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Rapid population growth combined with poor social and economic conditions is hindering development efforts in many countries. African birthrates are among the highest in the world, and population growth rates are expected to increase as improved health care lowers mortality. Ghana is one African nation that has recognized its population problem. It has promulgated an official population policy, and has established a family-planning program. The United States has provided about 75% of the $15.9 million of population assistance to Ghana. Ghana's program, however, has reached only a small percentage of the population, primarily urban. Recommendations: In planning development assistance for Ghana and other African nations, GAO recommends that the Administrator of the Agency for International Development, as appropriate: encourage governments, and provide support when necessary, to examine the relationships between social and economic change and fertility; help governments to establish population policies which encourage the types of social and economic development identified as having a maximum impact on fertility; consider the impact on population growth of planned U.S. development projects and work to integrate population and development projects; and take actions to encourage the establishment of an effective, systematic coordinating mechanism for population assistance in Ghana and in other countries where none exists. (Author/SC)

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Impact Of Population Assistance To An African Country

Department of State
Agency for International Development

Rapid population growth combined with poor social and economic conditions is hindering development efforts in many nations. African birthrates are among the world's highest, and population growth rates are expected to increase as improved health care lowers mortality. Ghana is one African nation that has recognized its population problem, promulgated an official population policy and established a family planning program.

The United States has provided about 75 percent of the $15.9 million of population assistance to Ghana. Ghana's program, however, has reached only a small percentage of the population, primarily urban. GAO believes changes are needed if the population growth rate is to be lowered significantly and recommends actions the Agency should take, including integration of population and development assistance, to meet this objective.

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JUNE 23, 1977

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-179421
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To the President of the Senate and the
Speaker of the House of Representatives

This is the second in a series of reports on world population growth, its impact on the quality of life, and programs designed to slow growth rates. This report focuses on an African country--Ghana--and addresses the population situation, interrelationships between population growth and social and economic development, and the effectiveness of the population-related activities of the Agency for International Development and others. We believe information of this type is useful to the Congress in considering population and development assistance legislation.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget; the Secretary of State; and the Administrator, Agency for International Development.

Elmer B. Staats
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

IMPACT OF POPULATION ASSISTANCE TO AN AFRICAN COUNTRY
Department of State
Agency for International Development

D I G E S T

This report addresses the impact of assistance by the Agency for International Development and others to help restrain population growth in a developing African country--the problems, restraints, and successes experienced.

Africa has a population of about 400 million, with birth rates among the highest in the world and a 2.6 percent growth rate. This may increase in coming years as currently high death rates are lowered by improved health conditions. Even at the current growth rate, the population will double in 27 years.

Eighteen of the world's 28 least-developed nations are in Africa. Health care is already inadequate, and practical education systems are lacking. Although about three-quarters of the labor force is engaged in agriculture, food production lags behind population growth.

The Agency provided $860 million in the fiscal year 1965-1976 period for programs to restrain population growth in developing countries. Of this total, about $50 million has gone directly from the United States to African nations.

Although most Asian and many Latin American nations have established population policies and family planning programs, less than one-fifth of the African governments, as of 1976, had done so.

The United States had regular bilateral population assistance programs in 1976 in nine African countries. GAO selected Ghana as a case study because it has a population growth problem, an official population policy, an established family planning program, and has

received more direct population-related aid from the United States than any other Sub-Saharan country.

Ghana's population jumped from just over 2 million in 1921 to over 10 million in 1976. The growth rate is now estimated at about 3 percent annually. Many demographers expect this to increase as expanding health services reduce mortality. Even at the current rate, the population is expected to double by the year 2000. (See pp. 3-5.)

Like many African countries, Ghana is trying to put an adequate system of birth and death registration into operation. Nevertheless, available data shows rapid population growth is an important hinderance to development efforts, including improvement in the quality of life. In Ghana:

--Economic growth has not kept pace with increases in population, resulting in a declining per capita real income since 1960. (See p. 8.)

--Domestic food production is not keeping pace with the growing demand. The nutritional status of the population has not improved in the last 10-15 years, and caloric deficiencies are common nationwide. (See pp. 8 and 9.)

--A high percentage of the people are young (under 15), placing a burden on those in the 15-65 work-age groups. (See pp. 5-7.)

--The number of children enrolled in primary and middle schools has increased, but because of population growth, the percentage in relation to the total eligible has decreased. (See p. 11.)

--Less than 30 percent (by estimate) of the population has access to reasonably adequate curative medical services; an even smaller percentage has access to health services to prevent sickness. (See pp. 11-13.)

--Housing and sanitation problems in urban areas are compounded by high levels of migration from rural areas. (See pp. 12-13.)

The Government of Ghana published a strong population policy statement in 1969 that U.S. officials believe could serve as a model for other African countries. It acknowledged the need for a population policy as an integral part of national social and economic planning. (See pp. 16 to 18.)

In January 1970, the government established the Ghana National Family Planning Program in the Ministry of Economic Planning to plan and coordinate family planning activities, using governmental and private organizations. Objectives include disseminating family planning information, increasing clinics providing family planning services, and expanding sales of commercial contraceptives. (See pp. 18 to 23.)

U.S. loans and grants to Ghana through fiscal year 1976 totaled about $300 million. U.S. population assistance began in 1968 and has reached about $9.75 million. Additional U.S. funds were supplied through other organizations. Population assistance from all donors, including Canada, the United Kingdom, the International Planned Parenthood Federation and its U.S. affiliate, and the United Nations Fund for Population Activities, totaled about $15.9 million by mid-1976. The Government of Ghana has been increasing financial support to its population program, for a total of $2.5 million since 1974. No effective mechanism exists for coordinating these sources of population assistance. (See pp. 24 to 29.)

Only about 7 percent of Ghana's 2 million women of reproductive age are counted as family planning acceptors in clinic records. About three-quarters of the registered clinics offering family planning are in urban areas. The program has hardly reached the rural areas where 70 percent of the

population live. It is not believed that an appreciable number of couples are using contraceptives sold commercially. (See pp. 32 to 38.)

Agency officials and others believe that more people would accept family planning if services were provided together with health care. Results of the U.S.-financed Danfa project in Ghana appear to be supporting these views. (See pp. 60 and 61.) However, Agency officials in Ghana also believe that the greatest acceptance level would occur in the context of social and economic development, a point made by a number of African countries at the World Population Conference in 1974. (See pp. 38-40.)

Because of factors such as government constraints and coordination problems, little effective integration of population and other development assistance has occurred. Until this situation is rectified, Agency officials believe it best to continue supporting the Ghana National Family Planning Program, with its emphasis on clinic and commercial distribution systems. (See p. 42.)

Expanding family planning programs will be necessary if such services are to be available to the majority. If such services are to be accepted to the extent required to reduce the population growth rate significantly, measures that improve social and economic environments and help reduce the motivation to have children need to be identified and put into operation. In a recent policy statement, the Agency has recognized the need for such an approach.

The effectiveness of population assistance is improved when there is full coordination of programs by multiple donors. In planning development assistance for Ghana and other African nations, GAO recommends that the Administrator of the Agency, as appropriate:

--Encourage governments, and provide support when necessary, to examine the relationships between social and economic change and fertility.

--Help governments to establish population policies which encourage the types of social and economic development identified as having a maximum impact on fertility.

--Consider the impact on population growth of planned U.S. development projects and work to integrate population and development projects.

--Take actions to encourage establishment of an effective, systematic coordinating mechanism for population assistance in Ghana and in other countries where none exists. (See pp. 44 and 45.)

The Department of State and Agency for International Development reviewed this report and commented that it accurately described the population and family planning situation in Ghana and that they agreed with the recommendations. (See p. 45 and apps. I and II.)

GAO plans to review the need to integrate population and other development programs and the extent to which the Agency has done so in assistance programs in Asia, Latin America, and Africa.

Contents

ABBREVIATIONS

AID	Agency for International Development
CCG	Christian Council of Ghana
FPIA	Family Planning International Assistance
GAO	General Accounting Office
GhRRM	Ghana Rural Reconstruction Movement
GNFPP	Ghana National Family Planning Program
IPPF	International Planned Parenthood Federation
PPAG	Planned Parenthood Association of Ghana
UNFPA	United Nations Fund for Population Activities

CHAPTER 1

THE POPULATION OF A DEVELOPING COUNTRY IN AFRICA

Africa's estimated population in 1975 was about 400 million, about 10 percent of the world's total. Its overall growth rate, estimated at 2.6 percent in 1975, is among the highest in the world. This rate is expected to increase as currently high death rates are lowered by improved health conditions. Even at the current growth rate, however, the population will double in 27 years.

Africa's growing population compounds a number of common population problems and undesirable situations: (1) 15 out of every 100 infants die before their first birthday, (2) life expectancy averages only 43 years, (3) each physician serves 15,800 people, and (4) food production is not keeping pace with population growth.

Official concern with population increases has been slow to develop in most African countries. Thg World Population conference in 1974, attended by most african nations, focused attention on african views. many countries feel that rapid economic and social development, along with increased foreign assisttance and a more equal distribution of the world's wealth and resources, can create the conditions for reductions in population growth rates. A number of African states recognize that population problems in some countries are hindering social and economic development.

The United States directly provided about $90 million in assistance to governments of African nations for population projects during the 1965-1976 period. In 1976 the U.S. Agency for International Development (AID) had regular bilateral population assistance programs in nine African countries--Botswana, Cameroon, Ghana, Kenya, Liberia, Morocco, Nigeria, Tanzania, Tunisia, and Zaire. In addition, the United States provides financial support to private and international organizations that are involved in family planning and other population-related activities in African nations.

We selected Ghana as a case study for this review because it has a population growth problem, an official population policy, an active program, and has received more population assistance from the United States than any other Sub-Saharan African country.

GHANA'S POPULATION SITUATION

Located on the Gulf of Guinea in West Africa, just a few degrees north of the Equator, the Republic of Ghana has an area of 92,100 square miles, slightly smaller than the State of Oregon. (See app. II.) Ghana's 1976 population is estimated at 10.1 million and its growth rate at about 3 percent. Oregon's 1975 population is estimated at 2.3 million; during the 1970-1975 period its population growth rate averaged about 1.8 percent annually, of which about 1.3 percent was due to migrants. At these rates, the population in Ghana will double in just 23 years and in Oregon 38 years.

The Ghanaian economy has a comparatively small modern urban sector, with an educated urban elite consisting of not more than perhaps 3 percent of the country's population. The elite is made up largely of civil servants and military pebsonnel, with much smaller components of professional and business people. The urban population enjys the major part of government expenditures, even though it comprises less than 30 percent of the country's population.

Conditions in the rural areas discourage the young (especially the educated) from pursuing rural and agricultural life and increase the drift to the already overcrowded cities. These same factors deter professionals, more affluent business people, and officials from accepting positions in the rural areas, which further deters modernization and development.

The rural areas, however, are extremely important in Ghana. Based on 1970 data, more than 70 percent of the population live in rural areas; almost 60 percent of total employment is in agriculture. Agriculture and forestry-related products contributed 70 to 80 percent of foreign exchange earnings during the period 1970 to 1973.

While demographic data adequate to describe the typical Ghanaian family is not available, research done in rural areas outside the capitol, Accra, suggests that the typical Ghanaian family in these areas that accepts family planning has five members. The father is a farmer, literate, but with only 1 to 3 years of primary school. The mother is married, illiterate, a Protestant, and a member of the Ga tribe. She is 28 and has had four pregnancies. She has three living children at the time of acceptance, having lost one child through miscarriage or infant mortality.

If she did not accpt family planning, she would probably become pregnant at least four more times and have at least three more children. Besides being a housewife, she also farms.

Population Size and Growth Rate

We believe population censuses are important not only for planning and evaluating population programs, but also for social and economic planning in all areas. A population census was taken in Ghana every 10 years from 1891 to World War II. A census was taken in 1948 and again in 1960, and the most recent one was taken in 1970. Unlike the earlier ones, the 1960 census provided much information on the demographic profile of the population. The 1960 census contains the most complete published data. Much of the information gathered in the 1970 census had not been analyzed in 1976 when we were reviewing the programs in Ghana.

Ghana. as many other developing countries, is trying to implement a system of vital registration capable of producing reliable estimates of birth and death rates and population growth. although the Births and Deaths Registration Act of 1965 made it compulsory to register births and deaths, it has not yet been possible to determine completeness of registration.

