-positivity is not always available in Africa. This has major implications for HIV prevention counseling in a continent which accounts for a majority of the HIV infections.
In Ghana, the demand for voluntary testing and counseling is insignificant at this stage of the HIV/AIDS epidemic and IEC interventions. However, based on the experience in other african countries and the high level of awareness on HIV/AIDS and the planned intensification of the IEC campaigns, it can be assumed that the demand for voluntary testing and counseling services may increase significantly. A significant number of private laboratories offer HIV testing, suggesting that the demand is increasing.

Since the PHRL and zonal regional laboratories will be ready to provide adequate laboratory support for HIV testing by the end of 1995, it is important to anticipate the demand for voluntary testing. It is critical that viable testing services be developed, counseling services, algorithms and policies be established and that procedures for HIV testing be designed.

GHANAPA will support the NACP to conduct a needs assessment and feasibility study on cost effective voluntary and testing services and design a fee system and appropriate procedures for these services as well as linkages between the laboratory network and the counseling services. In this regard, two study tours of MOH and selected NGO personnel will be funded in two African countries with extensive experience in voluntary testing and counseling.

E. Clinical Management of STDs

Successful programs for STD care have been designed to be "acceptable and accessible" to populations with the largest need. Furthermore, integration into primary health care (MCH and FP services) is desirable. A variety of simultaneous interventions is needed to change behavior in order to control the spread of STDs[7]. These include counselling for risk reduction; training in symptom recognition; compliance with medical prescriptions; and promotion of correct condom use.

"Points of first encounter" where the patient first comes into contact with health care is the most important because it is this care that most likely influences future behavior regarding the treatment and diagnosis of STDs. This first encounter does not necessarily occur in the formal system, but rather may occur at the local chemical seller, as confirmed by the USAID/Ghana commissioned STDs needs assessment study in the private sector. This emphasizes the need to train providers in the proper diagnosis, treatment and counselling, and additionally to link these providers with the provision of condoms through the social marketing program.

The use of syndromic approach to treat STDs is an strategy in countries without adequate laboratory support and poor treatment compliance. The World Health Organization (WHO) has recommended that health-care providers in developing countries treat patients with STDs on the basis of the group of symptoms, or syndrome, that the patient has, rather than for specific STDs. For example, providers would treat for vaginal discharge or a genital ulcer rather than gonorrhea or syphilis.

Since several STDs can cause a particular syndrome, providers may need to treat for several STDs at the same time. For example, urethritis in men is a symptom of both gonorrhea and chlamydia infection. Therefore, providers using the syndromic approach in areas where both are prevalent should treat patients with urethritis for both STDs.

Information about the patient"s sexual history can help to distinguish between syndromes that are sexually transmitted and other reproductive tract infections (especially candidiasis and bacterial vaginosis) which are not, or not usually sexually transmitted.

1. Current Treatment of STDs in Ghana

STD care appears to be poor both in the private and public sector.
In the public sector, a 1992 study of STD treatment at six urban MOH health centers in Accra and four in Kumasi found that in both males and females, no physical examinations were done. No vaginal specula were available.

AIDSCAP Technical Strategy, Family Health International, 1993.

At these facilities, health-care providers diagnosed all cases of urethral discharge as gonorrhea, and few were aware of non-gonococcal urethritis. Seventy percent of providers prescribed antibiotics at the first visit, without waiting for the results of a gram stain, culture, and sensitivity they might have ordered. Treatment of gonorrhea varied, with effective and non effective antibiotics used including cefuroxime, spectinomycin, amoxycillin, tetracycline, gentamicin, and co-trimoxazole.

Less than 10% of providers gave patients any health education about STDs. Educational materials were not available, and health talks on STDs were not given in the outpatient departments. Only 25% of health-care providers advised patients with STDs to notify their partners to seek medical care. Only 40% of providers asked patients to return for follow-up care. These providers estimated that 90% of persons advised to return did not do so.

Laboratory tests for STDs were done only occasionally. All laboratories had at least one laboratory technician and one functioning microscope. Microscope slides and reagents for gram stains usually were not available. Serological tests for syphilis were not done at any of the laboratories. Information on laboratory tests performed were not readily available in any of the laboratories.

In the private sector, the USAID/Ghana commissioned STD needs assessment found that the quality of care provided in the health centers is highly variable. Most providers indicated that they start treatment at the time of consultation. Laboratory tests are relied on in a small proportion of the cases. Speculum examinations of women were done for less than one fourth of women. Only a small number of providers used antibiotics active against resistant N. Gonorrhea. Most providers did not know how to treat Chlamydia, Chancroid, or Syphilis.

In the private Laboratories, N. Gonorrhea culture was the test most frequently cited, followed by HIV testing. HIV testing, offered by six labs, was the most costly test offered. Only one third of the N. Gonorrhea cultures were tested for drug sensitivity. Only one lab indicated that it properly incubated and interpreted the cultures. Eighty-two percent of labs doing N. Gonorrhea cultures used Blood Agar -- a media unsuitable for isolating N. Gonorrhea. The tests are usually conducted by lab technologists and lab technicians who are university trained professionals. All but one lab had at least one of these categories of personnel on their staffs.

With respect to equipment and supplies, only one provider, a CHAG hospital said that it had difficulty in obtaining supplies.

Also, the quality of care given to possible STD patients by drug vendors, like the providers, was variable. Antibiotics active against resistant N.Gonorrhea were not often used. The most disturbing finding was that less than half of the drug vendors referred their customers who failed treatment to health care providers for evaluation.

2. Status of Ghana"s Essential Drug List and National Formulary (EDLNF)

2.1 Drugs for STDs now in the Essential Drug List and National Formulary

The Essential Drug List and National Formulary contains a listing of the drugs on the Essential Drug List, information about each of the drugs, and guidance on how certain medical conditions should be treated. Because of the shortage of commercially published drug information in most developing countries (including Ghana), a national formulary manual is vital to provide information on the proper use of drugs included on the national formulary list. If the manual exists but has not been revised within five years, it may not reflect current information on the drugs listed.

The last time the Essential Drug List and National Formulary was published was 1988. In 1990, the list of drugs was revised but not published. In late 1991, a draft of a revised Essential Drug List and National Formulary was submitted to the MOH. This revision included current 1991 information about each of the drugs on the 1990 list. The MOH took no action on this draft. In late 1993, another revision of the Essential Drug List and National Formulary was submitted to the MOH. This revision included current 1993 information about each of the drugs on the 1990 list.

The revision of the Essential Drug List and National Formulary that is due to be printed has a two-page section on the treatment of STDs. This STD section contains recommendations on the treatment of urethral discharge in men and vaginal discharge. However, there are several problems with its recommendations.

First, none of the drugs on the list remain adequately effective in treating gonorrhea in Ghana. The STD section recommends that urethral discharge be treated with penicillin or amoxycillin. These antibiotics are very unlikely to be effective, due to antibiotic-resistant gonorrhea. The reason that the section cannot recommend effective antibiotics is that any drugs recommended in the Essential Drug List and National Formulary must already be on the Essential Drug List, and the Essential Drug List contains no drugs still effective for treating gonorrhea in Ghana.

Second, the STD section recommends that patients with urethral discharge be treated first for gonorrhea. If seven days later the discharge is still present, then the patient is treated for chlamydia, using tetracycline. This approach will require all patients with chlamydia to make a second visit to the health facility. However, many patients will not return for a second visit. As indicated earlier, WHO recommends that effective treatment for STD syndromes be provided in the first visit, and that in areas (such as Ghana) where both gonorrhea and chlamydia are common, patients with urethral discharge be treated for both illnesses at the first encounter.

Poor patient compliance should also be expected with regimens that use tetracycline to treat chlamydia or to treat syphilis in men and nonpregnant women allergic to penicillin. These regimens require patients to take two 250-mg tetracycline capsules four times daily for seven

days (for chlamydia) or 15 days (for syphilis). By contrast, regimens that use doxycycline to treat chlamydia or syphilis require patients to take one 100-mg doxycycline capsule two times daily for seven days and 15 days, respectively. It should be noted that, if the drugs are purchased via UNICEF, the doxycycline-containing regimens are less expensive. However, if drugs are purchased from retail pharmacies, the doxycycline-containing regimens are more expensive.

Third, miconazole is a very expensive drug with which to treat candidiasis. Less expensive, effective drugs are available. The regimen that uses clotrimazole 200 mg inserted in the vagina once daily for three days is far less expensive than a miconazole-containing regimen.

Four, the STD section is not consistent with the guidelines for the management of STDs that have been developed by the National AIDS Control Program of the MOH. These guidelines use algorithms for the treatment of urethral discharge, vaginal discharge, genital ulcers, and lower abdominal pain; the algorithms are similar to those developed by WHO for the syndromic approach to treating STDs.

2.2 The impact on treatment guidelines of adding a drug to the Essential Drug List and National Formulary

Currently, there is a general agreement on the urgent need to revise the EDLNF taking into account the available in-country and regional data on STD drug-resistant patterns. The NACP is currently recommending that the following drugs be included in the EDLNF: Ceftriaxone, Ciprofloxacin and Cefixime. Other drugs such as doxycycline, clotimazole and kanamycin are being also discussed among experts.

In developing treatment guidelines, the MOH can recommend only drugs that are in the Essential Drug List and National Formulary. This is the case even if the Essential Drug List and National Formulary includes no drugs effective in treating a particular illness. For example, in developing guidelines for the treatment of gonorrhea, the National AIDS Control Program has not been able to officially recommend any drug adequately effective for gonorrhea. Hence, a major impact of adding drugs effective for STDs to the Essential Drug List and National Formulary is that the MOH will be able to develop STD treatment guidelines recommending drugs more effective than those now in the national formulary.

2.3 The impact on drug supplies at health facilities of adding a drug to the Essential Drug List and National Formulary

Separate revolving (Cash and Carry) funds are maintained by the MOH (for the Central Medical Store), by each regional administration (for regional medical stores), and by each health facility. The Central Medical Store purchases only drugs listed in the Essential Drug List and National Formulary. Regional medical stores are supposed to purchase drugs only from the Central Medical Store, but in fact purchase drugs also from the private sector. Health facilities are supposed to purchase drugs only from the Central Medical Store and

regional medical stores, but they also purchase drugs directly from private sector. Some of the drugs purchased from the private sector by the regional medical stores and health facilities are not in the Essential Drug List and National Formulary.

Each region and facility has control of its own fund and can set its own pricing procedures. In reality, each facility can be considered a separate non-profit business, and therefore, needs to operate on a businesslike basis in order to survive.

Adding a drug to the Essential Drug List and National Formulary will enable the MOH to use the revolving fund of the Central Medical Store to purchase the drug, via the Ghana Supply Commission. Because the MOH often purchases large quantities of a drug, it might be able to obtain the drug for a low price, one possibly lower than what private wholesale drug suppliers would have to pay. Hence, adding a drug to the Essential Drug List and National Formulary enables the drug to be purchased at low price by the MOH, which can then sell the drug, via the Central Medical Store, to the regional medical stores and health facilities. The lower price available through large purchases can thereby be passed along to the patient.

As noted above, adding a drug to the Essential Drug List and National Formulary will enable the MOH to recommend the drug in its treatment guidelines. This will increase use of the drug by health-care providers, who will request that the health facility stock and sell the drug via its Cash and Carry Program. In addition, patients unable to purchase the drug at the health facility will go to pharmacists to buy the drug; the pharmacists in turn will begin to stock the drug as they see that demand for it has increased.

Hence, adding a drug to the Essential Drug List and National Formulary will result in the drug being more widely available. However, the misuse of the effective and relatively expensive STD drugs to be added in the EDLNF for other diseases will need to be addressed through training and education of the public health providers.

3. Drug Costs for syndromic treatment of STDs: retail pharmacy prices vs. wholesale international-market prices.

The following Table 2 summarizes the costs for syndromic treatment of STDs using selected drugs (Ciprofoxacin, ceftriaxone, doxycycline and clotimazole discussed for addition to the Essential Drug List and National Formulary, based on cost of these drugs in the wholesale international market vs. retail pharmacies in Accra. The costs are summarized in Table 2 below.

As shown in Table 2, the retail pharmacy prices for drugs used in the syndromic treatment of STDs are 2.4 to 8.9 times the wholesale international-market prices.

Of note is that the retail pharmacy prices for ciprofloxacin and doxycycline are 5.8 and 15.1 times, respectively, the wholesale international-market prices. The price advantage of the

international market for these drugs reflects the very low prices for ciprofloxacin and doxycycline when they are purchased through UNICEF.

Table 2. Costs for syndromic treatment of sexually-transmitted diseases using drugs recommended for addition to the Essential Drug List and National Formulary, based on cost of drugs in the international market vs. retail pharmacies in Accra.[a]

Syndrome	Wholesale International Drug Price (in US $)	Retail Pharmacy Drug Price (in US $)
Urethral Discharge	0.60	5.31
Vaginal Discharge		
Cervicitis and vaginitis[b]	1.36	7.70
Vaginitis only[c]	0.76	2.39
Genital Ulcer	2.01	4.91[d]
Lower Abdominal Pain	1.05	6.28

[a] Wholesale international-markets prices are drawn from several listings and are approximate. Retail pharmacy prices are based on the median price found in a survey of 16 retail pharmacies in Accra.

[b] Treatment for vaginitis and cervicitis includes treatment for gonorrhea, chlamydia, trichomoniasis, bacterial vaginosis, and candidiasis

[c] Treatment for vaginitis includes treatment for trichomoniasis, bacterial vaginosis, and candidiasis

[d] Benzathine penicillin 2.4 million U/vial was not available in the pharmacies surveyed. For purposes of comparison, the wholesale international-market price is used for the retail pharmacy price.

4. STD-related activities of other donor organizations

To date, almost all support to STD prevention and control has been to the public sector, although, as in many other African countries, that many Ghanaians prefer the private sector, including pharmacies, chemical sellers, itinerant drug peddlers and traditional healers, for confidential treatment of embarrassing STDs, since public clinics require registration and loss of anonymity.

4.1 Commission of the European Community

The EEC"s three-year assistance (1991-1993) in the amount of $340,000 included STD surveillance and the upgrading of clinical management of STDs, including equipping government STD clinics - one in Accra and one in Kumasi. EEC mission will continue its support to the public sector. Two million ECUs are programmed for the following two to three years. The Commission also will fund (1) training in STDs for medical officers, medical assistants, and nurses; (2) reprinting of STD leaflets; (3) the development and printing of an STD poster and flipchart; (4) the preparation of a final draft and printing of national guidelines for STD case management; and (5) training in STDs for regional HIV/AIDS counsellors

4.2 Gesellshaft fur Zusammenarbeit (GTZ, German AID)

GTZ supports laboratories in Wa (Upper West Region) and Tamale (Northern Region) to do serological tests, including HIV ELISA and Western blot tests, TPHA tests for syphilis, and hepatitis B antigen tests. In 1993, GTZ supplied the laboratory in Wa with equipment and reagents to culture N. gonorrhoea and do antibiotic sensitivity tests, using disk diffusion. A laboratory technologist in Wa received microbiology training in Kumasi at the laboratory of Komfo Anokye Teaching Hospital. In addition, a medical officer from Wa was trained in Kumasi in the clinical management of STDs.

4.3 Overseas Development Administration (British Aid)

The Overseas Development Administration (ODA) will support the establishment of STD clinics at the Regional Hospitals in Ho (Volta Region) and Koforidua (Eastern Region). Support will be in the form of medical equipment, consumable supplies, and laboratory reagents. These supplies will allow the STD clinics to collect specimens, perform culture and sensitivity testing for N. gonorrhoea, and do the RPR and TPHA serologic tests for syphilis. ODA also is funding STD-specialist training in Great Britain for two physicians, who on their return will be in charge of the STD clinics in Ho and Koforidua. ODA also will be providing equipment and supplies for an STD clinic in Korle By Hospital (Accra).

ODA also is funding refresher training in STDs for private physicians and pharmacists in Accra/Tema and Kumasi. ODA has funded a Health Education Research Unit in Kumasi, which will be developing a poster encouraging individuals with STD symptoms to seek appropriate treatment. It also has funded the reproduction of educational materials about STDs.

To summarize, the lack of adequate STD diagnosis and treatment in the public and private sector, lack of perceived seriousness of STDs by the general public, and unavailability of effective drugs to treat STDs in the public sector and their high costs, are all constraints to the control of HIV/AIDS in Ghana.

GHANAPA will use NPA conditionality to encourage the MOH to add appropriate antibiotics to the treatment of resistant strains of STDs to the Essential Drug List and National Formulary. The project will also provide training, materials and IE&C campaigns on the importance of proper diagnosis and treatment of STDs to private physicians, nurse midwifes, pharmacists and chemical sellers, and the general public, and complement donor support to MOH. GHANAPA will also establish a dialogue with other donors such as UNICEF to assist the MOH purchase low cost STD drugs.

G. AIDS-related illness /Tuberculosis

In the absence of a cure for HIV, thousands of young adults are suffering from long and chronic illnesses ending in premature death. Medical services in Africa, already inadequate, will become severely overburdened. In Abidjan, 60% of the beds in infectious disease wards currently are occupied by AIDS patients. In many hospitals throughout Africa, a fourth to a third (or more) of the patients in general medical wards are infected with HIV. Virtually all those diagnosed as having AIDS die within a few months. Survival has been increasing in developed countries from an average of less than 1 year to about 1-2 years but at a very high cost.

The challenge for health care providers in Africa is to provide AIDS patients with at least the minimum of medical and nursing care, as well as psychological and social support.
In Ghana, some NGOs with other donors support have developed a new form of care which incorporates home-based care and support for people with HIV/AIDS and their families, which are more viable approaches for resource-poor areas. GHANAPA will also support this trend through training health care providers in counseling both in the public and private sector.

AIDS related Tuberculosis is not yet a major problem in Ghana. Studies are clearly needed to monitor this problem and HIV programs should monitor trends of TB cases very closely, since an increase in the incidence of TB is believed to be an early "sentinel" indicator of HIV infection or AIDS in developing countries.

A major role in this area will be played by DANIDA, the Danish International Aid Agency. DANIDA will support an important $5,090,000 National Tuberculosis (TB) Control program through its Health Sector Support Program, which will focus on the strengthening of Primary Health Care (PHC) in the Upper West Region and PHC training institutions. Since TB is the leading HIV/AIDS-related opportunistic infection, support to TB control efforts will also contribute to improved care for AIDS patients.

IV. THE IMPORTANCE OF MAINTAINING THE LINK BETWEEN THE FAMILY PROGRAM AND AIDS PREVENTION AND CONTROL PROGRAM IN GHANA

The family planning program in Ghana has been of utmost importance for the achievements of the NACP. In fact, AIDS prevention activities have benefitted from years of investment in programs to motivate the use of family planning methods. This facilitated the dramatic increase of condom use witnessed with the outbreak of the HIV/AIDS epidemic. Priority 3 of the draft USAID Strategy for Population Assistance through the Year 2,000 is of particular importance for the NACP. It is envisioned that the FP program will intensify the demand for, and supply of non-clinical methods, including condoms, and that its activities will be extended into rural areas, which appear to be more seriously affected by AIDS than urban areas. Linking the proposed STDs/AIDS interventions and the promising, large-scale FP program into a single project may make it easier to achieve the HIV/AIDS-related project purpose and facilitate and financially support the implementation of HIV/AIDS activities. However, GHANAPA will support discrete operations research to monitor the effectiveness of this coordinated approach between the FP and AIDS prevention in Ghana.

V. PROPOSED PROJECTIONS OF THE HIV EPIDEMIC USING EPIMODEL

Epimodel is a simple computer program for short-term projections of HIV and AIDS cases developed by the World Health Organization. The model uses an HIV point prevalence estimate in combination with the estimated year HIV transmission became widespread and estimates of the annual rate of progression from HIV infection to AIDS in order to calculate past, current and future HIV and AIDS cases.

The basic assumptions used in the model are the vast majority (about 90%) of HIV-infected adults will develop AIDS within a 20 year period, and the annual progression rates from HIV infection to AIDS in adults are similar for all populations.

In the four proposed cases (see attachment), the following assumptions were made:

- 1994 HIV prevalence: 3.36 percent

- 1994 Number of HIV-infected: 330,000

- Estimated year HIV transmission became widespread: 1980

- Ghana has entered in the epidemic phase with an HIV incidence rate which will exceed one percent during the next five years. The proposed scenarios 1-4 were based on various progression rates of the HIV/AIDS epidemic following the proposed parabolic curves characterized by a gamma of 6, 7, 8 and 9 respectively. These 4 scenarios indicate an average HIV incidence of 0.8%, 1.0%, 1.2%, 1.4% and prevalence rate of 5.9%, 7.1%, 8.46% and 10% by the year 2000.

Scenarios 3 and 4 are consistent with the trends of the HIV epidemic observed in the African region. A variety of studies in Uganda, Zambia, Malawi show a consistent and rapid increase in HIV infection levels among pregnant women ((between 1.5-2.0 percent incidence). By 1990, more than 20 percent of the samples of pregnant women in those areas were infected, while in 1996 infections levels in both Lusaka and Lilongwe were below 10 percent. In contrast, pregnant women in Nairobi and Bangui have shown quite moderate increases. Infections levels for pregnant women in Abidjan increased also rapidly to around 10 percent by 1987-89, appeared to have plateaued by 1990, and have started increasing again.[8]

Based on these regional epidemiological data and the proposed scenarios, it is recommended that the goal of the project be to help stabilize the HIV/AIDS epidemic at no more than 1.5 percentage points above the estimated 1994 adult prevalence rate of 3.36 percent.

It is also proposed that the purpose of the project be to maintain the average adult HIV incidence at no more than 1.0 percent, following scenario 2 which predicts an HIV prevalence of 7.1 percent by the year 2000. This would allow to prevent 146,841 and 317,261 HIV infections against the predicted numbers of HIV infections in scenario 3 and 4 respectively. It is believed that this objective is attainable in view of the current encouraging level of condom use among individuals with risky behaviors and the proposed expansion and intensification of project activities.

In summary, USAID/Ghana concludes that the proposed strategies in policy development, behavior change and STD care are technically sound to combat the HIV epidemic and meet the project purpose. Also the proposed support interventions (e.g., operations research, and management information system) are appropriate to assist the project generate data needed for an impact evaluation of strategies by the end of the project.

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[8] An epidemiologic review of HIV/AIDS in Sub-Saharan Africa. (Peter Way and Karen A. A Stanacki). November 1993.

ANNEX G

USAID/GHANA

INSTITUTIONAL ANALYSIS FOR THE GHANA POPULATION AND AIDS PROGRAM

SEPTEMBER, 1994

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1.0 EXECUTIVE SUMMARY

1.1 CONCLUSIONS/RECOMMENDATIONS

All the 4 public sector organisations and 4 out of the 5 Non-governmental agencies (NGOs) were identified as institu-tionally capable of directly handling successfully the implementation of their individual project activities and program components under GHANAPA.

The 4 public sector organisations that will have key roles to play under GHANAPA are the Ministry of Health through 3 of its Units - Maternal Child Health and Family Planning (MCH/FP), Health Education Unit (HEU), National Aids Control Program (NACP) and the National Population Council.

The 4 NGOs that will support the public sector under GHANAPA are the Ghana Social Marketing Foundation (GSMF), Planned Parenthood Association of Ghana (PPAG), Ghana Registered Mid-wives Association (GRMA) and the Christian Health Association of Ghana (CHAG) which will participate only in STD/HIV component of GHANAPA.

The fifth NGO that does not have the institutional capability at the moment to participate directly under GHANAPA is the Ghana Society of Private Medical and Dental Practitioners of Ghana. However, the individual members of the Society will participate as important part of the distribution channels under GHANAPA.

Even though both the public sector institutions and the NGOs have some problems, they are not such as to impinge on their effective participation under GHANAPA.

In all cases, appropriate recommendations have been proposed in respect of each institution to address these problems to make them perform even better under GHANAPA.

i. NATIONAL POPULATION COUNCIL

ROLE OF THE NPC UNDER THE GHANAPA

NPC will be the umbrella organisation responsible for monitoring and coordinating the entire GHANAPA Program.

CONCLUSION

The effective implementation of GHANAPA, depends to a large extent on the absorptive capacity and the technical competence of the NPC which should be set up devoid of the short-comings of GNFPP listed below:

- The GNFPP did not have any clearly assigned role or legal instrument backing its authority.

- The integration of population planning into national develop-ment planning did not occur, neither did an appropriate insti-tutional mechanism develop to coordinate data collection, research, policy analysis, program implementation, monitoring and evaluation.

- The GNFPP was a secretariat within the Ministry of Finance and Economic Planning (MFEP), and did not have the necessary authority to mobilise inter-ministerial cooperation towards a common goal, neither did it have enough influence even within the MFEP to forward its own agenda.

- The GNFPP as part of the MFEP, was administratively outside the control of the Ministry of Health that had the primary responsibility of implementing public health policies.

- The GNFPP was given massive implementation responsibilities, without the necessary managerial capacity to operationalize these responsibilities. This problem also affected its coordination functions.

- Funding for the GNFPP's operations came mainly from donors and when these were withdrawn in the early eighties, it had no Ghanaian budget source to continue its operations.

RECOMMENDATIONS

Based on the past experiences of GNFPP, the following recommendations are proposed:

- **ORGANISATION AND LOCATION OF THE NPC**

The NPC must be an independent body, not located within any Ministry and reporting directly to the office of the President. It must be a parastatal as proposed by the report of the Consultants from the Ghana Institute of Management and Public Administration (GIMPA).

- **FUNCTIONS**

The NPC and its organs must only coordinate the GHANAPA PROGRAM. They should not be involved in direct implementation.

- **ESTABLISHMENT OF A PERMANENT SECRETARIAT OF THE NPC**

The Secretariat is the executive agency of the NPC and the proposed merger with the GNFPP should make its immediate establishment feasible to enable it play its role properly under GHANAPA.

- **INTER-ORGANISATIONAL COMMUNICATION**

The secretariat must develop strong and supportive working relationships with all the agencies - both public and private involved in GHANAPA.

The Population Sector Strategy Document (USAID/GHANA October 1993, p. 11) recommendation that it would be helpful for some of the major actors involved to visit countries where an NPC - type agency to see how such relationships and coordinating mechanisms work out in practice is endorsed.

- **FUNDING AND SUSTAINABILITY**

The GOG should have a direct budget line for the NPC. This budget line must be progressively reviewed to the extent that even in the absence of donor financial support, the NPC and its organs can be sustained.

ii. MINISTRY OF HEALTH

The Ministry of Health is the primary civil service institution responsible for the health needs of the Ghanaian population.

Its huge responsibilities, therefore, entails being a big bureau-cracy with all the attendant problems like the typical slow decision making process.

The MOH is very much aware of these handicaps and currently, there is a restructing exercise in place to make it perform more effectively.

There is also in place now the External AID Coordination Unit which helps expedite program/project fund disbursement.

The three key public sector organisations under GHANAPA - MCH\FP/ HEU/NACP - are all part of the MOH and share the common problems associated with huge bureaucracies.

It is hoped the on-going restructuring will go a long way to give the individual units quick and better access to funds disbursement to make their operations more efficient.

1. THE MATERNAL AND CHILD HEALTH/FAMILY PLANNING UNIT

ROLE OF THE UNIT UNDER GHANAPA

The Unit will continue to provide Family Planning services delivery, information and education to target audience including information and education on AIDS and STDs.

Specifically, the Unit's responsibilities include:

- Ensuring the daily delivery of MCH/FP services as part of an integrated health service package at each existing institution

- Zoning the catchment area for each institution (including hospitals)

- Developing functional health committees in each catchment area
- Conducting 12 outreach clinics per month within the catchment areas of each Level B station
- Identifying, training and supporting TBA's
- Strengthening DHMT/SDHT management
- Creating and supporting new outreach sites and accommodating staff
- Providing means of communication between each level of the health delivery system
- Instituting adequate supply distribution systems
- Institutionalising routine support and supervising strategies.

