



**Ghana Case Study:
'Give Them the Power'**

**A Repositioning Family
Planning Case Study**

September 2005



USAID
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

ACQUIRE Report

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By Julie Solo, Martina Odonkor, John M. Pile, and Jane Wickstrom



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This publication is made possible by the generous support of the American people through the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The contents are the responsibility of the ACQUIRE Project and do not necessarily reflect the views of USAID or the United States Government.

Printing: MBS Graphics

Printed in the United States of America. Printed on recycled paper.

Suggested citation: Solo, J., et al. 2005. *Repositioning family planning—Ghana case study: 'Give them the power.'* New York: The ACQUIRE Project/EngenderHealth.

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Acknowledgments

This report was developed for Repositioning Family Planning, an initiative undertaken and funded by the U.S. Agency for International Development (USAID), and it was researched and written under the auspices of the Population Technical Assistance Project (POPTECH). The final version of the report was published by the ACQUIRE Project. The report was made possible by the generous support of the American people through USAID. The contents are the responsibility of POPTECH and do not necessarily reflect the views of USAID or the United States government.

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The authors are grateful to the Repositioning Family Planning Task Force of USAID and to the cooperating agency representatives for their overall guidance in this case study. The authors also thank Shawn Malarcher, Elizabeth Warnick, and Alexandra Todd-Lippock at USAID for their inspiration and technical direction, and they acknowledge the assistance of David Barmettler, Melanie Kindsfather, and Callie Curtis at POPTECH. Sincere thanks also go to the staff of USAID/Ghana (particularly Jane Wickstrom); to Gloria Quansah-Asare (director of family planning for the Ghana Health Service), who provided technical expertise and in-depth knowledge of the health care sector; and to the many individuals with various governmental, nongovernmental, and private organizations whose knowledge and expertise contributed to this report.

Executive Summary

Family planning saves lives. Although this fact is well-known and documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. USAID has undertaken a project to document the success of the family planning programs in Ghana, Malawi, and Zambia to provide guidance in this strategy. The case study for Ghana was conducted in October 2004 by a team of four individuals, with data collection including document review, site visits, and interviews with 44 key informants.

Ghana's Population Policy in 1969 was one of the first on the African continent. However, on the 20th anniversary of the policy in 1989, an assessment documented the lack of progress in achieving the goals the policy had set out, in part because of the lack of grassroots involvement in its development and the lack of a strategic plan for implementation. The policy was revised in 1994 taking these factors into account, and the 1990s saw much more progress in improving family planning in Ghana. With a TFR of 4.4 and modern method CPR of 18.7%, the country is now well on the way to meeting the goals set out in the National Population Policy of 1994: to reduce the TFR to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020, and to increase modern CPR to 15% by 2000, 28% by 2010, and 50% by 2020.

Advocacy has played a key role in raising the profile of family planning. Presentations in the early 1990s showing the impact of population growth on the education and health sector in terms of numbers of schools and hospitals that would be needed “*were very revealing*” and prior to these presentations, many said that they had not seen family planning as an important issue. The way the information was presented was also important, with high-level former Ministry of Health (MOH) staff giving the information so that it was “colleagues talking with colleagues” rather than outsiders pushing an idea. Such advocacy will be important in coming years in ensuring that family planning remains a priority in the various aspects of health sector reform. The sector-wide approach (SWAp) and the Poverty Reduction Strategy tend to be strongly oriented towards the Millennium Development Goals (MDGs), with limited attention to family planning, and the family planning and reproductive health program has remained somewhat outside of the health sector reform process (Mayhew and Adjei, 2004). There is growing recognition within some parts of the MOH that since the reduction of maternal mortality is part of the MDGs in Ghana, and family planning is the best preventive measure, more work should be done with institutionalizing the family planning program.

The National Reproductive Health Service Policy and Standards, developed in 1996 and revised in 2003, was an important step in removing barriers to services, and more

generally, raising the profile of reproductive health. Findings from the 1993 Situation Analysis study were an important impetus in bringing about the development of standardized family planning guidelines. For example, this study had found that almost 90% of service providers would not give any contraceptive method to a woman with fewer than three children, and that many would require spousal consent or that a woman be married before they would provide methods. Training in Ghana has attempted to break down these barriers, and one innovative approach has been to bring in satisfied clients during provider training to address method-specific biases and misperceptions.

Having supportive policies is a key aspect of a successful family planning program, but it is only through their implementation that there is an impact on reproductive health; “a good document doesn’t make a woman have good access to contraceptives.” There have been a number of activities to improve family planning services in Ghana, in both the public and private sector and at both the clinic and community level. Over half of current users (54%) now rely on the private sector, primarily through the Ghana Social Marketing Foundation (GSMF International). A number of new methods have been made available over the past ten years, including injectables, Norplant[®], and vasectomy. Introduction of these methods has included attention to both supply and demand, has emphasized effective promotion, been attentive to client needs, addressed provider biases, identified champions, and instilled ownership. In addition, nurses have been trained to provide Norplant[®] to increase access to this method, since doctors are less frequently available.