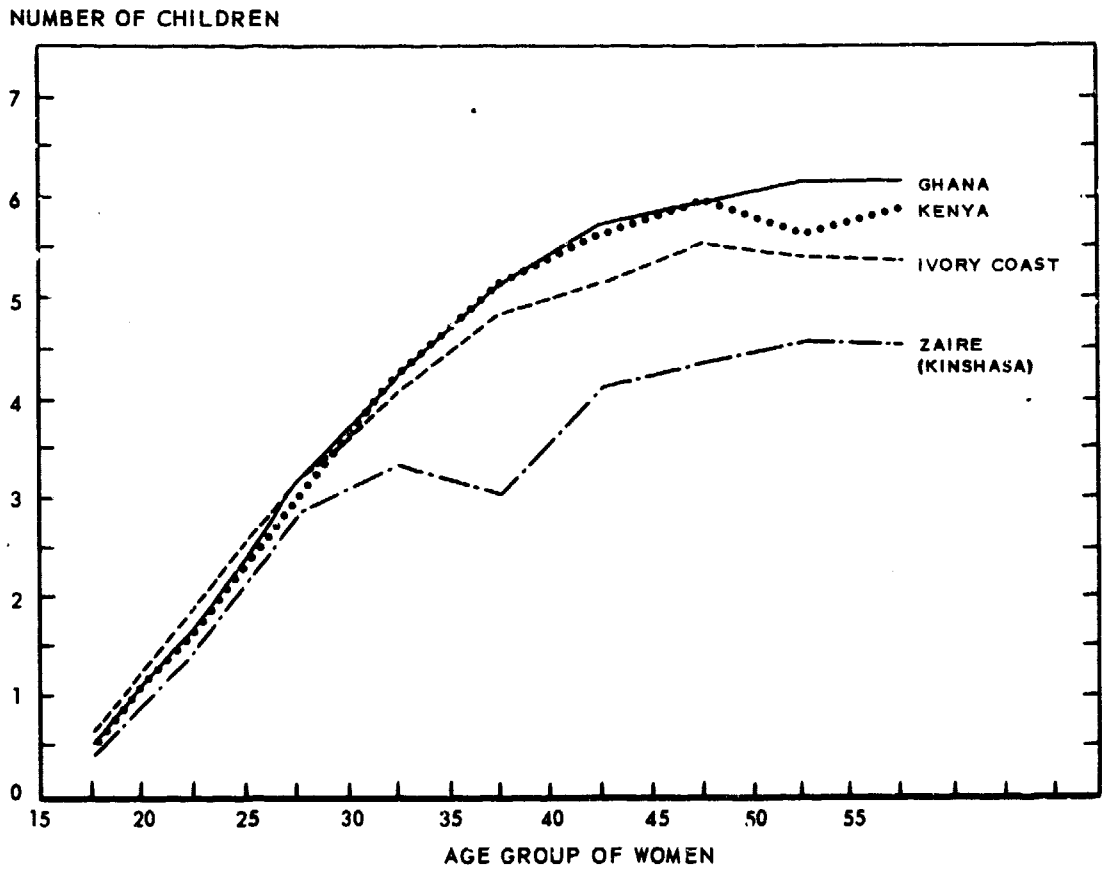
Ghana's population was just over 2 million in 1921. It reached 6.7 million by 1960, 8.6 million by 1970, and was estimated by a government ministry to reach 9.8 million in 1975. It was estimated to be 10.1 million in 1976. Recognizing the possible under-enumeration of the 1970 census and the possible over-enumeration of the 1960 census, some government officials believe that the average rate of growth during the 10-year period was 2.6 percent annually.

Estimates of the 1976 growth rate range from 2.7 percent to 3.3 percent. AID officials in Washington have officially estimated the population growth rate at 2.7 percent, but, agree with USAID/Ghana and Ghana National Family Planning Program officials that the annual rate is now about 3 percent. A further increase in the growth rate, however, is believed likely as the mortality rate falls during the next decade. Ghana's goal is to reduce the growth rate to 1.75 by the year 2000.

Fertility, mortality, and population growth trends

The fertility rate is estimated to be 45 to 55 births per 1,000 persons per year. This rate is high, even for tropical Africa, which has fertility rates among the highest in the world. In Ghana, the average number of children born to women was estimated in a 1969 study to range from 6.5 to 7.3. The graph below shows fertility in Ghana and some other African countries.

AVERAGE NUMBER OF CHILDREN EVER BORN



SOURCE: DYNAMICS OF POPULATION GROWTH IN GHANA, S.K. GAISIE

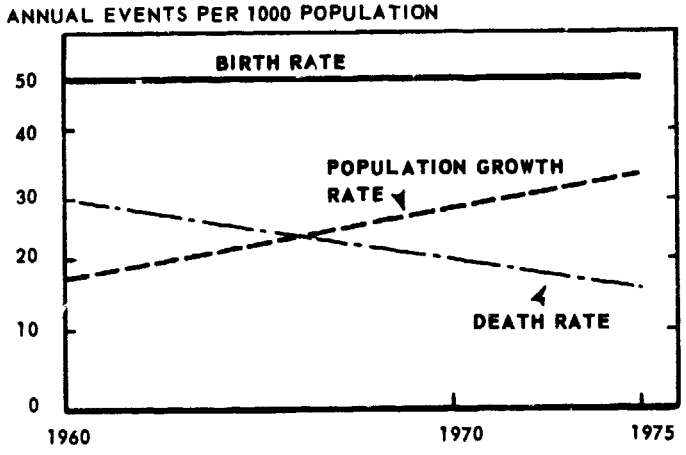
Large families are still favored by most Ghanaians. The table below shows that the Ghanaian ideal family size and the proportion of families wanting four or more children exceed even developing country ideals.

	Ideal family size	Percent wanting 4 or more children
Europe and North America	2.0 - 3.1	4.0 - 49
Asia (excl. Japan), Latin America and North Africa	3.2 - 5.0	25 - 80
Ghana rural	7.5	98(female)
Tropical Africa-rural	6.0 - 7.5	90 - 98
Tropical Africa-urban elite	4.3 - 6.1	88 - 89

Note: "The Control of Family Size in Tropical Africa," (1968) Dr. John C. Caldwell.

The mortality rate (deaths per 1,000 persons per year) was estimated by the government to have declined from 30 in 1960 to 20 in 1970. This compares with the world average mortality rate of 12 for the 1970-1975 period. With estimates of the current population growth rate around 3.0 percent, the population would double in 23 years. The population growth rate, however, is expected to increase in the next few years because of an anticipated decline in the mortality rate as health services are expanded, and because an increasing percentage of the population will be reproductive-age women.

Trends of Ghana's birth, death, and growth rates are depicted below.

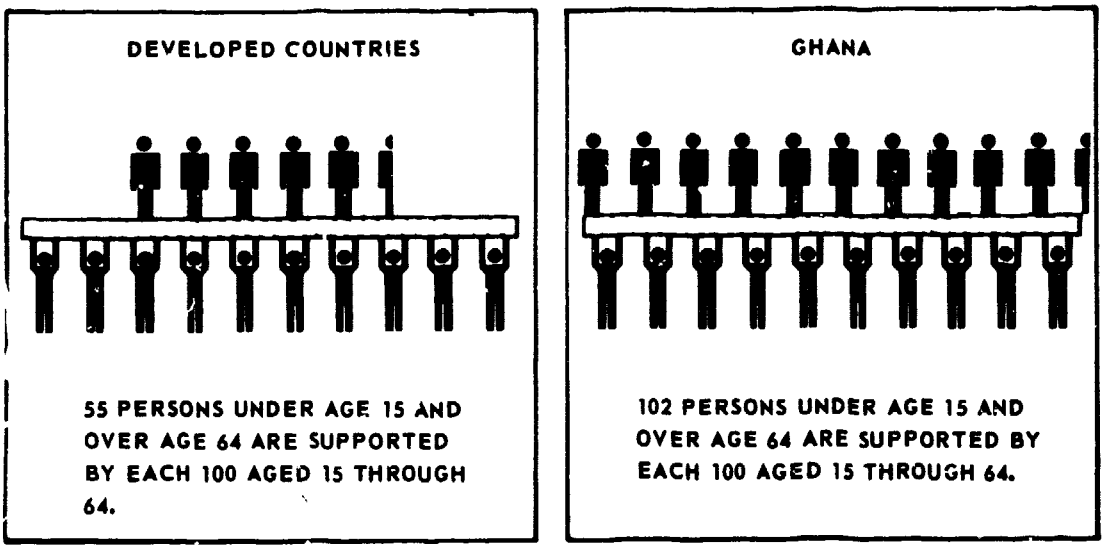


High percentage of dependents

Ghana's high population growth rate has resulted in an increasing percentage of the population in the dependent

age groups. The pecentage of the population under 15 years in 1960 was 44 percent, 47 percent in 1970, and 48 percent in 1975. By comparison, in the United States, 25 percent of the population is under 15. Since 3 percent of Ghana's population is over age 65, only 49 percent of the population is in the 15-65 year old economically-active age group. Of this group, 45 percent are women 15-49 years old, and it is estimated that about 16 percent of them are pregnant at any one time. The graph and age distribution pyramids below illustrate the high proportion of dependents in Ghana.

DEPENDENTS SUPPORTED BY ADULTS IN DEVELOPED COUNTRIES VERSUS GHANA, 1975

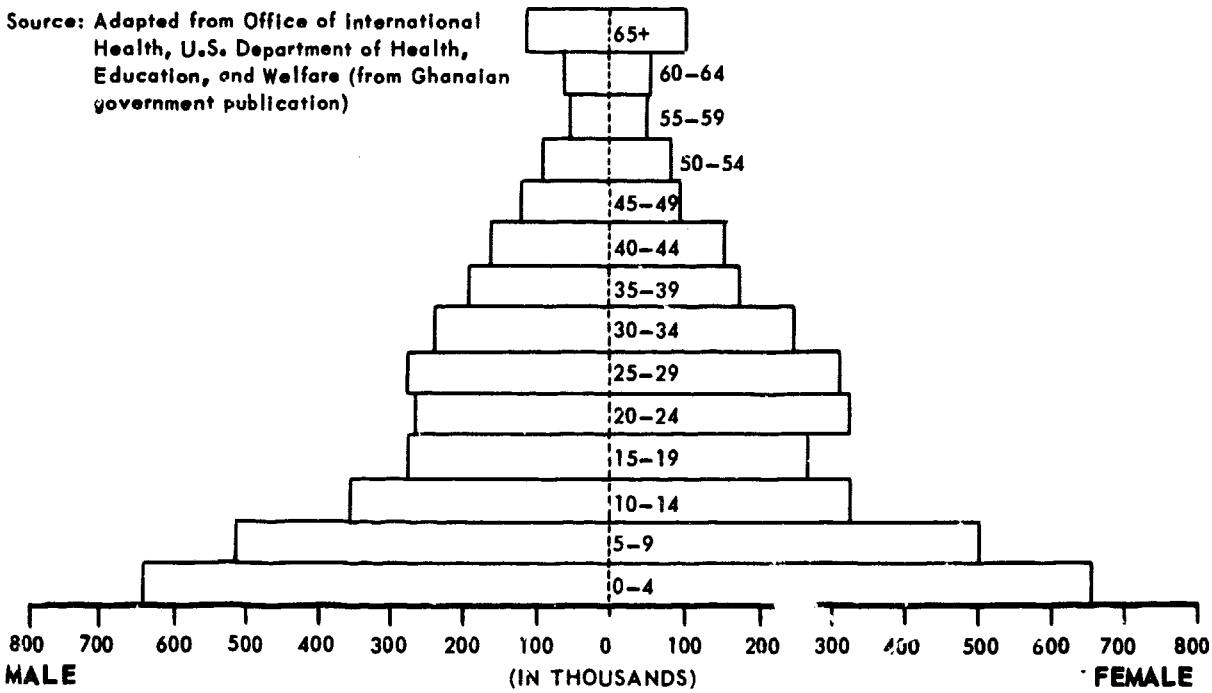


Source: U.S. Bureau of the Census, based on United Nations data and Government of Ghana Ministry of Economic Planning data.

POPULATION PYRAMIDS: 1960 AND 1970
DEMONSTRATING PREPONDERANCE OF YOUTH IN GHANA

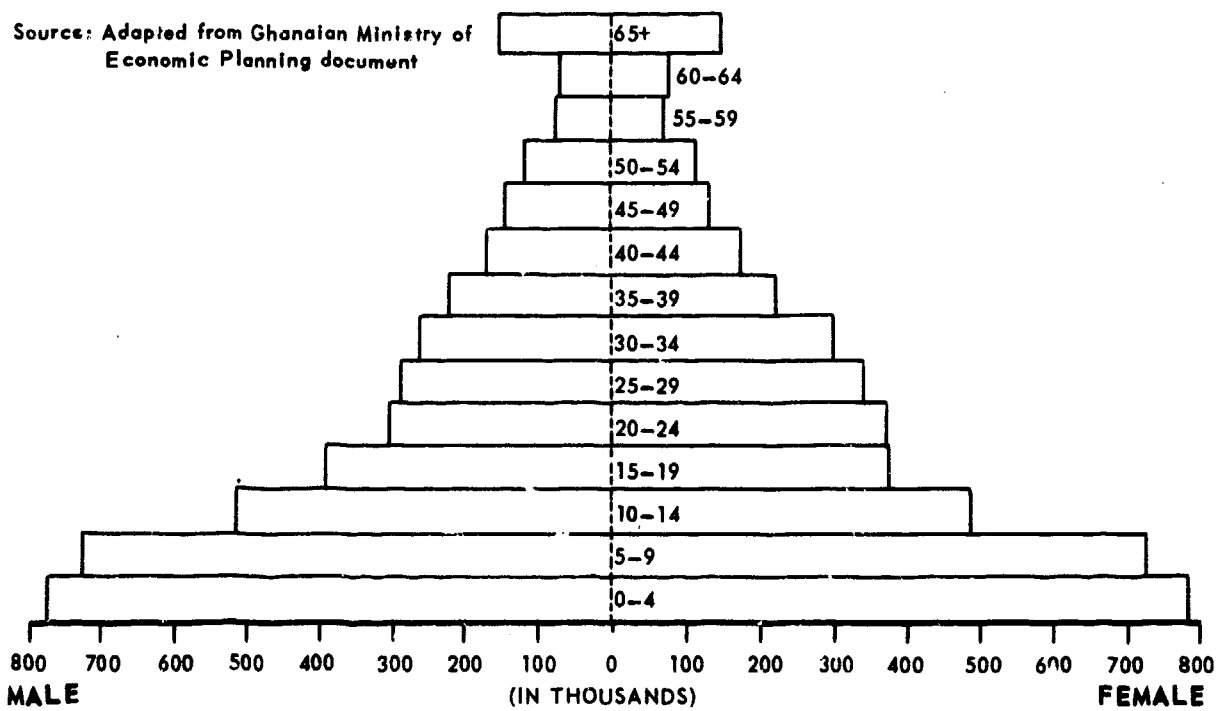
1960 AGES

Source: Adapted from Office of International Health, U.S. Department of Health, Education, and Welfare (from Ghanaian government publication)



1970 AGES

Source: Adapted from Ghanaian Ministry of Economic Planning document



CHAPTER 2

IMPACT OF POPULATION GROWTH ON THE QUALITY OF LIFE IN GHANA

Ghana's population was estimated at about 10.1 million in 1976, up 1.5 million from the 1970 census count. Population growth is impeding social and economic development efforts. The country's gross national product (GNP) in constant dollars grew during the 1960 to 1972 period but per capita income, in constant dollars, declined by 7 percent during the same period. Manifestations of the high population growth rate include increased food imports, burdened health facilities, and a smaller proportion of eligible students in school.