KEY OPERATIONAL PROBLEMS

The FPHP Document prepared by USAID identified the following major constraints in the area of service delivery: (p. c 16)

- insufficient manpower
- insufficient supplies and equipment
- inadequate number of service delivery
- lack of staff accommodation and community attitudes.

Discussions with the management of the MCH/FP confirmed the above problems as well as other handicaps. For example, being part of a bigger system i.e. the MOH, the ability of the MCH/FP to take quick decisions and make flexible adjustments to new situations and demands is hampered. This also applies to the disbursement of funds.

CONCLUSION

The MCH/FP inspite of its constraints has participated successfully in past programs and is institutionally capable of being part of GHANAPA.

The unit could do even better under GHANAPA if the problems identified are satisfactorily resolved.

RECOMMENDATIONS

MANAGEMENT/STAFFING

- **HEADQUARTERS**

There is the need to strengthen the staff in the head office to effectively pursue their monitoring, supervisory and evaluation roles.

The following appointments should be considered:

- 1 Deputy to the Head of the Unit (a medical officer with specialisation in public health)
- 2 nurses with qualifications in maternal and Public Health
- data analyst with background training in demography and statistics

Since there is currently a ban on recruitment to the civil service it will be necessary to put in special request through the NPC to the Head of Civil Service for special dispensation to recruit.

The alternative is to source personnel (medical officers and nurses) from the MOH establishment.

- **REGIONS, DISTRICTS AND LOCALITIES**

The management of the regional and district outlets needs to be strengthened to effectively cope with the added responsibility of catering for the National Traditional Birth Attendants.

Presently 24 of the 84 PHNs are located in Accra alone.

A needs assessment of staffing in the districts will be necessary.

- **EQUIPMENT AND LOGISTICS**

Based on the Project Document and the discussions with the management of the MCH/FP, there is the need to resource the head office to ensure an effective and efficient role under GHANAPA.

At the moment, the Headquarters of the MCH/FP has 2 computers (one has broken down since March, 1994), 3 vehicles, 1 duplicating machine (under repairs).

The provision of 1 additional desk top computer, 2 lap top com-puters (for field work), 1 duplicating machine and 1 cross country vehicle will greatly improve the operations of the head office.

Regional, district and local equipment needs could not be established and a needs assessment will be necessary.

- **SUSTAINABILITY OF SUPPLIES**

The MCH/FP listed as one of its constraints its inability to meet demand and hence sustain its contraceptive delivery program because of inadequate staff to handle contraceptive supplies, delays in shipping and clearing and returns/reports on stocks from the Regions.

The MCH/FP has now put in place a machinery to improve returns/ reports from the Regions and the MOH is also negotiating with Donors for more reliable supplies.

- **FUNDING**

The present system of allocating funds is considered too bureaucratic and it makes quick access to, and disbursement of funds difficult which adversely affects their operations.

There is therefore the need to improve disbursement and access to funds.

The implementation of the decentralization system, as envisaged in 1995, should improve the accessibility to funds for MCH/FP operations in the Regions/Districts.

2 HEALTH EDUCATION UNIT

ROLE OF THE UNIT UNDER GHANAPA

The Unit will be responsible for the Information, Education and Communication (IEC) aspects of GHANAPA using the following channels:

- Clinic level education and community level education using the mass media
- Placing advertisements on the mass media to support community level education and disseminating information on contraceptives to motivate demand.

The projected expansion program under GHANAPA include the following:

- Extending the campaigns currently concentrated in 4 Regions - Ashanti/Central/Eastern/Western to the 6 other Regions.
- Improving the communication support for the 10 Regional Health Education officers
- Supplying twice a year complete packages of audio-visual materials to the Regions.
- Providing mass media and community mobilization support for each Region at least once a quarter.

- Organising at least three workshops to foster inter-sectoral collaboration with both governmental and non-governmental organisations to plan health education programs.

KEY OPERATIONAL PROBLEMS

The main problems identified are:

- High production cost of 16mm films for the use on the audio-visual vans
- Slow disbursement of funds for the execution of programs
- Slow expenditure returns and reports from the regions for the preparation and evaluation of budgets and programs.
- Inadequate training for Management staff, in the area of personnel management, financial management and stores management.

CONCLUSION

The HEU inspite of the constraints of being part of a huge bureaucracy programs has successfully participated in past programs and the present management is capable of handling the activities envisaged under GHANAPA.

However, if the identified bottlenecks like, inadequate management training, obsolete audio visual equipment and poor reporting from the Regions are resolved satisfactorily HEU will be a more effective partner under GHANAPA.

Under the on-going restructuring exercise, HEU will be located under Technical Coordination and Research Division of MOH.

RECOMMENDATIONS

- Appropriate management training based on training needs assessment of Headoffice and Regional staff is necessary to improve efficiency.
- Replacing the existing 16mm projectors in the audio-visual vans with video equipment which will be more cost effective as it is comparatively cheaper to produce video films as against 16mm films.
- The engagement of 2 stenographers and 2 artists will strengthen the headoffice staffing position to handle effectively the envisaged increase workload in administration and IE&C materials production under GHANAPA.
- Replacing the existing 16mm projectors in the audio-visual vans with video equipment which will be more cost effective as it is comparatively cheaper to produce video films as against 16mm films.

- The engagement of 2 stenographers and 2 artists will strengthen the headoffice staffing position to handle effectively the envisaged increase workload in administration and IE&C materials production under GHANAPA.

3. THE NATIONAL AIDS CONTROL PROGRAM

ROLE OF THE NACP UNDER GHANAPA

It is clear from the aims and objectives of NACP that for the AIDS/ STD control component of GHANAPA, it will be responsible for co-ordinating the HIV/AIDS activities of the MOH, other government ministries and NGO's.

KEY OPERATIONAL PROBLEMS

- The present level of the Head of NACP within the reporting relationship of the organisation structure of the MOH is obviously not commensurate to the importance of the office under GHANAPA. The problem is illustrated by the chain of command - the head of NACP reports to the HEAD of Epidemiology Unit, who reports to the Director of Public Health who reports to the Director of Medical Services.

- Inadequate GOG resource allocation and the almost total dependence on donors may affect the sustainability of the public sector AIDS/STD activities

- Slow disbursement of funds

- Lack of good STD/HIV prevalence data which limits the ability to plan and program resources.
- Inadequate technical staff in the areas of STD and IEC
- Inadequate logistics to support regional activities

CONCLUSION

The NACP inspite of being buried in a huge bureaucracy has performed creditably in past programs and is institutionally capable of coordinating the HIV/AIDS component of GHANAPA.

The NACP like all the other MOH institutions will be affected by the on-going reforms in the MOH. The NACP under the proposed structure will be located under the Technical Coordination and Research Division (TCRD).

The essence of the creation of the TCRD is to effect a shift from vertical program management currently practised by most of the technical divisions of MOH towards technical advisory and co-ordination functions.

RECOMMENDATIONS

- The on-going restructuring of the MOH and the creation of the Technical Coordination and Research Division where the NACP is located will shift the vertical program management towards technical advisory and coordination functions

- The envisaged advisory and coordination role of NACP will require strengthening of its technical capabilities and the engagement of 6 STD specialists should be given serious consideration

- The provision of logistics for regional operations and the engagement of the services of additional IEC officers should be considered against the role of HEU under GHANAPA and whether NACP would not be more effective as an advisory and coordination unit

- The slow disbursement of funds should be resolved to improve the performance of NACP

- Resources should be made available for continuous data collection on STD/HIV prevalence.

iii. THE GHANA SOCIAL MARKETING FOUNDATION

KEY OPERATIONAL PROBLEMS

STAFFING

The key problem facing GSMF is the absence of the full complement of staff envisaged.

RELATIONSHIP WITH THE MINISTRY OF MOBILISATION AND THE INTERNAL REVENUE SERVICE

Even though the GSMF is supposed to be a non-profit organisation, it has problems with the Ministry of Mobilization and the Internal Revenue Service.

With the Ministry of Mobilization, the problem is that since the GSMF generates revenue, the Ministry's guidelines do not allow it to register the GSMF as an NGO.

With the IRS, the issue is that, because the GSMF says it might export some products, it should be liable to taxation. What the GSMF wants here is an exemption.

CONCLUSIONS

The GSMF since its inception some two years ago has demonstrated that it is institutionally capable of executing activities assigned to it under GHANAPA.

However, GSMF has been dependent to a large extent on FPHP support and putting in place the full complement of staff is the way forward for it to play its major role under GHANAPA.

RECOMMENDATIONS

- The engagement of the full complement of staff to fill the following positions will improve the operational performance of GSMF.

  - Marketing Manager
  - Business Manager
  - Director of clinical unit/Medical representative

- A meeting with representatives from the following organisations/agencies should be convened by NPC to resolve the problem of the NGO status and the payment of tax since it could affect the pricing structure of GSMF products and therefore its sales target:

  - Ministry of Mobilisation
  - The GSMF
  - The IRS
  - USAID
  - Ministry of Finance and Economic Planning

iv. THE PLANNED PARENTHOOD ASSOCIATION OF GHANA

ROLE OF PPAG UNDER THE GHANAPA PROGRAM

a. Promoting and distributing contraceptive products and also targeting opinion leaders, traditional leaders through IE&C, so that through them a larger population could be reached in terms of the dissemination of information on contraceptive use.

b. Playing an advocacy role in women empowerment and life skills education.

KEY OPERATIONAL PROBLEMS

- Poor management information system
- Inadequate funds to operate optimally
- Poor conditions of service
- Unreliable transportation in rural areas and the effect on the operations of the CBDS
- Inadequate trained CBDs - one CBD serving 10-15 communities.
- Irregular supply of contraceptive products

- Poor inter-agency cooperation and collaboration in accessing new markets for family planning services.

CONCLUSIONS

PPAG inspite of the problems identified is a major institution with a good track record in past programs making it a capable agency under GHANAPA.

The resolution of the problems identified will make the PPAG perform even better under GHANAPA.

RECOMMENDATIONS

- **COMMUNITY BASED DISTRIBUTORS**

- The engaging and training of more volunteer CBDS should be pursued in collaboration with other agencies like GSMF, MCH/FP, GRMA to minimise duplication of efforts at the community level

- Efforts should be made to recruit professionals as CBDS, so they could bring their expertise to bear on the work of the PPAG.

- Providing bicycles and motor bikes to be paid for with earned commissions will help to ease the transportation problem of CBDS to the assigned communities and improve their operational efficiency

- **SUPPLY OF CONTRACEPTIVE PRODUCTS**

  The supply of contraceptive products should be planned and scheduled on a regular basis.

- **MANAGEMENT INFORMATION SYSTEM**

  Ensuring the prompt and regular returns of reports from the Regions for central processing of data at the head office will go a long way to improve the management information system.

- **EQUIPMENT**

  Future investment in Audio-visual equipment should be considered alongside the activities of other Agencies like Health Education Unit to minimise duplication of effort and resources.

- **FUNDING**

  The PPAG plans to diversify its sources of funding to include the GTZ, ODA, CIDA and USAID to help it meet the cost of its expanded operations.

- **REGIONAL OFFICES**

  Investment in vehicles particularly for the Regions for supervisory and re-supply functions should again be considered along side the activities of other GHANAPA Implementing agencies to maximise the utilization of resources.

v. THE GHANA REGISTERED MIDWIVES ASSOCIATION (GRMA)

ROLE OF THE GRMA UNDER GHANAPA

- Give continuing education under the GHANAPA Program to midwives in family planning services, so that they can give qualitative care to families.

- Increase the contraceptive prevalence rate in the country through intensive counselling on family planning and AIDS/STDS

- Training in IUCD insertion and outreach programs

KEY OPERATIONAL PROBLEMS

- **SOURCING OF PRODUCTS**

The sourcing of contraceptive products from GSMF is considered a problem because members find the retail prices not competitive for their consumers who are also served by the public sector with comparatively lower prices.

- **POST TRAINING PRACTICE**

Some members trained in providing family planning services are usually not actively promoting the sales of contraceptive products among the target consumers.

This accounts for the low level of contraceptive product sales by the Association.

The level of outreach services undertaken by trained members is also considered unsatisfactory.

CONCLUSION

The GRMA has successfully participated in past programs and as presently set up is institutionally capable of participating directly under GHANAPA.

However, the resolution of the problems identified will make the Association even more capable.

RECOMMENDATIONS

- TRAINING

The PID on page 13 states among other things that GHANAPA will continue to provide training to the GRMA on long-term methods as well as supply short term methods through the GSMF. The continuous training of more members will help to minimise the negative effect of the drop out trainees on the Association's contribution to the successful implementation of GHANAPA.

- SOURCING OF PRODUCTS

It will be necessary to structure the prices of contraceptive products supplied to the public and private sector to make them competitive.

- VEHICLES

The provision of 1 cross-country vehicle will help the Association's executives to improve field visits to their members to motivate and sustain their interest in the program.

- OFFICE EQUIPMENT

1 lap top and 1 Desk top computer will assist the Head Office to improve dissemination of information to its members.

vi. THE SOCIETY OF PRIVATE MEDICAL AND DENTAL

ROLE OF THE SOCIETY UNDER THE GHANAPA

The members of the Society expect to continue to provide Family planning services particularly the long term methods like IUCDS/Injectables/Sterilization under the program.

KEY OPERATIONAL PROBLEMS

The major problem identified is the absence of a focal point to direct the activities of the Society.

The Society has no permanent office, secretarial or administrative staff.

CONCLUSIONS

The Society as presently constituted is not considered ready and capable of directly participating as an institution under GHANAPA.

Inspite of the loose nature of the Society its members have increasingly been participating in the distribution of contraceptive products and benefited from the supply of clinical equipment and training sponsored by USAID.

Their numbers will obviously have an impact on the service delivery points under GHANAPA.

RECOMMENDATIONS

The nature of the Society does not lend itself to channelling distribution through the Association without burdening the Executive members. There is, therefore the need for GSMF or its distributors to employ detailmen to supply individual members of the Society.

Training programs and equipment support would, however, be better channelled through the Society.

vii. THE CHRISTIAN HEALTH ASSOCIATION OF GHANA

ROLE OF CHAG UNDER GHANAPA

The CHAG indicated its preparedness to participate in the AIDS/STD component of GHANAPA.

A concept paper on their involvement has already been prepared for approval by the Board of CHAG and a copy will be made available to USAID.

KEY OPERATIONAL PROBLEMS

- Lack of inputs necessary for installing a management information system
- Inadequate office equipment
- Inadequate professional staff

CONCLUSION

Inspite of the constraints listed, CHAG has the institutional capacity and with its unique accessibility to the rural communities its services under GHANAPA will be invaluable in the HIV/AIDS component of GHANAPA.

RECOMMENDATIONS

- The need for training personnel, equiping and installing a management information system within CHAG should be given serious consideration.

- Training of the professional staff to upgrade their skill should also be considered

- Equiping the office with 1 photocopier and 1 duplicating machine will help improve communication within the 107 units

- There is a need for the headoffice to have a Reference Library for use by the professional staff

2.0 BACKGROUND

USAID/GHANA is planning to design the new $45 million Ghana Population and AIDS Program (GHANAPA) which has as its major purpose: to increase the use of modern and effective family planning methods and to reduce the rate of increase of HIV prevalence. Successful accomplishment of this purpose will be measured by:

1. increasing the Contraceptive Prevalence Rate (CPR) from approximately 15% to 25%;
2. increasing the percentage of CPR derived from longer lasting family planning methods from 20% to 40%;
3. limiting the increase of HIV prevalence to 8 percentage points over the 1994 level.

GHANAPA consists of Non-Project Assistance (NPA) and project assistance components. The NPA component totals $13 million in cash transfer assistance which will support GOG policy reforms to:

1. enhance the sustainability of family planning AIDS/HIV/ STD programs by increasing budgetary support, improving contraceptive price, forecasting and stocking procedures and changing customary practices that impede family planning service delivery;
2. improve services by increasing the availability of all contraceptive methods and selected drugs for treatment of STDs.

Project assistance includes a $20 million bilateral grant and $12 million in contraceptive commodities. This component finances technical assistance, training, commodities and the establishment of an endowment for the Ghana Social Marketing Foundation to:

1. support policy reform efforts;
2. increase demand for family planning;
3. expand provision of family planning services;
4. foster greater sustainability of family planning programs;
5. promote safe sexual behaviour;
6. encourage proper diagnosis and treatment of STDs;
7. improve the surveillance of AIDS/HIV/STDs.

Marketing and Social Research Institute Ltd (MSRI) was commissioned on May 11, 1994 to undertake the study following the acceptance by USAID/GHANA of proposal submitted by MSRI in response to a request by Mr. Floyd R. Spears, Executive officer, USAID/GHANA in a letter dated March 8, 1994 together with a Scope of Work for the project and received by MSRI on March 23, 1994.

3.0 OBJECTIVES

The overall objective of this component of the study is to assess the capability of 4 public sector and 5 NGOs to successfully implement project activities and program components of GHANAPA.

4.0 RESEARCH APPROACH

4.1 METHODOLOGY

Desk research reviewing existing relevant documents and personal interviews with questionnaires by fieldstaff and consultant were used to collect data for the analysis.

4.2 SAMPLE

9 [nine] agencies that are considered relevant for the successful implementation of GHANAPA were contacted for data for the analysis.

The organisations are:

- National Population Council
- Ministry of Health (MOH)
- Maternal, Child Health/Family Planning
- Health Education Unit
- National AIDS Control Program
- Ghana Social Marketing Foundation
- Planned Parenthood Association of Ghana
- Ghana Registered Midwives Association
- The Society of Private Medical and Dental Practitioners Ghana
- Christian Health Association of Ghana

4.3 TYPE AND FORMAT OF INSTRUMENT

Questionnaires were designed and administered by trained interviewers.

4.4 EVALUATION OF FIELDWORK

The major constraint was the short period available for data collection for the study.

NATIONAL POPULATION COUNCIL

1.0 ORGANISATION

1.1 LEGAL STATUS

The interim secretariat of the National Population Council (NPC) is set up together with the Social Sector Policy Unit (SSPU) within the Ministry of Finance and Economic Planning.

As presently located, its status is just like that of the Ghana National Family Planning Program (GNFPP), of 1969.

The proposed organogram of the NPC that has been submitted to Government for approval sees the NPC as a parastatal. This has not been approved yet. The proposition if accepted will put NPC's role in proper perspective under GHANAPA.

It is envisaged that placing the NPC under the office of the President, will not only enhance its organisational image, but also put issues on population, family planning, AIDS/STDs at the highest level of public policy decision making.

1.2 AIMS AND OBJECTIVES

The National Population Council is charged with addressing population issues in the country. Specifically, the objectives of NPC are:

- Coordinating population programs and activities in Ghana
- Coordinating the implementation of Family Planning and related activities
- Ensuring the implementation of the country's population policy
- Ensuring the full participation of the private sector in the population policy formulation
- Representing the Government of Ghana to donors and the international community on population issues.

1.3 ORGANISATIONAL STRUCTURE

- **THE NATIONAL POPULATION COUNCIL (NPC)**

The Council is currently made up of 21 persons representing a number of government agencies, institutions of higher education, NGOs and private individuals. The Council is headed by a chairperson.

- **THE SECRETARIAT OF THE NPC**

The Secretariat will serve as the executive arm of the NPC with the following objectives:

- Provide technical and administrative support to the NPC
- Guide and coordinate the preparation of plans of action and implementation
- Establish and operationalise a national system for research, evaluation and monitoring of population programs
- Promote the integration of population factors in development planning
- Maintain a population data bank to promote the exchange of information on population
- Promote the development of human resources to support policy implementation
- Liase with donors and coordinate their resource input
- Publish a bi and annual population report
- Generally provide leadership on population issues

The proposed Secretariat will have the status of a parastal organisation and will have six units and five Technical Advisory Committees (TAC(S). The TACS include:

- Research, coordination, monitoring and evaluation
- Population information, education and communication
- Family Planning Services
- Population policy programs
- Personnel/Administration.

A Technical Coordinating Committee (TCC), is designed to coordinate the work of the TACS.

1.4 OFFICE ACCOMMODATION/EQUIPMENT

The refurbished GNFPP building is proposed to house NPC

1.5 VEHICLES

The NPC currently has 5 vehicles, 3 from USAID and 2 from the United Nations Fund for Population Activities.

2.0 MANAGEMENT/STAFFING

The NPC Secretariat presently has 9 personnel who are also responsible for SSPU activities.

1 Director

1 Senior Economic Planning Officer

3 Economic Planning Officers

1 Assistant Economic Planning Officer

2 Stenographer Secretaries (GRADE II)

1 Messenger

The proposed merger with the Ghana National Family Planning Program (GNFPP) will obviously strengthen the management of the NPC with qualified technical and administrative staff.

The GNFPP has the following technical and administrative staff at its Headquarters and in the Regions.

TECHNICAL

1 Acting Executive Director with background in family planning coordination.

1 Coordinator for training (IEC)
1 Principal Information Office (IEC)
1 Senior Executive Officer who assists the Principal Research Officer

TOTAL: 4

ADMINISTRATION

1 Acting Director of Administration
1 Assistant Director
2 Higher Executive Officers

TOTAL: 4

REGISTRY

1 Executive Officer (Library supervision)
1 Stenographer Grade 2
2 Typists Grade 1
1 Typist Grade 2

TOTAL: 5

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REGIONS

Greater Accra	-	1 Assistant Regional Family Planning officer
Central	-	Vacant. Temporary Responsibility with regional Administration
Ashanti	-	1 Assistant Regional family planning officer
Eastern	-	do
Brong-Ahafo	-	do
Western	-	do
Volta	-	do
Upper East	-	do
Northern	-	do
Upper West	-	do
TOTAL:	**9**	

DISTRICTS

No representation. The GNFPP relies on the communities.

In all, there are 21 qualified officers of the GNFPP at the Headquarters and the regions who could be used for GHANAPA when the GNFPP becomes part of the NPC.

There is the need however, as currently being discussed, to strengthen the regional middle level support staff and improve coordination at the districts.

4.0 ROLE OF THE NPC UNDER THE GHANAPA

NPC will be the umbrella organisation responsible for monitoring and coordinating the entire GHANAPA Program.

5.0 FUNDING

The NPC Secretariat as presently constituted, is a subvented organisation with funding provided by GOG and donors.

6.0 CONCLUSION

The effective implementation of GHANAPA, depends to a large extent on the absorptive capacity and the technical competence of the NPC which should be set up devoid of the short-comings of GNFPP listed below:

- The GNFPP did not have any clearly assigned role or legal instrument backing its authority.

- The integration of population planning into national development planning did not occur, neither did an appropriate institutional mechanism develop to coordinate data collection, research, policy analysis, program implementation, monitoring and evaluation.

- The GNFPP was a secretariat within the Ministry of Finance and Economic Planning (MFEP), and did not have the necessary authority to mobilise inter-ministerial cooperation towards a common goal, neither did it have enough influence even within the MFEP to forward its own agenda.

- The GNFPP as part of the MFEP, was administratively outside the control of the Ministry of Health that had the primary responsibility of implementing public health policies.

- The GNFPP was given massive implementation responsibilities, without the necessary managerial capacity to operationalize these responsibilities. This problem also affected its coordination functions.

- Funding for the GNFPP's operations came mainly from donors and when these were withdrawn in the early eighties, it had no Ghanaian budget source to continue its operations.

7.0 RECOMMENDATIONS

Based on the past experiences of GNFPP, the following recommendations are proposed:

- **ORGANISATION AND LOCATION OF THE NPC**

The NPC must be an independent body, not located within any Ministry and reporting directly to the office of the President. It must be a parastal as proposed by the report of the Consultants from the Ghana Institute of Management and Public Administration (GIMPA).

- **FUNCTIONS**

The NPC and its organs must only coordinate the GHANAPA PROGRAM. They should not be involved in direct implementation.

- **ESTABLISHMENT OF A PERMANENT SECRETARIAT OF THE NPC**

The Secretariat is the executive agency of the NPC and the proposed merger with the GNFPP should make its immediate establishment feasible to enable it play its role properly under GHANAPA.

- **INTER-ORGANISATIONAL COMMUNICATION**

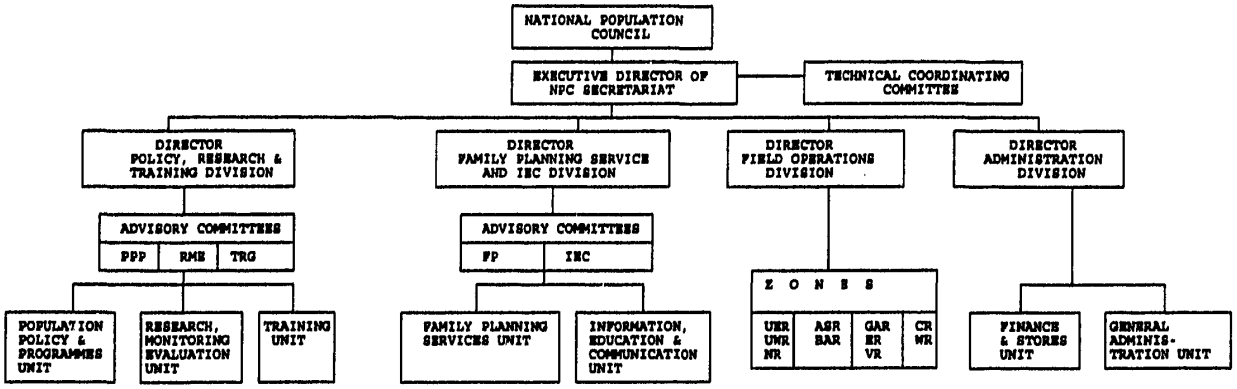
The secretariat must develop strong and supportive working relationships with all the agencies - both public and private involved in GHANAPA.

The Population Sector Strategy Document (USAID/GHANA October 1993, p. 11) recommendation that it would be helpful for some of the major actors involved to visit countries where an NPC - type agency to see how such relationships and coordinating mechanisms work out in practice is endorsed.

- **FUNDING AND SUSTAINABILITY**

The GOG should have a direct budget line for the NPC. This budget line must be progressively reviewed to the extent that even in the absence of donor financial support, the NPC and its organs can be sustained.

PROPOSED ORGANISATIONAL STRUCTURE OF THE NPC



PPP	-POPULATION POLICY & PROGRAMS UNIT	UER	-UPPER EAST REGION	GAR	-GT. ACCRA REGION
FP	-FAMILY PLANNING SERVICES UNIT	UWR	-UPPER WEST REGION	ER	-EASTERN REGION
TRG	-TRAINING UNIT	NR	-NORTHERN REGION	VR	-VOLTA REGION
RME	-RESEARCH, MONITORING & EVALUATION UNIT	ASR	-ASHANTI REGION	CR	-CENTRAL REGION
IEC	-INFORMATION, EDUCATION AND COMMUNICATION UNIT	BAR	-BRONG-AHAFO REGION	WR	-WESTERN REGION

The Technical Coordinating Committee is to be Constituted by Chairpersons of the Technical Advisory Committees and Directors if Divisions of the Secretariat

THE MINISTRY OF HEALTH

THE MISSION STATEMENT AND OBJECTIVE OF THE MINISTRY OF HEALTH (MOH)

The MOH is the primary civil service institution responsible for the health needs of the entire Ghanaian population.

The MOH formulates national policies for the health delivery system and ensures that all the various parts of the system functions within the policy framework

FUNCTIONS OF THE MOH

The MOH is responsible for the coordination of the entire health services in Ghana which include:

- activities leading to the prevention of diseases
- activities leading to the promotion and maintenance of good health
- co-ordination of services and facilities for the treatment of diseases and the rehabilitation of patients
- provision of manpower resources for the health sector of the economy
- procurement of financial and all other resources required by the health sector of the economy on account of which it coordinates the search for all inflows as well as the utilization of local and foreign financial and technical assistance in the health sector
- co-ordination of the development of medical sciences in its totality, including research into and application of traditional medicine in Ghana.

ORGANISATION

The MOH is organized into headquarters (central), regional, district and sub-district levels of administration.

The MOH is undergoing a restructuring exercise. The attached organogram might therefore not be permanent.