Training has focused on building capacity of local systems to conduct the training to enhance sustainability; “we give them the power... so they feel that it is their program and so they take ownership,” as one technical assistance agency explained (EngenderHealth, 2004). There has also been particular attention to training providers in counseling. Over time, Situation Analysis studies have shown a marked increase in the proportion of providers who had received training on counseling for family planning, from 38% in 1993 to 60% in 2002.

Under the Ghana Family Planning and Health Program (1991–1996), information, education, and communication (IEC) activities addressed constraints identified by the 1993 Demographic and Health Survey (DHS), including widespread myths, rumors, and health fears. The Health Education Unit of the MOH coordinated a campaign that involved both the private and public sector. However, a lack of funding limited regional efforts by the public sector and some of the advertising materials developed by GSMF created controversy, leading to the television ads being cancelled and then only allowed to air after 10:00 pm; “A negative reaction came from a vocal minority who interpreted the ads as encouraging promiscuity. Part of the problem stemmed from the lack of legitimizing mass media support from the public sector” (Adamchak et al., 1995). In 2001, the Ghana Health Service and private sector partners launched the Life Choices’ behavior change campaign in order to reposition family planning in people’s mind and to dispel rumors about methods. The campaign gave people the knowledge and tools to see that family planning was directly related to their lives and personal aspirations for a better future. Vans with information, materials and songs moved throughout the country,

enlivening community meetings and sparking debate on family planning issues. Nearly seven out of 10 men and half of the women interviewed in the 2003 Ghana Demographic and Health Survey (GDHS) reported they had heard the key slogan of the campaign—“Life choices: It’s your life, it’s your choice.”

As a member of the Ghana Health Service stated, “Even if I get educated [about family planning], if there are no commodities there, I will get pregnant.” Over the years, a significant proportion of the support from USAID and UNFPA has been spent on procurement of contraceptive methods. Along with this support, there have been important efforts to improve the logistics system. Before 1998, there were stockouts because MOH staff needed additional training in logistics management, and so USAID provided support for training and improving the system. Since 2000, respondents state that there have been no natural stockouts, only “artificial because of maldistribution,” meaning that it has not been an issue of not having the methods, but whether they are moved effectively and efficiently from the central level to the regions and districts.

Ghana was the site of an innovative project in providing community-based health care. Beginning as a pilot project in Navrongo in northern Ghana, the success of the experimental phase in lowering both fertility rates and childhood mortality has led the government to adopt the lessons into national policy in the Community-based Health Planning and Services (CHPS) initiative. A key to the success of the scaling up has been local ownership both at the community level and the national level; “what is unique about CHPS is that it is the first home-grown intervention that we have developed ourselves. It is not something that as found somewhere and a donor is trying to introduce in Ghana.”

Some of the key lessons from the family planning program in Ghana include:

- Policies are only effective through their implementation, and this requires a clear implementation plan and grassroots involvement in their initial development.
- Training must address attitudes as well as teaching skills, and using satisfied clients can be an effective way to address providers bias towards specific methods.
- Social marketing can be a very effective complement to public sector services.
- Bringing health to the doorstep of rural people is essential to improve access.
- Programs must be responsive to the local context, for example by placing family planning in a broader health context.
- Ensure ownership of programs, at the national level, at the regional and district levels, and in the community.

Introduction

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well-documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, it is extremely difficult for African country programs to make significant gains in strengthening their family planning programs and thereby raising contraceptive prevalence. USAID has committed itself to providing incremental assistance to a selected number of focus countries at the very early stages of program development. To help guide these investments, lessons learned by countries in the region which have made significant progress will be very useful.

Therefore, USAID has undertaken a project to document the success of the family planning programs in three countries in Sub-Saharan Africa over the past 10–20 years, and to identify which program interventions led to that success. The three countries selected for analysis are Ghana, Malawi, and Zambia, all of which have shown considerable growth in contraceptive prevalence and significant fertility decline despite a challenging environment and limited resources. Their success can provide guidance for other Sub-Saharan African countries. The case studies will be used by USAID to guide strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region. In addition, a synthesis paper will pull out key lessons from the three case studies.