FOOD PRODUCTION NOT KEEPING PACE WITH DEMAND

Specialists generally agree that the nutritional status of Ghana's population has not improved in the last 10 to 15 years. Net food availability has not increased much, if at all, during this period. Caloric deficiencies are common in all parts of the country, with lowest income children and pregnant and lactating mothers receiving only about 50 percent of their requirements. Protein deficiencies are equally common. On the average, only about 60 percent of the protein requirements of the total population have been met, with the most severe shortfalls occurring among infants and young children.

Agriculture in Ghana is characterized by small scale farming--30 percent of the farm holdings are less than 2 acres, and more than 80 percent are less than 10 acres. It is estimated that small farmers, cultivating 10 acres or less, produce about 80 percent of the total food crop production.

Domestic food production kept pace with demand until the late 1950s. Demand was expanding due to population growth and increasing purchasing power. Increases in food production were being achieved mainly through acreage expansion. This continued until about 1958, when domestic production no longer kept pace with demand. Since then, Ghana has had to import increasing quantities of food.

The agricultural sector has made substantial contributions to Ghana's foreign exchange earnings, contributing between 70 and 80 percent from 1966 to 1973. These earnings resulted almost entirely from cocoa exports. Imports of food and live animals averaged more than 17 percent of Ghana's total merchandise imports for the same period, adding to the country's foreign exchange shortages.

Population growth and land use patterns

To maintain soil fertility, small landholders have developed a complex system of land rotation which requires 6 to 8 years of fallow to 1 to 3 years of cropping.

With low population densities and abundance of arable land resources, land rotation and traditional farming practices have done well in maintaining soil fertility and safeguarding the delicate balance between exploitation and regeneration of Ghana's soils. However, with increasing population densities and commercialization, the system of land rotation has in some cases been modified and in other cases used continuously for cropping. For example, in some densely populated areas, such as parts of northern Ghana, the system of land rotation has been replaced by compound farming, characterized by continuous cropping with manure. There is doubt whether the use of manure is sufficient to maintain the present low levels of productivity over a period of time.

According to AID, the following problems have occurred as a result of shortened fallow:

--Loss of soil fertility.

--Soil degradation and erosion.

--Persistent weed growth.

--Increasingly poor yields.

Impact of high fertility on both food supply and demand

Ghana's high fertility rate is causing an increased food demand. To some extent, it also contributes to agricultural productivity by increasing labor input. On the other hand, an AID official told us, the rate of fertility has a subtle effect on the supply side of food production. It is

acknowledged that women farmers in Ghana produce more of the food grown on small farms for domestic consumption than do men. Frequent pregnancies (often with resulting illness and malnutrition) reduce the time and energy these women can devote to farming.

All in all, the two most important challenges of Ghanaian agriculture (according to the USAID Development Assistance Program) are the high rates of population growth and urbanization. These demographic force have the following implications for agriculture:

--Large increases in the market-dependent population.

--Possible shifts in preferences of the market-dependent population to consumption patterns which may be less easily supported by established cropping patterns.

--A decline in the size of the potentisal agricultural labor force (people willing to work in agriculture) but large increases in the size of the total and urban labor force in relation to the employment opportunities of the Ghanaian economy.

EDUCATION: AN IMPORTANT PART OF DEVELOPMENT

The government sees education as a major factor in the nation's social, cultural, and economic future. It has an important role in improving the quality of human life and contributes to a sound economic foundation.

Although education had developed unevenly with the gradual changes in the social system, by 1957 enrollment in primary (ages 6-12) and middle (ages 12-16) schools was nearly half a million. In 1961 free compulsory primary and middle school education was established. Beginning with the 1974-75 school yeaz, such schooling consists of 6 years of primazy and 3 years of middle school.

One of the major objectives of Ghana's educational policy is to progressively increase the number of children in school so that by 1980 every child has access to at least a basic formal education. To achieve this goal, Ghana realizes that it must overcome the present shortage of school spaces.

Proportion of children in school decreasing

Furthermore, although the number of children enrolled primary and middle schools has been increasing, the percent of eleigible children enrolled has been decreasing as shown below.

School Enrollment as a Percentage of Population

Year	Enrollment in primary and middle schools	Population ages 5-14	Percent children in school	Children ages 5-14 not in school
1957	571,580	1,529,199	37.4	957,619
1965-66	1,404,930	2,045,734	68.7	640,804
1970-71	1,389,804	2,452,835	56.7	1,063,031
1971-72	1.415,801	2,543,590	55.7	1,127,789
1974-75	1,490,667	2,835,477	52.6	1,346,810

Ghana is allocating increasing funds for education. The per capita education expenditure for 1974 was 40 percent above that of 1971. Ghana's 1975-76 budget for education provided for expanding primary and middle school enrollment by 70,000. But during that same period the number of children aged 5-14 was expected to increase by at least 100,000. So, while more money is being spent on education, the increase is not keeping pace with the increasing number of primary and middle school age children; the proportion of such children in school has been decreasing.

Quantitative projections indicating the impact of the rising population on school enrollment were made by the Bureau of the Census' International Statistical Programs Center and are included in appendix IV.

HEALTH CARE INADEQUATE DESPITE PROGRESS

A primary requirement for economic and social development is acknowledged to be improving the health of the people. Although the number of health personnel and facilities has increased markedly over the last 20 years, Ghanaians continue to be malnourished. The rural poor suffer a disproportionate burden of diseases from largely preventable causes, because the geographic distribution and allocation of health facilities still greatly favors the urban areas. It is estimated

that less than 30 percent of the population has access to reasonably adequate curative services and an even smaller percentage to preventive health services. The problems are being compounded by a steady increase in population and the resulting increase of a dependent population less resistant to infectious diseases because of undernutrition and malnutrition. According to AID, the following is necessary to improve health in Ghana.

--Better management of existing resources.

--More doctors and paramedical personnel.

--More simple functional health facilities, particularly in the rural areas.

--Increased rural water supplies.

--Educating the public on sanitation and health service benefits.

Ghana's rural areas have few doctors and hospital beds. In 1971 (the most recent year for which data is available), the rural Upper Region had an average of 1 doctor for every 100,000 people. Even in Greater Accra, where medical facilities are most available, the ratio of doctors to people is 1 to 6,000. Similarly, hospital beds ranged from 1 bed for about 1,520 people in the rural Brong-Ahafo Region to 1 for 290 people in Greater Accra.

Quantitative projections indicating the impact of rising population growth on needs for health manpower were made by the Bureau of Census' International Statistical Programs Center and are included in appendix IV.

Water supply and waste disposal facilities, while almost universally deficient, are also more available in urban areas. In 1973 the government estimated that 40 percent of the population had a piped water supply. According to 1975 estimates, however, rural communities receive only 10 percent of the total supply. On a per capita basis, larger city availability approaches that of developed countries, towns under 20,000 have a lesser amount, and villages have scarcely been touched. (Canada is providing assistance in this area.)

Waste disposal facilities are entirely inadequate; the modern sewerage system under construction in Accra will be Ghana's first. There is general agreement that the incidence

and prevalence of diseases related to poor environmental sanitation represents a serious problem. The problem is compounded by population growth and rural-urban migration. Ghana is trying to improve health facilities and services, but at the same time, must also attempt to provide for the 300,000 annual population increase.

Ghana's policy paper on population (see p. 17) notes that high fertility and optimum health are not commonly found together. While high fertility is not the sole cause of poor health, the control of fertility does contribute to improved health.

URBAN MIGRATION AND ECONOMIC GROWTH

Per capita real income has been stagnant in the past decade, and migration to urban areas has increased. The 1970 census shows over 37 percent of the population was born in a region other than where it was counted. The figure for 1960 was about 14 percent. The regional growth rates between 1960 and 1970 ranged from 5.6 percent in the Greater Accra to only 1.4 percent in the Eastern and Upper Regions. An important reason for the different growth rates is migration. Cities are growing faster than rural areas. Available health and social services are strained, and rural-urban migrants often arrive lacking urban skills according to AID. Much of the urban growth has been in the form of shanty towns, and housing and sanitation is characterized as deplorable.

The urban population may surpass the rural population by 2000. Based on the United Nations medium population estimates and analysis, the Bureau of Census' International Statistical Programs Center (ISPC) projects that the number of Ghanaians living in rural areas will rise from 6.8 million in 1975 to 9.8 million in 2000, but the number of Ghanaians in urban areas will advance from 3.2 million in 1975 to 10.5 million in 2000.

Foreign immigration is not significant and has largely been curtailed since enforcement of the Alien Compliance Order of 1969, which brought about the deportation of a number of aliens.

FACTORS INFLUENCING FERTILITY IN GHANA

Historically, the high birthrate in Ghana has been related to culture and environment--tribal society, attitudes,

and practical considerations. Studies have shown that family fertility decisions are responsive to changes in the family's economic and social environment and in personal attitudes. But, the nature of fertility determinants, the changes they undergo, and their interdependence, is complex and the relative importance of different factors is difficult to assess. Several factors affecting fertility may change simultaneously.

Traditional way of life

In the past, high fertility was considered necessary to offset high infant and child mortality. There was a cultural preference for sons to insure survival of the family line. Parents had to depend on grown children for support in their old age. Under conditions of subsistence agriculture, children began to contribute at an early age and cost little to support. Aspirations were low and expectations of a better life were largely absent. The relationship between high fertility and poor maternal and child health was not understood. Traditionally, the value of a woman was defined largely in terms of her ability to bear children. The weight of community and family pressures encouraged high fertility.

Kinship societies

Traditionally, Ghanaian tribal societies have been organized along matrilineal or patrilineal groupings with several generations living together as extended families. Property holding, inheritance, and family decisionmaking are organized around those with common blood relationships rather than between husbands and wives.

These corporate kin groups place high value on children as a means of perpetuating a man's lineage and as security in old age. A large family has been a mark of prestige and honor to the parents. One tribe honors a mother of 10 in a public ceremony of congratulations. By contrast, barren women are often regarded with contempt and pity.

Corporate kin groups provide economic and personal support for their members in the bearing and nurturing of children. Individuals, therefore, have a sense of security in undertaking marriage and parenthood. Children, as members of the lineage, are looked after by other members of the kingroup. Furthermore, the economic burden of rearing children is shared because a child draws from the general storehouse and not the parents' income alone.

Education

Data indicates that completed fertility for Ghanaian women, both urban and rural, aged 45 and over, is inversely related to educational status.

Completed Fertility (Average Number of Children Ever Born Per Woman Aged 45 and Over) By Educational Status (note a)

Educational status	Completed fertility		
	All women	Urban	Rural
No education	6.2	5.7	6.2
Elementary	5.5	5.2	5.9
Secondary	2.1	2.5	1.0
University	0.4	0.5	---

a/ Source: "Dynamics of Population Growth in Ghana" S. K. Gaisie.

Research in Ghana has not determined precisely why education corresponds with reduced fertility. It may lead to marriage postponement, increased knowledge of contraceptives, changed attitudes toward birth control, and, by providing greater employment opportunities for women, increase the "opportunity cost" of children.

Whatever the reason(s), it is clear that traditional beliefs and practices are affected by social and economic changes. The Ghana Rural Reconstruction Movement Mampong Valley project may provide some useful data in this area (see app. VIII).

Urbanization

As urbanization increases, one might expect the kinship influence to diminish. There is some indication that in urban areas practical considerations have begun to overtake cultural practices as determinants of fertility.

In Ghana, rural fertility exceeds urban fertility by 15 percent, and the urban-rural differences within regions range from 3 percent in the north where urbanization is minimal to 36 percent in Ashanti. Explanations offered by a Ghanaian demographer for the urban-rural differential included: marriage at a later age in urban areas, greater use of contraceptives in larger towns, and different age structures of urban and rural populations.

CHAPTER 3

GHANA'S DEVELOPMENT AND POPULATION POLICIES

Ghanaian population growth attracted government attention after the 1960 census showed a population increase of two-thirds more than the 1948 census. Concern and interest grew during the decade, resulting in the publication of an official population policy in 1969. AID officials believe this paper, "Population Planning for National Progress and Prosperity," could serve as a model for other African countries.

In January 1975, the government published "The Guidelines for the Five-Year Development Plan" for 1975-80. This is a qualitative statement of development strategy and outline for a plan whose major goals include economic growth, full employment, equitable income distribution, national economic independence, maintenance of a reasonable external balance of payments, and reasonable price stability. We believe that rapid population growth will hinder, directly or indirectly, full achievement of many of these goals.