The Divisions important to GHANAPA and which are identified and examined in this study are:

- Maternal, Child Health and Family Planning
- Health Education Unit
- National AIDS Control Program

THE MATERNAL AND CHILD HEALTH/FAMILY PLANNING UNIT

MINISTRY OF HEALTH

1.0 ORGANISATION

1.1 LEGAL STATUS

The Maternal and Child Health/Family Planning Unit [MCH/FP] is part of the organisational structure of the Ministry of Health (MOH).

It operates three general areas of the MOH's mandate, viz, Safe Motherhood, Family Planning and Child Survival. These can be broken down into the specific areas of: maternal care, Family planning, communicable diseases control, diarrhoea diseases and malaria control.

From its legal status and mandate, it could be said that the MCH/FP is one of the key public sector agencies in the GHANAPA Program.

1.2 AIMS AND OBJECTIVES

- Provides the policy framework for services provided for monitoring the health of mothers and children.
- Ensures the availability of supplies of equipment needed for operating the above-mentioned services.
- Provides supervisory support services for the regions by annual reviews of their programs

1.3 ORGANISATIONAL STRUCTURE

The Unit is headed by a Senior Medical Officer (SMOH) who reports directly to the Deputy Director of Medical Services (Public Health).

The SMOH is assisted by 1 Deputy Director of Nursing Services (DDNS/PH), with support from 1 Principal Nursing Officer (PNO), 1 Senior Nursing Officer (SNO), 1 Nursing Officer (NO), and 1 Public Health Nurse (PHN).

At the regional level, the MCH/FP Unit is headed by a PNO, assisted by 1 SNO, 1 NO and 1 PHN.

2.0 MANAGEMENT/STAFFING

Currently, the country wide strength of personnel of the MCH/FP is as follow: 1 DDNS, 2 SMO's, 20 PHNO's, 107 SNO's, 76 NO's and 84 PHN's. These professionals are supported at all levels by auxiliary nursing staff.

The management of the MCH/FP states that staff turnover is not very high.

According to available records, total of 1086 institutions offer the MCH/FP services with 30% of such services being managed by the MOH. The distribution of institutions at the regional level is regarded as inadequate. The MOH requires an additional 246 health facilities to meet the national average ratio in each region. These facilities may be governmental or non-governmental.

However, based on the Primary Health Care guidelines of 1978 which recommend one health institution (Level B facility) per 8 Km radius, a total of 525 new Level B health institutions offering MCH/FP services is required for Ghana in the long term.

Even though it has not been possible to get the exact number of localities with MCH/FP services, available data indicates that only about 50% of the total population live within an 8 Km radius of a service delivery point.

According to the current national strategy for achieving the MCH/FP objectives and targets based upon the principles of Primary Health Care (PHC), the following picture emerges:

NO SERVICE DELIVERY	**NATIONAL**	NATIONAL SUPPORT TEAM TO VISIT EVERY REGION ONCE PER YEAR
10 REGIONAL MANAGEMENT TEAMS	**REGIONAL HEALTH MANAGEMENT TEAM**	REGIONAL MANAGEMENT TEAM. TO VISIT DISTRICTS AT LEAST ONCE EVERY QUARTER.
110 DISTRICT HEALTH MANAGEMENT TEAMS	**DISTRICT HEALTH MANAGEMENT TEAM**	DISTRICT HEALTH MANAGEMENT TEAM TO VISIT CLINIC TEAM AT LEAST ONCE PER MONTH.

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679 HEALTH STATIONS DAILY INTEGRATED SERVICE	**HEALTH STATION**	1 COMMUNITY (TBA)
12 OUTREACH SITES PER HEALTH STATION. MONTHLY INTEGRATED SERVICES	**DELIVERY SITE**	TRADITIONAL BIRTH ATTENDANT TRAINER TO VISIT EVERY TBA AT LEAST ONCE PER MONTH

3.0 DISTRIBUTION OF CONTRACEPTIVES

Since 1970, the Division has been distributing the following of contraceptives products :

- The Pill
- Condoms
- Foaming Tablets
- Injectables
- IUCDS

Demand has been increasing according to the MCH/FP's Indicators and Targets. Their record attainments and targets for modern contraceptive use: 1992 - 4.5%, 1993 - 8% and by 1995 10% CYP of W.I.F.A respectively.

4.0 ROLE OF THE UNIT UNDER GHANAPA

The Unit will continue to provide Family Planning services delivery, information and education to target audience including information and education on AIDS and STDs.

Specifically, the Unit's responsibilities include:

- Ensuring the daily delivery of MCH/FP services as part of an integrated health service package at each existing institution
- Zoning the catchment area for each institution (including hospitals)
- Developing functional health committees in each catchment area
- Conducting 12 outreach clinics per month within the catchment areas of each Level B station

- Identifying, training and supporting TBA's
- Strengthening DHMT/SDHT management
- Creating and supporting new outreach sites and accommodating staff
- Providing means of communication between each level of the health delivery system
- Instituting adequate supply distribution systems
- Institutionalising routine support and supervising strategies.

5.0 SOURCES OF FUNDING

The Unit is funded by GOG annual budgetary allocation and donors.

6.0 KEY OPERATIONAL PROBLEMS

The FPHP Document prepared by USAID identified the following major constraints in the area of service delivery: (p. c 16)

- insufficient manpower
- insufficient supplies and equipment
- inadequate number of service delivery
- lack of staff accommodation and community attitudes.

Discussions with the management of the MCH/FP confirmed the above problems as well as other handicaps. For example, being part of a bigger system i.e. the MOH, the ability of the MCH/FP to take quick decisions and make flexible adjustments to new situations and demands is hampered. This also applies to the disbursement of funds.

7.0 CONCLUSIONS

The MCH/FP inspite of its constraints has participated successfully in past programs and is institutionally capable of being part of GHANAPA.

The unit could do even better under GHANAPA if the problems identified are satisfactorily resolved.

8.0 RECOMMENDATIONS

8.1 MANAGEMENT/STAFFING

- HEADQUARTERS

There is the need to strengthen the staff in the head office to effectively pursue their monitoring, supervisory and evaluation roles.

The following appointments should be considered:

- 1 Deputy to the Head of the Unit (a medical officer with specialisation in public health)
- 2 nurses with qualifications in maternal and Public Health
- data analyst with background training in demography and statistics

Since there is currently a ban on recruitment to the civil service it will be necessary to put in special request through the NPC to the Head of Civil Service for special dispensation to recruit.

The alternative is to source personnel (medical officers and nurses) from the MOH establishment.

- REGIONS, DISTRICTS AND LOCALITIES

The management of the regional and district outlets needs to be strengthened to effectively cope with the added responsibility of catering for the National Traditional Birth Attendants.

Presently 24 of the 84 PHNs are located in Accra alone.

A needs assessment of staffing in the districts will be necessary.

- EQUIPMENT AND LOGISTICS

Based on the Project Document and the discussions with the management of the MCH/FP, there is the need to resource the head office to ensure an effective and efficient role under GHANAPA.

At the moment, the Headquarters of the MCH/FP has 2 computers (one has broken down since March, 1994), 3 vehicles, 1 duplicating machine (under repairs) .

The provision of 1 additional desk top computer, 2 lap top computers (for field work), 1 duplicating machine and 1 cross country vehicle will greatly improve the operations of the head office.

Regional, district and local equipment needs could not be established and a needs assessment will be necessary.

- **SUSTAINABILITY OF SUPPLIES**

The MCH/FP listed as one of its constraints its inability to meet demand and hence sustain its contraceptive delivery program because of inadequate staff to handle contraceptive supplies, delays in shipping and clearing and returns/reports on stocks from the Regions.

The MCH/FP has now put in place a machinery to improve returns/ reports from the Regions and the MOH is also negotiating with Donors for more reliable supplies.

- **FUNDING**

The present system of allocating funds is considered too bureaucratic and it makes quick access to, and disbursement of funds difficult which adversely affects their operations.

There is therefore the need to improve disbursement and access to funds.

The implementation of the decentralization system, as envisaged in 1995, should improve the accessibility to funds for MCH/FP operations in the Regions/Districts.

THE HEALTH EDUCATION UNIT

MINISTRY OF HEALTH

1.0 ORGANISATION

1.1 LEGAL STATUS

The Health Education is set up unit within the Ministry of Health (MOH). It is one of the key organisations in the public sector that can be relied upon for implementing GHANAPA.

1.2 AIMS AND OBJECTIVES

- Educates the general public on general health issues
- Undertakes research to develop and produce IE&C materials

1.3 ORGANISATIONAL STRUCTURE

The Unit is headed by a Principal Health Educator who reports directly to the Deputy Director of Medical Services (Public Health), in the Ministry of Health.

The Unit is assisted by a Senior Health Educator and a Health Educator who is currently the Training Co-ordinator for the Contraceptive Supply Project.

There are also 9 Assistants Health Educators, two of whom are graphic artists and three health officers: one in charge of drama who liaises with the Ghana Broadcasting Corporation, one in charge of the AIDS program and the last in charge of monitoring and evaluating the family planning education component.

At the regional level, the Unit is headed by Health Educational officer who is in charge of educational programs and campaigns in the region. According to the PID (p16), currently all the regions except Volta and Upper East, have Health Education Officers in charge.

The total staff strength of the Unit both at headoffice and in the regions is 47.

4.0 ROLE OF THE UNIT UNDER GHANAPA

The Unit will be responsible for the Information, Education and Communication (IEC) aspects of GHANAPA using the following channels:

- Clinic level education and community level education using the mass media
- Placing advertisements on the mass media to support community level education and disseminating information on contraceptives to motivate demand.

The projected expansion program under GHANAPA include the following:

- Extending the campaigns currently concentrated in 4 Regions - Ashanti/Central/Eastern/Western to the 6 other Regions.
- Improving the communication support for the 10 Regional Health Education officers
- Supplying twice a year complete packages of audio-visual materials to the Regions.
- Providing mass media and community mobilization support for each Region at least once a quarter.
- Organising at least three workshops to foster inter-sectoral collaboration with both governmental and non-governmental organisations to plan health education programs.

5.0 SOURCES OF FUNDING

The Unit is funded mainly by GOG through Treasury Allocations to the MOH.

Other sources of funding are from the World Vision International, the USAID and WHO, but these are for specific programs or projects.

6.0 KEY OPERATIONAL PROBLEMS

The main problems identified are:

- High production cost of 16mm films for the use on the audio-visual vans
- Slow disbursement of funds for the execution of programs
- Slow expenditure returns and reports from the regions for the preparation and evaluation of budgets and programs.
- Inadequate training for Management staff, in the area of personnel management, financial management and stores management.

7.0 CONCLUSION

The HEU inspite of the constraints of being part of a huge bureaucracy programs has successfully participated in past programs and the present management is capable of handling the activities envisaged under GHANAPA.

However, if the identified bottlenecks like, inadequate management training, obsolete audio visual equipment and poor reporting from the Regions are resolved satisfactorily HEU will be a more effective partner under GHANAPA.

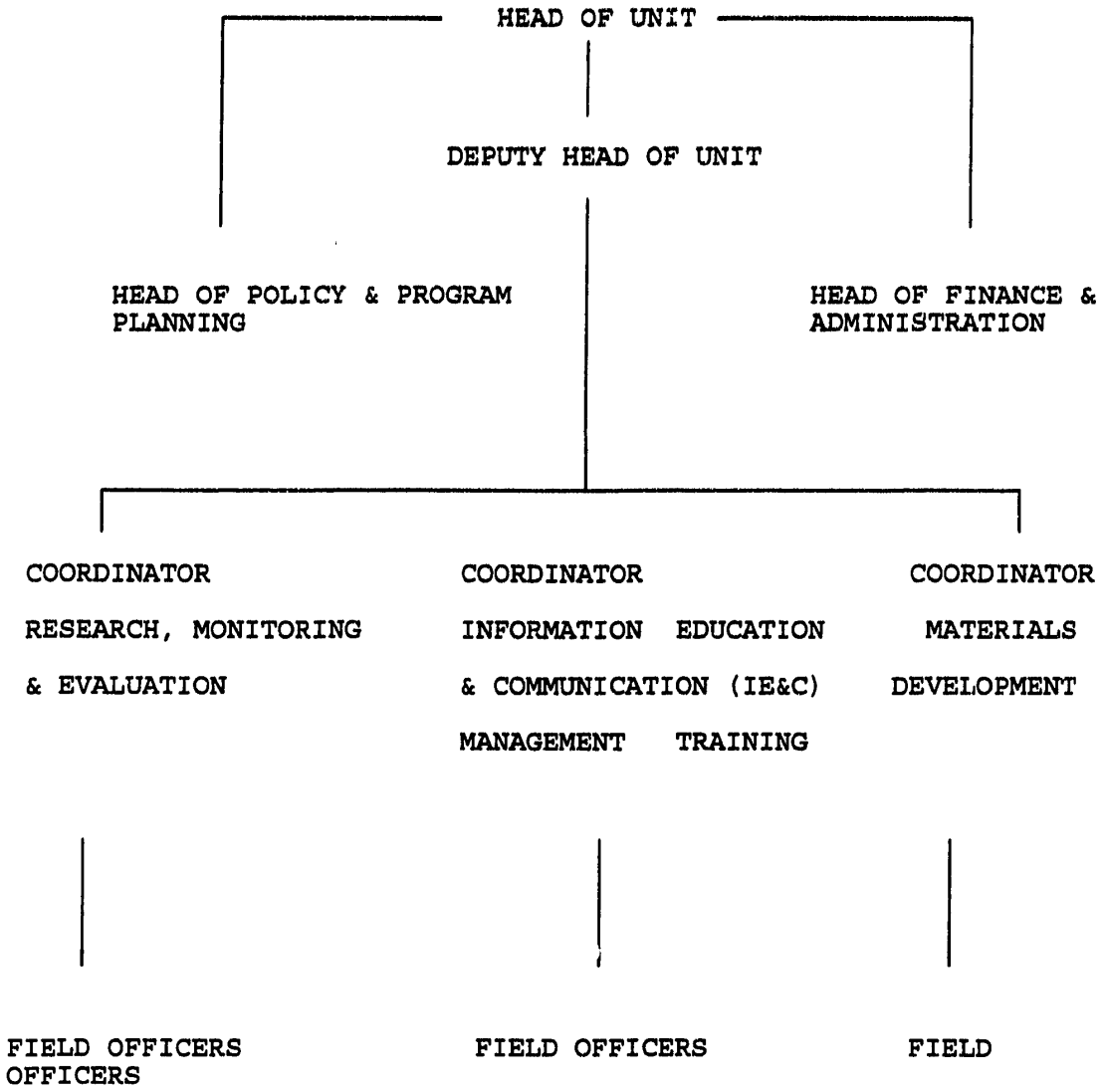
Under the on-going restructuring exercise, HEU will be located under Technical Coordination and Research Division MOH.

8.0 RECOMMENDATIONS

- Appropriate management training based on training needs assessment of Headoffice and Regional staff is necessary to improve efficiency.
- Replacing the existing 16mm projectors in the audio-visual vans with video equipment which will be more cost effective as it is comparatively cheaper to produce video films as against 16mm films.
- The engagement of 2 stenographers and 2 artists will strengthen the headoffice staffing position to handle effectively the envisaged increase workload in administration and IE&C materials production under GHANAPA.

ORGANISATIONAL CHART

MINISTRY OF HEALTH EDUCATION UNIT



THE NATIONAL AIDS CONTROL PROGRAM

MINISTRY OF HEALTH

1.0 ORGANISATION

1.1 LEGAL STATUS

The National AIDS Control Program (NACP) is set up within the Epidemiology Unit of the Ministry of Health (MOH). It was established in 1988.

1.2 AIMS AND OBJECTIVES

- coordinates the HIV/AIDS activities of the MOH, other government Ministries and NGO's in Ghana.
- educates the populace to prevent the further spread of HIV infection.
- assists through counselling to reduce the impact and the stress of AIDS on affected individuals, families and communities.
- increase the effectiveness of HIV/AIDS prevention and control efforts through expanded activities in I E & C, laboratory services and health information system.

1.3 ORGANISATIONAL STRUCTURE

The NACP is a sub-unit within the Epidemiology unit.

The head of NACP reports to the Head of Epidemiology.

2.0 MANAGEMENT/STAFFING

The NACP staff include the Program Manager, 1 STD Coordinator, 1 Counselling Coordinator, 1 Health Information Officer, 1 Information, Education and Communication Officer.

3.0 ROLE OF THE NACP UNDER GHANAPA

It is clear from the aims and objectives of NACP that for the AIDS/ STD control component of GHANAPA, it will be responsible for co-ordinating the HIV/AIDS activities of the MOH, other government ministries and NGO's.

4.0 SOURCES OF FUNDING

According to the GHANAPA PROJECT Identification Document (641 - D131 Program Assistance Initial Proposal 641 - 0132, P.26), approximately 80% of the MOH non-personal expenditures for AIDS/STD control is contributed by donors including the WHO/UNDP, EC, the Dutch, German and British Governments with USAID being the largest contributor. The remaining 20% is covered by the MOH.

The MOH projects a total 1994 recurrent and capital budget of $6.7 million for AIDS/STD control. Of this amount, $4.9 million represents donor spending and the remaining $1.8 million MOH expenditures.

USAID provides $4 million, about 91% of total donor resources in AIDS/STD control, but that figure includes approximately $3 million in capital expenditures and technical assistance for the laboratories.

Total recurrent expenditures for 1994 are estimated at $3.7 million. This level is expected to increase slightly over subsequent years.

The picture which emerges clearly from the above is that, the AIDS/STD Control program is donor driven in terms of funding.

5.0 KEY OPERATIONAL PROBLEMS

- The present level of the Head of NACP within the reporting relationship of the organisation structure of the MOH is obviously not commensurate to the importance of the office under GHANAPA. The problem is illustrated by the chain of command the head of NACP reports to the HEAD of Epidemiology Unit, who reports to the Director of Public Health who reports to the Director of Medical Services.

- Inadequate GOG resource allocation and the almost total dependence on donors may affect the sustainability of the public sector AIDS/STD activities

- Slow disbursement of funds

- Lack of good STD/HIV prevalence data which limits the ability to plan and program resources.

- Inadequate technical staff in the areas of STD and IEC

- Inadequate logistics to support regional activities

6.0 CONCLUSION

The NACP inspite of being buried in a huge bureaucracy has performed creditably in past programs and is institutionally capable of coordinating the HIV/AIDS component of GHANAPA.

The NACP like all the other MOH institutions will be affected by the on-going reforms in the MOH. The NACP under the proposed structure will be located under the Technical Coordination and Research Division (TCRD).

The essence of the creation of the TCRD is to effect a shift from vertical program management currently practised by most of the technical divisions of MOH towards technical advisory and co-ordination functions.

7.0 RECOMMENDATIONS

- The on-going restructuring of the MOH and the creation of the Technical Coordination and Research Division where the NACP is located will shift the vertical program management towards technical advisory and coordination functions

- The envisaged advisory and coordination role of NACP will require strengthening of its technical capabilities and the engagement of 6 STD specialists should be given serious consideration

- The provision of logistics for regional operations and the engagement of the services of additional IEC officers should be considered against the role of HEU under GHANAPA and whether NACP would not be more effective as an advisory and coordination unit

- The slow disbursement of funds should be resolved to improve the performance of NACP

- Resources should be made available for continuous data collection on STD/HIV prevalence.

THE GHANA SOCIAL MARKETING FOUNDATION

(GSMF)

1.0 ORGANISATION

1.1 LEGAL STATUS

The Ghana Social Marketing Foundation (GSMF) is an incorporated company limited by guarantee, ie, a non-profit Non-Governmental Organisation (NGO).

1.2 OBJECTIVES/GOALS

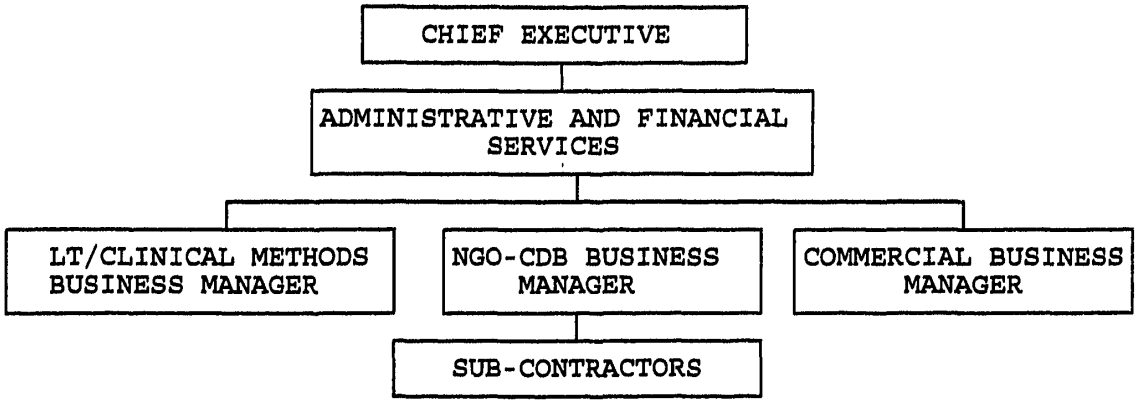
The basic aim of the foundation is to empower Ghanaian families to achieve an improved quality of life through the provision of affordable and accessible family planning and maternal and child health products and services.

The Foundation is charged with utilizing the existing private sector, commercial and clinical network to deliver Contra-ceptives and Maternal and Child Health products to the population at subsidized prices with a bid to increasing the prevalence of contraceptive use.

1.3 ORGANISATIONAL STRUCTURE

The GSMF is with full complement of staff will be a five person marketing company, but initially as a four person company made up of the Chief Executive and three other business unit managers to handle the following units: Long Term and Clinical Methods, NGO - CBD Program and the Commercial Marketing Units.

Administrative and financial services would be purchased as currently happening under the FPHP.
It is expected that eventually, a Marketing Director would emerge from among one of the three Business Managers to make the GSMF a five person company.


CHIEF EXECUTIVE
ADMINISTRATIVE AND FINANCIAL SERVICES
LT/CLINICAL METHODS BUSINESS MANAGER
NGO-CDB BUSINESS MANAGER
COMMERCIAL BUSINESS MANAGER
SUB-CONTRACTORS

2.0 MANAGEMENT/STAFFING

2.1 CHIEF EXECUTIVE

The position of Chief Executive is currently the only one that has been filled and is responsible for the day-to-day management of the Foundation, both in terms of administration and operations. The business is currently in commercial marketing as well as the NGO - Community Based Distribution.

The current incumbent has the operational responsibility for the training of service providers, sales and distribution, advertising, research and packaging. There is also the development of the long term clinical methods market and the CBD Program.

As the program expands, there is the need to build the company on sustainable basis by bringing in some extra hands to take over the performance of some of the responsibilities and thus give the Chief Executive enough room to manage the long term and strategic issues of the company.

2.2 LONG TERM AND CLINICAL METHODS BUSINESS UNIT

The USAID has indicated that under the new project, longer term methods are going to be the key for a massive growth of contraceptive prevalence.

Currently the ratio is 80/20, with the temporary methods having the lion's share.

Between 1995 - 2000, the tilt is supposed to move towards longer term methods in a 60/40 ratio with the bulk of the longer term methods being contributed by injectables and IUDS.

Under the current project, the GSMF is beginning a modest entry into the longer term methods by recruiting and working with private sector physicians and midwives to deliver this service in IUDS and injectables in addition to orals.

This service involves detailing, training and product distri-bution to a total of about 1,000 service providers.

As a major business unit, this requires the oversight of a business manager to coordinate and manage the activities of both distributors, and training subcontractors as well as initiate any relevant research for this sector.

The position needs to be filed by the end of 1994 when the momentum of the development of the longer term business would have started taking root.

2.3 NGO - COMMUNITY BASED DISTRIBUTION UNIT

The unit is currently managed under the FPHP but is due to be transferred to the GSMF by the end of 1994 for the new project which will provide funds for the training and motivational activities of NGOs to be recruited under the Community-based distribution of contraceptives.

The position involves the recruitment, training, management, and monitoring of NGOs under the Community-based (CBD) development program.

The CBD program in several countries has provided the main thrust to the growth of contraceptive prevalence, eg. Zimbabwe and Kenya and looks very promising for Ghana.

The current incumbent will transfer as the Business Unit Manager for NGOs under the new project by the beginning of 1995.

2.4 COMMERCIAL MARKETING AND DISTRIBUTION BUSINESS UNIT

This Unit is currently under the thrust of the Foundation and manages the sales and distribution, training of private sector providers, research, advertising and marketing agenda of the Foundation. These activities are currently managed by the Chief Executive.

With the full structural development of the Foundation and its expansion into other areas including the management of the endowment fund, it is necessary to have an additional person to manage this portfolio to ensure that it continues with its momentum. This position should be filled by mid 1995.

2.5 FINANCIAL AND ADMINISTRATIVE SERVICES

It is envisaged that these service will continue to be purchased from CME as currently being done by FPHP.

It may, however, be necessary to hire a Chief Financial officer in the future to manage the endowment funds and see to their proper investment as against contracting a bank or investment agency that will charge between 1 - 2% commission for managing the funds.

I have been informed that all other personnel needed to handle administrative functions would be hired through the sub-contract with the CME.

2.6 SUB-CONTRACTING ARRANGEMENTS

At the moment, the GSMF has sub-contracting arrangements with 14 companies, viz,

3 Advertising Companies
3 Distribution Companies
3 Training Companies
2 Research Companies
2 Printing Companies
1 packing Company

It also has warehousing leasing arrangements with the Ghana Industrial Holding Company (Pharmaceutical Division).

The distribution companies are Starwin, Johnson Wax and Danafco.

These sub-contracting arrangements work out in different ways. For example, with the three distributors, the GSMF does not pay any direct monies. What it does is to give them the right to charge between 20 - 35% of the warehouse price. The GSMF however, gives them support services, eg. computers, pick-up trucks which still are GSMF properties.

With the other companies, the GSMF has standing contracts with them. Whenever there is the need for their services in their respective areas, the GSMF approaches them to draw up technical and financial proposals on the subject.

3.0 DISTRIBUTION OF CONTRACEPTIVE

3.1 THE CONCEPT OF SOCIAL MARKETING OF CONTRACEPTIVES IN GHANA

The concept of social marketing of contraceptives has been pioneered by USAID since the early 1960s and deals with utilizing modern marketing techniques of advertising, promotions, market segmentation, pricing, distribution etc to market social goods.

In Ghana, various attempts were made to social market contraceptives from early 1970. It was however not until 1985 when the Ghana Social Marketing Program (GSMP) was launched did a serious impact begin to have an effect.

The GSMP achieved a lot of success and by 1988 had contributed 3.1% of the total modern contraceptive prevalence of 6.2%.

According to the 1993 FPHP Consumer Baseline Survey, the social marketing of contraceptives contributed about 43% prevalence of 14.9%, additionally 44% of all methods are delivered through the social marketing channels, versus 43% by most channels making it the largest supplier of contraceptives in Ghana.

It is against this backdrop that the Ghana Social Marketing Foundation (GSMF) has been incorporated to give a much longer life to the population control issue through the provision of contraceptive and MCH services using the private sector.

3.2 ROLE OF THE GSMF IN CONTRACEPTIVE DELIVERY SERVICES

Since 1986, the GSMP now GSMF has been involved basically in the distribution of temporary contraceptives. These include:

- Condoms
- Pills
- Foaming tablets

There has been a growth pattern in the quantity of contraceptives because of the introduction of new distribution techniques. For example, the GSMF is now using commercial networks for distribution to make contraceptives easily accessible to the population.

THE GSMF COMMODITY SALES ACCORDING TO METHOD BY YEAR

YEAR	CONDOMS	FOAMING TABLETS	ORALS	TOTAL
1986	1,323,600	-	-	1,323,600
1987	2,519,100	544,200	284,900	3,348,200
1988	3,501,100	614,500	350,000	4,465,600
1989	3,214,300	724,700	431,300	4,370,300
1990	3,586,500	1,602,172	451,082	5,639,754
1991	3,748,300	1,911,332	453,839	6,113,471
1992	4,026,651	2,190,392	379,097*	6,596,140
% INCREASE	204	302	33	

* The decline of oral sales in 1992 was a result of;

1. Supply problem due to start-up of new USAID/contract for the procurement of contraceptives;
2. Difficulties with the local distributor.