The guidelines emphasize agricultural and rural development, pointing out that development efforts in the past have been concentrated in the largest urban areas, resulting in an inequitable distribution of social services and facilities. Improvement in the distribution of education and health services are identified as important objectives.

Although the guidelines for the 1975-80 development plan have been published for some time, when we did this review the plan itself was not published.

AID officials believe, however, that family planning policy and programs will be an integral part of the plan. High government officials have shown increased interest in a family planning policy. For example, the government supported a national family planning seminar in January 1976.

GHANA'S POPULATION POLICY

As stated, official concern over the population growth rate developed during the 1960s. The 1963 "Seven-Year Development Plan" warned that the rapid population increase would impede development and strain the economy. In 1966-67, a multivolume study ("A Study of Contemporary Ghana") pointed

out that economic savings could be realized by reducing the rate of population growth.

In 1968, the Ghana Manpower Board prepared a statement of national population policy. This was published in 1969 as the official policy paper "Population Planning for National Progress and Prosperity." In his preface to the policy statement, the Commissioner for Economic Affairs noted:

> "This is the first time in the history of this country that the Government has defined its policies on population and has taken a definite stand in the matter of population growth...
>
> The size of our present population does not pose immediate problems for us. However, the rate at which the population is increasing will very certainly create serious social, economic, and political difficulties before the turn of the century. If we want to alter the rate of growth, even marginally, in two decades' time, we must initiate action now."

The statement itself read, in part:

> "The population of Ghana is the nation's most valuable resource...
>
> The welfare of the nation is now endangered by a subtle, almost imperceptible demographic change. During vhe past three or four decades the death rate has been slowly falling, permitting more children to survive into adulthood and adding years to the life expectancy of our people. But while the death rate has been falling, there has been no noticeable change in the birth rate...
>
> Unless birth rates can be brought down to parallel falling death rates, Ghana's population will climb at a rate very dangerous to continuing prosperity, and the children of the next few generations will be born into a world where their very numbers may condemn them to life-long poverty...
>
> Ghana is now producing more children than it can comfortably provide for..."

AID summarized the statement's major policy recommendations as follows:

--Details of the population program were to be developed by participation of national and regional, public and private entities.

--Reduction of morbidity and mortality were to be an important part of the program.

--Quantitative goals were to be set on the basis of reliable demographic data.

--The government would encourage and provide information and assistance to persons wishing to space or limit the size of their families, but this would be done through persuasion rather than coercion.

--Efforts would be made to expand the nondomestic role of women in the economy to reduce pro-natalist influence.

--Policies would be adopted to regulate internal migration and immigration.

--Agreements with international public and private organizations would be developed to benefit from their experience and assistance in population programs.

Considering its promulgation date, we believe Ghana's official population policy is comprehensive and progressive. U.S. officials believe it could serve as a model for other African countries. Like the World Population Plan of Action (which resulted from the World Population Conference held in Bucharest, Romania, in August 1974), it stressed the interrelation of social, economic, and cultural development with population goals and policies.

GHANA NATIONAL FAMILY PLANNING PROGRAM

In January 1970, the government authorized the establishment of the Ghana National Family Planning Program (GNFPP). Because the population policy and GNFPP were considered integral parts of social and economic development work, the secretariat was placed within the Ministry of Economic Planning. The secretariat is responsible for planning and coordinating the activities of GNFPP.

GNFPP was designed to utilize existing institutions, facilities, and personnel in both the public and private

sectors. Various ministries and agencies were to be involved in family planning activities.

--The Ministry of Health is primarily responsible for the provision of contraceptive services, for patient education, and for the training of technical personnel involved in the service program.

--The Ministry of Information and the Ministry of Labor, Social Welfare, and Cooperatives are primarily responsible for the information and education components of the program. The personnel and facilities of these ministries are utilized for both the mass media and personal contact programs.

--Personnel from the Ministries of Education and Agriculture (Extension Services Division) are also to contribute to the information and education aspects of the program.

--The Planned Parenthood Association of Ghana (PPAG) and the Christian Council of Ghana (CCG), both in the private sector, provide contraceptive services and play important roles in the training and public information activities.

The secretariat has overall responsiblity for planning and coordinating the activities of GNFPP, while the participating agencies are responsible for the operational aspects of the program.

GNFPP 5-YEAR PLAN: 1973-1978

In 1970, GNFPP developed a 5-year (1973-78) plan of action which had an overall goal of reducing the population growth rate to 1.75 percent annually by 2000. The plan noted, however, that initially, the death rate would probably decline much faster than the birthrate so that not much decline in the growth rate should be expected before 1985. GNFPP realizes that the growth rate in Ghana is anticipated to rise to 3.5 percent per year before it declines.

The 5-yeaz plan called for GNFPP not only to expand family planning services but also to create an environment conducive to generating increased demand for such services. Generally, the plan specifies:

(1) Increasing the number of family planning clinics offering a full range of services.

(2) Expanding commercial outlets for distributing non-prescription contraceptives.

(3) Establishing satellite clinics at district and village levels using mobile health and family planning teams.

(4) Staffing family planning clinics with qualified nurses, auxiliaries, health educators, and field workers.

(5) Recruiting and training traditional village birth attendants (who help women with their deliveries), physicians, family planning nurses and auxiliaries, community health nurses, and part-time and full-time field workers.

Most outside financial support for GNFPP has come from the United States. While other donors have supported population programs in Ghana, mostly in research and university training, the United States has been the major outside supporter of operational family planning services. During fiscal years 1971-1976, the United States provided about $3.2 million to GNFPP. The Ghanaian government began providing financial support to GNFPP in 1974 and has been increasing its support each year. Through fiscal year 1976, it had committed about $2.5 million. The sources of GNFPP funding are shown in appendix V.

GNFPP billboard in Accra. One of several displayed in urban areas.

Ministry of Health Maternal and Child Health Clinic in Cape Coast, Central Region. This clinic provides family planning on Tuesdays from 2:00 to 4:00 p.m. It had 168 new acceptors in 1975.

GNFPP ACTIVITIES: ROOM FOR IMPROVEMENT

GNFPP secretariat was established in the Ministry of Economic Planning to plan and coordinate the family planning program. GNFPP provides nonclinical contraceptives (foams and condoms) for the commercial distribution program. Some 600 commercial outlets are said to be involved. It also is involved in disseminating information, training paramedics, family planning nurses, and field personnel, and coordinating population programs. GNFPP operates no family planning clinics on its own, but clinics in Ghana register with it and supply data on family planning acceptors.

From 1972 through 1975, the number of family planning clinics registered with GNFPP increased from 140 to 189. We estimate, however, that only about three-fourths of these clinics are active in family planning and report their activities. Of these active clinics, about 50 percent are operated by the Ministry of Health, and the remainder by PPAG, CCG, and other private organizations. The family planning clinics operated by the Ministry of Health use facilities of its health clinics, whereas almost all of those operated by PPAG and CCG offer only family planning services. While Ministry of Health family planning clinics are collocated with health clinics, family planning sessions are separate from health clinic sessions and often are offered for only a few hours per week.

During our discussions, GNFPP, AID, and other officials expressed a need for better coordination between the ministries and GNFPP. Officials of GNFPP secretariat believe that the ministries should be more involved in family planning. For example, hospital and other Ministry of Health facilities and staff had not been made available for family planning services as expected by GNFPP, and trained family planning nurses did not always practice family planning at health clinics. GNFPP officials also noted difficulty getting the Ministry of Information to distribute GNFPP literature.

Another improvement would be to increase the number of hours family planning services are available at the Ministry of Health clinics. AID officials want family planning to become an integral part of the maternal/child health clinic.

We asked Ghanaian, AID, and other officials how such situations can be resolved. Some felt that placing GNFPP secretariat in the Ministry of Health would provide greater continuity of family planning and health care services. One

observer noted that the existence of a separate organization charged with family planning generally creates conflict. GNFPP officials commented that a strong family planning organization was necessary in Ghana, at least in the early phases of program development, because of the pro-natalist culture within which the program was to operate. They stated GNFPP was placed within the Ministry of Economic Planning because various ministries and private organizations were supposed to play an active part in the total effort. One of GNFPP's chief concerns has been to convince the relevant ministries of the importance of family planning to their particular programs. They hope that once this concern and commitment has materialized, the ministries will assume increasing responsibilities for the family planning program, and integrate it more fully within the total development effort.

Recent signs indicate that the family planning program in Ghana may be at a turning point. High government officials have affirmed the importance of family planning in the context of total development. The Ministry of Health has also shown more interest in family planning. It has pointed out the importance of family planning as an integral part of maternal/child health care and has planned seminars for regional health personnel to explain and encourage that relationship. AID officials noted, however, that family planning has still been offered only in separate sessions and not as an ongoing function of the maternal/child health clinic.

CHAPTER 4

U.S. AND OTHER DONOR ASSISTANCE

The United States, multilateral organizations, and other countries have provided a substantial amount of economic assistance to Ghana since 1946. Assistors and amounts provided include:

Country or organization	Amount (in millions)
United States	a/$290.4
World Bank (International Bank for Reconstruction and Development/ International Development Association	a/ 162.3
African Development Bank	a/ 10.3
United Nations programs	a/ 35.7
Federal Republic of Germany	b/ 128.0
United Kingdom	b/ 86.1
Canada	b/ 63.6
Total	$776.4

a/ Assistance fiscal years 1946-1975.
b/ Assistance calendar years 1960-1974.

Assistance to Ghana has gone through several phases. From 1962-66 assistance from governments and multilateral agencies averaged about $30 million per year. During the period 1967-71, the United States and other Western donors increased their average annual assistance to $67 million. Assistance slowed, however, in 1972 when a new government was formed. In late 1974 and in early 1975 bilateral-debt rescheduling agreements were signed by all major donors, clearing the way for major assistance.

U.S. ECONOMIC ASSISTANCE

U.S. economic assistance from 1962 to 1971 increased from $11.6 million per year in the first 5 years to $31 million per year in the second 5 years. Most of the assistance from 1967 to 1971 was directed to balance-of-payments support through loans to finance import of commodities and Public Law 480 sales of agricultural commodities.

U.S. assistance following Ghana's 1972 change of government was relatively limited. Only AID's population program assistance continued at its pre-1972 level. Beginning in 1975, after the debt resettlements, the United States planned significant increases in aid. In fiscal years 1973 through 1976, U.S. economic assistance totaling about $60 million was obligated, including a large loan approved before the change in government, but withheld until after the debt settlements.

In 1961, Ghana became the first country with a Peace Corps program. Since that time, more than 1,500 Peace Corps volunteers have served in Ghana--two-thirds of these have served in the education sector. In 1976, 176 of the 211 volunteers were working in this field. Peace Corps expenditures in Ghana over the last 5 years have averaged about $1.5 million yearly.

OTHER DONORS' ASSISTANCE

The World Bank Group expects to provide up to $70 million annually in the next 3 years, concentrating on livestock, agricultural, and rural development. Of particular note is the proposed $21 million credit from the International Development Association for an integrated agricultural development project for the Upper Region. (See p. 41.) The Federal Republic of Germany is concentrating its assistance on a rural development scheme centered on rice production in the Northern and Upper Regions and expects to provide about $16 million per year from 1975 to 1980. The Canadians have a major village water supply project in the Upper Region and want to increase assistance to the rural sector. Canada's commitment is expected to approximate $20 million per year. The United Kingdom plans to provide support to the Upper Region agricultural development project.

POPULATION ASSISTANCE TO GHANA

Less than 2 percent of all economic assistance from all donors to Ghana has been for population programs. For fiscal years 1971-76, population assistance from countries and international and private organizations has totaled about $15.9 million. Approximately 75 percent (about $11.9 million) of this assistance has come from the United States, through various channels. (See app. VI.) Donor assistance to population programs over the next few years is expected to total about $10.6 million, with the United States providing almost 75 percent of that assistance, directly and indirectly.

Officials of two other major countries told us they believed their assistance was needed more in agricultural and rural development than in population programs.

U.S. STRATEGY FOR POPULATION ASSISTANCE

The United States' assistance to Ghana's population programs has come from (1) AID's centrally-funded programs, planned and managed by AID's Washington Office of Population and Mission-planned bilateral programs, (2) funding of private organizations, and (3) support of the United Nations Fund for Population Activities.

AID's 5-year strategy for providing population assistance to Ghana, issued in January 1975, included the following points:

--Assist in modernizing the planning and management structures in GNFPP and the Ministry of Health.

--Strengthen the integrated family planning sector approach within the Ministry of Health.

--Continue to improve the commercial distribution section of Ghana's overall population program.

--Continue working with other donors who support information, education, and communication efforts in the family planning area.

--Continue support for ongoing research and evaluation projects.

--Encourage GNFPP support of the voluntary agency portion of the program.

AID envisions that, if the above strategy is successful, it will have provided a base for the family planning delivery system by the end of fiscal year 1980. Major elements will be

--a strengthened management, planning, and support staff of GNFPP,

--an expanded commercial distribution program for contraceptives, and

--two hundred Ministry of Health facilities and an appreciable number of voluntary agency facilities offering integrated family planning services.

U.S. POPULATION PROJECTS

Since fiscal year 1971, there have been two AID bilateral population projects and five regional or worldwide projects which involve family planning activities in Ghana. (See app. VI.) Each of these projects is briefly described in appendix V and summarized below. An eighth project supports family planning in the context of rural development, but funds are not allotted to AID's population category.

One bilateral project supports the Ghana National Family Planning Program. Over $3.2 million (primarily for commodities, budget support, and training) was granted during the fiscal year 1971-76 period. AID expects to provide about $3 million in the next 3 years. The other major bilateral project is support of the Danfa rural health and family planning project. Implemented through a contract with the University of California, this project seeks to test various approaches to delivering health and family planning services and strengthening Ghanaian personnel capability in related areas.

Five regional projects now include activities in Ghana. The university teaching of population dynamics project has presently been implemented at the University of Ghana. About $1.5 million had been provided by mid-1976. The demographic teaching and research project at the University of Cape Coast involves teaching at that school and studying mortality trends in southwest Ghana. The World Education Incorporated family life education project has a program in Ghana to integrate family planning components into the adult education network. The African health training institutions project involves both seminars and work with health schools in Ghana and eight other nations. A project designed to improve commercial contraceptive distribution in five countries is planned for Ghana.

OTHER DONORS' POPULATION PROGRAMS

Private organizations, the United Nations Fund for Population Activities (UNFPA), and third countries have provided assistance to Ghana's population programs. The U.S. Government contributes significant portions of the funds to several of the private organizations and UNFPA. (See app. VI.) Two private organizations, the International Planned Parenthood Federation and Family Planning International Assistance, are directly involved in the provision of family planning services. A third private organization, the Ford Foundation, has provided funds to pay the salary of a technical assistant

responsible for establishing a research and evaluation unit within the GNFPP. The UNFPA is providing funds for research and improved demographic data gathering. The United Kingdom and Canada have provided small amounts of equipment and funds to GNFPP. Appendix VI lists population assistance to Ghana.

International Planned Parenthood Federation (IPPF) and Planned Parenthood Association of Ghana

IPPF affiliate in Ghana is the Planned Parenthood Association of Ghana (PPAG), which staffs and operates about 36 family planning clinics. A number of these are open only one day per week. These clinics are not collocated with facilities which deliver other health services and in the past have provided only family planning services. PPAG officials, however, are experimenting with clinics that provide some maternal and child health services as well. In addition to providing contraceptives at its clinics, the PPAG also promotes family planning through home visits, talks, lectures, group meetings, film shows, and exhibitions by its field workers.

PPAG's involvement began in 1967. IPPF has provided $2.1 1/ million since 1971, to support PPAG operations. The United States is a major contributor to IPPF. Annual IPPF funding of PPAG currently is about $400,000. As a major participant in GNFPP's new activities, PPAG will also benefit from AID's 1977-1979 population program support project (see pp. 59 and 60).

Family Planning International Assistance and Christian Council of Ghana

Family Planning International Assistance (FPIA) is the overseas division of the U.S. IPPF affiliate, the Planned Parenthood Federation of America. FPIA supports another private Ghanaian organization providing family planning services--CCG. The CCG operates 12 free-standing family planning clinics. While these clinics do not provide any other form of health service, they do provide marriage and family counseling. FPIA began supporting CCG in July 1973; prior to that CCG was supported by IPPF. FPIA has provided about $200,000 to CCG. Like PPAG, CCG is to have a role in GNFPP's

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1/ This figure includes IPPF support of Christian Council of Ghana (CCG) prior to 1973. See comments in FPIA section.

new intensive outreach demonstration project, which receives AID funding. (See p. 55.)

United Nations Fund for Population Activities

Current UNFPA activities in Ghana include the United Nations Regional Institute for Population Studies and assisting the births and deaths registry under Ghana's Central Bureau of Statistics.

The Institute seeks to promote and strengthen research and training in demography and related fields in English-speaking countries of Africa. Housed at the University of Ghana near Accra, the Institute is a joint effort of the United Nations and the Ghana Government and offers three programs:

--A 12-month course leading to a graduate diploma in population studies.

--A course lasting at least 9 months for a master of arts degree in population studies.

--A Ph.D. degree program in population studies.

Other Institute activities include data collection, government advisory services, and seminars and workshops in interested countries. The total cost of the project, which began in 1972, is expected to be $2.8 million through 1977, with 1975 expenditures estimated at $300,000.

The other active UNFPA project is assistance for the expansion of the national registration system for births and deaths and development of vital statistics. This 7-year project aims at establishing a nationwide birth and death registration system and capability to use vital statistical data in making reliable estimates of the country's population. The project began in January 1976; UNFPA's contribution is expected to be $2.8 million.

NEED FOR EFFECTIVE COORDINATION OF POPULATION ASSISTANCE

Foreign governments, international organizations, and private nonprofit orgarizations are providing population assistance to Ghana. The diagram on page 31 illustrates the flow of this aid, often through intermediaries, to recipient organizations.

We observed, however, that there is no systematic, effective coordinating mechanism that seeks to maximize benefits from limited resources and to make sure that the nature and results of projects are fully disseminated. Specifically, we noted the absence of a regularly-scheduled meeting of representatives of donor and recipient organizations--both private and governmental--to discuss the population situation and related projects.

Without making a full examination, we did learn of several situations which might have been prevented by such meetings. For example:

--A PPAG and a Ministry of Health clinic offering family planning were located closely together, but we were told that coordination between their field workers was ineffective.

--One GNFPP official pointed out that the U.S. Mission-planned Danfa project (see pp. 60 and 61) and two U.S. centrally-planned projects [university teaching of population dynamics and demographic teaching and research (see p. 62)] were not fully coordinated to the extent desirable.

--A professor with the demographic teaching project told us he was unaware of social and economic data being collected by the Danfa project (see pp. 60-62) and was also unaware of research being done by the U.N.-funded Regional Institute for Population Studies Program.

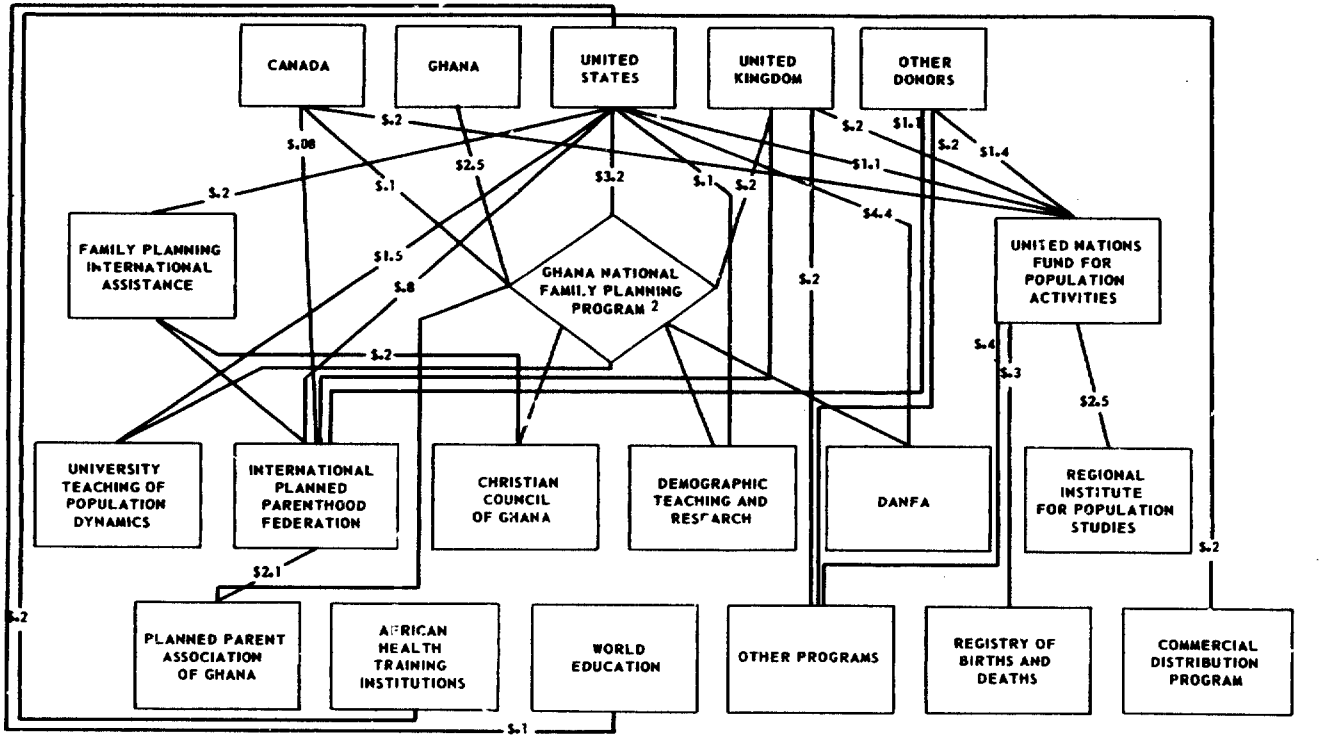
--A CCG official said he was unaware that his organization had a defined role in AID's 1977-79 support grant to GNFPP. (See pp. 58-60.)

We believe effective systematic coordination mechanisms are needed to maximize the impact of population assistance when multiple donors and organizations are concerned. For example, in Costa Rica, meetings of organizations involved in population assistance and family planning projects are held.

We recommend that AID act to encourage establishment of effective systematic coordinating mechanisms for population assistance in Ghana and other African countries where none exist. (See p. 45.)

POPULATION ASSISTANCE TO GHANA BY DONOR AND RECIPIENT ORGANIZATION
FISCAL YEARS 1971 – 1976

(FIGURES IN MILLIONS, ROUNDED [1])



[1] UNFPA and IPPF funds are co-mingled before distribution. Therefore, the U.S., British, and Canadian shares of UNFPA's and IPPF's Ghana programs were derived using their percentage of total UNFPA and IPPF funding. See Appendix IV.

[2] Data on the GNFPP budget was not available.

CHAPTER 5

OBSERVATIONS ON RESULTS OF GHANA'S POPULATION PROGRAMS AND SUGGESTIONS FOR IMPROVEMENTS

Ghana's population policy was published in 1969, and commitments to population programs began soon after. Now, a framework has been established and the program has made some progress. However, it has reached only a small proportion of the population, especially in the rural areas where 70 percent of the population lives. Records indicate about 93 percent of the approximately 2 million women of reproductive age are not clinic acceptors of family planning.

FAMILY PLANNING PROGRAM FRAMEWORK ESTABLISHED

Ghana's 1969 population policy statement is considered to be probably the best in Africa, and Aid officials believe it could serve as a model for other African countries. GNFPP, charged with implementing the policy, attracted attention to Ghana's population situation and, most recently, has begun eliciting support from other sections of the government. Since 1974, Ghana has committed increasing amounts of financial support to GNFPP--the 1976 commitment was over $1 million. About 140 Ministry of Health and other clinics are registered with GNFPP and dispensing contraceptives. Commercial distribution has also been systemized. This framework for family planning is probably the most important accomplishment of the overall program to date.

NOT ENOUGH ACCEPTORS - A MEASURE OF THE FAMILY PLANNING PROGRAM'S INEFFECTIVENESS

Measuring the results of family planning programs is difficult in developing countries which, like Ghana, lack good demographic and other data. Although contraceptives are dispensed through both clinics and commercial outlets, only clinics keep data on contraceptive acceptors. From this data, GNFPP compiles the number of new acceptors and revisits to clinics. AID officials warned us these statistics may not accurately indicate actual contraceptive use and therefore do not necessarily measure program effectiveness. Recognizing this limitation, we analyzed the number of new acceptors and revisits to family planning clinics since fiscal year 1972. Although this data does not include the estimated 10,000-12,000 acceptors who use commercial distribution outlets, their exclusion does not materially affect the overall results of the program.

Family Planning Clinic Data

Time-frame	Avg. No. new acceptors per month	Avg. no. revisits per month	Avg. no. total visits per month	Clinics (note a)	Avg. no. acceptors per clinic per month	Avg. total visits per clinic per month
Fiscal year						
1972	2,117	5,169	7,286	140	15.1	52.0
1973	2,672	7,689	10,361	160	16.7	64.8
1974	2,616	8,927	11,543	179	14.6	64.5
1975	2,956	10,366	13,322	187	15.8	71.2
7/75-12/75	2,509	11,088	13,597	189	13.3	71.9

a/ This figure represents the total number of clinics registered with GNFPP. Not all clinics are actually active in family planning, oalthough GNFPP does not have precise figures. We determined from monthly reporting statistics that of the 189 clinics registered with GNFPP in 1975, only 140 were active.

The above statistics show the clinic program is averaging about 13,600 visits a month with a total of about 140,000 new acceptors during the period July 1971 to December 1975. Thus, about 93 percent of the approximately 2,000,000 women of reproductive age (15-49) are not clinic acceptors. In addition, the data shows that despite the modest increase in the number of clinics registered, the number of new acceptors has remained relatively constant and actually decreased during the most recent reporting period. The 2 to 3,000 new clinic acceptors per month has not even kept pace with the monthly increase of almost 5,000 women of reproductive age.

Nonclinical contraceptives (foam and condoms) are supplied through 600 commercial outlets. Information on this aspect of the program is limited. AID officials know how many contraceptives are shipped to Ghana for both the clinical and commercial distribution portions of the program. They do not know and are unable to determine, because of poor data, the stock levels or sales volume through commercial outlets, but have estimated that in 1975, commercial distribution was reaching 10,000 to 12,000 continuing acceptors.