The worldwide contract is now in place and distribution has been expanded to include three local distributors.

SOURCE: GSMF Quality Returns, 1986 - 1992 (culled from GHANAPA PROJECT Document, p.12)

3.3 INTENDED EXPANSION OF DISTRIBUTION WITHIN THE NEXT 5 YEARS

The GSMF intends expanding in the next few years into:

a. Supermarkets
b. Petrol filling stations
c. Hotels
d. Hair Dressing saloons

4.0 SOURCES OF FUNDING

Under GHANAPA, USAID is to give direct grant to the GSMF to carry out its activities as well as set up an endowment fund with a capital of $5 million to ensure the financial sustainability of the GSMF beyond the year 2000.

There are two main sources of funding which to the GSMF are inadequate. these are:

- Funds from the USAID
- Income from the sale of contraceptives

5.0 KEY OPERATIONAL PROBLEMS

5.1 STAFFING

The key problem facing GSMF is the absence of the full complement of staff envisaged.

5.2 RELATIONSHIP WITH THE MINISTRY OF MOBILISATION AND THE INTERNAL REVENUE SERVICE

Even though the GSMF is supposed to be a non-profit organisation, it has problems with the Ministry of Mobilization and the Internal Revenue Service.

With the Ministry of Mobilization, the problem is that since the GSMF generates revenue, the Ministry's guidelines do not allow it to register the GSMF as an NGO.

With the IRS, the issue is that, because the GSMF says it might export some products, it should be liable to taxation. What the GSMF wants here is an exemption.

6.0 CONCLUSIONS

The GSMF since its inception some two years ago has demonstrated that it is institutionally capable of executing activities assigned to it under GHANAPA.

However, GSMF has been dependent to a large extent on FPHP support and putting in place the full complement of staff is the way forward for it to play its major role under GHANAPA.

7.0 RECOMMENDATIONS

- The engagement of the full complement of staff to fill the following positions will improve the operational performance of GSMF.
  - Marketing Manager
  - Business Manager
  - Director of clinical unit/Medical representative
- A meeting with representatives from the following organisations/agencies should be convened by NPC to resolve the problem of the NGO status and their payment of tax since it could affect the pricing structure of GSMF products and therefore its sales target:
  - Ministry of Mobilisation
  - The GSMF
  - The IRS
  - USAID
  - Ministry of Finance and Economic Planning

THE PLANNED PARENTHOOD ASSOCIATION OF GHANA

1.0 ORGANISATION

1.1 LEGAL STATUS

The Planned Parenthood Association of Ghana is a registered Non-Governmental Organisation [NGO] under the Company's Code of Ghana. It is a member of the International Planned Parenthood Federation.

1.2 GOALS AND OBJECTIVES

- To assist national efforts aimed at improving the socio-economic life of the population.
- To disseminate information on family planning and services.
- To promote the physical and mental health of families, especially children through better spacing of births.
- To promote better health and nutrition of families especially children.
- To initiate and promote education and other programmes aimed at responsible family life for adults and the youth.

1.3 ORGANISATIONAL STRUCTURE

The PPAG has a National Council consisting of 16 members at the top.

There is also an Executive Director, supported by 3 Directors one for finance, another for administration, and the last for other programmes.

There are six Regional/Programme Officers.

The middle level officers follow the managers and the junior staff are below.

In the districts are the Community - Based Distributors (CBDs).

2.0 MANAGEMENT/STAFFING

The head office in Accra is manned by the following:

1 Executive Director

1 Consultant

3 Directors

6 Managers

5 Officer (class 2)

3 Officer (class 2)

7 Junior staff

2 Junior staff

In the districts, PPAG officers are (CBDs) volunteers who are not full time employees.

The PPAG has 38 clinics as at the end of February 1994.

It has 30 supervisors with each supervisor in charge of 10 Community Based Distributors (CBDS). There are 397 CBDS as at the end of December 1993 who service 1696 communities.

All the supervisors have been trained. Each region has one more training outstanding for the CBDS.

The PPAG is endowed with very qualified and experienced management personnel.

3.0 DISTRIBUTION OF CONTRACEPTIVES AND TYPES

Since 1967, the PPAG has been involved in the distribution of contraceptives in Ghana.

The contraceptive products distributed include:

- The Pill - Microgynom, Engynom
- Injectables - Depoprovera
- Spermicides - Sampoon, Emco
- Condoms
- Intra Uterine Contraceptive Devices [IUCDS]
- Sterilization.

The range of contraceptive services offered by PPAG and community based clinics have expanded over the years.

PPAG intends moving into regions where they are not currently operating that is the Volta Region in 1994, and the Upper East and Upper West Region subsequently.

PPAG also plans to expand its services by training Community Based Distributor (CBDs), to cover towns and villages which are not presently covered.

4.0 ROLE OF PPAG UNDER THE GHANAPA PROGRAM

a. Promoting and distributing contraceptive products and also targeting opinion leaders, traditional leaders through IE&C, so that through them a larger population could be reached in terms of the dissemination of information on contraceptive use.

b. Playing an advocacy role in women empowerment and life skills education.

5.0 SOURCES OF FUNDING

- 90% of PPAG's funding comes from the IPPF.
- The Government of Ghana also gives financial support under the 2nd Ghana Health and Population Project.
- Funding also comes through the Japan Organisation for International Co-operation for family planning.

6.0 KEY OPERATIONAL PROBLEMS OF THE PPAG

- Poor management information system
- Inadequate funds to operate optimally
- Poor conditions of service
- Unreliable transportation in rural areas and the effects on the operations of the CBDS
- Inadequate trained CBDs - one CBD serving 10-15 communities.
- Irregular supply of contraceptive products
- Poor inter-agency cooperation and collaboration in accessing new markets for family planning services.

7.0 CONCLUSIONS

PPAG inspite of the problems identified is a major institution with a good track record in past programs making it a capable agency under GHANAPA.

The resolution of the problems identified will make the PAAG perform even better under GHANAPA.

8.0 RECOMMENDATIONS

- **COMMUNITY BASED DISTRIBUTORS**

  - The engaging and training of more volunteer CBDS should be pursued in collaboration with other agencies like GSMF MCH/FP, GRMA to minimise duplication of efforts at the community level

  - Efforts should be made to recruit professionals as CBDS, so they could bring their expertise to bear on the work of the PPAG.

  - Providing bicycles and motor bikes to be paid for with earned commissions will help to ease the transportation problem of CBDS to the assigned communities and improve their operational efficiency

- **SUPPLY OF CONTRACEPTIVE PRODUCTS**

  The supply of contraceptive products should be planned and scheduled on a regular basis.

- **MANAGEMENT INFORMATION SYSTEM**

  Ensuring the prompt and regular returns of reports from the Regions for central processing of data at the head office will go a long way to improve the management information system.

- **EQUIPMENT**

  Future investment in Audio-visual equipment should be considered alongside the activities of other Agencies like Health Education Unit to minimise duplication of effort and resources.

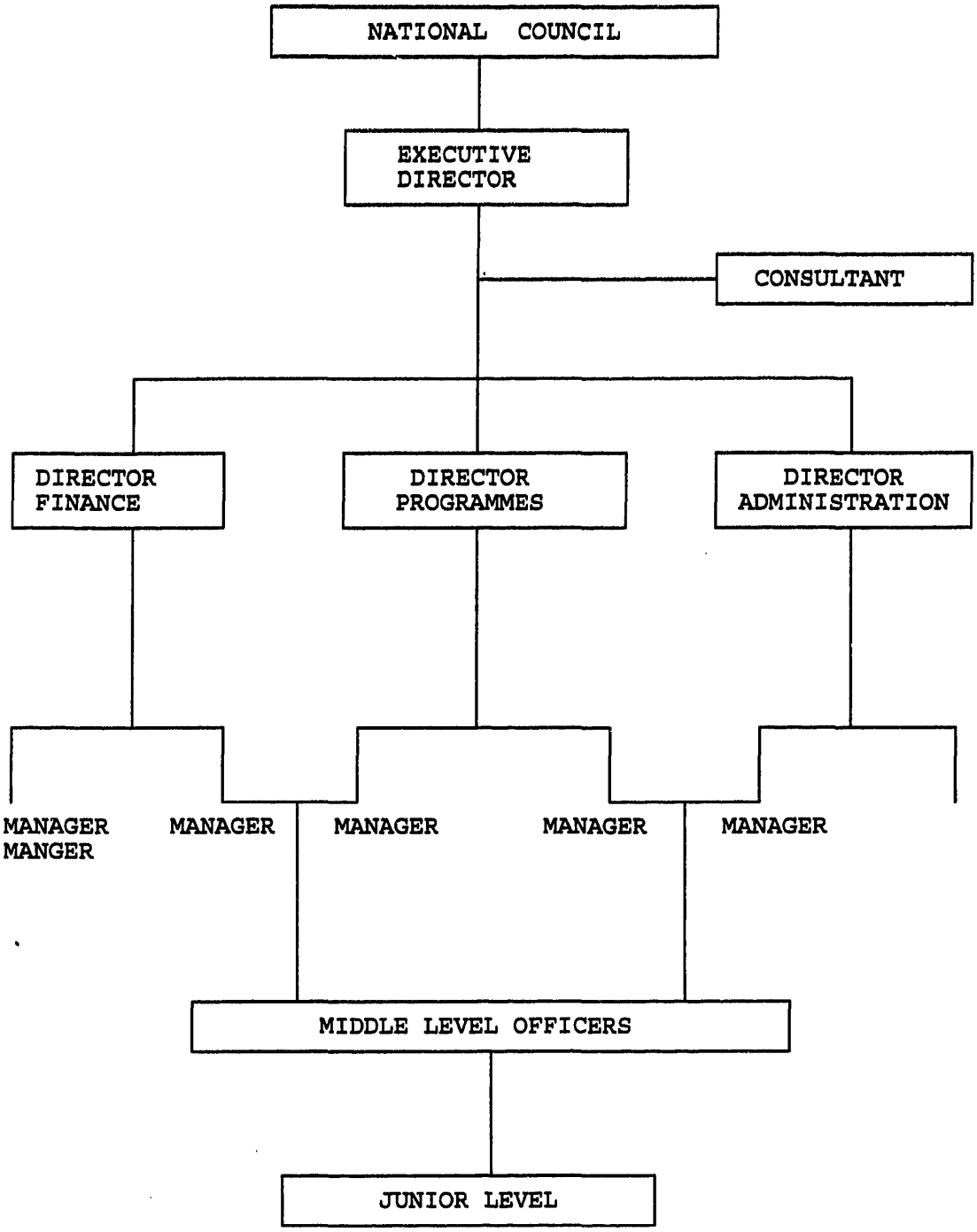
- **FUNDING**

  The PPAG plans to diversify its sources of funding to include the GTZ, ODA, CIDA and USAID to help it meet the cost of its expanded operations.

- **REGIONAL OFFICES**

Investment in vehicles particularly for the Regions for supervisory and re-supply functions should again be considered along side the activities of other GHANAPA Implementing agencies to maximise the utilization of resources.

PPAG - ORGANOGRAM



THE GHANA REGISTERED MIDWIVES ASSOCIATION (GRMA)

310

1.0 ORGANISATION

1.1 LEGAL STATUS

The GRMA is a Non-Governmental Association made up of qualified registered nurse midwives who serve as both private and public practitioners and provide pre-natal and family planning services through public and private hospitals and clinics throughout Ghana.

1.2. AIMS AND OBJECTIVES

To organise all registered midwives in Ghana into a corporate body with the aim of:

- Raising the standard of the practice of midwifery in Ghana to the highest possible level
- Cultivating friendliness, mutual respect, goodwill, unity and understanding among midwives in particular and between midwives and the community in general
- Cooperating with medical practitioners and institutions in educating the general public on matters relating to improving the standard of care for women, children and the family
- Advancing the provision of maternal care and developing the role of the midwife as a professional practitioner in her own right
- Encouraging, educating and motivating women and the family to seek qualified medical aid
- Scheduling visits and meetings for members to encourage the exchange of professional ideas
- Publishing journals, monographs, pamphlets, reports of conferences, seminar discussions, visits and other papers relevant to the aims of the Association
- Maintaining at Headquarters, a centre for the dissemination of exchange of information on midwifery matters

1.3 ORGANISATIONAL STRUCTURE

The Association conduct its affairs from the Headoffice located in Accra through the Association's executive officers of the Regions.

The Association operates in the 10 Regions and at the time data was collected, 8 Regions had presented their list of active members to the national headquarters. The members practice in both the public and private sectors. The breakdown of membership by Regions is as follows:

REGION	TOTAL MEMBERSHIP	IN PRIVATE PRACTICE
Brong-Ahafo	58	45
Ashanti	52	46
Northern	38	7
Upper East	25	3
Greater Accra	123	92
Volta	27	17
Eastern	59	49
Central	52	28
	---	---
TOTAL	**434**	**280**

The head-office estimates that inclusive of the Western and Upper West Regions which had not presented their list of members, the total strength of the current members will be between 450 - 500.

2.0 MANAGEMENT/STAFFING

The headoffice has 12 staff headed by a Director.

POSITION	NUMBER
Director	1
Administrative Officer	1
Data Processing Officer	1
Public Relations Officers	2
Secretary	1
Typist	1
Trainers	2
Drivers	2
Auxiliary	1

The GRMA finds its present headquarters staff as adequate in relation to its role in the implementation of GHANAPA

The Association has no high staff turnover and is adequately well-equipped in terms of office space and equipment.

3.0 DISTRIBUTION OF CONTRACEPTIVES

Since 1988, the GRMA has been distributing oral contraceptives, injectables, IUCDS, and condoms.

The GHANAPA Project Identification Document (PID) states that while the GRMA accounts for only a small percentage of overall NGO provision of family planning services, it has provided approximately 40,000 new family planning acceptors (GHANA/PID p. 13). There is the need to further build on this initiative.

4.0 ROLE OF THE GRMA UNDER GHANAPA

- Give continuing education under the GHANAPA Program to midwives in family planning services , so that they can give qualitative care to families.
- Increase the contraceptive prevalence rate in the country through intensive counselling on family planning and AIDS/STDS
- Training in IUCD insertion and outreach programs

5.0 SOURCES OF FUNDING/RESOURCES

The major sources of funding for the GRMA have been:

- THE USAID
- The Carnegie Corporation of New York
- The American College of Nurses and Midwives
- The University of Columbia
- Membership dues and fund-raising activities.

6.0 KEY OPERATIONAL PROBLEMS

- **SOURCING OF PRODUCTS**

The sourcing of contraceptive products from GSMF is considered a problem because members find the retail prices not competitive for their consumers who are also served by the public sector with comparatively lower prices.

- **POST TRAINING PRACTICE**

Some members trained in providing family planning services are usually not actively promoting the sales of contraceptive products among the target consumers.

This accounts for the low level of contraceptive product sales by the Association.

The level of outreach services undertaken by trained members is also considered unsatisfactory.

7.0 CONCLUSION

The GRMA has successfully participated in past programs and as presently set up is institutionally capable of participating directly under GHANAPA.

However, the resolution of the problems identified will make the Association even more capable.

8.0 RECOMMENDATIONS

- **TRAINING**

The PID on page 13 states among other things that GHANAPA will continue to provide training to the GRMA on long-term methods as well as supply short term methods through the GSMF. The continuous training of more members will help to minimise the negative effect of the drop out trainees on the Association's contribution to the successful implementation of GHANAPA.

- **SOURCING OF PRODUCTS**

It will be necessary to structure the prices of contraceptive products supplied to the public and private sector to make them competitive.

- **VEHICLES**

The provision of 1 cross-country vehicle will help the Association's executives to improve field visits to their members to motive and sustain their interest in the program.

- **OFFICE EQUIPMENT**

1 lap top and 1 Desk top computer will assist the Head Office to improve dissemination of information to its members.

THE SOCIETY OF PRIVATE MEDICAL AND DENTAL PRACTITIONERS OF GHANA

1.0 ORGANISATION

1.1 LEGAL STATUS

The Society of Private Medical and Dental Practitioners is a Non-Governmental Organisation which is a sub-group of the Ghana Medical Association. It is made up of doctors and dentists operating their own private clinics.

1.2 AIMS AND OBJECTIVES

- Provides continuing medical education for its members
- Encourages good and ethical clinical practices
- Provides health services in all forms to the Ghanaian population

1.3 ORGANISATIONAL STRUCTURE

As presently constituted, the Society is a very loose organisation. It has a National Executive Council, a National Executive and Regional Executives.

There are 2 part time honorary secretaries.

2.0 DISTRIBUTION OF CONTRACEPTIVES

Over the past four years, the Society has been involved in the distribution of the following contraceptives products through their clinics:

a. The Pill
b. Condoms
C. IUCDs

According to the Society, there has been an increasing demand over the years for the contraceptive Services its members provide.

3.0 ROLE OF THE SOCIETY UNDER THE GHANAPA

The members of the Society expect to continue to provide Family planning services particularly the long term methods like IUCDS/Injectables/Sterilization under the program.

4.0 SOURCES OF FUNDING

The Society is self-funding through the payment of annual dues by its members.

Currently, membership is about 300, with 50% based in Accra, 30% in Kumasi and the rest in the other regions.

5.0 KEY OPERATIONAL PROBLEMS

The major problem identified is the absence of a focal point to direct the activities of the Society.

The Society has no permanent office, secretarial or administrative staff.

6.0 CONCLUSIONS

The society as presently constituted is not considered ready and capable of directly participating as an institution under GHANAPA.

Inspite of the loose nature of the Society its members have increasingly been participating in the distribution of contraceptive products and benefited from the supply of clinical equipment and training sponsored by USAID.

Their numbers will obviously have an impact on the service delivery points under GHANAPA.

7.0 RECOMMENDATIONS

The nature of the Society does not lend itself to channelling distribution through the Association without burdening the Executive members. There is, therefore the need for GSMF or its distributors to employ detailmen to supply individual members of the Society.

Training programs and equipment support would, however, be better channelled through the Society.

THE CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)

1.0 ORGANISATION

1.1 LEGAL STATUS

The Christian Health Association of Ghana (CHAG) was founded in September 1967 as an NGO to serve as the coordinating body for church - related health institutions.

1.2 AIMS AND OBJECTIVES

To assist government to provide good quality and affordable health care to Ghanaians especially, the most needy.

1.3 ORGANISATIONAL STRUCTURE

The CHAG has a Council, a Board, 3 sub-committees appointed to serve under the Board, namely, DRUG, Primary Health Care (PHC) and Finance.

An Executive Secretary who reports directly to the Board is in charge of day-to-day administration of the Secretariat.

2.0 MANAGEMENT/STAFFING

In CHAG, 14.4% of total nursing staff are professionals as against 40% set by the MOH according to the staffing norms. On the average, each CHAG hospital engages the services of 11 professional nurses; 53 non-professional nurses; 1 medical assistant and 3 medical doctors.

Only 19.4% of the total staff of CHAG (6549) are professionals or have basic professional training. Most of the institutions are therefore poorly staffed particularly the pharmacy and laboratory Units. The average number of staff of each CHAG hospital is 136 with an average number of beds being 155.

3.0 ROLE OF CHAG UNDER GHANAPA

The CHAG indicated its preparedness to participate in the AIDS/STD component of GHANAPA.

A concept paper on their involvement has already been prepared for approval by the Board of CHAG and a copy will be made available to USAID.

4.0 SOURCES OF FUNDING

The Association depends largely on membership fees for running the Secretariat.

Other sources of funding are through WHO for specific projects.

5.0 KEY OPERATIONAL PROBLEMS

- Lack of inputs necessary for installing a management information system
- Inadequate office equipment
- Inadequate professional staff

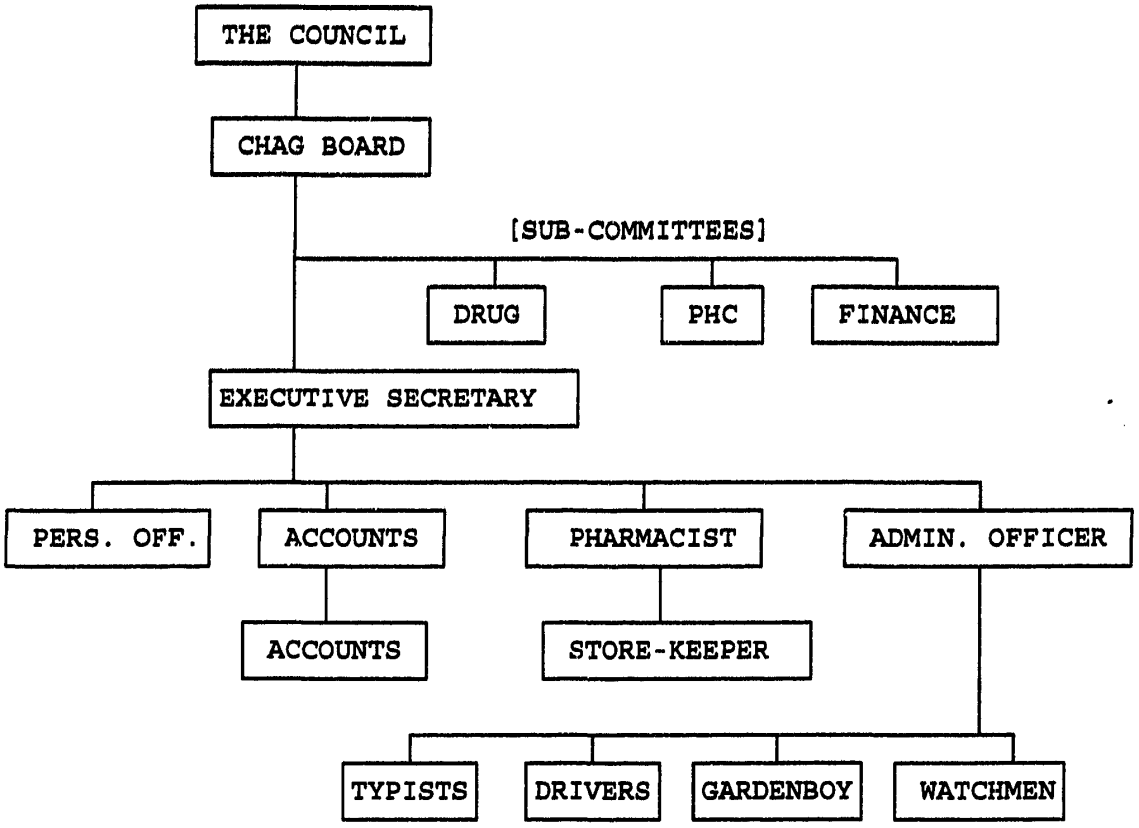
6.0 CONCLUSION

Inspite of the constraints listed, CHAG has the institutional capacity and with its unique accessibility to the rural communities its services under GHANAPA will be invaluable in HIV/AIDS component of GHANAPA.

7.0 RECOMMENDATIONS

- The need for training personnel, equiping and installing a management information system within CHAG should be given serious consideration.
- Training of the professional staff to upgrade their skill should also be considered
- Equiping the office with 1 photocopier and 1 duplicating machine will help improve communication within the 107 units
- There is a need for the headoffice to have a Reference Library for use by the professional staff

CHAG


THE COUNCIL
CHAG BOARD
[SUB-COMMITTEES]
DRUG
PHC
FINANCE
EXECUTIVE SECRETARY
PERS. OFF.
ACCOUNTS
PHARMACIST
ADMIN. OFFICER
ACCOUNTS
STORE-KEEPER
TYPISTS
DRIVERS
GARDENBOY
WATCHMEN

ANNEX H

USAID/GHANA

FINANCIAL AND ECONOMIC ANALYSIS

FOR THE

GHANA POPULATION AND AIDS PROGRAM

320

MAY 1994

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1.0 EXECUTIVE SUMMARY

The current USAID/GHANA [GHANAPA] project under consideration which follows, almost immediately FPHP project aims specifically to increase further the contraceptive prevalence rates in general, and in particular the use of longer lasting family planning methods. In addition, the project will try to reduce the increase of HIV prevalence to an acceptable percentage points over on the 1994 level.

To accomplish these objectives, USAID has designed the $45 million project. In an era of limited resources, it is necessary to carry out financial and economic analysis to determine whether or not the stream of projected expenses can be covered by the project funding participants that have been identified in the implementation document.

The outcome of such analysis would afford the participants the opportunity of making final changes to implementation plans before they are finally executed in order to achieve maximum results.

In view of the availability of most of the data on expenditures and projected number of possible new users of family planning methods, it was not necessary to utilize the step-down methodology in its entirety. The relevant assumptions were therefore made at the appropriate stages to help with the analysis.

Over the past few years, the Ministry of Health (MOH) budget as a proportion of the National Budget has been decreasing. However, with the accelerated growth strategy which is being pursued by the government with assistance of the World Bank, the (real) GDP growth rate is expected to be between 8% and 10% and this projected growth (if achieved) would generate enough revenue to the government so that the required contributions to the implementation of GHANAPA projects would be made.

With the enhanced budgetary resources expected in subsequent years during the accelerated growth strategy period, it is also expected that more resources would also be allocated to the PHC centres in the economy. Without a corresponding increase in resources to the PHC strategy, most of the people in the rural areas may not have access to the new family planning services.

Constraints to resource management and use exist in the Ministry of Health and attention must be directed towards their systematic removal. The budgeted funding must be available on time and modalities for utilizing such funds should be made flexible enough and under the control of the immediate implementating officer - ie not all funds should be controlled from the centre. In other words, decentralisation must be felt to be implemented at all levels of the MOH set-up, especially regarding the implementation of the GHANAPA program.

To maintain the current level of donor support and if possible attract more support, it is necessary that existing resources must be seen to be utilized efficiently and correspondingly

higher levels of cost-recovery ratios established.

With the existing commitment on the part of the government towards the PHC concept and the directives on expenditure controls in the public sector issued by the Ministry of Finance and Economic Planning, it is expected that waste would be substantially reduced (if not completely eliminated) in the sector so that available resources would yield maximum returns.

The economic analysis has shown that, even though the main structure of the economy has not changed much, most of the bottlenecks that were identified in 1983 have been removed with the introduction of the ERP/SAP. As a result of the implementation of the Economic Recovery Program (ERP), the economy has been able to maintain an average growth rate of about 6% pa over the period (1983-1988); government's fiscal position improved from deficits to moderate surpluses; the broad money supply decreased thus helping to reduce inflation from very high double digit numbers to moderate or near single-digit numbers. Even though cocoa exports increased, revenue derived from this increase in production decreased. Since cocoa is one of the major export products on which the nation derives most of its foreign exchange, this reduction in proceeds implied a reduction in our ability to import the required capital items for further economic growth.

Growth in population, which has been estimated to be around 3.2% pa has had an adverse effect on the impact of the increased resources into the social sector - especially in health and education.

The cost benefit analysis of the program has clearly shown that the project has an internal rate of return of nearly 21%. This is a reasonably very high internal rate of return for a project whose benefits were not completely identified and quantified. There will be more savings on education as a result of births averted through the program than on health, even though savings on health are realized much earlier (about 6 years earlier). The project, therefore, would be, very beneficial to Ghana if it is implemented according to the existing plans and all participating agents perform their part of the agreement as expected.

2.0 BACKGROUND

USAID/GHANA is planning to design the new $45 million Ghana Population and AIDS Program (GHANAPA) which has as its major purpose: to increase the use of modern and effective family planning methods and to reduce the rate of increase of HIV prevalence. Successful accomplishment of this purpose will be measured by:

1. increasing the Contraceptive Prevalence Rate (CPR) from approximately 15% to 25%;

2. increasing the percentage of CPR derived from longer lasting family planning methods from 20% to 40%;

3. limiting the increase of HIV prevalence to 8 percentage points over the 1994 level.