AID recognizes that the results of GNFPP's program have been disappointing and that it has not reached a significant number of Ghanaians. The targets established in the 1970-75 GNFPP/AID Population Program Support project have not been reached. The original target was to reach 96,000 new acceptors annually (8,000 an month) by 1975; in fiscal year 1975, there were only about 35,500 new acceptors. By 1972 some 5,000 retail outlets were to be selling subsidized contraceptives, yet in 1975 only 600 such outlets were reported to be doing so. AID has included Ghana in a new program to improve commercial distribution. (See p. 60.)

PPAG family planning clinic (House No. 88/3) in Cape Coast, Central Region. This clinic is open daily and had 2,191 new acceptors in 1975--the highest number of any clinic.

PPAG experimental clinic in Awutu. This clinic, open only one day a week, is providing maternal and child health care as well as family planning services.

We agree with AID and GNFPP officials that changes are needed if a significant reduction in Ghana's population growth rate is to be achieved. Family planning services are generally unavailable, and programs that motivate people to accept family planning need to be identified and developed. AID-funded projects in Ghana suggest some approaches.

Family planning services limited

Although about 140 of the targeted 160 clinics were offering family planning services in 1975, they were concentrated in urban areas and had limited hours. For example, one PPAG clinic was only open on Thursdays from 8 a.m. to 3 p.m., and one Ministry of Health clinic was open only 2 hours per week for family planning services (See photos on pp. 21 nd 36.)

We analyzed acceptors and clinics to determine what areas of the country were being served. In 1975, 77 percent of the clinics were in urban areas, and they accounted for 88 percent of the acceptors. Yet, only 30 percent of the Ghanaian population live in urban areas--leaving almost three-quarters of the population to be served by less than one quarter of the clinics.

In fact, over 30 percent of the acceptors were from the 2 largest cities, and over 50 percent were from the 6 cities with a population of over 50,000. Further demonstration of this urban predominance is shown by the table below, which indicates a direct relationship between urbanization and the availability and acceptance of clinic family planning services. While postulating that an urban clinic may receive acceptors from surrounding rural areas, clinic personnel said most acceptors at such a clinic are from the urban area.

Regional Breakdown: Urbanization and Family Planning Acceptors

Region	Percent urban (note a)	Percent acceptors (note b)
Greater Accra	85.5	18.0
Ashanti	30.0	9.0
Central	28.5	6.5
Western	27.0	10.0
Eastern	24.5	7.0
Brong-Ahafd	22.0	4.5
Northern	20.5	3.0
Volta	16.0	5.0
Upper	7.0	1.0

a/ Percent of region's population in towns of over 5,000 in 1970.
b/ Total acceptors, July 1970 to December 1975, as a percent of the female population aged 15-49 in 1975.

Unless the family planning program reaches the rural areas, Ghana's high fertility rate is expected to remain substantially unchanged.

How to reach more potential acceptors--the Danfa project

The Danfa rural health and family planning project, supported by AID, is testing the relative effectiveness of family planning services delivered in conjunction with (1) health education and comprehensive health programs, (2) in conjunction with health education, and (3) by itself in the present rural Ghanaian setting. Acceptor rates ranged from 14 percent in the first case to only 3.3 percent in the last. (See pp. 60 and 61.)

As a result of these findings, officials connected with the Danfa project have developed a spectrum of potential acceptors for the rural areas studied in that project. They believe about 10 percent of the women would accept family planning services without any motivational efforts. Some 25 percent more would accept family planning if it were provided with health care at a clinic. Another 15 percent would accept family planning if it were provided with health care in their village. However, Danfa officials say that at the present time 50 percent would not accept family planning using any of the Danfa approaches.

Danfa and AID officials in Ghana believe a similar spectrum could be developed for other sections of Ghana, but note that the percentage of women in each category would change, depending on the area's rural or urban characteristics. Generally speaking, urban areas would have larger percentages of people in the first two categories and rural areas more isolated than Danfa would have larger percentages of people in the latter two.

Urban and rural approaches

Danfa officials believe project results to date support the following approaches to delivery of family planning services:

> In urban areas: demand for family planning services generated by family planning education could be met by government maternal/child health clinics supplemented in high demand areas by special family planning clinics and private agency clinics. The clinics should be backed by a well organized commercial distribution network for condoms, foam, and pills.
>
> In rural areas: delivery of family planning services should be coordinated with the delivery of health services. This would take place through existing health centers and posts and should include satellite clinic and mobile family planning teams for the more remote areas. There should also be commercial distribution through existing commercial outlets; major rural markets might provide another outlet.

The Mampong Valley Approach

AID has approved a 3-year support program for the Ghana Rural Reconstruction Movement (GhRRM) project in the Mampong Valley. This project is based on the premise that family planning should be an integral part of local-based social and economic development. Since field operations began in spring 1974, project officials have contacted the 20 villages involved and begun programs to improve agriculture and crafts, promote better nutrition and hygiene, expand literacy, and demonstrate the need for and benefits of community cooperation. They feel it is now appropriate to introduce family planning education and services.

Many people we spoke with believed that the approach used in this Mampong Valley project is the best way of

delivering family planning assistance. This project should provide a valuable test of that hypothesis if adequate controls and data collection are maintained. A description of the project is provided in appendix VIII.

NEED TO INTEGRATE FAMILY PLANNING WITH OTHER DEVELOPMENT PROJECTS

The Danfa research findings to date appear to indicate that many Ghanaians are more likely to accept family planning if it is provided together with health care. It appears to also indicate, as AID officials in Ghana believe, that before a large percentage of Ghanaians, particularly those living in rural areas, will accept family planning, their social patterns and economic status must change.

Development, through changes in economic and social status, is associated with changes in individual attitudes toward family size and, consequently, toward family planning according to many studies. Data that is accumulating on the determinants of fertility suggest that different aspects of development (such as increased female education and reduced infant mortality) affect motivation to limit family size to varying degrees. Not enough is yet known about the determinants of fertility and the ways that they can be modified by development policies and projects.

Development projects may affect the population growth rate directly or indirectly and to varying degrees. This impact should be examined and, to the maximum extent consistent with other goals, development projects should be structured so as to increase motivation to limit family size.

Implementing family planning programs in areas that have been reached or are being reached by other development programs could lead to expanded acceptance. Both AID and Danfa officials believe the country's overall development program can help gain acceptance of family planning, and that one way to assure that family planning is benefiting from other development programs is through integration.

Potential for family planning combined with other development projects

Most family planning services in Ghana are not provided as an integral part of health services and are not integrated

with development projects. AID officials agreed that there are projects currently underway or planned such as the two discussed below, which could incorporate family planning education and services.

AID is planning a district planning and rural development project which aims to improve the quality of life of the poor in selected rural areas and growth centers of Ghana. Anticipated subprojects include feeder roads, community storage facilities, village water systems, land clearing, conservation, afforestation, small scale irrigation, and social services. Efforts to develop an economic infrastructure in rural market towns to help develop rural industries are also planned. In discussions during a visit to one site of the proposed project, we noted that AID officials confirmed that family planning services were not available even though, according to health clinic personnel, there was already some demand for these services. The AID official commented that family planning could be provided with health care in local Ghanaian districts where this project would be implemented. He also said project planning should take into account the expected increase in demand for family planning services.

AID officials also said it is theoretically possible to incorporate AID family planning projects with other donors' development projects. They cited the International Development Association's new Upper Region agricultural development project, a 5-year project with the objective of expanding agriculture in the region by developing small-scale agriculture. Activities are to include: (1) establishing a network of service centers to provide farm supplies and credit, (2) constructing small health clinics at some of the service centers, (3) strengthening veterinary services, (4) establishing 10 group ranches, (5) providing trained extension service field assistance, and (6) rehabilitating and constructing small dams. We discussed including family planning in this project with AID officials. They agreed that family planning could be provided in planned health clinics and would be a good way to expand family planning services in the Upper Region. However, they pointed out there would be a problem of coordination since several donors and government ministries are involved. (See pp. 29 and 30.)

U.S. POPULATION ASSISTANCE PLANS

AID has approved a 3-year extension of its population program support project for GNFPP. (See pp. 53-55.) GNFPP will continue to concentrate on both family planning clinics

and commercial contraceptive distribution systems during this period, although both components are to be expanded to rural areas.

The project does not aim at effective integration of family planning with health care and other development sectors. AID officials said that while such integration is desirable, currently there are constraints. Government ministries, particularly the Ministry of Health, have had reservations about including family planning in their programs. Consequently, AID officials are pursuing family planning approaches which they believe would be as little affected as possible by internal coordination problems. They said that continued support of family planning in clinics and commercial distribution systems may offer the best chance of success, considering these constraints. AID officials told us that for the present, the family planning program can be expanded by providing contraceptive information and supplies without promotion by health education. AID hopes that by 1980, when the new population program support project terminates, a strong family planning organization will be in place and coordination problems within the government will be resolved. They hope that coordination of family planning and health services and integration of population and development planning could then be worked out.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

The interrelationships between population growth and development sectors such as agriculture, education, and health are complex and critical. Rapid population growth can offset the benefits of economic growth and thwart improvements in the quality of life. The important link between development and population growth is recognized in Ghana's population policy, which states:

> "A national population policy and programme are to be developed as organic parts of social and economic planning and development activity."

AID and Ghanaian population officials we talked with in Ghana fully agreed that population and other development programs should be integrated. The Danfa project seems to be demonstrating the advantages of integrating family planning and other health programs. The GhRRM Mampong Valley project postulates that the demand for family planning will increase with local-based development in other sectors.

The Congress has stressed coordinating family planning services with both health programs and programs designed to raise the standard of living of the poor. The section of the December 1975 amendment to the Foreign Assistance Act of 1961, Section 104b, on Population Planning and Health states in part that:

> "Assistance provided under this section shall be used primarily for extension of low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and to the poorest economic sectors, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach; health programs which emphasize disease prevention, environmental sanitation, and health education; and population planning programs which include education in responsible parenthood and motivational programs, as well as delivery of family planning services and which are coordinated with programs aimed at reducing the infant mortality rate, providing better nutrition to pregnant women and infants, and raising the standard of living of the poor."

The close relationship between population growth and development was stressed in the World Population Plan of Action:

> "***Policies whose aim is to affect population trends must not be considered substitutes for socio-economic development policies, but as being integrated with those policies in order to facilitate solution of certain problems facing both developing and developed countries and to promote a more balanced and rational development."

Although AID officials in Ghana have stressed the importance of integrating population projects with other development projects, we found that little effective integration has taken place. While reaching a rural society with family planning programs is a common problem in developing countries, we believe AID can nevertheless do more to help by identifying factors of development amenable to policy direction that will create demand for family planning services. The Danfa project is providing some information of this type on related aspects of health care (See pp. 60 and 61). In addition, AID can and should work with other donors and act as a catalyst in encouraging integration of both social and economic development projects and projects intended to reduce population growth. In a recent policy statement AID recognized the need to support development efforts that encourage smaller families.

Accordingly, we recommend that the Administrator of AID, in developing assistance plans for Ghana and other African countries, as appropriate:

- --Encourage governments and provide support when necessary to examine the relationships between social and economic change and fertility.

- --Help governments to establish population policies which encourage the types of social and economic development identified as having a maximum impact on fertility.

- --Consider the impact on population growth of planned U.S. development projects and work to integrate population and development projects.

--Take actions to encourage establishment of an effective, systematic coordinating mechanism for population assistance in Ghana and other countries where none exists.

We plan to review the need to integrate population and other development programs and the extent to which AID has done so in assistance programs in Asia, Latin America, and Africa.

AGENCY COMMENTS

The Department of State and AID reviewed this report and commented that it accurately described the population and family planning situation in Ghana and that they agreed with the recommendations. The State Department applauded the report's emphasis on the need to integrate population activities into the whole development-planning process. AID stated that it was planning to take appropriate actions in line with the recommendations. State and AID comments are included in appendices I and II. We also discussed the report with AID officials at the Mission in Ghana. They also agreed with the report and recommendations and stated that it was useful to them.

CHAPTER 7

SCOPE OF REVIEW

The review was conducted to examine U.S. population assistance in an African country, Ghana, and past, present, and planned efforts of the Government and donors to reduce the population growth rate. In Ghana we conducted interviews with and/or reviewed records of organizations including:

U.S. Embassy, Ghana
USAID Mission, Ghana
Peace Corps
World Bank Group
United Nations Development Program
World Health Organization
International Planned Parenthood Federation
Family Planning International Assistance
World Education, Inc.
Population Council
Planned Parenthood Association of Ghana
Christian Council of Ghana
Ghana Rural Reconstruction Movement
Canadian High Commission
British High Commission
Embassy of the Federal Republic of Germany

We also held discussions with several officials from national, regional, and district government of Ghana agencies including: the Ghana National Family Planning Program, the Ministry of Health, the Ministry of Economic Planning, and the Ministry of Social Welfare. In Ghana we also visited population, health, and/or agriculture projects in six of Ghana's nine regions. (See app. III.)

We discussed projects with AID's Office of Population in Washington and received the data in appendix II from the International Statistical Programs Center, Bureau of the Census.

Data in any developing country is limited and subject to inaccuracies; Ghana is no exception. Data included in this report is based on estimates of various researchers. Often there were conflicts between sources. In these cases we used what we considered to be the most accurate or an average of the conflicting data. We believe the data was adequate for our purposes and permitted us to reach certain conclusions reflected in the report.

APPENDIX I

DEPARTMENT OF STATE

Washington, D.C. 20520

March 28, 1977

Mr. J. K. Fasick
Director
International Division
U.S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Fasick:

I am replying to your letter of December 14, 1976, which forwarded copies of the draft report: "Population Assistance to an African Country."