GHANAPA consists of Non-Project Assistance (NPA) and project assistance components. The NPA component totals $13 million in cash transfer assistance which will support GOG policy reforms to:

1. enhance the sustainability of family planning AIDS/HIV/ STD programs by increasing budgetary support, improving contra-captive price, forecasting and stocking procedures and changing customary practices that impede family planning service delivery;

2. improve services by increasing the availability of all contraceptive methods and selected drugs for treatment of STDs.

Project assistance includes a $20 million bilateral grant and $12 million in contraceptive commodities. This component finances technical assistance, training, commodities and the establishment of an endowment for the Ghana Social Marketing Foundation to:

1. support policy reform efforts;

2. increase demand for family planning;

3. expand provision of family planning services;

4. foster greater sustainability of family planning programs;

5. promote safe sexual behaviour;

6. encourage proper diagnosis and treatment of STDs;

7. improve the surveillance of AIDS/HIV/STDs.

Marketing and Social Research Institute Limited (MSRI) was commissioned to undertake the study following the acceptance by USAID/GHANA of proposal submitted by MSRI in response to a request by Mr. Floyd R. Spears, Executive officer, USAID/GHANA in a letter dated March 8, 1994 together with a Scope of Work for the project and received by MSRI on March 23, 1994.

The study was subsequently commissioned on April 26, 1994.

3.0 OBJECTIVES

3.1 FINANCIAL AND ECONOMIC ANALYSIS

The overall objective of this component of the study is to conduct an economic and financial analysis of the family planning and AIDS/STD components of GHANAPA in accordance with USAID guidance contained in Handbook 3, Appendix 3F.

The specific objectives are:

- To determine the financial viability of the proposed activity and whether the stream of projected expenses can actually be covered by the project participants identified in the implementation plan.
- To determine the least - cost solution to achieving the objectives of GHANAPA.
- To evaluate alternative means of achieving the desired result, and establish that the recommended design is the least cost option;
- To assess the method of implementation and financing taking account of local and foreign currency costs.
- To evaluate the sustainability of the project based on the GSMF trust fund to be created.

4.0 RESEARCH METHODOLOGY

4.1 FINANCIAL AND ECONOMIC ANALYSIS

The financial and economic analysis will be guided by the following cost measurement methodology:

There are a number of issues that must be considered if cost analysis activities are to be successful. Among the most important of these is the way in which costs are measured. If there is exclusive reliance on total cash outlays on programme outputs, an obvious error would be made. To avoid this common pitfall, we shall not use measures of expenditures but rather the cost of inputs in order to allow for efficiency in the use of resources. Expenditures incurred directly for the achievement of the desired outcome would be considered. Apart from being the wrong level of cost, the expenditure approach does not allow the ability to project the costs of a different set of services.

It would be ideal, therefore, to derive estimates from institutions and government records, and reconstructing costs using a STEP-DOWN METHODOLOGY. This methodology is based on scrutiny of the production process, which then enables attribution of all hospital expenditure, for example, to specific departments ("cost centres") and the distribution of all costs (including overhead and the costs of intermediate outputs) to final service categories using allocational criteria, such as time.

The main advantage of the STEP-DOWN METHODOLOGY is that it more closely approximate economic costs of resources than can accounting costs provide. We shall utilize the true costs of a resource (economic cost or opportunity cost) in order to determine the true minimum cost of the program. We are aware that often, private cost is a good measure of a resource. However, at times, market prices may not reflect the opportunity cost of a resource, for a variety of reasons - the main one being the existence of taxes.

Some program inputs have a heavy foreign exchange requirement (eg. pharmaceutical and equipment), which have in the past been incorrectly valued at official exchange rates. With the introduction of the bureaux, their rates should now reflect the true cost of foreign exchange. Similarly, the cost of labour may be incorrectly valued by "market" wage rates. We shall utilize the technique of SHADOW PRICING to determine the real economic price of goods or services where no market price exists or where it is distorted.

Ideally, costs to the consumer should be included in the estimation process (eg. the cost of travel time and waiting time which represent wages forgone, or an alternative measure of the value of time in non-wage activities.

Because the program is built on the foundations laid by the Ghana Contraceptive Supplies Project, MARGINAL COST ANALYSIS will be the relevant measure of the cost to use when making resource allocation decisions. Marginal cost is the additional cost of providing one more unit of desired output. This requires the availability of base-line data as well as regular periodic data on modern contraceptive rate and total contraceptive prevalence. Thus, with the selection of the target group, the appropriate intervention would be determined and costs measured using the STEP-DOWN METHODOLOGY and bearing in mind the MARGINAL ANALYSIS.

The benefits of the program would be the increase in modern contraceptive rate and total contraceptive prevalence as well as the increased use of ORS. There will also be a reduction in the number of people infected with AIDS as a result of the program (on the margin).

4.2 ECONOMIC ANALYSIS

An economic analysis of any family planning program accepts the correlations between family planning interventions and effects such as the increase in total contraceptive prevalence. The economic model will, therefore, specify a relationship between the resources used (inputs) and the possible results (outcomes). Inputs include training, vehicles, staff, and contraceptive commodities. Depending on the purpose of the costing exercise, non-program inputs such as women's time and financial resources will be important measures. Inputs are combined into interventions to produce outputs, which can be defined as intermediate service outputs, such as increased family planning service coverage, or as ultimate outcomes, such as increase in contraceptive prevalence.

The simplest and most often used approach consisting of a single equation which relates inputs to a single output shall be utilized. To determine whether project benefits exceed projected costs, the present values of benefits and costs shall be compared. Both micro (individual) and macro (project) aspects would be considered.

5.0 FINANCIAL ANALYSIS

5.1 PROJECT COSTS AND RECURRENT EXPENDITURE

To accomplish the main objectives stated in the background, USAID is providing $32 million for the program assistance component to support the GOG in promoting Family Planning and Aids control programs and another $13 million Non - Project Cash Transfer Assistance to support GOG policy reform. The project assistance component includes a $20 million bilateral grant and $12 million in contraceptive commodities.

- **NON - PROJECT ASSISTANCE**

To encourage policy reform and to help alleviate the increased burden by the public sector from expanding family planning services and AIDS control ($13 million).

- **PROJECT ASSISTANCE**

To improve private and public sector's capacity to provide family planning and AIDS prevention and control services through the provision of technical assistance, training, equipment and commodities for the family planning and AIDS program ($20 million) and OYB transfer for centrally-procured contraceptives ($12 million)

5.2 FINANCIAL SUSTAINABILITY

5.2.1 HEALTH EXPENDITURES AND NATIONAL BUDGET

Over the past few years (1989- 1992) the MOH as a proportion of the National Budget has been falling from 13.8% to only 7.8% in 1992 (Table 5.6) with the government's commitment to increase coverage and quality of primary health care services through the intensification of maternal and child health services and family planning (1993 Memo) it is expected that this falling trend would be reversed and a greater proportion of national budget devoted to the health sector. Nominal GDP grew about 17% between 1991 and 1992 and was projected to grow by about 31% between 1992 and 1993 (Table 5.7) but because of the high rate of inflation, real GDP (in 1975 prices) grew by only 3.9% between 1991 and 1992.

With the accelerated growth strategy adopted by Ghana, the GDP (real) growth rate is expected to be between 8% and 10% and this would generate enough revenue to the government to be able to provide even more resources to the health sector.

5.2.2 PRIMARY HEALTH CARE EXPENDITURE

Using the formula that has already been devised and agreed upon, which stipulates the proportion or each budget sub-head which can be regarded as expenditure on Primary Health Care, (Table 6.7) shows the trend from 1986-1993. From the table, PHC has been allocated, in the past, an average of 24.3% of the National Health Budget between 1986-1993. However, between 1992 and 1993, the amount devoted to PHC from the total health budget increased by over 80% and this increased the proportion spent on PHC from 24.07% in 1992 to 27.32% in 1993.

To satisfy the move towards allocating more resources to the PHC centres, it is expected that the objective of the Ghanapa project would be achieved due to the enhanced budgetary resources. For MCH/FP Services alone, there was an increase in allocation of 150% between 1992 and 1993.

For accurate measurement and monitoring of the allocations deemed to be spent on PHC activities (using the formula), there is the urgent need to have a separate budget line for PHC activities.

5.2.3 BUDGETARY CONTROL AND DECENTRALISATION

In spite of the avowed decentralisation process in Ghana a greater proportion of budgetary resources are still controlled at the National Level.

Considering the non-personnel portion of the recurrent expenditures (ie. excluding personal emoluments and subventions), a study by SCF (1993) has shown that the 1992 approved estimate for the MOH indicated that 66% of budgetary resources remained under the control of the Central Administration (most of this being held ostensibly for the bulk procurement of drugs and medical supplies). It was also found that 8% was allocated to the two leading hospitals and 25% was apportioned to the 10 regional health directorates.

At the regional level, the Director of Health Services (who is the designated "vote controller") further allocates the non-personnel items (items 2-5) of the regional budget among the various spending officers in the region. This allocation and the one at the district level are also heavily weighted in favour of the hospitals in the area. Allocations, therefore, to the "supposed - decentralised" PHC units in the districts and sub-districts become very negligible.

This pattern of control over resources contrasts sharply with the clearly articulated policy commitment to PHC and to decentralisation within the health system.

The practice whereby the centre procures drugs and medical supplies on behalf of the regions as well as that of the regions also spending on behalf of the districts without their express authorization should be reviewed. This practice leads to the purchase of unwanted items and also the wrong quantities.

The idea of composite budgeting should be pursued vigorously so that in addition to dividing the budget into technical areas (dental, environmental, epidemiology, laboratories, MCH, Medical Care, etc.), we should also have the budget divided into sections showing the magnitude of the funds going into programmes which correspond with service outlets (eg. regional hospitals, district hospitals, level C, level B, level A, etc).

It is expected that with a new organisational structure of the MOH, the budget would be prepared to reflect both the re-structuring and the decentralization process.

5.2.4 CONSTRAINTS TO RESOURCE MANAGEMENT AND USE

Resource managers in the health sector face several constraints. These constraints include the limited budgeted funds, the delays in receiving approval to utilize funds and the lack of flexibility in utilizing the available funds. Funds which are available on time are more useful than those which are delayed. Similarly, funds which are flexible are more useful than those which are earmarked and that local control of funds is more efficient than those which are controlled from the centre.

The Ghanapa project would be more successful if funds budgeted for in the budgets of 1994-1999 as the counterpart funds for the project would be available for use on time and would also be flexible and under the control of those in charge of the project at the district level. Regional and central supervision and monitoring would, of course, be necessary and that should not lead to unnecessary interference in the execution of the project.

During the period (1994-1999) therefore, managers at the lower levels should be given the power to plan their activities and thereby to direct patterns of resource use in their activities and thereby to direct patterns of resource use in their areas of operation. In the budget-preparation stages, they should be made to feel that their inputs to the national budgets are greatly valued and not a waste of time. If budget hearings are held on Regional/District basis, those managers would also have the opportunity to defend their budgets and MFEP may be sympathetic to the course at the level.

In addition to lower allocations, local managers also face the problem of delays in obtaining the approved estimates for the financial year. "Preliminary approval of the budget does not normally occur until after the start of the financial year". Even once the budget proposal has received preliminary approval, it may be subsequently revised (usually downwards). What is even worse is that this "revised" approved estimate which forms the basis of the financial encumbrances (FES), cannot be spent in full because of the imposition of drawing limits" (p.30 SCF, 1993).

A study by SCF (1993) states that in one district (East Akim District in the Eastern Region), the FEs for each quarter were received 6 weeks into the quarter. This delay alone would have serious implications for any project in the district.

Even though the operation of FEs and Drawing Limits (DLs) are an important feature of the budget implementation process, in that they help in the expenditure monitoring and control in the machinery of government administration, they must be issued on time. For the drawing limits, their use must be reviewed because they distort the planning decision variables. With the new plan to control expenditures by MFEP with the help of the MDAS, the use of the drawing limits may be less attractive.

Ghana has a relatively high health expenditure/GDP ratio of about 2% compared with the 1% GDP ratio commonly experienced in the developing countries. In spite of this impressive record, the amount of funding for health is described as inadequate in relation to the health system's requirements.

MOH is expected to continue with the cost-recovery plan for AID- donated contraceptive with the target of achieving 50% recovery of the value of the contraceptives by the year 2,000. Even though current cost-recovery rate (5.5%) is not impressive, it is expected that there will be significant increase in the near future. To achieve full-financial sustainability of the contraceptive program, full-cost recovery will be achieved by the year 2,000 as prices of commodities are increased by 15% per annum until 2,000 and thereafter by 5%.

5.2.5 RETURN TO PROJECT FUND

To maintain a high level of contraceptive prevalence and thus ensure financial sustainability of the Ghana Population And Aids Program, a substantial proportion of the cost of the value of contraceptive would have to be recovered through sales. To avoid major disruptions to the whole program, price increases for contraceptives would be introduced gradually overtime so that by the year 2000, all subsidies on contraceptives would have been removed.

It is expected that these increases in prices of contraceptives would provide the required incentives to the private sector in order to substantially take over the importation, distribution and sale of contraceptives at market-oriented prices.

To keep track of the cost-recovery funds generated from the sale of contraceptives in the public sector, the MOH established the RETURN TO PROJECT FUND IN 1983. The operation of the fund was such that 80% of the revenues derived from the sale of contraceptive products were deposited into a specified account with the Controller and Accountant-General. The remaining 20 percent was kept at the collection points -ie. the district or Region concerned. Between 1983 and 1992, or by March 1993, the fund had accumulated over ¢37 million.

Since the initial deposits, there has not been any withdrawal from the account to purchase contraceptives to replenish the stock under any of the programs for which the account was set up. The Controller And Accountant-General should be informed of the existence and rationale of such a fund and, with him, the necessary modalities worked and agreed upon so that delays are not created in the utilization of the funds. It must be emphasised that without the constant replenishment of the stock of contraceptives through the utilization of the proceeds from the fund, the program's objectives may be difficult to achieve.

It is expected that whatever operational arrangements are arrived at under the FPHP for utilizing the funds in the RETURN TO PROJECT ACCOUNT, the same would be applied under the current GHANA POPULATION AND AIDS PROGRAM.

5.2.6 DONOR SUPPORT AND ACTIVITIES

Several bilateral and multi-ilateral donors as well as some external NGOs provide assistance to the MOH in various forms.

There is a close coordination among donors and as a result almost all projects in the sector, have been planned to compliment other activities by MOH and hence wasteful duplications are avoided.

According to the UNDP figures, major donors for health in 1991 were USAID ($5.3m, 35%) World Bank/IDA ($4.0m, 26%), UK/ODA ($1.8m, 12%) and UNICEF ($1.3m , 9%), USAID and IDA are expected to continue to donate external assistance for health with commitments amounting to $5-6m per annum during the period 1991 - 1995. Other potential major players in the area of health are the African Development Fund, Saudi Fund for Development, UNFPA and UNICEF. (SCF, MARCH, 1993 PAGE 35).

For the 1991 - 1996 period external assistance is estimated at $162.8m out of which 23%, 21% and 16% would be contributed by ADB, USAID and World Bank respectively. It must be noted that of this total, 28% would be devoted to Family Planning activities in the country.

TABLE 5.1: EXTERNAL ASSISTANCE 1991 - 1996 IN HEALTH/FP

DONOR	TOTAL FOR HEALTH ($M)	%	($MILLION) AMOUNT FOR FAMILY PLANNING	%
WORLD BANK	27.0	16	4.7	10
UNFPA	4.6	3	4.6	10
UNICEF	10.0	6	.0	0
ODA	1.6	1	1.6	3
USAID	35.0	21	34.8	77
WHO	2.7	2	.0	0
SCF	0.5	0	.0	0
DANIDA	22.0	14	.0	0
GTZ	1.7	1	.0	0
EEC	10.7	7	.0	0
ADB	38.0	23	.0	0
SAUDI FUND	9.0	6	.0	0
TOTAL	162.8	100	45.7	100

SOURCE: POPULATION SECTOR STRATEGY, USAID/GHANA, OCT 1993 PAGE 41

In 1994, donor support to MOH is estimated to exceed $54 million. In addition to donor support, MOH has budgeted the cedi equivalent of $55 million for recurrent expenditures and the cedi equivalent of $8 million for capital expenditure. This makes a total 1994 MOH budget of $115 million.

The major types of assistance provided by the major donors in health are shown in the table below:

TABLE 5.2 MAJOR TYPE OF ASSISTANCE PROVIDED BY DONORS.

DONOR	TYPE OF ASSISTANCE	AMOUNT - $ MILLION
ADB	EQUIPMENT AND CONSTRUCTION	15.5
EEC	REGIONAL AND DISTRICT BUDGETS - ESPECIALLY TRANSPORTATION, SANITATION AND MANAGEMENT SYSTEMS	11.0
WORLD BANK	PHC HOSPITAL REHABILITATION, MANAGEMENT AND LOGISTICS	6.8
ODA	HEALTH EQUIPMENT, MANAGEMENT AND TRAINING	5.6
DANIDA	TB PROGRAMME & PHC IN UPPER WEST REGION	
GTZ	PHC IN NORTHERN REGION (INCLUDING EP AND AIDS)	
SCF (UK)	PHC IN EASTERN REGION	
JICA	BIOMEDICAL RESEARCH ACTIVITIES, VEHICLES AND COLD CHAIN EQUIPMENT	5.4
	1994	
UNFPA	FP	1.4
WB	CONTRACEPTIVES TO PPAG	0.3
DANIDA	NEO SAMPOON TO MOH	0.154
TOTAL		**$54.0 MILLION**

SOURCE: PID, USAID/GHANA

ASSUMPTIONS: OPTION A

1. GDP growth rate of 5% pa between 1994-1996; 7% pa between 1997 - 2000

2. Total Government Expenditures grow at 36% pa (average between 1988 - 1992).

3. Health Expenditures grow by 44% pa (average between 1988 - 1992).

TABLE 5.3 IMPLICATIONS FROM ASSUMPTIONS IN OPTION A

YEAR	GDP	G. EXP	HEALTH EXP	% HEALTH	% GDP
1994	4,128,996	563,273	48,141	8.5	1.2
1995	4,335,447	766,051	69,923	9.13	1.6
1996	4,552,218	1,041,830	99,825	9.6	2.2
1997	4,870,873	1,416,888	143,748	10.2	3.0
1998	5,211,834	1,926,968	206,997	10.7	4.0
1999	5,576,663	2,620,676	298,076	11.4	5.3
2000	5,967,629	3,564,120	429,229	12.0	7.2

ASSUMPTIONS: OPTION B

1. GDP growth rate of 5% pa (between 1994 - 1996, 7% pa (between 1997 - 2000).

2. Government Expenditures to be 13% of GDP while Government Revenues will be 15% of GDP.

3. Health Expenditure to be 13% of total government expenditures.

TABLE 5.4: IMPLICATIONS FROM ASSUMPTIONS IN OPTION B

YEAR	GDP	G EXP	HEALTH EXP.	HEALTH GDP
1994	4,128,996	536,769	69,780	1.7
1995	4,335,447	653,60[illegible]	73,269	1.7
1996	4,552,218	591,788	76,932	1.7
1996	4,870,873	633,213	82,318	1.7
1998	5,211,834	677,538	88,080	1.7
1999	5,576,663	724,966	94,246	1.7
2000	5,967,629	775,791	100,853	1.7

THIS EXCLUDES FOREIGN ASSISTANCE OF ABOUT $27 MILLION PER ANNUM.

TABLE 5.5: IN REAL 1975 PRICES (¢ MILLION)

YEAR	GDP REAL 1975 PRICES	G. EXP	HEALTH EXP.	HEALTH GDP
1994	8,267	1,075	140	1.7
1995	8,680	1,128	147	1.7
1996	9,114	1,185	154	1.7
1997	9,570	1,248	162	
1998	10,048	1,306	170	
1999	10,550	1,372	178	
2000	11,078	1,440	187	

TABLE 5.6: TRENDS IN GOVERNMENT EXPENDITURE AND HEALTH AS PROPORTION OF TOTAL EXPENDITURES

YEAR	¢ MILLIONS TOTAL GOV'T EXPENDITURES	¢ MILLIONS TOTAL HEALTH EXPENDITURES	HEALTH AS % OF TOTAL EXPENDITURE
1972	534.5	31.3	5.9
1973	545.1	38.8	7.1
1974	738.5	66.6	9.0
1975	1,161.5	95.5	8.2
1976	1,438.6	118.0	8.2
1977	1,945.2	158.9	8.2
1978	3,017.8	257.1	8.5
1979	4,094.3	353.2	8.6
1980	4,671.5	325.2	7.0
1981	7,719.3	492.8	6.4
1982	9,778.1		
1983	14,755.3	821.5	5.6
1984	34,965.6	1,569.8	4.5
1985	54,450.0	3,658.5	6.7
1986	95,587.1	4,750.0	5.0
1987	100,915.0	5,449.9	5.4
1988	147,019.0	12,655.2	8.6
1989	207,070.0	28,667.4	13.8
1990	254,473.0	21,930.6	8.6
1991	340,262.0	36,420.2	10.7
1992	498,813.0	38,892.5	7.8
1993			14.0
1994			13.0
1995			9.6

SOURCE: THE SAVE THE CHILDREN FUND (UK) STUDY, MARCH 1993 AND OWN CALCULATIONS

5.2.7 CONCLUSION

From the above information on the level of GDP growth of between 8% and 10% projected for the years 1993-2,000, the growth rate in revenue of about 46% and accounting for about 15% of GDP and 2% points about the proportion of expenditure to GDP, an improvement in the cost - recovery efforts to about 15% of recurrent expenditures of MOH budget, and with relatively more resources being devoted to PHC, there will be enough resources accruing to the Government of Ghana to be able to maintain the implementation of a national population program beyond the completion of both the Family Health Population Program and the Ghana Population and Aids Program.

With committed policy towards the PHC concept, the budgetary allocation to the sector will continue to increase as long as the ERP/SAP produces the projected revenue levels in addition to the strict enforcement of expenditure controls.

The cost - recovery program for the sale of contraceptive will also improve the financial sustainability and feasibility and as the private sector takes on a greater share of the supply and sale of commodities at market prices, the magnitude of the implied subsidy on the commodities, would be greatly reduced. This will further enhance the revenue mobilization efforts of the MOH.

TABLE 5.7: GDP TRENDS

YEAR	¢ MILLIONS CURRENT PRICES	¢ MILLIONS CONSTANT 1975 PRICES
1972	2,815.4	5,487.8
1973	3,501.2	5,646.1
1974	4,660.1	6,033.0
1975	5,283.0	5,283.0
1976	6,526.2	5,096.5
1977	11,163.4	5,212.4
1978	20,986.1	5,654.2
1979	28,230.6	5,212.1
1980	42,852.9	5,537.5
1981	72,626.1	5,344.0
1982	86,450.8	4,974.1
1983	184,038.4	4,733.3
1984	270,560.6	5,157.5
1985	343,048.4	5,420.1
1986	511,372.7	5,701.9
1987	745,999.8	5,975.3
1988	1,051,196.3	6,311.6
1989	1,417,214.4	6,632.6
1990	2,031,686.3	6,848.5
1991	2,574,774.1	7,216.6
1992	3,008,779.2	7,498.0
1993	3,932,377.0	

SOURCE: THE SAVE THE CHILDREN FUND (UK) STUDY, MARCH 1993 AND OWN CALCULATIONS

6.0 ECONOMIC SUMMARY AND ANALYSIS

6.1 ECONOMIC SUMMARY

6.1.1 INTRODUCTION

Ghana became the first independent and sovereign nation in Sub-Saharan Africa on 6th March, 1957. At that time, Ghana had, in her rich diverse, and natural resource endowment, and her relatively, well-trained man-power, a good potential for growth and development. This potential is yet to be realized to the full. Over the past three decades after independence, various domestic policies which were aimed at improving the managerial skills of the people, the uncompromising external environment and a rapidly growing population, have all contributed to the non-realization of the bright potential the nation had at independence.

Ghana once enjoyed a relatively high standard of living compared with most West African nations. However, circumstances partially beyond our control led to a downward economic spiral in almost all key economic indicators between 1970 and 1982. Per capita real income declined by 30%; domestic savings and investment declined from 12% and 14% of GDP respectively in 1970 to almost insignificant levels; and inflation ran at 44% per over the period.

6.1.2 STRUCTURE OF THE ECONOMY

The Ghanaian economy has, all along, been dualistic in the sense that two district sub-economies co-exist. These are the small-capital-intensive modern sector involved in mining and industrial activities and a large traditional, mainly agricultural sector. There are very weak linkages, however, between these two sub-economies although agricultural sector is potentially capable of producing the bulk of the raw materials for the domestic industry, and in turn industry can supply most of the inputs of the agricultural sector.

The consumption patterns, tastes, and living standards also depict the same dualistic nature on the economy. The educated (mostly) urban dwellers as those engaged in the modern sector, have a demand structure that relies heavily on imported goods and services whilst the traditional sector depends mainly on subsistence farming.

Industry, mining, commercial farming, transportation and construction, depend heavily on imports. With impart capacity being limited (seriously) by its dependence mainly on the revenue from cocoa and to some extent on gold and timber, the performance of the economy has, all the time been very sensitive to developments in the industrialized countries, particularly of the West.

What is even worse is that, agricultural activity is still mainly rain-fed and as a result, any unpredictable patterns of rainfall have adverse effects on food and export crop production.

The share of agriculture in GDP increased gradually from 43.5% in 1965 to 57.9% in 1980; industry's share, remained at 18.6% in 1965 and 1973 but declined to 11.9% in 1980; services sector's share declined from 37.9% in 1965 to 32.4% in 1973 and experienced a further decline to 30.2% in 1980. The manufacturing component of the industrial sector grew between 1965 to 1973 from a share of 9.8% in 1965 to 11.7% in 1973 but, subsequently declined to 7.8% in 1980. Thus, between 1973 and 1980 all major components of the GDP suffered declines in share of GDP except for the agricultural sector.

6.1.3 THE ECONOMIC RECOVERY PROGRAM (ERP)

The combination of the external and internal factors led to a major secular decline in the economy. On April 21, 1983, the Economic Recovery Program (ERP) was launched by the new government that came into power on 31st December, 1981.

The major objectives of the ERP were to shift relative prices in favour of production, particularly for exported and efficient import sub-situation; restore fiscal and monetary discipline, initiate the rehabilitation of the country's productive base and economic and social infrastructure; and encourage private investment.

The most important measure was the movement toward a more realistic exchange rate with a series of devaluations of the cedi from ¢2.75 - US $1.00 in 1993 to ¢90 = as $1.00 in 1986. To regulate external trade, the government established a second-tier foreign exchange auction market in 1986 to cover almost two-thirds of external transactions.

As a result of the changes in the exchange rate, administered prices were adjusted to reflect the new trend. For a wide range of products, prices and distribution were dismantled.

In the areas of fiscal policy, the following specific measures were taken: -

1. The government concentrated on eliminating subsidies

2. to mobilize resources, improved tax collection mechanism, and selective increases in consumption taxes and charges were put in place and

3. to offset partially the drastic erosion real incomes, Public Sector salaries and wages and statutory minimum wages were raised.

For the public expenditure policy area, the government made significant improvements. With respect to recurrent expenditures, the highest priorities were placed on the restoration of the viability and efficiency of public adminstration. The support to the health and education sectors was expanded and the allocations for operation and maintenance were increased. To cater for adequate provisions for the rehabilitation of key sectors, the government prepared a rolling three-year Public Investment Programme (PIP) at the beginning of 1986.

The ERP was followed by the Structural Adjustment Program (SAP) the first phase of which covered the period 1987 - 88. The main objectives of the Program were: -

1. To maintain an incentive framework that stimulates growth, encourages savings and investment, and strengthens the balance of payments;

2. To improve resource use, particularly in the public sector, while ensuring fiscal and monetary stability.

The program comprises policy and institutional reforms in the areas of trade and exchange rate management, the cocoa sector, public re-source management, state-owned enterprises reforms, public sector management, financial sector policies and private sector development.

Under the Trade and Exchange Rate Reforms,

1 the official and auction exchange rates were unified at ¢150 = US$1.00 in February 1987

2 access to the auction market was expanded and by February 1988, all goods had become eligible for the auction (except a few)

3 in February 1988, the government permitted Banks and authorised dealers to establish foreign exchange bureaux to buy and sell foreign exchange at freely determine prices.

4 the foreign exchange markets were unified on April 27, 1990 - under which the exchange rate was freely determine in the context of an extended auctions conducted by the Bank of Ghana. As a result, the spread between the auction and bureau rates declined from about 50% in Jan/Feb. 1989 to about 9% in April 1990.

The Cocoa Section Policies included: -

1 the raising of the producer price of cocoa to about 36% of the F.O.B price in 1987/88 to about 50% of the F.O.B price in 1989/90 crop year;

2 the trimming of the operational expenses of COCOBOD by retrenching about 17,000 workers between 1987 - 89;

3 the withdrawal from direct productive activities by ceasing operation on 52 of its 92 plantations.

Under the Resource Management Program, the government introduced several tax reforms aimed at promoting equity and efficiency.

1. personal income taxes were reduced and personal allowances were increased;

2 the corporate tax rate was reduced to 45% percent for manufacturing, construction, farming and export sectors;

3 indirect tax structure was restructured to increase sales taxes and import duties on cars;

4 management information systems were computerised in order to improve tax administration.

The State-owned Enterprise Reforms aimed at creating an appropriate policy framework, initiating a divestitive program and strengthening management. As a result, the government advertised for sale 32 State-owned enterprises in 1988.

Public sector management policy was aimed at improving the efficiency of the Civil Service through reductions in staffing as well as increase in salaries for top-level Civil Servants. Between 1978 and 1990, about 46,000 civil servants have been removed from the government's payroll.

A wide range of financial sector reforms have been introduced. Interest rate controls and sectoral credit ceilings were abolished in order to improve allocative efficiency of the banking system. The legal framework governing banking activities was revised with the promulgation of the new Banking Law in 1989.

Private Sector Development aimed at building an economic environment attractive to private investors. These included exchange rate policies, financial sector policies and a public expenditure program which focused principally on infrastructure rehabilitation and the delivery of public services.

6.1.4 THE ECONOMIC CONSEQUENCES OF THE REFORMS

As a result of the various policy measures that were implemented during the ERP/SAP period,

1. the economy maintained an average growth rate of about 6% pa;

2. the cocoa sector and the non-cocoa agricultural sector benefitted from good rainfall, improved infrastructure and greater availability of inputs;

3 the government's fiscal position improved markedly. Revenues as a share of GDP rose from 5% in 1983 to about 14.4% in 1989. Recurrent expenditure rose from 7% of GDP in 1983 to 11% of GDP in 1989; capital expenditures grew from negligible levels to 8.3% of GDP in 1989; the over-all budget deficit, which accounted for 3.1% of GDP in 1984, widened to 5.7% in 1989, but was financed by foreign grants and concessionary loans;

4. The broad money supply grew by 27% in 1989, down from 54% in 1987 and 43% in 1988;

5. Improved food supplies led to the decline of inflation in the first years of the ERP from 122% in 1983 to 10% in 1985. While inflation has moderated somewhat to 31.4% in 1988 and 25.2% in 1989 it has not been decreasing at the anticipated rate;

6. Despite an increase in cocoa production by about 90% from 1984 (160,000 tons) to 305,000 tons in 1989, export receipts from cocoa only grew by 26% from US $382m to US$392m between 1984 to 1989. Non-cocoa exports, on the other hand more than doubled over the same period on the strength of gold, timber and electricity.

6.1.5 PUBLIC FINANCE IN GHANA

The state of public finance in Ghana has improved considerably as a result of the favourable economic policies contained in the Economic Recovery Program (ERP) which was introduced in 1983.

Most subsidies on commodities have been removed, more resources have been mobilized through improved tax collection and selective in-crease in charges/fees have been introduced. Incentive system in the public sector has been improved through upward adjustments in wages and the establishment of minimum wages in order to effect (partially) any erosion in real income of the workers.

Public expenditure policy has improved with priority attention being paid to recurrent

expenditure with a view to restoring the viability and efficiency of public administration. Increases in allocation to the social sector, although not very significant, have led to improvement in the delivery of services in this sector.

The rapid growth in revenue, accompanied by a relatively low growth in expenditures have resulted in increasing levels of budget surpluses since 1986 (Table 6.8).

In spite of the rapid increase in total government expenditures (above 40% per annum since 1986), government expenditures have maintained a fixed percentage of GDP around 14.3% . This has been due to the fact that GDP itself has been increasing at a faster rate during the period (Table 6.1).

The revenue performance during the same period has been slightly higher than expenditures by about 4% on the average. As a result, budget surpluses have been the norm since 1986 from a mere ¢229 million (1986) to ¢3,387 million (1990). The surplus was ¢10.350 million in 1989.

The estimated budget surplus for 1991 is more than 50% of actual revenue for 1986. This indicates the optimistic view held by the government about the performance of the economy. It also demonstrates how effective and serious revenue has been since the time of the ERP and SAP. The actual budget balance has been minimal due mainly to the heavy repayments for the two years 1986-87 when they amounted to more than net borrowing. This trend has been reversed since 1988 with net borrowing exceeding repayments by 4.7% in 1988 and go as high as 73% in 1990. The corresponding figure for 1991 is 77%.

Table 6.1 shows six major trends in public finance over the period 1980-1990.

1. Actual revenue have been financing an ever increasing pro-portion of current expenditures. In 1980 actual revenues provided only 52% but in 1986 actual revenues accounted for 121% of current expenditures. In 1990, the ratio was more than 151%.

2. The proportion of actual revenue that financed the total (current and capital) expenditures increased very slowly from 41% in 1980 and reaching 100% in 1986 to only 105% in 1989 and subsequently decreased to just over 101% in 1990. However, this figure increased to more than 112% in 1991.

3. There has been a general increase in allocation to capital relative to current expenditure from 13.4% in 1986 to 19.9% in 1988. However, since 1989, the trend has been downwards from 18.7 percent in 1989 to 18.3% in 1990. The unstable trend is indicative of the unco-ordinated development strategies in the country.

4. Budget surpluses contributed a relatively insignificant share of GDP, accounting for just about 0.04% in 1986 and 0.73% in 1989. However, during the period of deficits, deficits accounted for as much as 2.3% of GDP in 1983.

5. Taxes have contributed a fairly constant proportion of GDP of more that 12% from 1986-1988. In 1986, the proportion dropped to slightly more that 9% mainly due to the fact that while tax revenue increased by 4%, GDP increased by more than 34% between 1988 and 1989.

6. Total expenditure claimed a relatively constant proportion of 14% of GDP, on the average, for the period 1985-1989.

6.1.6 HEALTH EXPENDITURES IN GHANA

Even though accurate data on total health expenditures are not available, it has been estimated by the World Bank using the GLSS data that the private - for profit sector accounted for 52.4%, the missions 11.9% and the public sector (including Aid) accounted for 35.7% of total health expenditures in Ghana. A greater proportion (i.e. 80%) of the "public sector" expenditures on public (MOH) health services was financed from general revenue, 6% from the user charges (i.e. cost recovery) and 14% from external assistance. Currently, Donor funding in the health sector is about 28% of the sector's overall budget. Out of the total expenditures, 70% has been devoted to recurrent items with 30% going to capital items.

Between 1980-1989, an average of 7.6% of total Government Expenditures were devoted to the health sector, with 1980 (6,43%) and 1989 (10.11%) being about 2.5% point more than the average share. Development Expenditures alone had a share of 7.0% in 1884, 7.6% in 1986 and 18% in 1989 of the health budget. Even though the share of the total Government Expenditure of 7.6% to Health does not appear to be much (but comparing the rate of increase, we find that) the level of Expenditures has been increased yearly by more than 35% each year between 1984-1989. In real 1984 cedis, and starting from ¢2,270.4 million in 1984, the increase in real expenditure over the entire period (1984-1989) was 77.4% which is almost eight fold.

Per capita health expenditures have been rising steadily from ¢38 in 1980 to ¢816 in 1988 in nominal terms representing an increase of over twenty fold over the period. The absolute increase appears to be substantial but taking into account the inflation rate during the period of about 152% (World Bank, page 511), we have a nominal increase of thirteen-fold. In real-terms (1984). The increase in per capita health expenditures between 1983 and 1988 was 2.26%. The gross inadequacy of the level of recurrent expenditures to health is reflected in the prevalence of the common occurrence of the six killer diseases.

A far less attractive situation is shown by examining the capital Health Expenditure over the period. With 110 hospitals (1985) scattered all over the country but mostly in the urban centres, the average population per hospital is as high as 114,000 while the 387 Health Centres/posts/ clinics serve an average of 32,000 per facility. There were 673 patients to a bed (1985) out of a total of 18,614 beds in all the hospitals and clinics.

Utilization of these facilities is relatively low especially by the rural people as a result of the long distances between their places of residence and the nearest facility. As such, only 41.8% of the population on the average, used the facilities provided. The Upper East, Upper West and Northern Regions have far lower utilization rates than the average of just around 11%. The highest utilization rate is in the Brong Ahafo Region i.e. the Forest belt - with reported common diseases being - diarrhoeal diseases, upper respiratory infection, measles, diseases of the skin and anaemia. (GLSS)

TABLE 6.1: PUBLIC FINANCE INDICATORS 1980 - 1991

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
A. ACTUAL REVENUE AS % OF CURRENT EXPENDITURE	51.81	5.7	52.5	76.4	99.7	104.8	121	137.8	138.5	144.3	134.8	151.1
B. ACTUAL REVENUE AS % OF TOTAL EXPENDITURE	41.1	4.9	45.8	67.5	82.4	84.2	100	103.8	102.6	105	101.2	112.8
C. DEVELOPMENT EXPENDITURE AS % OF TOTAL EXPENDITURE	17.4	10.1	9.24	8.93	14.5	15.2	13.4	17.3	19.9	18.7	18.3	17.2
D. BUDGETARY DEFICIT/SURPLUS AS % OF GDP	N/A	N/A	N/A	2.3	1.5	2.0	0.04	0.54	0.37	0.73	N/A	N/A
E. TAX-GDP RATIO	N/A	N/A	N/A	N/A	5.63*	10.24*	12.12	12.72	2.29	9.49	N/A	N/A
F. TOTAL EXPENDITURE AS % OF GDP	N/A	N/A	N/A	5.3*	10.15	13.96	14.3	14.3	14.25	14.4	N/A	N/A

X WORLD BANK DATA

N/A NOT AVAILABLE

TABLE 6.2: INDICATORS OF FISCAL PERFORMANCE. 1965 - 1988 (RATIOS) FINANCING AS RATIO OF DEFICIT

(AS RATIO TO GDP) INTERNAL BANK OR EXTERNAL

YEAR	REVENUE	EXPENDI-TURE	DEFICIT	LOANS	GHANA	LOANS
1	2	3	4	5	6	7
1965	0.19	0.26	0.06	0.88	n.a	0.03
1966	0.15	0.20	0.05	0.87	n.a	0.34
1967	0.17	0.23	0.06	0.76	n.a	0.19
1968	0.18	0.24	0.06	0.71	n.a	0.27
1969	0.17	0.20	0.03	0.65	n.a	0.41
1970	0.19	0.22	0.02	0.90	n.a	0.96
1971	0.18	0.22	0.04	0.82	n.a	0.27
1972	0.15	0.21	0.06	0.49	0.08	0.51
1973	0.11	0.17	0.05	0.90	0.83	0.01
1974	0.13	0.17	0.04	0.01	0.94	0.01
1975	0.15	0.23	0.08	1.00	1.51	0.00
1976	0.13	0.25	0.11	1.00	0.88	0.00
1977	0.13	0.23	0.09	0.99	0.36	0.01
1978	0.07	0.16	0.09	0.91	0.22	0.04
1979	0.10	0.17	0.07	0.00	0.21	-
1980	0.07	0.11	0.04	0.84	1.78	0.16
1981	0.05	0.11	0.06	0.92	0.38	0.08
1982	0.06	0.11	0.06	0.91	0.14	0.08
1983	0.06	0.08	0.03	0.78	0.09	0.20
1984	0.08	0.10	0.02	0.63	0.49	0.37
1985	0.12	0.14	0.02	0.53	0.27	0.46
1986	0.14	0.14	0.00	17.78	0.60	18.78
1987	0.15	0.14	0.01	0.32	0.66	0.13
1988	0.15	0.14	0.01	0.62	0.64	0.23
1989	0.15	0.14	0.01	0.85	0.66	0.27
1990	0.13	0.13	0.01	2.17	1.28	1.91
1991	0.15	0.13	0.02	1.03	0.72	0.25

BUDGET SURPLUS
SOURCE: APPENDIX E15 AND OWN CALCULATIONS

TABLE 6.3: HEALTH EXPENDITURES PER HEAD OF POPULATION

YEAR	% OF GDP	% OF BUDGET	REAL EXPENDITURES 1984 ¢M	NOMINAL EXPENDITURE ¢M	PER HEAD	
					NOMINAL ¢	REAL 1984
1980	0.95	6.43	277255		38	258
1981	0.71	6.09	1988		46	179
1982	0.62	6.09	1627		47	141
1983	0.35	4.38	875		54	74
1984	0.84	8.50	2270	2270	184	184
1985	1.07	8.74	3052	3999	314	240
1986	1.15	8.28	3423	5854	445	260
1987	1.05	7.93	3273	9502	575	241
1988	1.21	9.01	3992	12880	816	284
1989	1.40	10.11		19853		
1990	1.27	10.10		25706		
1991						

SOURCE: HEALTH STATISTICS OF GHANA, WORLD BANK, 1989 AND OWN ESTIMATES.

The sector utilizes the second largest share of the recurrent expenditure, accounting, in the last three years for an average of about 10.2%. In terms of capital expenditure, the sector is the fourth largest, even though its share of the National capital expenditure has declined from 6.65% in 1992 to about 4.7% in 1994. See Table 6.4)

TABLE 6.4: SHARE OF MOH EXPENDITURE IN TOTAL NATIONAL EXPENDITURE:

	1992 %	1993 %	1994 %
SHARE OF MOH RECURRENT EXPENDITURE	13.26	13.12	10.14
SHARE OF MOH CAPITAL EXPENDITURE	6.65	6.35	4.65
SHARE OF MOH IN TOTAL EXPENDITURE	11.61	11.57	8.69

SOURCE: PUBLIC EXPENDITURE REVIEW GOG 8TH APRIL 1994 P.46.

With the MOH the proportion of personnel expenditure within the recurrent expenditure increased substantially from 38.2% in 1992 to 56.7% in 1993 and 1994 in spite of the directive to the MOH to reduce its 1992 manpower level by 8.7% (see Table B. below)

The proportion of the non-personnel portion of the expenditures under the control of the central administration decreased from GOG Public Expenditure Review, 1993. 8th April 1994. p.45.

TABLE 6.5: PROPORTION OF RECURRENT EXPENDITURES

	1992	1993	1994
TOTAL RECURRENT EXPENDITURE (A)	29,084	446,533	49,041
PERSONAL	11,110	26,365	27,764
% (B/A)	38.2	56.7	56.7
% OF RECURRENT EXPENDITURE	50.7	35.5	
% MOH/TOTAL GOG EXP.	7.0	8.3	8.69
KORLE-BU TEACHING HOSPITAL			
KOMFO-ANOKYE TEACHING HOSPITAL	3.6	4.4	

50.7% in 1992 to 35.5% in 1993 and is further budgeted to decrease in 1994. The teaching hospitals had slightly more resources for recurrent expenses from a combined total of 10.6% in 1992 to 12.7% in 1993. Similarly, for the other regional and district hospitals, typically the Regional Directors of Health Services (RDHS) and District Medical Officers (DMOs), retained a greater proportion of the non-recurrent budgets for their respective areas under their control. As such, they also made purchases on behalf of hospital and health centers in the regions and districts. This system did not promote efficient utilization of resources at all levels - National to district. In the absence of district budgets, it is difficult to assess the level of actual resources reaching the district and sub-district levels.

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The provision for supplies and stores decreased by 26.0% from ¢8.5 billion in 1992 to ¢6.3 billion in 1993. The major sub-items within this item are:

TABLE 6.6: MAJOR COMPONENTS OF ITEMS UNDER SUPPLIES AND STORES - MOH

	1992(¢M)	1993(¢B)	1994(¢B)
IMPORTATION OF DRUGS	3.3 (39%)	1.0	
LOCAL PURCHASE OF DRUGS	1.2	1.0	
IMPORTATION OF DRESSING MATERIALS	1.0	0.4	
LOCAL PURCHASE OF DRESS MATERIALS	0.5	1.1	
CHEMICALS AND CONSUMABLES	1.2	1.2	
MEDICAL INSTRUMENT & STORES	1.2	1.2	
OTHERS	0.1	0.4	
	¢ 8.5	¢6.3	

The current streamlining of feeding, the purchase and distribution of drugs and dressing and the payment of subventions in addition to the improvement in the expenditure monitoring for the sector, would all contribute to preserve scarce resources and help utilize these resources efficiently.

TABLE 6.7: RECURRENT BUDGETS FOR PRIMARY HEALTH CARE 1986-1988 (¢ MILLION)

HEAD	SUB-HEAD	PROGRAM	% OF HEAD	RECURRENT BUDGET ESTIMATES							
				1986	1987	1988	1989	1990	1991	1992	1993
160		MOH (GENERAL SERVICES)		351	455	671	1,138	1,414	2,168	2,316	2,207
	1	GENERAL ADMINISTRATION	15	285	400	596	961	1,200	1,616	1,636	1,467
	2	BUDGET & PLANNING DIVISION	0								
	3	COMMON SERVICES	0								
	4	REGIONAL HEALTH ADMINISTRATION	45	49	38	52	104	135	428	535	223
	5	STORES	15	11	9	12	11	20	26	27	50
	6	HEALTH EDUCATION	80	6	8	11	76	59	98	118	476
	7	CENTRE FOR HEALTH STATISTICS	0								
	8	TRAINING	0								
	9	INTERNAL AUDIT	0								
	10	RESEARCH CENTRE FOR PLANT MEDICINE	0								
161		KORLE BU TEACHING HOSPITAL		33	22	36	57	94	111	153	296
	1	GENERAL ADMINISTRATION	0								
	2	MEDICAL/DENTAL SERVICE	10	33	22	36	57	94	111	153	296
	3	GENERAL SERVICES	0								
162		KOMFO ANOKYE HOSPITAL		17	13	13	34	56	60	84	166
	1	GENERAL ADMINISTRATION	0								
	2	MEDICAL/DENTAL SERVICE	10	17	13	13	34	56	60	84	166
	3	GENERAL SCIENCES	0								

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RECURRENT BUDGETS FOR PRIMARY HEALTH CARE 1986 - 1988 (CONTD.)
(¢ MILLION)

HEAD	SUB-HEAD PROGRAMME	% OF HEAD	RECURRENT BUDGET ESTIMATES							
			1986	1987	1988	1989	1990	1991	1992	1993
163	MEDICAL/DENTAL SERVICES		1.151	1,042	1,524	2,574	3,164	3,788	4,447	10,035
	1. DENTAL SERVICES	0								
	2. ENVIRONMENTAL HEALTH SERVICE	100	323	298	438	63	820	1,016	1,264	2,470
	3. EPIDEMIOLOGICAL DIVISION	100	281	251	350	46	596	713	767	1,883
.	4. HEALTH LABORATORIES	10	5	5	6	1	19	23	66	65
	5. MATERNAL & CHILD HEALTH	100	206	192	326	80	848	1,029	1,236	3,098
	6. MEDICAL CARE	15	297	264	357	56	745	822	919	2,073
	7. MENTAL HEALTH	0								
	8. NUTRITION SERVICES	100	39	32	47	9	136	185	195	526
	9. NATIONAL BLOOD TRANSFUSION SERVICE									
	TOTAL		1,552	1,562	2,243	3,820	4,728	6,127	7,000	12,713
	PRIMARY HEALTH CARE AS % OF TOTAL		23.8	22.0	22.8	24.0	23.36	23.9	24.07	27.32

SOURCE: **WORLD BANK ESTIMATES AND OWN CALCULATIONS**

TABLE 6.8: GROWTH OF GDP BY KIND OF ECONOMIC ACTIVITY AT CONSTANT 197 5 PRICES (PERCENTAGES)

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
AGRICULTURE	-2.56	-3.25	19.11	9.71	0.65	3.11	0.04	3.38	4.25	2.02	4.75
INDUSTRY	-14.46	16.67	-6.77	11.94	17.60	7.56	11.34	10.27	2.63	6.93	3.70
MINING AND QUARRYING	-7.34	-8.38	-13.64	13.49	6.45	-3.03	7.89	35.82	9.96	6.35	6.75
MANUFACTURING	-19.27	-20.49	-11.17	12.90	24.32	10.95	10.01	9.24	0.59	5.88	1.02
ELECTRICITY AND WATER	11.86	-8.11	-38.91	42.96	20.73	18.03	18.73	6.74	7.73	14.61	7.91
CONSTRUCTION	-4.79	-91.15	27.43	2.33	2.81	-2.66	15.02	4.55	4.17	7.31	9.14
SERVICES:	2.73	4.65	4.54	6.63	7.52	6.50	9.38	7.83	6.67	7.93	6.27
W/SALES AND RETAIL TRADE RESTAURANTS AND HOTELS	-1.92	10.38	-5.26	10.15	13.68	9.02	17.45	7.41	9.43	10.94	9.44
TRANSPORT, STORAGE AND COMMUNICATION	6.76	1.3	7.26	12.76	8.43	5.62	10.89	10.18	7.85	12.21	9.93
FINANCE, INSURANCE, REAL ESTATE AND BUSINESS SERVICES	1.66	-1.38	14.12	9.26	2.58	7.66	5.48	6.73	3.94	7.29	5.49
COMMUNITY, SOCIAL AND PERSONAL SERVICES	15.23	-4.99	7.09	20.10	7.76	46.02	19.20	5.98	9.55	5.81	3.72
TOTAL GROSS DOMESTICS IN PURCHASER'S VALUE	-3.18	-5.85	-4.34	8.96	5.09	5.20	4.80	6.22	0.89	3.33	5.30

SOURCE: CALCULATED FROM DATA OBTAINED FROM IMF FINANCIAL STATISTICS AND QUARTERLY DIGEST OF STATISTICS. ACCRA, MARCH, 1989 - 1992.

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TABLE 6.9: SUMMARY OF GOVERNMENT FINANCES AS PERCENT OF GDP

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
REVENUES	6.0	5.5	8.0	11.3	13.6	14.1	14.5	15.12	18.16	19.23
RECURRENT EXPENDITURE	9.3	7.4	8.6	11.2	11.9	10.8	10.8	10.49	9.76	10.24
CURRENT BUDGET SAVINGS	-3.3	-1.8	-0.6	0.1	1.7	4.3	4.0			
DEVELOPMENT EXPENDITURE	0.9	0.6	1.2	2.1	1.9	2.5	3.1	3.37	2.77	2.96
DEFICIT/SURPLUS	-4.7	-2.7	-2.1	-2.7	-0.7	-0.3	0.9	1.27	0.63	1.96
NET DOMESTIC FINANCING	4.3	2.3	1.1	1.2	1.0	-0.4	0.6	1.08	1.38	-2.01
NET FOREIGN FINANCING	0.3	0.4	1.0	1.5	-0.3	0.7	0.2	0.35	1.21	0.49

SOURCE: GSS, QUARTERLY DIGEST OF STATISTICS, SEVERAL ISSUES.

6.2 ECONOMIC ANALYSIS

6.2.1 IMPACT OF I. E. & C CAMPAIGN ON AIDS TRANSMISSION.

- **SUMMARY**

There is no doubt that the evaluation of a program of this nature will be very difficult to undertake. However, in spite of the unavailability of accurate data in the area, it may be possible to quantify the few agreed-upon tangible/outputs of the program and hence be able to carry out a rough Cost - Benefit Analysis. Even with very conservative estimates available, the analysis of the rough estimates of the benefits of the outputs suggest that the internal rate of return of this section of the program is positive in real terms.

- **ASSUMPTIONS**

The following assumptions were used in arriving at the above conclusion:

1. About 41.6% of the total funding available under the programme will be utilised for the AIDS control section of the programme. This will amount to a total of $ 18.720 million (compiled from Deloitte & Touche, April 1994).

2. Since the strategy under consideration moves us through the "growth" phase by the year 2000, if the AIDS information campaign is equally effective, then we estimate that for each year, the project continues (1994 - 99), it would encourage the following number of additional individuals to use contraceptives:

TABLE 6.10: CURRENT AND PROJECTED NUMBER OF USERS OF MODERN METHODS

YEAR	NUMBER	ADDITIONAL USERS PER YEAR
1993	389,000	-
1994	426,000	47,000
1995	488,000	52,000
1996	547,000	59,000
1997	613,000	66,000
1998	687,000	74,000
1999	769,000	82,000
2000	818,000	49,000

It is postulated that there will be a 10% - 12% annual increase in the number of new users during the life of the project.

3. That between 2% and 4% of the new users would have the AIDS virus.

4. Over the course of the year, each person with the virus has a 3.375% chance of infecting someone else. (This is based on the average number of sexual contacts per year of 150 multiplied by the

probability of contacting AIDS per contact of 0.0225. [This pre-supposes that each of the sexual contacts will be with a different person - which is very unlikely. On the other hand, if we assume that only a third of the contacts will be with different persons, then the probability of a person with the virus infecting someone else within a year is now 1.125%.

5. That 25% of the new users would revert each year. Hence, 25% of users who started using condoms in 1994 will stop after 1 year, and only 705 will continue to use condoms the second year. The following year, 25% of the 705 will discontinue use, and so forth. In 1999, a total of over 4901 people infected with the AIDS virus will be using condoms, which will prevent almost 306 infections that year. By 2015, a total of 1654 infections will be prevented.

TABLE 6.11: IMPACT OF I. E. & c AND CAMPAIGN ON AIDS TRANSMISSION

YEAR	NEW USERS OF CONDOMS DUE TO IE&C PROGRAM	% OF NEW USERS WHO HAVE AIDS VIRUS	NO. OF USERS W/AIDS VIRUS	NO. OF AIDS CARRIERS WHO CONTI-NUE TO USE CONDOMS AFTER 1ST YEAR	TOTAL NO. OF AIDS CARRIERS DSWG CONDOMS	AIDS INFECTIONS PREVENTED
						3.375%
1994	47,000	2.0	940	0	940	317
1995	52,000	2.5	1,300	705	2,005	677
1996	59,000	3.0	1,770	1,504	3,274	1,105
1997	66,000	3.5	2,310	2,456	4,766	1,609
1998	74,000	4.0	2,960	3,575	6,535	2,206
1999	82,000	4.0	3,280	4,901	8,181	2,761
2000	49,000		1,960	6,136	8,096	2,732
2001				7,542	7,542	2,545
2002				5,657	5,657	1,909
2003				4,242	4,242	1,432
2004				3,182	3,182	1,074
2005				2,386	2,386	805
2006				1,790	1,790	604
2007				1,342	1,342	453
2008				1,007	1,007	340
2009				755	755	255
2010				566	566	191
2011				425	425	143
2012				319	319	108
2013				239	239	81
2014				179	179	60
2015				134	134	45
TOTAL CASES PREVENTED						21,452

6.2.2 ECONOMIC IMPACT

A few simple assumptions are used in arriving at an estimate of the internal rate of return for the program. These are:

1. That, it takes, on the average, 8 years for an HIV infected person to develop AIDS.

2. That, it takes, on the average, 1½ years for an AIDS patient to die.

3. Loss of output as a result of the death of an AIDS patient -

Number of years of working life lost	15yrs	
Value of output/year	$681	
Total value		¢6,810 per person

(assuming a 55 year life expectary and 5% pa opportunity cost of capital).