The enclosed comments were prepared by the Director of the Office of Population Affairs.

We appreciate having had the opportunity to review and comment on the draft report. If I may be of further assistance, I trust you will let me know.

Sincerely,

Daniel L. Williamson, Jr.
Deputy Assistant Secretary
for Budget and Finance

Enclosure: As stated

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GAO DRAFT REPORT: POPULATION ASSISTANCE TO GHANA

The Office of the Coordinator of Population Affairs and the Office of Population Affairs (OES) have reviewed the GAO report on Population Assistance to Ghana. We find it usefully details information about economic and social problems resulting from Ghana's high rate of population growth (3% annually). As it does so, it provides a good basis for understanding the particular population situation of Africa. And inasmuch as Ghana has had for a number of years one of the few direct government policies in Africa to limit population growth, the report is also useful in describing an African response to population problems. It does so, by summarizing the Ghanaian policy and various programs and projects of interest to us, recognizing a number of deficiencies in the overall Ghanaian family planning effort and at the same time suggesting measures for its improvement. U.S. assistance efforts, which are also described in some detail, are considered by us to be at an appropriate level and generally effective.

We have no major criticism of the report and applaud its emphasis on the need for integrating population activities into the whole development effort and for noting that, particularly in Africa, family planning is most effective when delivered as part of general health care services. Finally we would like to recommend that future GAO reports include an assessment of whether the Ambassador and his country team are playing positive roles in supporting Ghanaian population policy and programs as well as our assistance.

Clifford R. Nelson
Director, Office of Population Affairs

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APPENDIX II

AUDITOR GENERAL

Mar 31 1977

Mr. J. K. Fasick
Director
International Division
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fasick:

Thank you for providing the draft report "Population Assistance to an African Country" for AID comment. Agency personnel familiar with the population program in Ghana found the draft report generally accurate. The Agency is prepared to agree with the three recommendations contained in the report.

If we can be of further assistance in this matter, please let me know.

Sincerely yours,

for
Harry C. Cromer

Attachment: a/s

AID COMMENTS ON GAO REPORT: POPULATION ASSISTANCE TO AN AFRICAN COUNTRY

The following represents AID's views on certain issues posed by the GAO draft report "Population Assistance to an African Country."

We found the report generally an accurate description of the Ghanaian family planning program and we are thoroughly in agreement with the intent of the three recommendations. We have organized our comments as responses to the three recommendations of the draft report first stated on page v and repeated on page 51.

The first recommendation is that AID should encourage the Government of Ghana "to examine relationships between socio-economic change and fertility....in order to identify the areas where development would have maximum impact on fertility." AID has financed a variety of research projects, including one in Ghana, on this general subject and we are fully awake to the importance of an understanding of these relationships for sound policy and program development. The draft reports some interesting evidence from Ghana on the effect of education of women on fertility. Other possible relationships are also touched upon, including the causes of differential urban and rural fertility and the possible impact of reduced infant mortality on the number of children desired. We agree with the recommendation that more attention needs to be paid to socio-economic factors and we fully intend to examine areas where research might be undertaken. We would then be better able to have a family planning program in Ghana which reflects a fuller understanding of the socio-economic determinants of fertility.

A second recommendation urges AID to be more active in establishing an "effective systematic coordinating mechanism for population assistance in Ghana." In support of this recommendation, the draft report notes "the absence of regularly scheduled meetings of representatives of donor and recipient organizations", (page 36). The specific examples cited in the report relate to the lack of coordination between donors and the Government of Ghana as well as within the Government of Ghana and within USAID. The GAO's recommendation has great merit, and is in accord with our general policy on aid coordination.

The third recommendation urges AID to "consider the impact of planned U.S. development projects" and to "integrate population projects and development projects which have a potential for influencing fertility."

AID has become increasingly concerned about the effect of development projects on fertility. We have proposed to Congress that a new section be included in the authorizing legislation dealing with this particular subject. We will

be pursuing this objective in Ghana as in all other AID assisted countries. Consequently this particular recommendation is completely acceptable to us. The subject of "integrating" population and development projects is a bit more complex. The report looks at this question in two ways: first of all with respect to the "integration" of family planning into the country's general health program, and secondly to the "integration" of family planning into development projects. These have different operational implications.

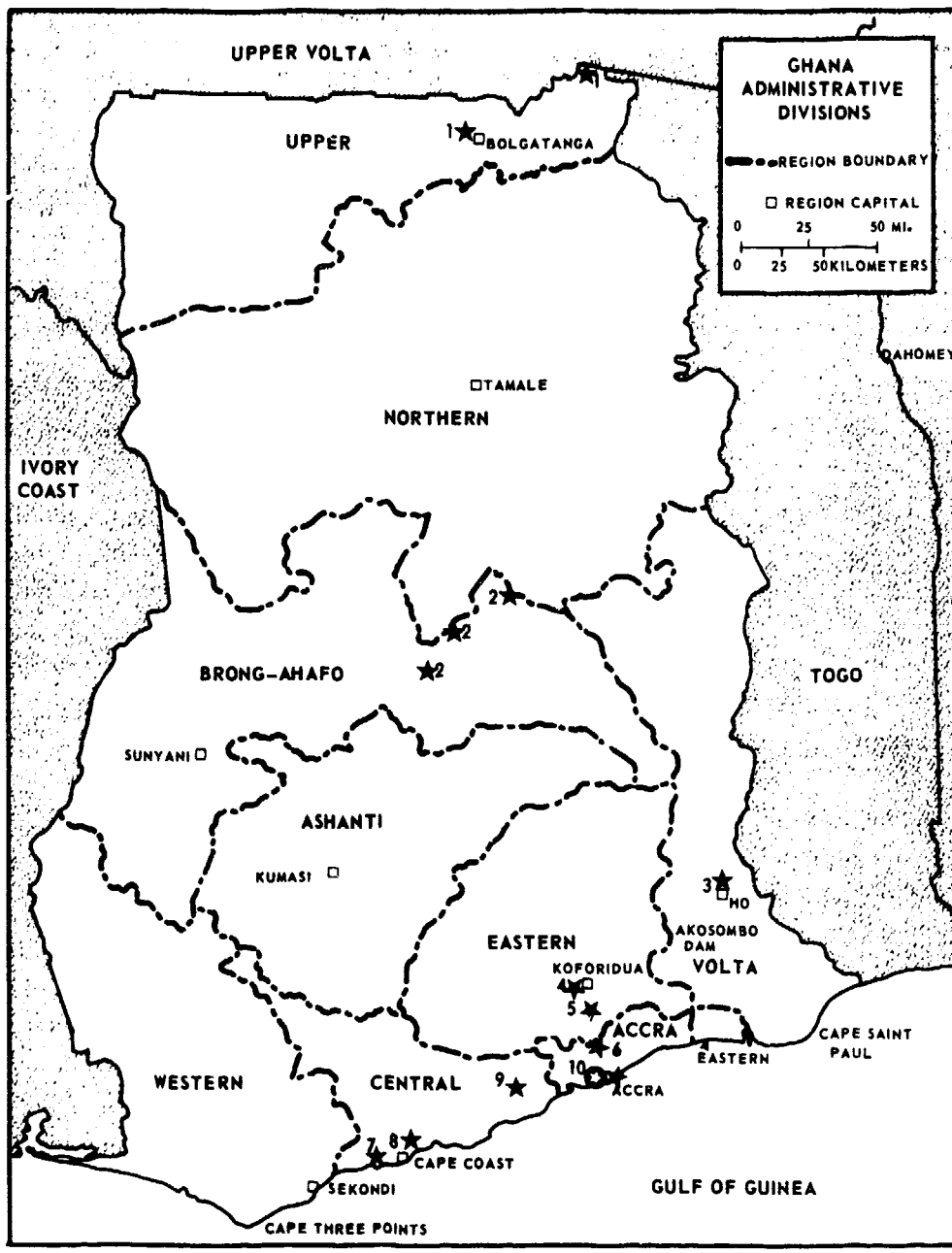
Most of the specific evidence adduced in the body of the report relates to the operations of the GNFPP and to the absence of "coordination" between GNFPP and the Health Ministry. The draft report mentions this "coordination" problem a number of times. The Danfa motivation study appears to imply that the failure to increase the rate of new family planning acceptors relates partly to the absence of adequate "coordination" between GNFPP and the Health Ministry. Although the GNFPP was placed in the Ministry of Planning in order to "integrate" family planning into the total development effort the draft report observes that this has not been accomplished. The report notes that the Mission hopes that the "coordination" problem will be resolved by 1980 and integration of family planning and other development sectors can then be worked out (page 49).

We call to your attention that other approaches, such as the proposed commercial and community-based distribution systems, might be as effective as "coordination" in achieving a higher family planning acceptor level, and that an improved structure, staffing and bureaucratic relationship of GNFPP might also raise the effectiveness of the family planning program.

GAO note: Page references in this appendix may not refer to the final report. Also, recommendation 1 is divided into recommendations 1 and 2 in the final report and recommendation 2 is now recommendation 4.

APPENDIX III

MAP OF GHANA



★SITES OF PROJECTS AND FAMILY PLANNING CLINICS VISITED BY GAO TEAM.

1. TWO SITES OF THE AGRICULTURE REHABILITATION AND HEALTH PROMOTION PROJECT: BOLGATANGA AND BAWKU: UPPER REGION.
2. THREE SITES OF THE DISTRICT PLANNING AND RURAL DEVELOPMENT PROGRAM: ATEBUBU, YEJI, AND PRANG, BRONG-AHAFO REGION.
3. TWO FAMILY PLANNING CLINICS IN HO, VOLTA REGION.
4. TWO FAMILY PLANNING CLINICS IN KOFORIDUA, EASTERN REGION.
5. SITE OF THE GHANA RURAL RECONSTRUCTION MOVEMENT PROJECT: MAMPONG, EASTERN REGION.
6. SITE OF THE DANFA RURAL HEALTH AND FAMILY PLANNING PROJECT: DANFA, ACCRA REGION.
7. THREE FAMILY PLANNING CLINICS AND HEADQUARTERS FOR THE DEMOGRAPHIC TEACHING AND RESEARCH PROJECT AT THE UNIVERSITY OF CAPE COAST, CAPE COAST, CENTRAL REGION.
8. FAMILY PLANNING CLINIC AT SALT POND, CENTRAL REGION.
9. FAMILY PLANNING CLINIC AT EWUTU, CENTRAL REGION.
10. TWO FAMILY PLANNING CLINICS IN ACCRA, ACCRA REGION.

APPENDIX IV

BUREAU OF THE CENSUS PROJECTIONS: IMPACT OF POPULATION GROWTH IN GHANA

The following data was supplied by the Socio-Economic Analysis Staff, International Statistical Programs Center, U.S. Bureau of the Census. The Long-Range Planning Model (LRPM-2) developed by that office was used to make these projections. The medium Census staff projections are derived, in part, from United Nations medium-population growth estimates.

Projected Population (in millions)

1975	10
1980	12
19[illegible]	13
1990	15
1995	18
2000	20

Projected Life Expectancy at Birth

Period	Male	Female
1975-1980	44.4	47.6
1980-1985	46.9	50.2
1985-1990	49 3	52.7
1990-1995	51.8	55.3
1995-2000	54.2	57.8

Actual and Projected Education Needs
(in thousands of students)

	Primary	Secondary	University
1950	270	7.1	0.2
1975	1,200	120.0	7.6
2000	3,230	865.0	88.7

Total Education Operations Costs
(millions, 1975 U.S. $)

1950	$ 49
1975	$137
2000	$496

Actual and Projected Health Manpower Needs

	1950	1975	2000[1]
Physicians	210	715	2980
Medical Assistants	20	229	2980
Dentists	20	43	1990
Pharmacists and Assistants	80	618	1990
Midwives	1500	2955	4970
Nurses	2000	8412	18880
Other	40	567	1990
Sanitation	200	787	1940
Total	4070	14326	37720

[1] Based on achieving World Health Organization minimum goal (for 1985) guidelines for developing countries by the year 2000.

APPENDIX IV

Projected Work	Population (15-64) (in millions)
1975	5.3
1980	6.1
1985	7.0
1990	8.1
1995	9.4
2000	10.9

Ratio to Population

Year	Labor Force (in thousands)	Ratio
1975	3870.0	0.39
1980	4360.0	0.38
1985	4920.0	0.37
1990	5580.0	0.36
1995	6410.0	0.36
2000	7400.0	0.37

Ratio to Work-age Population (Age 15-64)

Year	Labor Force	Age 0-14 years	65 & over
1975	0.73	0.85	0.036
1980	0.71	0.85	0.041
1985	0.70	0.85	0.045
1990	0.69	0.86	0.050
1995	0.68	0.84	0.055
2000	0.68	0.80	0.061

Based on the United Nations medium population estimates and analysis, the Bureau of the Census' International Statistical Programs Center (ISPC) projects that the number of Ghanaians living in rural areas will rise from 6.8 million in 1975 to 9.8 million in 2000 but the number of Ghanaians in urban areas will advance from 3.2 million in 1975 to 10.5 million in 2000.