TABLE 6.12: ECONOMIC IMPACT OF THE AIDS CONTROL PROGRAMME - IE&c AND BLOOD TRANSFUSION CAMPAIGN

YEAR	REDUCED NO. OF AIDS INDUCED DEATH DUE TO IE		
		II	OPTION II 3.375% ($000)
1994			$ 2,787
1995			$ 2,912
1996			$ 3,536
1997			$ 3,744
1998			$ 3,744
1999			$ 1,997
2000			
2001	317	317	2,159
2002	677	677	4,610
2003	1,105	1,105	7,525
2004	1,609	1,609	10,957
2005	2,206	2,206	15,003
2006	2,761	2,761	18,796
2007	2,732	2,732	18,605
2008	2,545	2,545	17,331
2009	1,909	1,909	13,000
2010	1,432	1,432	9,752
2011	1,074	1,074	7,314
2012	805	805	5,482
2013	604	604	4,113
2014	453	453	3,085
2015	340	340	2,315
TOTAL BENEFITS MINUS TOTAL COST OF AIDS PROGRAM			$121,347.00

If we continue the analysis to the year 2020, we shall have:

YEAR	II		II
2016	255	255	1,737
2017	191	191	1,301
2018	143	143	974
2019	108	108	735
2020	81	81	552

TOTALS BENEFITS EXCLUDING
TOTAL COST OF AIDS PROGRAM. = $126,646.00

7.0 COST BENEFIT ANALYSIS

7.1 CRITICAL ASSUMPTIONS

The following assumptions have been made in carrying out the Cost-Benefit Analysis:

1 That GOG disburses the $15 million contributions towards the project in equal amounts:

2 That 50% of GOG contribution would be classified as additional cost to the project - the other 50% being the cost towards normal recurrent expenses of the MOH institutions involved in the project.

3 Cost per head of health expenditures cabulated as

$$hi = \frac{\text{Health Expenditures (1993)}}{\text{pop (estimated) 1993}} \$24.00$$

This hi will be used to tabulate the savings on health due to births averted.

4 Cost per head on education: We shall utilise (as was done in the previous analysis) the figure of $24. per head per year.

5 That savings on education will be realized 6 years after the birth has been avoided. For the period (4-6) years, its assumed that costs are borne by parents in private nurseries. For savings on health expenditurs, they accrue immediate any birth is averted.

6 That with intervntion, the rate of increase in population will be 2.6% from 1999 to 2010; but between 1994-1999, the rate would be 3.1%.

7 Terminal year for the project cost-benefit analysis 2010 OR 2000?

8 Loss of output resulting from death due to AIDS - estimated as GDP/head X x PVIFA 5%, 15 years = $681 x 10 = $6810.

FOOTNOTE: **ESTIMATED POPULATION FOR 1993 = 15.6MILLIONS**
EXCHANGE RATE ¢800 = US$1.00

7.2 MACROECONOMIC IMPACT

Government Expenditures have been, on the average, 13.56% of GDP between 1984 and 1989, rising from 10.15% in 1984 to 14.4% in 1989. If the growth in GDP is maintained at 5.4% (1983-1990), then the estimated GDP in purchaser's value in 1975 prices would be ¢8.779 billion for 1995. The projected GOG public expenditures would be ¢1.23 billion for 1995.

1.054 x 7,498.0 = 7,902.892 - 1993) Real
8,329.648 - 1994) 1975
8,779.449 - 1995) prices.
9,253.5394 - 1996)

Nominal (current prices) growth rate of 40%.

7.3 COST-BENEFIT ANALYSIS

7.3.1 INTRODUCTION

Cost-benefit analysis has become a part of the required proceedures for the evaluation of most projects in most countries. Especially for social programs, its use has almost become a standard tool. There are, however, problems in its use particularly regarding the identification of all benefits and costs as well as the quantification of some of the benefits of the program.

7.3.2 COST OF THE PROGRAM

The Ghana Family Planning and Aids Control program has components in its cost structure. These represent the sources of finding for the program with a total cost of $613 million made up as follows:-

	US$	GRANT	CONTRACEPTIVE PROCUREMENT
Project Assistance Component	32.00	20	12
Non-Project Assistance component	13.00		
USAID/WASHINGTON	1.30		
GOG	15.00		

The funds would be disbursed as follows:

TABLE 7.1: EXPENDITURES IN $000 OF US DOLLARS

FY	PROJECT ASST.	NON-PROJECT ASST.	OYB TRANSFERS	GOG CONTR.	USAID/ WASH.	TOTAL US$100
1994	$6,700	$ -	$ -	$ -	$ -	$6,700
1995	2,500	2,500	2,000	3,000	-	10,000
1996	2,500	3,000	3,000	3,000	-	11,500
1997	3,000	3,000	3,000	3,000	-	12,000
1998	3,000	3,000	3,000	3,000	-	12,000
1999	2,300	1,500	1,000	3,000	-	7,800
TOT.	**$20,000**	**$13,000**	**$12,000**	**$15,000**	-	**$60,000**
				USAID/WASHINGTON		**1,300**
						$61,300

If we assume that only half of GOG's contribution, which mainly covers personal emoluments and the use of existing facilities, would be actually considered as part of the incremental costs of the project, then we have the following expenditure flows for the period of the project.

TABLE 7.2: ACTUAL ADDITIONAL COST TO PROJECT

FY	000's OF US $
1994	6,700
1995	8,500
1996	10,000
1997	10,000
1998	10,000
1999	6,300
	52,500
USAID/WASH.	1,300
TOTAL	**$53,800**

7.3.2. BENEFITS OF THE PROJECT

"At current rates of growth of per capita income (about 2% per annum), Ghana would require about 20 years for per capita income to grow from its present level of US$400 to US$600." (World Bank - Ghana 2000 and Beyond-February 1993 - p.1). The main reason for the above bleak forecast is the fact that while the current economic growth rate of GDP is 5.4%, the population is increasing at the rate of 3.1%.

The main benefit, therefore, of the Family Planning component of the project would be the reduction in fertility from 6.1 to 5.3 which would cause an appreciable reduction in population of the country by the year 2000, and hence increase per capita income in the country. These benefits would, first of

all, accrue to the individual families that would use the products of the project. This would be evident in the increase in resources for health and education (in particular) per member of the family as a result of a number of unwanted births averted. The effect, therefore of the project on poverty and income inequality is obvious and can easily be felt quickly at the lower income levels.

For the Aids Control Programme, the reduction in the rate of increase of the prevalence of HIV infection, would reduce the number of deaths of the active members of the population due to AIDS. The benefits, therefore, accrue both to the individual, who become healthy most of the time and also to the nation from output contributions (net of intake) to the society.

The project also has other favourable impacts on several social issues. For example, the knowledge about the beneficial use of family planning methods would be diffused throughout all the social sectors of the different communities; the traditional burden on the woman would be reduced as a result of the population management skills acquired through family planning. Women would have more time available to engage in productive activities asopposed to devoting a greater proportion of their lives on prolonged nursing and childcare.

Most of these benefits mentioned above are difficult to quantify. We shall, therefore, concentrate on the main quantifiable benefits to be derived from the Ghana Family Planning and AIDS Control programme from the reduced number of births and the number of aids infections prevented.

For the number of births prevented, we shall measure the benefits in terms of savings on health and educational expenditures as a result of the programme. For the numbr of AIDS infections prevented, we shall measure the benefits interms of the savings in the value of output that would have been lost to the nation as a result of the deaths of an aids - infected person.

7.3.4 BIRTHS AVERTED

In the project document it is expected that the marketing and promotional strategies would help increase the modern contraceptive prevalence rate from 15% in 1994 to 25% in 2000. The population is assumed to grow at 2.6% from 1995 till the year 2000.

Without the project, the population of the country is projected to grow at the rate of 3.1% per annum between 1994 and 1999. Column 2 in Table 7.3 shows the projected population without the projects Column 3 also shows the population projections with the intervention of the Family Planning and Aids Control program. The differences (between Columns 2 and 3) in Column 4 shows the impact of the program on the population to year 2010.

TABLE 7.3: POPULATION PROJECTIONS AND REDUCTIONS

YEAR	WITHOUT INTERVENTION(000)	WITH INTERVENTION (000)	REDUCTIONS OR POP. (000)
1994	17,468		
1995	18,010	17,922	88
1996	18,568	18,388	180
1997	19,144	18,866	278
1998	19,737	19,357	380
1999	20,349	19,860	489
2000	20,980	20,377	603
2001	21,630	20,907	723
2002	22,301	21,451	850
2003	22,992	22,009	983
2004	23,705	22,581	1124
2005	24,440	23,168	1272
2006	25,198	23,770	1428
2007	25,979	24,388	1591
2008	26,784	25,020	1764
2009	27,614	25,670	1944
2010	28,470	26,338	2132

7.3.5 SAVINGS ON HEALTH

The rate at which the population grows as well as the size and composition of the population will affect the availability of resources needed to provide health care services to the population. The nation's PHC objective of achieving Health for all by the year 2000, implies that a lot of resources would be needed in order to achieve the objective. With high growth rate and a relatively younger population enough resources may not be generated for the purpose. The national health bill for 1993 was estimated at ¢51,687 million (Recurrent ¢46,533 million + PIP ¢5,154 million), while population is projected at 16,854,000.

If we include donor funding, which is estimated to be about 28% of the sector's overall budget then this amount in 1993 works out to about $3.83 per capita (using a rate of ¢800 = US$1.00). This figure is a little lower than the 1989 figure of $4.60 due to the devaluation of the cedi). Assuming there is no increase in real cost, Column 3 of Table 7.4 calculates the health savings between 1994 and 2010.

7.3.6 SAVINGS ON EDUCATION

Using the findings of a study commissioned by the World Bank on the Ghana Education Sector in 1985, the cost per pupil in primary school in Ghana was estimated to be around $24 per year. It will be assumed that GOG will maintain this real cost (and if possible reduced it) during the life of this project. Column 5, therefore, shows the calculations of savings on the education sector as a result of the project. There may be some slight understatement of costs since during the first 12 years (pre-University education) costs may increase over the different levels - Primary, JSS and Senior Secondary. However, in view of the fact that some proportion of students in JSS may not be able to enter SSS, the understatement may be small in magnitude.

TABLE 7.4: SAVINGS CALCULATIONS FOR HEALTH AND EDUCATION

YEAR	BIRTHS AVERTED (000)	SAVINGS ON HEALTH ($000)	PUPILS NOT IN SCHOOL ($000)	SAVINGS ON EDUCATION ($000)	TOTAL SAVINGS ($000)
1994					
1995	88	337	-	-	337
1996	180	689	-	-	689
1997	278	1,065	-	-	1,065
1998	380	1,455	-	-	1,455
1999	489	1,873	-	-	1,873
2000	603	2,309	88	2,112	4,421
2001	723	2,769	180	4,320	7,089
2002	850	3,294	278	6,672	9,966
2003	983	3,765	380	9,120	12,885
2004	1,124	4,305	489	11,736	16,041
2005	1,272	4,872	603	14,472	19,344
2006	1,428	5,469	723	17,352	22,821
2007	1,591	6,094	850	20,400	26,494
2008	1,764	6,756	983	23,592	30,348
2009	1,944	7,446	1,124	26,976	34,422
2010	2,132	8,166	1,272	30,528	38,694

TABEL 7.5: COST-BENEFIT ANALYSIS WORKSHEET

YEAR	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
COST	6.700	8.5	10.0	10.5	10.5	7.6											
B_1		0.34	0.69	1.07	1.46	1.87	4.42	7.09	9.97	12.89	16.04	19.34	22.82	26.49	30.35	34.42	38.69
B_2	-	-	-	-	-	-	-	1.60	4.01	4.49	5.21	5.86	6.25	3.64	2.74	2.04	1.53
$B_1 + B_2 = B$	-	0.34	0.69	1.07	1.46	1.87	4.42	8.69	13.98	17.38	21.25	25.20	29.07	30.13	33.09	36.46	40.22
B-C	-6.7	-8.16	-9.31	-9.43	-9.04	-5.73	4.43	8.69	13.98	17.38	21.25	25.20	29.07	30.13	33.09	36.46	40.22
DF(10%)	1	0.909	0.826	0.751	0.683	0.621	0.564	0.513	0.467	0.424	0.385	0.350	0.319	0.290	0.263	0.239	0.218
PV(10%)	-6.7	-8.08	-7.69	-7.08	-6.17	-3.56	2.49	4.46	6.53	7.37	8.18	8.82	9.27	8.74	8.70	8.71	8.77
PV(15%)	-6.7	-7.10	-7.04	-6.20	-5.17	-2.85	1.91	3.27	4.57	4.29	4.57	4.71	5.44	4.91	4.67	4.48	4.30

PV(C) = 39.28
PV(B) = 82.04
NPV = 42.76

PV(C) = 35.06
PV(B) = 47.12
NPV = 12.06

ASSUMPTION (1) 10% COST OF CAPITAL

ASSUMPTION (2) 15% COST OF CAPITAL

B_1 = Total Savings on both Health and Education

B_2 = Total Benefits from lives saved from death resulting from AIDS infection.

$$\frac{x-15}{12.06} = \frac{x-10}{42.76}$$

$42.76x - 641.4 = 12.06x - 120.6$
$30.7x = 520.8$

...x = 5.89
...IRR = 20.89%

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ANNEX I

DETAILED PROCUREMENT PLAN

A. **Overview:** GHANAPA is financed 100% from the Development Fund for Africa (DFA) appropriated account. All procurement will be conducted pursuant to the procurement guidelines for activities financed under DFA and Agency procurement regulations. Accordingly, the project will utilize, to the extent practical, goods and services of US origin and from US sources. Most technical assistance will be of US or Ghanaian origin. Any vehicles procured under GHANAPA will be of US origin. Participant training will be conducted in the US or other developing countries. Generally, commodities procured will be of US or Ghanaian source and origin, with the exception of specialized equipment and materials which may need to be purchased from other free world sources (Code 935). Computer equipment purchases may be from other free world country sources and will be of US origin. USAID/Ghana, with the assistance of USAID/Washington's Transportation Division (FA/OP/TRANS), will make every effort to ensure that commodities procured directly by USAID, or through USAID contractors, will be shipped on US flag carriers in compliance with the US Cargo Preference Act. The USAID Project Manager will maintain records of all project procurement by USAID geographical code and will report this information annually to USAID/Washington's Africa Bureau. With the development of the procurement plan in accordance with Africa Bureau Guidelines, USAID/Ghana is maximizing US procurement to the extent possible.

B. **Procurement Responsibilities:** The majority of off-shore and local procurement will be done by USAID. This includes procurement of technical assistance, training, contraceptives and other equipment and materials.

1. Technical Assistance: All technical assistance contracts, cooperative agreements and grants will be handled through the resident USDH contracting officer. GHANAPA plans to award a major cooperative agreement to AVSC to provide technical assistance to both the private and public sector's clinical contraceptive programs. Additional contracts will be awarded to assist USAID in project management, monitoring and evaluation and financial assessment and review. Additional technical assistance will be provided by core funded USAID/Washington projects which will be managed by the respective contracts officer in USAID/Washington.

2. Participant Training: Participant training under GHANAPA will be coordinated by the Population and AIDS Coordinating Committee, and the USAID HPN Training coordinator. The USAID/Ghana Participant Training Officer of the Education Human Resources Development Office, will process all participant training under GHANAPA. This will include visa and health processing, procuring airtickets and maintenance costs.

3. Grants to Ghanaian Non-Governmental Organizations: The mission will make grants to the Ghana Social Marketing Foundation (GSMF), Ghana Registered Midwives Association (GRMA), and the Planned Parenthood Association of Ghana (PPAG) as part of

the project activities. Each of these NGOs will be registered with USAID as indigenous PVOS prior to awarding the grants.

4. Endowments: GHANAPA will develop endowments for the GSMF and a Center for Population and Development to be located at the University of Ghana - Legon. The endowments will be established through a grant to a US based NGO which will serve as trustee for the investments. Specific arrangements for the endowments will be dependent on final guidance which is being developed by USAID/Washington.

C. Methods of Implementing and Financing

The GHANAPA program will use several different methods of financing in implementing the USAID contribution. Advances will be provided to Ghanaian NGOs as part of their grants, once they have been certified by the Controller's office and registered by USAID. The Cooperative Agreement with AVSC will be financed by a Bank Letter of Credit. Most other USAID inputs will be paid for directly by the USAID Controller's Office, with the possible exception of several operations research studies and training activities which may be financed through grants to eligible institutions. The Methods of Implementation and Financing are illustrated below:.

METHODS OF IMPLEMENTATION AND FINANCING

Method of Implementation	Method of Financing Appr. Amount	
Grants to NGOs	Advances	5,500
TA AVSC	Direct L/Com	3,000
Monitoring/Evaluation	Direct Pay	1,200
AIDS/STD		
Commodities	Direct Pay	461
Local TA	Direct Pay	150
Training	Advances	580
Operations Research	Direct Pay	75
Project Support		
Commodities	Direct Pay	755
Short Term Training	Direct Pay	1,000
Project Management/Administrative		1,629
Audits	Direct Pay	150
Total Bilateral Grant Agreement		14,500
Endowment Grant	Direct Pay	5,500
Contraceptives	OYB Transfer	11,000
NPA	Direct Pay	14,000
Central Funded TA	Central Funded Cooperative Agreements	13,000
TOTAL PROGRAM		58,000

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ANNEX J

IMPLEMENTATION SCHEDULES

I. IMPLEMENTATION SCHEDULE FOR NPA PROGRAM ASSISTANCE

	Event	Responsible Party	Month
1.	PAAD authorized and Grant Agreement signed	USAID/GOG	10/94
2.	Informal tranche review	USAID/GOG	1/95
3.	Tranche Review	USAID/GOG	2/95
4.	Conditions for Tranche #1 met.	GOG	3/95
5.	Issuance of PIL to certify conditions Met disbursement of Tranche #1	USAID	4/95
6.	Informal tranche review	USAID/GOG	1/96
7.	Tranche Review	USAID/GOG	2/96
8.	Conditions for Tranche # 2 met	GOG	3/96
9.	Issuance of PIL to certify conditions met and disbursement of Tranche #2	USAID	4/96
10.	Informal tranche review	USAID/GOG	1/97
11.	Tranche Review	USAID/GOG	2/97
12.	Mid-Term Evaluation	USAID/GOG	2/97
13.	Conditions for Tranche #3 met	GOG	3/97
14.	Issuance of PIL to certify conditions met and disbursement of Tranche #3	USAID	4/97
15.	Informal Tranche Review	USAID/GOG	1/98
16.	Tranche Review	USAID/GOG	2/98
17.	Conditions for Tranche #4 met.	GOG	3/98
18.	Issuance of PIL to certify conditions met and disbursement of Tranche #4	USAID	4/98
19.	Informal Tranche Review	USAID/GOG	1/99
20.	Tranche Review	USAID/GOG	2/99
21	Conditions for Tranche #5 met.	GOG	3/99
22.	Issuance of PIL to certify conditions met and disbursement of Tranche #5	USAID	4/99
23.	Final Project Evaluation	USAID/GOG	1/2000
24	Project Closeout	USAID	7/2000

II. IMPLEMENTATION SCHEDULE FOR PROJECT ACTIVITIES

	Event	Responsible Party	Month
	YEAR 1		
1.	Project Authorized and Grant Agreement signed	USAID/GOG	8/94
2.	Issue RFP for US NGO to act as trustee for endowments	USAID	8/94
3.	PIL #1 issued	USAID	9/94
4.	PACC organizes and begins regular monthly meetings	PACC	9/94
5.	Scopes of work prepared and requests made for Western Consortium Population Fellows for HPN Office and Center for Population	USAID/U of Ghana	9/94
6.	Project Start-up Workshop(s)	USAID/PACC	9/94
7.	Sign Agreement with AVSC	USAID/AVSC	10/94
8.	Semi-Annual Review	USAID	10/94
9.	Project monitoring system developed and functioning.	USAID/GOG	10/94
10.	Plans for short-term Local and External technical assistance developed	USAID/NPC/MOH Central CAs	10/94
11.	Initiation of Short Term Technical Assistance	USAID/Central CA	11/94
12.	Sign agreement with PPAG	USAID/PPAG	12/94
13.	HPN Western Consortium Fellows arrive	WC	1/95
14.	First HIV/STD Surveillance Report	MOH	1/95
15.	GSMF & GRMA registered as PVOs	USAID	2/95
16.	GSMF grant signed	USAID/GSMP	3/95
17.	GRMA grant signed	USAID/GRMA	3/95
18.	Semi-Annual Review	USAID	4/95
19.	Consumer Survey begun	NPC/GSMF/GRMA	4/95
20.	Agreement signed establishing an endowed Chair for Center for Population and Development at University of Ghana - Legon	USAID/US based NGO/ U of Ghana	4/95
21.	Agreement signed establishing endowment for GSMF	USAID/US based NGO/ GSMF	4/95

	Event	Responsible Party	Month
	YEAR 2		
22.	CTU updates initiated	MOH/Central CA	8/95
23.	Semi-Annual Review	USAID	10/95
24.	Situation Analysis	GSS	3/96
25.	Semi-Annual Review	USAID	4/96
26.	CBD comparison study	GSMF/Pop Council	4/96
27.	Semi-Annual Review	USAID	10/95
28.	Clinical guidelines for FP providers revised, printed & disseminated	MOH	12/95
	YEAR 3		
29.	Center for Population and Development hires Distinguished Professor	Center	8/96
30.	Semi-Annual Review	USAID	10/96
31.	Mid-term Evaluation	USAID	2/97
32.	Consumer Survey	NPC	3/97
33.	Semi-Annual Review	USAID	4/97
34.	Contraceptive Price Study	NPC/GSMF	5/97
	YEAR 4		
35.	Semi-Annual Review	USAID	10/97
36.	Demographic Health Surveys Begun	GSS/MACRO	2/98
37.	Semi-Annual Review	USAID	4/98
38.	Situation Analysis	GSS/Pop Council	4/98
	YEAR 5		
39.	Semi-Annual Review	USAID	10/98
40.	Consumer Survey	NPC	3/99
41.	Semi-Annual Review	USAID	4/99
	YEAR 6		
42.	Semi-Annual Review	USAID	10/99
43.	Final external evaluation	USAID/GOG	1/2000
44.	Semi-Annual review	USAID	4/2000
45.	Project closeout and final reporting	USAID	7/2000

PERFORMANCE MONITORING PLAN FOR STRATEGIC OBJECTIVE 2, TARGETS AND SUBTARGETS

PERFORMANCE INDICATOR	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Strategic Objective 2: Reduce fertility Indicators:						
Total fertility rate	Unit: # (births) Definition: The average # of children a woman will have, assuming that current age specific rates (15 - 49) remain constant during her childbearing years. Population cohort is women in union from 15 to 49 years of age	DHS 1993, 1998	DHS reports	Every five years	Yes	HPN Office Centrally funded OR-TA project contracts with GSS for carrying out the survey
Comments/Notes: The 1993 Demographic and Health Survey (DHS) has been completed. Publication of the survey results is expected by end July 1994.						
Target 2.1: Increase the use of modern methods of family planning						
Modern method contraceptive prevalence rate	Unit: % Definition: % of women in union, ages 15 to 49, who use modern methods of contraception	DHS 1993; 1998 Consumer surveys (CS), 1993, 1995, 1997, 1999	HPN will contract follow-up surveys to the 1993 baseline survey of consumer knowledge, attitude and practice with regard to family planning. Data will be compared to similar information collected through the DHS.	Every two years	Yes	HPN Office
Couple years of protection by sector (modern methods).	Unit: # Definition: CYP, disaggregated by major provider: Ministry of Health (MOH), Planned Parenthood Association of Ghana (PPAG), Ghana Social Marketing Foundation (GSMF), Ghana Registered Midwives Assn. (GRMA)	MOH, PPAG, GSMF, GRMA	CYP data from service provider facilities to be supplied by MOH, PPAG, GSMF, GRMA	Quarterly	Yes	HPN Office
Comments/Notes: Comments/Notes: Modern methods include: injectables, IUDs, vaginal foaming tablets, condoms, oral contraceptives and sterilization. CYP conversion factors are: vaginal foaming tablets, 100 = 1 CYP; condoms, 100 = 1 CYP; oral contraceptives, 13 cycles = 1 CYP; injectables, 4 = 1 CYP; IUCDs, 1 = 2.5 CYP; female sterilization, 1 procedure = 8 CYP CYP.						

PERFORMANCE INDICATOR	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Satisfied demand	Unit: % The proportion of total demand for family planning by women in union satisfied by current contraceptive use (all methods) Calculation: PDS = C/D Where: PDS is the proportion of total demand for family planning that is satisfied by current contraceptive use (all methods) C is the number of women currently using a contraceptive method for the purpose of either limiting or spacing D is the total number of women with a demand for family planning	DHS 1993, 1998; CS 1995, 1997, 1999		Every two years	Yes	HPN Office
Comments/Notes:						

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PERFORMANCE INDICATOR	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Target 2.2: More appropriate contraceptive method mix						
CPR derived from longer acting methods	Unit: % Definition: ratio of CPR, long-term methods, to CPR, all modern methods. Long-term methods include: injectables, IUDs, sterilization and Norplant, when it becomes available after 1996	DHS 1993, 1998; CS 1995, 1997, 1999		Every two years	Yes	HPN Office
CYP derived from longer acting methods	Unit: % Definition: ratio of CYP, long-term methods, to CYP, all modern methods. Long-term methods include: injectables, IUDs, sterilization and Norplant, when it becomes available after 1996	MOH, PPAG, GSMF, GRMA		Quarterly	Yes	HPN Office
Comments/Notes: Modern methods include: injectables, IUDs, vaginal foaming tablets, condoms, oral contraceptives and sterilization. CYP conversion factors are: vaginal foaming tablets, 100 = 1 CYP; condoms, 100 = 1 CYP; oral contraceptives, 13 cycles = 1 CYP; injectables, 4 = 1 CYP; IUCDs, 1 = 2.5 CYP; female sterilization, 1 procedure = 8 CYP.						

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PERFORMANCE INDICATOR	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Subtarget 1: Increase availability of and access to family planning services and commodities						
FP service providers who restrict provision of FP services on the basis of marital status or spousal consent	Unit: % Definition: the proportion of service providers who do not offer FP services for either of these reasons: No consent from husband Client is not married	Situation analyses, 1996 and 1998	Contractor on centrally funded OR/TA project contracts with GSS to conduct situation analysis Strategy recommended is to repeat observations in the facilities visited during the 1993 study . And as the program expands to include more facilities and service providers the number of facilities under study in the situation analysis should also be expanded.	Every 2.5 years	Yes First analysis carried out in 1993	HPN Office
Facilities in the public/private sector equipped, completed or rehabilitated for provision of longer acting methods	Unit: # Definition: # of facilities renovated and equipped for providing VSC, Norplant, IUCD	Cooperative Agreement for Delivery of Long-Term and permanent methods		Bi-Annual report from Cooperative Agreement	Yes	HPN Office
Subtarget 2: Increase family planning knowledge and approval						
Respondents who know 3 or more contraceptive methods	Unit: % Definition: % of respondents who can spontaneously (i.e. without prompting) name 3 or more contraceptive methods.	DHS 1995, 1998 CS 1995, 1997, 1999		Every two years	Yes	HPN Office
Women who think their husbands/partners approve of couples using a method to avoid pregnancy	Unit: % Definition: % of women who respond that they think their husbands/partners approve of couples using a method to avoid pregnancy	DHS 1993, 1998 CS 1995, 1997, 1999	This question as worded appears in current DHS. It must be added to the 1995 CS.	Every two years.	Yes	HPN Office

Comments/Notes: This selection of indicators has been changed from previous API indicators: % of women citing lack of knowledge as a reason for non-use; % of married women whose husbands approve of family planning; % of husbands who approve of family planning. The number of methods known (unprompted) is an indicator of how many people are exposed to and remember IE&C messages about specific methods. The two indicators which report on male approval of family planning have been rolled into one. However, the number of women who report partner disapproval as the most important reason for not using contraception should continue to be tracked in the CS.

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PERFORMANCE INDICATOR	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Target 2.3: Improve FP program sustainability by increasing resources in the public and private sector						
CYP provided through the public sector	Unit: # Definition: The CYP provided by the MOH disaggregated into long-term (IUCD, injectable, implant, VSC) and short -term (condoms, pills, VFTs) methods.	MOH		Quarterly	Yes	HPN
CYP provided through the private sector	Unit: % Definition: Proportion of total CYP provided through the private sector. Disaggregated into long-term and short-term methods.	GSMF, PPAG, GRMA		Quarterly	Yes	HPN
Cost recovery from MOH commodity sales	Unit: % Definition: Proportion of the cost of commodities paid by clients in public sector facilities	MOH		Annual	Planned	HPN
Comments/Notes:						

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Table 3. STRATEGIC OBJECTIVE 2: BASELINE, EXPECTED RESULTS AND ACTUAL RESULTS

PERFORMANCE INDICATORS	UNIT OF MEASURE	BASELINE DATA		EXPECTED AND ACTUAL RESULTS											
				1995		1996		1997		1998		1999		2000	
		1993	VALUE	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual
Strategic Objective 2: Reduce Fertility Indicators:															
Total fertility rate	# of projected births	1993	5.5											5.0	
Target 2.1: Increase the use of modern methods of family planning															
Modern method contraceptive prevalence rate among women in union	%	1993	10%											20%	
Couple years of protection by sector (modern methods): CYP: Ministry of Health CYP: GSMF CYP: PPAG CYP: GRMA	Years of protection (in ,000s)	1993	350											622	
Satisfied demand	%	1993	26.4%											50%	
Target 2.2: More appropriate contraceptive method mix Indicators:															
% of modern method CPR derived from long-term methods	%	1993	20%											40%	
CYP derived from long-term methods	# (in ,000s)	1993	95											267	

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PERFORMANCE INDICATORS	UNIT OF MEASURE	BASELINE DATA		EXPECTED AND ACTUAL RESULTS											
				1995		1996		1997		1998		1999		2000	
		1993	VALUE	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual
SubTarget 1: Increase availability of and access to family planning services and commodities															
Indicators:															
FP service providers who restrict provision of services on the basis of marital status or spousal consent	%	1993													
# of facilities equipped, completed or rehabilitated for provision of longer acting methods (both private and public sector)	# of facilities	1993	60											115	
Comments/Notes:															
SubTarget 2: Increase family planning knowledge and approval															
Indicators:															
Respondents who can spontaneously name 3 or more contraceptive methods	%	1993	About 23%											50%	
Women who think their husband/partner approves of couples using a method to avoid pregnancy	%	1993													
Comments/Notes:															

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PERFORMANCE INDICATORS	UNIT OF MEASURE	BASELINE DATA		EXPECTED AND ACTUAL RESULTS											
				1995		1996		1997		1998		1999		2000	
		1993	VALUE	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual	Expd	Actual
Target 2.3: Improve FP program sustainability by increasing resources in the public and private sector															
Indicators:															
CYP provided through the MOH	# (in ,000s)	1994	176											240	
CYP provided through the private sector (short-term methods)	%	1993	65%											75%	
CYP provided through the private sector (long-term methods)	%	1993	15%											25%	
Cost recovery from MOH commodity sales	%	1993	5.5%											15%	
Comments/Notes:															

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Table 4. PERFORMANCE MONITORING PLAN FOR TARGET OF OPPORTUNITY AND SUBTARGETS

PERFORMANCE INDICATORS	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
Target of Opportunity: Increase knowledge and practice of HIV/AIDS risk reduction behavior Indicators:						
Percent of respondents reporting using a condom during the most recent sexual intercourse with a non-regular partner	Unit: % Definition: A non-regular partner is any partner of less than 12 months	DHS 1998 CS 1995, 1997, 1999	No baseline data is available for this indicator, a recommended WHO prevention indicator. A baseline will be established with the 1995 CS	Every 2 years	No	HPN/GSMF
% of respondents able to cite as least two acceptable ways of protecting from HIV infection.	Unit: % Definition: % of respondents who answer that AIDS can be avoided by (1) young people delaying start of sexual activity; (2) abstaining from sex; (3) using condoms; (4) staying with one partner; (5) using new needles or blades; or (6) receiving non-contaminated blood for transfusions.	DHS 1998 CS 1995, 1997, 1999		Every two years	Yes	HPN/GSMF
Subtarget 1: Improved diagnosis and effective treatment of STDs Indicators:						
% of STD cases managed as established in national guidelines	Unit: % Definition: % of STD cases which are managed as established by national guidelines on diagnosis, treatment and counseling.	Situation Analysis in public & private sector facilities	Assessment will require two OR studies (1) an extension of the situation analysis of FP service sites in all those MOH facilities which provide (or can provide) STD care. and (2) a special study, comparable to the 1994 study of STD diagnosis in private sector facilities.	1996, 1998	No	HPN GSS will do Situation Analysis under OR-TA project Study of private sector facilities will be contracted locally

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PERFORMANCE INDICATORS	DEFINITION OF INDICATOR AND UNIT OF MEASUREMENT	DATA SOURCE	METHOD/APPROACH	FREQUENCY OF DATA COLLECTION	DATA CURRENTLY COLLECTED?	RESPONSIBLE OFFICE
% of clients seeking STD care who receive appropriate advice on condoms and partner notification	Unit: % Definition: % of clients who are advised to use condoms with non-regular or casual partners and who are advised to notify partners to seek treatment for STDs	Situation Analysis in public & private sector facilities		1996, 1998		
Subtarget 2: Improved HIV/STD surveillance Indicators:						
% reported sero-positive for HIV	Unit: % Definition: % of the low risk specimens analyzed annually in the sero-surveillance system reported as HIV positive Testing will be performed anonymously on women ages 15-24 presenting for ante-natal care.	Reporting from the sentinel surveillance system	Specimens will be collected from sentinel sites (2 in each region) and analyzed for HIV seropositivity. Specimens recorded as positive will be forwarded to one of the zonal laboratories for a second, more sensitive test for confirmation.	Annual	Yes Baseline will be available for 1994	HPN
% reported sero-positive for syphilis	Definition: % positive results recorded on specimens screened for syphilis. Testing will be performed anonymously on pregnant women ages 15-24 presenting for ante-natal care. Testing for syphilis is performed routinely as part of ante-natal care.	Reporting from the sentinel surveillance system	Because of the possibility of positive VDRL with yaws, a second, more sensitive test will be performed to confirm results.	Annual	Yes Baseline will be available for 1994	HPN

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Table 5. TARGET OF OPPORTUNITY: BASELINE, EXPECTED RESULTS AND ACTUAL RESULTS

PERFORMANCE INDICATOR	UNIT OF MEASURE	BASELINE DATA		ACTUAL AND EXPECTED RESULTS											
				1995		1996		1997		1998		1999		2000	
		YEAR	VALUE	Expd	Actual	Expd	Actual	Expe	Actual	Expd	Actual	Expd	Actual	Expd	Actual
Target of Opportunity: Increase awareness of and practice of AIDS risk reduction behavior															
Indicators:															
Percent of respondents reporting using a condom during the most recent sexual intercourse with a non-regular partner	%	1995												50%	
% of respondents who can cite at least two acceptable ways to avoid HIV infection	%	1993	61%											75%	
Subtarget 1: Increased diagnosis and effective treatment of STDs															
Indicators:															
% of STD cases managed as established in national guidelines	%	1996												60%	
% of clients seeking STD care who receive appropriate advice on using condoms and partner notification	%	1996												50%	
Subtarget 2: Improved HIV/STD surveillance															
Indicators:															
% reported sero-positive for HIV	%	1994													
% reported sero-positive for syphilis	%	1994													

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ANNEX K

STATUTORY CHECKLIST: Ghana Population and AIDS (Ghanapa) Program

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE? YES

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

N/A. The project will increase the use and availability of family planning services and improve testing and treatment of HIV/AIDS/STD.

2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

3. **Congressional Notification**

a. **General requirement** (FY 1994 Appropriations Act Sec. 515; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?	YES
b. **Special notification requirement** (FY 1994 Appropriations Act Sec. 520): Are all activities proposed for obligation subject to prior congressional notification?	NO
c. **Notice of account transfer** (FY 1994 Appropriations Act Sec. 509): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?	N/A
d. **Cash transfers and nonproject sector assistance** (FY 1994 Appropriations Act Sec. 537(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?	YES. The CN expired on August 23, 1994.
4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	YES. The Mission has conducted analyses and has prepared detailed budgets for the use of funds.
5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?	N/A

6. **Water Resources** (FAA Sec. 611(b)): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A

7. **Cash Transfer/Nonproject Sector Assistance Requirements** (FY 1994 Appropriations Act Sec. 537). If assistance is in the form of a cash transfer or nonproject sector assistance:

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? YES

b. **Local currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account? N/A

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government? N/A

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?	N/A
(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?	N/A
8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	N/A
9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	N/A. The program will support the Ministry of Health and local NGOs to increase their capacity to provide family planning and AIDS/STD Prevention services.
10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	N/A
11. **Local Currencies**	
a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The Government of Ghana will contribute $15 million in local currency.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NO

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1994 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

b. **Textiles (Lautenberg Amendment)** (FY 1994 Appropriations Act Sec. 513(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? NO

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3)(as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? NO

14. **PVO Assistance**

a. **Auditing and registration** (FY 1994 Appropriations Act Sec. 568): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? — YES

b. **Funding sources** (FY 1994 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? — N/A

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). — N/A. The Project Agreement is not subject to the Case-Zablocki Act.

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? — YES.

17. **Abortions** (FAA Sec. 104(f); FY 1994 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? NO

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? NO

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) YES

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.) NO

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or impart, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? NO

18. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? NO

19. **U.S.-Owned Foreign Currencies**

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1994 Appropriations Act Secs. 503, 505): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. YES

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NO

20. **Procurement**

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? YES

b. **U.S. procurement** (FAA Sec. 604(a): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section? YES

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? N/A

d. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) — N/A

e. **Construction or engineering services** (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) — NO

f. **Cargo preference shipping** (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? — NO

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? — YES

h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — YES

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i. **Consulting services** N/A

(FY 1994 Appropriations Act Sec. 567): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

j. **Metric conversion** YES

(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

k. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? YES

l. **Chemical Weapons** (FY 1994 Appropriations Act Sec. 569): Will the assistance be used to finance the procurement of chemicals that may be used for chemical weapons production? NO

21. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

22. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

23. **Communist Assistance** (FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? YES

24. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? YES

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? YES

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25. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? YES

26. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES

27. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? YES

28. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? YES

29. **Export of Nuclear Resources** (FY 1994 Appropriations Act Sec. 506): Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? YES

30. **Publicity or Propaganda** (FY 1994 Appropriations Act Sec. 557): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? NO

31. **Marine Insurance** (FY 1994 Appropriations Act Sec. 531): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? YES

32. **Exchange for Prohibited Act** (FY 1994 Appropriations Act Sec. 533): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? NO

33. **Commitment of Funds** (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? NO

34. **Impact on U.S. Jobs** (FY 1994 Appropriations Act, Sec. 547):

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? NO

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? NO

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? NO

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1994 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	N/A
2. **Tied Aid Credits** (FY 1994 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	NO
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The program has been developed with the full participation of the Ministry of Health, and Ministry of Finance - the two organizations responsible for implementing and coordinating the program. Skills development and training are integral aspects of the program.

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5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	YES
6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	The program purposes to increase women's access to family planning and AIDS/STD prevention services throughout the country and ecncourage the active enrolment of men. The project will work through several local NGOs to ensure that participation reaches all social economic levels.
7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	YES
8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	YES
9. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	YES

10. **Disadvantaged Enterprises** (FY 1994 Appropriations Act Sec. 558): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The Mission plans to sign a cooperative agreement with the Association of Voluntary Surgical and Contraceptive. (AVSC) and has indicated in the agreement that all efforts be made to use HBCUs, where applicable, for training and service.

11. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

NO

12. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

YES

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet

N/A

been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? NO

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? NO

13. **Energy** (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? N/A

14. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for- nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. N/A

15. **Deobligation/Reobligation** (FY 1994 Appropriations Act Sec. 510): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

16. **Loans**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. **Long-range plans** (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

c. **Interest rate** (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter? N/A

d. **Exports to United States** (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

17. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor- intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

The program provides USAID donated contraceptive commodities ;to the Ministry of Health, and local NGOs, to increase provision of family planning service throughout Ghana. Over 4,000 distribution are currently used with and estimated 10,000 by end of program. The program supports skills development and training for family planning service providers and Ministry of Health and local NGO personnel to increase provision of family planning services in Ghana.

18. **Agriculture, Rural Development and Nutrition,** and **Agricultural Research** (FAA Secs. 103 and 103A):

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value;

N/A

improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

19. **Population and Health** (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

The program purposes to increase women's access to family planning and AIDS/STD prevention services throughout the country and encourage the active enrolment of men. The project will work through several local NGOs to ensure that participation reaches all social economic levels.

20. **Education and Human Resources Development** (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

The project will support training of health care providers in contraceptive methods, contraceptive technology, counselling and referral which are a mix of formal and non-formal mechanism

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21. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;	N/A
b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;	The program will provide grants to three (3) local PVOs to increase their capacity to provide family planning and AIDS/STD prevention services. Technical assistance will be provided through grants to AVSC.
c. research into, and evaluation of, economic development processes and techniques;	N/A
d. reconstruction after natural or manmade disaster and programs of disaster preparedness;	N/A
e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;	N/A
f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.	N/A

22. **Capital Projects** (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level? N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? N/A

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1994, this provision is superseded by the separate account requirements of FY 1994 Appropriations Act Sec. 537(a), see Sec. 537(a)(5).) N/A

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1994, this provision is superseded by the separate account requirements of FY 1994 Appropriations Act Sec. 537(a), see Sec. 537(a)(5).) N/A

5. **Capital Projects** (Jobs Through Exports Act of 1992, Sec. 306, FY 1993 Appropriations Act, Sec. 595): If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided. (Please note the definition of "capital project" contained in section 595 of the FY 1993 Appropriations Act. Note, as well, that although a comparable provision does not appear in the FY 94 Appropriations Act, the FY 93 provision applies to, among other things, 2-year ESF funds which could be obligated in FY 94.)

N/A

ACTION: AID-3 INFO: AMB DCM (5)

ANNEX M

VZCZCAR0380
PP RUEHAR
DE RUEHC #7357/01 0842215
ZNR UUUUU ZZH
P 242214Z MAR 94
FM SECSTATE WASHDC
TO RUEHAB/AMEMBASSY ABIDJAN PRIORITY 4377
RUEHAR/AMEMBASSY ACCRA PRIORITY 5400
BT
UNCLAS SECTION 01 OF 02 STATE 077357

LOC: 203
25 MAR 94
CN: 11411
CHRG: AID
DIST: AID

AID ADM

E.O. 12356: N/A
TAGS:
SUBJECT: ECPR GUIDANCE CABLE - GHANAPA PID/PAIP (641-0131/641-0132) AND AD HOC DELEGATION OF AUTHORITY

1. THE ECPR, CHAIRED BY A/DAA J. WOLGIN, MET ON MARCH 2, 1994. THE PID (641-0131) WAS APPROVED AT A LIFE-OF-PROJECT AMOUNT OF DOLS 32.0 MILLION WITH ESTIMATED OBLIGATIONS OF DOLS 6.6 MILLION AND 5.0 MILLION FOR FISCAL YEARS 94 AND 95 RESPECTIVELY. THE PAIP (641-0132) WAS APPROVED AT A LIFE-OF-PROJECT AMOUNT OF DOLS 13.0 MILLION WITH ESTIMATED OBLIGATIONS OF DOLS 1.0 MILLION AND DOLS 4.5 MILLION FOR FISCAL YEARS 94 AND 95 RESPECTIVELY. OFFICES REPRESENTED AT THE ECPR INCLUDED AFR/CCWA, AFR/DP, G/R&D/POP/RCD, GC/AFR, STATE AF/W AND USAID GHANA. THE MISSION IS TO BE COMMENDED FOR ITS EXCELLENT SUBMISSION. THE FOLLOWING GUIDANCE IS PROVIDED FOR MISSION ACTION DURING THE PP/PAAD DESIGN PHASE.

2. PROJECT FOCUS - THE CONCERN WAS RAISED AS TO THE MISSION'S DECISION NOT TO INCLUDE CHILD SURVIVAL ACTIVITIES IN THE PROGRAM. WHILE BOTH THE MISSION'S CFSP AND THE GHANAPA PROGRAM DO NOT FOCUS ON CHILD SURVIVAL AND SAFE MOTHERHOOD ACTIVITIES, MISSION REPRESENTATIVES NOTED THAT THIS IS NOT MEANT TO IMPLY THAT THESE AREAS ARE NOT IMPORTANT. USAID/GHANA IS CURRENTLY CONDUCTING SAFE MOTHERHOOD AND BREASTFEEDING ACTIVITIES THROUGH THE GHANA REGISTERED MIDWIVES ASSOCIATION. ALTHOUGH THE PRIMARY FOCUS OF THE GHANAPA PROGRAM IS FAMILY PLANNING AND HIV/AIDS CONTROL, OTHER REPRODUCTIVE HEALTH ACTIVITIES SUCH AS BREASTFEEDING WILL CONTINUE TO BE SUPPORTED. USAID/GHANA WILL INCLUDE GENERAL LANGUAGE IN THE PP TO NOTE THAT THEY ARE PROVIDING ASSISTANCE IN THESE AREAS. THE MISSION WILL ALSO INCLUDE SOME INFORMATION ON WHAT OTHER DONORS ARE DOING IN THESE AREAS (IN ADDITION TO PROVIDING MORE INFORMATION ON OTHER DONOR ACTIVITIES).

ADDITIONALLY, THE MISSION WAS REQUESTED TO INCLUDE INFORMATION IN THE PP DISCUSSING THE IMPACT OF INTEGRATING THE FAMILY PLANNING AND HIV/AIDS ACTIVITIES AND TO IDENTIFY POTENTIAL AREAS OF OVERLAP.

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3. OTHER DONOR SUPPORT TO FAMILY PLANNING AND HIV/AIDS - THE JAPANESE GOVERNMENT WILL BE EXPANDING THEIR PROGRAM IN HIV/AIDS AND POPULATION AND HAS IDENTIFIED GHANA AS A PRIORITY COUNTRY. IN THIS REGARD, USAID/GHANA IS ENCOURAGED TO DISCUSS WITH THE JAPANESE THE MODALITIES FOR ENSURING THAT BOTH PROGRAMS ARE COMPLEMENTARY.

4. ENDOWMENT FUND - THE MISSION IS CONSIDERING WHETHER OR NOT THE ENDOWMENT FUND SHOULD BE IN US DOLLARS OR LOCAL CURRENCY OR A COMBINATION. USAID/W ENCOURAGED THE MISSION TO CONTINUE THE DESIGN PROCESS OF THE ENDOWMENT FUND PENDING THE RELEASE OF USAID/W GUIDANCE. WHILE THE ESTABLISHMENT OF THE FUND SHOULD BE INCLUDED IN THE PROJECT'S AUTHORIZATION, THE ENDOWMENT MAY HAVE TO BE APPROVED IN USAID/W IF THE FORTHCOMING USAID/W GUIDANCE SO REQUIRES. USAID/W REQUESTS THAT THEY BE KEPT ABREAST OF ACTIVITIES DURING THE DESIGN PROCESS OF THE ENDOWMENT.

5. CONDITIONALITY - IT WAS AGREED THAT TRANCHE ONE CONDITIONALITY FOR THE "ESTABLISHMENT OF A SYSTEM FOR AN IMPROVED PUBLIC SECTOR CONTRACEPTIVE PRICING STRUCTURE" WILL BE REWRITTEN SO AS TO CLEARLY SPECIFY THAT THE GOG WILL INCREASE CONTRACEPTIVE PRICES PRIOR TO ANY
WAS FURTHER
AGREED THAT THE MAGNITUDE OF THE INCREASE AND THE SCHEDULE FOR FUTURE PRICE ADJUSTMENTS WILL BE DETERMINED FROM AN ANALYSIS OF CONTRACEPTIVE PRICING STRUCTURES AND MARKET FORCES.

6. ALSO IN TRANCHE ONE CONDITIONALITY, THE THIRD POLICY FOR "IMPROVED CONTRACEPTIVE COMMODITY FORECASTING AND STOCKING PROCEDURES," THE DISBURSEMENT OF FUNDS WILL BE PROVIDED AFTER THE NEW FORECASTING FORMULA HAS BEEN DEVELOPED "AND ACCEPTED" BY THE GOVERNMENT AND STAFF

TRAINED ON REVISED PROCEDURES.

7. INSTITUTIONAL ANALYSIS - THE INSTITUTIONAL ANALYSIS SECTION OF THE PAAD WILL HAVE TO ADDRESS THE CAPACITY OF THE GOG TO IMPLEMENT THE PROGRAM'S REQUIRED CONDITIONALITIES.

8. GOVERNMENT OF GHANA INCREASE IN MOE EXPENDITURES - ALTHOUGH THE PID/PAIP PROPOSES TO ENCOURAGE THE GOG TO

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INCREASE THE MOH EXPENDITURES IN FAMILY PLANNING FROM 25 PERCENT TO 40 PERCENT, THE MISSION IS ENCOURAGED TO MONITOR THE EFFECTS OF THESE BUDGET TRANSFERS ON OTHER SECTORS OF THE GOVERNMENT, ESPECIALLY THOSE SECTORS WHERE USAID HAS BEEN ACTIVELY INVOLVED.

9. AD HOC DELEGATION OF AUTHORITY - PURSUANT TO DELEGATION OF AUTHORITY 551, A-DAA/AFR HEREBY DELEGATES AUTHORITY TO THE MISSION DIRECTOR, USAID GHANA, TO APPROVE THE GHANAPA PP/PAAD (641-0131/641-0132) FOR A COMBINED TOTAL OF US DOLS 45.0 MILLION. THIS AD HOC DELEGATION OF AUTHORITY SHALL BE EXERCISED IN ACCORDANCE WITH THE REGULATIONS, PROCEDURES AND POLICIES PROMULGATED WITHIN USAID IN EFFECT AT THE TIME THIS AUTHORITY IS EXERCISED.
CHRISTOPHER
BT
#7357

NNNN

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UNCLAS AIDAC SECSTATE 229290

ANNEX N

ACTION: AID-1
INFO: AMB-1 DCM-0

DISTRIBUTION: AID
CHARGE: AID

RECEIVED
25 AUG 1994
USAID/GHANA

VZCZCAR0645
RR RUEHAR
DE RUEHC #9290 2370613
ZNR UUUUU ZZH
R 250614Z AUG 94
FM SECSTATE WASHDC
TO AMEMBASSY ACCRA 6948
BT
UNCLAS STATE 229290

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: SUBMISSION AND EXPIRATION OF CONGRESSIONAL NOTIFICATION

1. CONGRESSIONAL NOTIFICATIONS FOR GHANA POPULATION AND AIDS PROGRAM (PA) 641-0131 FOR DOLS 2,660,000; AND GHANA POPULATION AND AIDS PROGRAM (NPA) 641-0132 FOR DOS 5,000,000 WENT TO THE HILL ON AUGUST 8, 1994 AND EXPIRED ON AUGUST 23, 1994 WITHOUT OBJECTION.

2. OBLIGATIONS MAY NOW BE INCURRED.
TALBOTT
BT
#9290

NNNN

UNCLAS AIDAC SECSTATE 229290

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GHANAPA BUDGET

GHANTOTS.WK3
19-Oct-94

ITEM/YEAR	YEAR 1 FY1994	YEAR 2 FY1995	YEAR 3 FY1996	YEAR 4 FY1997	YEAR 5 FY1998	YEAR 6 FY1999	TOTAL
I. BILATERAL GRANT AGREEMENT							
A. AIDS/STD COMPONENT							
A. LAB REAGENTS & SUPPLIE	73,000	73,000	73,000	74,000	74,000	74,000	441,000
B. LOCAL TA	20,000	30,000	20,000	30,000	30,000	20,000	150,000
C. TRAINING	65,000	125,000	85,000	125,000	95,000	85,000	580,000
D. OPERATIONS RESEARCH		20,000		20,000	35,000		75,000
Sub-total AIDS	158,000	248,000	178,000	249,000	234,000	179,000	1,246,000
B. MONITORING AND EVALUATION							
A. DHS			500,000				500,000
B. SURVEYS AND STUDIES	25,000	25,000	30,000	140,000	10,000	140,000	370,000
C. EVALUATIONS			165,000			165,000	330,000
Sub total Analytic & OR Studies	25,000	25,000	695,000	140,000	10,000	305,000	1,200,000
C. PROJECT SUPPORT							
A. PERSONNEL							
1. TAACS	103,000	230,000	122,000	128,000	190,000		773,000
2. Program Manager	160,000	117,000	122,000	128,000	190,000		737,000
B. ADMINISTRATIVE	20,000	20,000	20,000	20,000	20,000	19,000	119,000
A. COMMODITIES/EQUIP	165,000	140,000	160,000	125,000	120,000	75,000	775,000
B. PARTICIPANT TRAINING	140,000	220,000	180,000	190,000	140,000	130,000	1,000,000
Sub total	608,000	727,000	594,000	591,000	660,000	224,000	3,404,000
D. AUDITS		30,000	30,000	30,000	30,000	30,000	150,000
TOTAL BILATERAL	791,000	1,030,000	1,497,000	1,010,000	934,000	738,000	6,000,000
II. NGO GRANTS							
A. GSMF GRANT							
1. Administration & Recurrent		210,000	236,000	245,000	226,000	233,000	1,150,000
2. Promotion		425,000	425,000	425,000	425,000	355,000	2,055,000
3. Training		65,000	50,000	50,000	50,000	50,000	265,000
4. Research		65,000	65,000	65,000	65,000	65,000	325,000
5. Warehousing/pack		70,000	70,000	70,000	70,000	70,000	350,000
6. NGO support		85,000	85,000	85,000	40,000	40,000	335,000
2. Less Income		200,000	240,000	290,000	350,000	400,000	1,480,000
Sub total GSMF	0	720,000	691,000	650,000	526,000	413,000	3,000,000
B. GRMA GRANT							
1. PERSONNEL			55,000	55,000	55,000	55,000	220,000
2. MEETINGS			24000	4000	20000	4000	52,000
3. TRAINING		38,000	183,000	186,000	76,000	52,000	535,000
4. ADMIN./ EQUIPMENT		9,000	30,000	30,000	30,000	30,000	129,000
5. SUPPORT/ OTHER		2,000	15,000	16,000	15,000	16,000	64,000
Sub-total GRMA	0	49,000	307,000	291,000	196,000	157,000	1,000,000
C. PPAG GRANT							
1. MALE INVOLVEMENT		120,000	65,000	58,000	70,000	87000	400,000
2. CBD		241,000	75,000	73,000	63,000	68000	520,000
3. ADOLESCENTS		193,000	92,000	90,000	100,000	105000	580,000
Sub total PPAG	0	554,000	232,000	221,000	233,000	260,000	1,500,000
D. AVSC COOPERATIVE AGREEMENT							
1. SUBPROJECTS	371,000	493,000	231,000	497,000	125,000	160,000	1,877,000
2. SALARY & WAGES	85,000	91,000	99,000	107,000	116,000	124,000	622,000
3. CONSULTANTS	16,000	16,000	16,000	22,000	22,000	16,000	112,000
4. TRAVEL & TRANS.	28,000	29,000	31,000	31,000	31,000	31,000	181,000
5. OTHER	25,000	28,000	29,000	29,000	69,000	30,000	208,000
Sub total AVSC	525,000	657,000	406,000	686,000	363,000	361,000	3,000,000
E. ENDOWMENTS GRANT		3,000,000	2,500,000	0	0	0	5,500,000
TOTAL NGO GRANTS	525,000	4,980,000	4,136,000	1,848,000	1,318,000	1,191,000	14,000,000
III. NPA	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	0	14,000,000
IV. OYB TRANSFER	0	2,000,000	2,000,000	3,000,000	3,000,000	1,000,000	11,000,000
GRAND TOTAL	3,316,000	11,010,000	10,635,000	8,858,000	8,252,000	2,929,000	45,000,000