SUPPORT TO GNFPP BY YEAR AND DONOR

(000's omitted)

Donor	Fiscal year 1971	1972	1973	1974	1975	1976	Total
United States	$531.1	$560.8	$654.2	$ 602.4	$ 420.6	$ 445.0	$3,214.1
United Kingdom	-	-	-	65.0	100.0	25.0	190.0
Canada	130.0	-	-	-	-	-	130.0
Total outside support	$661.1	$560.8	$654.2	$ 667.4	$ 520.6	$ 470.0	$3,543.1
Ghana	-	-	-	640.9	833.9	1,012.0	2,486.8
Total support	$661.1	$560.8	$654.2	$1,308.3	$1,354.5	$1,482.0	$6,020.9

APPENDIX V

APPENDIX VI

ASSISTANCE TO POPULATION PROGRAMS IN GHANA

Donor/project	Percent U.S. funds (note a)	Total fiscal years 1971-1976	U.S. funds	Amount planned for future years by all donors (note b)
USAID (See p. 27.)				
Population program support	-	-	-	-
Population program support	-	3,214	-	2,986
Danfa rural health	-	4,354	-	1,771
University teaching of population dynamics	-	1,547	-	800
Demographic teaching and research	-	138	-	102
World Education Inc.	-	79	-	-
African health training institutions (note c)	-	177	-	61
Commercial distribution	-	236	-	404
Total USAID (note d)	100%	9,745	9,745	6,124
UNFPA (See p. 29.)				
Regional Institute for Population Studies	-	2,473	-	300
Registry of births and deaths	-	256	-	2,136
Others (inactive)	-	358	-	-
Total UNFPA	35.6%	3,087	1,099	2,436
IPPF/PPAG (See p. 28.)	38.5%	2,106	811	1,400
FPIA/CCG (See pp. 28-29.)	99.0%	231	229	300
Canada	-	130	-	150
United Kingdom	-	394	-	150
Others	-	218	-	-
Total external	74.7%	15,911	11,884	10,560
Ghana/GNFPP	-	2,487	-	3,498
Total	64.6%	18,398	11,884	$14,058

a/ Estimated U.S percentage of actual organization funding; national origins of country support are not segregated.

b/ Funds projected for current projects. U.S. totals are given through fiscal year 1979; most other organization totals are through completion of current projects or fiscal year 1979.

c/ Expenditures are on a regional basis; amounts applicable to Ghana could not be segregated. Since health schools in nine countries are involved, one-ninth of project funds were arbitrarily allocated to Ghana or the purposes of this review.

d/ USAID also supports a number of world-wide and regional projects which may benefit Ghana.

APPENDIX VII

POPULATION PROJECTS IN GHANA SUPPORTED BY U.S.AID

Population program support project

An important bilateral population project in Ghana has been the population program support project which supports the Ghana National Family Planning Program. (See pp. 18-20.) From initiation of the project in 1971 through 1976, AID has granted more than $3.2 million--about $1.6 million for commodities, about $300,000 for training and almost $1.2 million in local currency budget support for GNFPP, and the remainder for personnel and other costs. The stated goal of the project was to develop the capacity of GNFPP to expand family planning services. This was to be accomplished by strengthening GNFPP support and service network, to include (1) planning and management, (2) inservice training, (3) contraceptive supply, (4) research and evaluation, and (5) intensive service and contraceptive supply outreach in pilot areas.

The $1.6 million provided for commodities during the 1971-76 period included almost $1.1 million in contraceptive supplies. Nonclinical contraceptives (condoms and vaginal foam) are distributed through the Ghana National Trading Corporation and family planning clinics, while clinical contraceptives (birth control pills, intrauterine devices) are distributed only through the clinics. In addition, GNFPP, supported by AID, has trained 1,266 family planning nurses, fieldworkers, and others.

APPENDIX VII

People Trained In Family Planning Services (1970-75) (note a)

Type	Trained by GNFPP/GOG	DANFA	PPAG	Total
Clinical				
Nurses	87	9	-	96
Nurse midwives	-	8	5	13
Others (note b)	90	78	36	204
Field workers				
Full-time	148	-	104	252
Part-time	941	-	-	941
Total	1,266	95	145	1,506

a/ In addition, 67 participants have been trained in the United States in family planning training and demographic research, but are not expected to be directly involved with family planning service delivery.

b/ Personnel such as traditional birth attendants, field supervisors, and clinic assistants.

In June 1976, AID approved a 3-year extension of its population program support project.

AID has increased the annual funding and continued to support GNFPP for basically the same program of family planning clinics and a commercial distribution system. Goals for numbers of new acceptors and clinics have not been established. In addition, the project seeks to improve family planning programs through:

--A new intensive demonstration project in the Eastern and Volta Regions to be implemented by the Planned Parenthood Association of Ghana and the Christian Council of Ghana that will demonstrate and expand various family planning systems into new areas (through satellite clinics and community-based personnel).

--An intensive rural commercial distribution in the Upper and Northern Regions which will increase the availability of contraceptives--an information campaign will accompany the program.

--A new program of motivational research for selected studies in addition to that undertaken by the Danfa rural health and family planning project. (See Danfa project description below).

--An increased inservice training program for expanded family planning training.

During the 1977-79 extension of the grant, AID expects to directly provide $3 million, while commitments of the Ghanaian Government and others to GNFPP are expected to total $5.9 million.

Danfa rural health and family planning project

This important bilateral project seeks to enable Ghana to extend and improve rural health and family planning services by (1) identifying, testing, and demonstrating practical and reliable approaches to delivery of health and family planning services and (2) strengthening the capability of the Ghana Medical School Department of Community Health to train personnel in direct service delivery and operational research programs in public health, maternal and child health, and family planning. Another purpose is to improve coordination with various Ghanaian institutions including the Ministry of Health and GNFPP. The project, which began in August 1970,

is expected to run through 1978. It is implemented through a contract with the University of California, Los Angeles. AID obligations through fiscal year 1976 are estimated at $4.4 million. Total U.S. costs through the planned fiscal year 1978 completion date are expected to exceed $6 million.

To test various approaches for delivery of health and family planning services, four distinct geographical areas were selected for intensive study. Each area has a population of 10,000 to 15,000 and is near the village of Danfa, a rural area in the Greater Accra Region. In area I, family planning was combined with health education and comprehensive health care; area II combined family planning and health education; and area III added family planning to the existing situation. Area IV, originally a control area with no new services, was eliminated from the project. The areas also serve as training and research sites.

Comparisons of results in the three areas for July 1972 through December 1974 show that area I, which offers family planning along with a comprehensive health program, has the highest rate of family planning acceptors.

Acceptor Rates by Area (note a)

	Area I	Area II	Area III	7/72-12/74
Population WRA (note b)	2,808	2,285	3,387	8,470
Number of female acceptors (15-44)	394	192	113	699
Acceptor rates	14.0%	8.4%	3.3%	8.3%

a/ Data supplied by Danfa project officials.
b/ WRA--women of reproductive age (ages 15-44)

Rates of continued use for all contraception methods were highest in area I and higher in area II than in area III. Also, a smaller percentage of women acceptors had become pregnant since acceptance in area I as compared to areas II or III.

University teaching of population dynamics

This regional project, implemented through a contract to the University of North Carolina, was designed to help selected African universities introduce interdisciplinary instruction and research on population into their curriculum and research programs.

The project, which began in 1972, was originally intended to encompass universities in several African countries. Although the project did fund a seminar on population dynamics teaching at the University of Monrovia in mid-1976, so far it has only been implemented at the University of Ghana. A population dynamics center has been established in Ghana and assistance has been provided for selected research and fellowship support, including students from a number of anglophone African countries. In addition, a special-purpose library of population-related texts has been established. The project is expected to run through fiscal year 1979 and will cost more than $2.3 million. AID obligations through 1976 total about $1.5 million.

Demographic teaching and research project at the University of Cape Coast

The purpose of this regional project is to support (1) demographic teaching at the University of Cape Coast in Ghana and (2) research on mortality and fertility levels and trends in southwest Ghana. The project supervisor teaches two courses in the department of sociology at the university and directs the research. A baseline census was taken in 1974 of the project area, which includes approximately 20,000 people in 8 villages. Researchers hope to analyze the sociological data collected to learn how village social structures and attitudes about the family and community affect fertility behavior.

The project, financed by a subgrant of an AID grant to the Population Council, began in September 1973 and is expected to continue until about 1978 and cost about $240,000.

World Education Incorporated: family life education project

The purpose of this worldwide program, which operates in several Asian, African, and Latin American countries is to plan and implement an integrated program of adult education.

APPENDIX VII

In Ghana, World Education emphasizes a relevant education process that will motivate people to think about development. It expects to include family planning education in adult classes but not distribute contraceptives. The Ghana project, which began in 1974, has trained community leaders and has established programs in several areas. Funded by an interregional grant of $79,200 from AID, the project is expected to end in late 1976 with an overall evaluation of project results.

Family planning courses at health training institutions

This 5-year regional project helps faculties of African health training institutions develop and implement family planning curricula within the contexts of family and reproductive health curricula. The project, implemented through an AID contract with the University of North Carolina, involves work with medical, nursing, midwifery, and other health training institutions in Ghana, Liberia, Cameroon, Nigeria, Kenya, Tanzania, Ethiopia, Sudan, and Zambia. The project is developing prototype curricula on family planning and health. In addition, seminars have been held for physicians and nurse and medical educators on family planning in the context of health care. Total cost is to be $2.1 million, through fiscal year 1978, with estimated obligations through fiscal year 1976 of $1.6 million. Costs applicable to Ghana could not be separated.

Commercial distribution

A centrally-funded project to improve commercial distribution of contraceptives in five countries, including Ghana, has been approved by AID. A 3-year estimated $640,157 cost plus fixed-fee contract was signed by AID June 1976, with Westinghouse Electric Corporation to undertake this work in Ghana. AID officials told us that in March 1977 GNFPP has approved this project, although there is still some question concerning inclusion of oral contraceptives without prescription since this is contrary to a regulation of Ghana's Pharmacy Board. Recision of the regulation is under consideration by the Board. AID officials anticipate that this project will also contribute to GNFPP's planned commercial distribution project in the Upper and Northern Regions (see p. 60) once this stumbling block in the program is overcome.

APPENDIX VIII

SAMPLE PROJECT INTEGRATING POPULATION AND DEVELOPMENT

In June 1976 AID approved a 3-year support grant under a regional project for the Ghana Rural Reconstruction Movement (GhRRM), a rural community development effort which plans to include family planning. The project was established in the Mampong Valley, 40 miles northwest of Accra, to help the 5,000 people in some 20 villages identify practical ways in which they can raise their productivity, increase cash incomes, improve health and nutrition, increase literacy, and improve the quality of life. This organization, indigenous to Ghana, has operated on a limited budget, most of which (about $30,435 in 1974-75) has come from the private New York based international institute of rural reconstruction with which it is affiliated.

Since project officials believe many of the villagers' problems are interrelated and are compounded by civic inertia, activities are aimed at encouraging group action and the notion that in working together, individuals can exercise some control over the social and economic factors affecting their lives. Field operations, which began in April 1974, have been small scale because of limited budget. Nevertheless, project workers have contacted all of the villages and have initiated a program incorporating the following:

--A demonstration program in improved cropping, animal production and care, food processing methods, and training in cottage crafts and trade skills.

--Health education programs promoting improved nutrition, hygienic practices, and environmental sanitation.

--Literacy programs and cultural acitivities.

--A demonstration program on the need for and benefits of cooperative community activities.

We visited the Mampong Valley project and attended the graduation ceremony of the first class of teachers who will be working with the villagers. We viewed displays of nutritional information on local foods and improved food storage, and also saw a demonstration of water-purification methods. Project workers were enthusiastic and proud of their achievements.

The project's concept paper observes that the quality of human life is determined by population dynamics (i.e., changes over time) and social and economic development. The central hypothesis is that:

> "The provision of community development action programmes, such as education, health, roads, etc., will provide for the people the needed release from civic inertia to propel the community towards self-sustained development; and that such positive gains will be safeguarded through the adoption of population programmes that reflect the increased need to reduce desired and completed family size, which in turn will generate increased demand for family planning services."

Officials connected with the Mampong Valley project emphasize that development and population matters are interrelated and must be treated together to improve human life. Project workers believe that, having won the confidence of the villagers and having shown them how they can help themselves through local resources, they are now ready to introduce family planning education and services as another essential element in the process of improving their lives. They plan to introduce family planning information and assistance through their 1976-77 health education program. The Mampong Valley project officials have also applied for assistance from GNFPP. We were told by GNFPP officials that they envision providing training for project family planning nurses and fieldworkers, and supplying contraceptives.

AID's 3-year support program for the project is to provide $175,000 for staff salaries, vehicle and commodity procurement, construction, and training. This project is not being funded under AID's population assistance category.

APPENDIX IX

PRINCIPAL AID OFFICIALS RESPONSIBLE FOR ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Appointed
ADMINISTRATOR:	
John J. Gilligan	Mar. 1977
Daniel Parker	Oct. 1973
John A. Hannah	Mar. 1969
ASSISTANT ADMINISTRATOR: BUREAU FOR POPULATION AND HUMANITARIAN ASSISTANCE:	
Allen R. Furman (acting)	Mar. 1977
Fred O. Pinkham	Apr. 1976
Allen R. Furman (acting)	Mar. 1976
Henry S. Hendler (acting)	Feb. 1976
Harriet Crowley (acting)	Feb. 1975
Jerald A. Kieffer	July 1972
DIRECTOR, OFFICE OF POPULATION, BUREAU FOR POPULATION AND HUMANITARIAN ASSISTANCE:	
R. T. Ravenholt	July 1972
MISSION DIRECTOR, GHANA:	
Irvin Coker	May 1976
Haven North	Nov. 1970