Methodology

This report documents the achievements, the process, and the keys to success from the family planning program in Ghana. The sources of data for this case study included in-depth interviews with key informants (Appendix 1) and document review (Appendix 2). A team of four people, including two consultants from New York and two team members from Ghana (one from USAID and one independent consultant), conducted interviews and site visits in Ghana from October 20–29, 2004. In addition, the two U.S.-based consultants interviewed a number of individuals at USAID/Washington and from the Population Council/New York office. In total, 44 individuals were interviewed. Quotations from these interviews appear throughout the report in italics. The following were the main questions addressed in these interviews:

1. What are the main achievements and successes of the family planning program in Ghana in the past 10 years?
2. What were the main reasons for success? (including program factors, policies, and societal/cultural factors)
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Are there any regions of the country or segments of the population that have been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in Ghana?
7. What do you see as the main lessons learned from the work on family planning in Ghana?

The information presented in this report gives a picture of the family planning program in Ghana; based on the data and opinions of key informants, key lessons are identified. However, these findings have some limitations. First, since we are looking at the program over the past 10–15 years, it can be difficult to get accurate information about the past. This is due to both turnover of staff and the fact that people are generally more conversant about and more interested in discussing their current programs. In addition, directly attributing particular outcomes—e.g., increase in CPR—to specific interventions is difficult. However, based on the wide range of information, it is possible to make general conclusions about effective aspects of the program that contributed to the country's success.

Findings

Timeline

Year	Key Policy and Program Activities	Impact	Context
1961 ⇒	<ul style="list-style-type: none"> Christian Council of Churches begins providing family planning information. 		Pronatalist government
1966 ⇒	<ul style="list-style-type: none"> Small-scale family planning program emerges in clinics. Government studies population issues in terms of manpower planning. 		
1967 ⇒	<ul style="list-style-type: none"> Planned Parenthood Association of Ghana (PPAG) is established. 		
1968 ⇒	<ul style="list-style-type: none"> USAID supports Family Planning and Demographic Data Development Project in FY1968–1970. Final report “Population Planning for National Progress and Prosperity” lays foundation for population policy. 		
1969 ⇒	<ul style="list-style-type: none"> Population policy is established. 		
1970 ⇒	<ul style="list-style-type: none"> Ghana National Family Planning Program is established, with a Secretariat to coordinate all ministries. Between 1970 and 1976, 306 new family planning clinics are registered with the Ministry of Health (MOH). USAID Phase I assistance to GOG 1971–1975 and Phase II 1976–1982 trains providers, and provides contraceptives and informational materials. 		
1979 ⇒	<ul style="list-style-type: none"> Ghana Fertility Survey is conducted. Continued USAID support from Phase II and many centrally-funded projects increases access to family planning; by 1981, more than 5,000 providers have been trained in family planning. 	CPR: 5.5%	
1985 ⇒	<ul style="list-style-type: none"> Ghana Social Marketing Program is established using local packager, distributor, and marketer DANAFCO. Contraceptive Supplies Project (1985–1990) (\$7 million) increases access to modern methods through improved logistics, clinical training, and IEC in public and private sectors. 		
1988 ⇒	<ul style="list-style-type: none"> A Demographic and Health Survey (DHS) is conducted. 	TFR: 6.4 CPR: 5.2%	
1990–1991 ⇒	<ul style="list-style-type: none"> MOH and nongovernmental organizations (NGOs) are trained in family planning, especially Ghana Registered Midwives Association and PPAG. Ghana Family Planning and Health Program (FPHP), a six-year, \$30 million USAID-funded project, begins (and continues until 1996), including \$6.5 mil for contraceptive procurement. 		
1992 ⇒	<ul style="list-style-type: none"> National Population Council reporting directly to the president is established. 		<ul style="list-style-type: none"> Multiparty democracy
1993 ⇒	<ul style="list-style-type: none"> A DHS is conducted. Situation Analysis is conducted. Ghana Social Marketing Foundation is incorporated. 	TFR: 5.3 CPR: 10.1%	
1994 ⇒	<ul style="list-style-type: none"> Population policy is revised. Navrongo Community Health and Family Planning Project (CHFP) is launched. USAID funds 10-year, \$6 million project on Improving Access and Quality of Clinical Family Planning Services in the Public and Private Sectors in Ghana. 		<ul style="list-style-type: none"> International Conference on Population and Development
1995 ⇒	<ul style="list-style-type: none"> Ghana Population and AIDS Project (GHANAPA), a \$45 million project, begins. (It operates from 1995 to 2000 and is extended to 2002. 		<ul style="list-style-type: none"> Beijing conference
1996 ⇒	<ul style="list-style-type: none"> Policy is approved to allow nurses to provide Norplant implants and training begins. <i>National Reproductive Health Service Policy and Standards</i> are set. A situation analysis is conducted. 		<ul style="list-style-type: none"> Ghana Health Services and Teaching Hospitals Act Beginning of sector-wide approach
1998 ⇒	<ul style="list-style-type: none"> A DHS is conducted. 	TFR: 4.4 CPR: 13.3%	

(cont.)

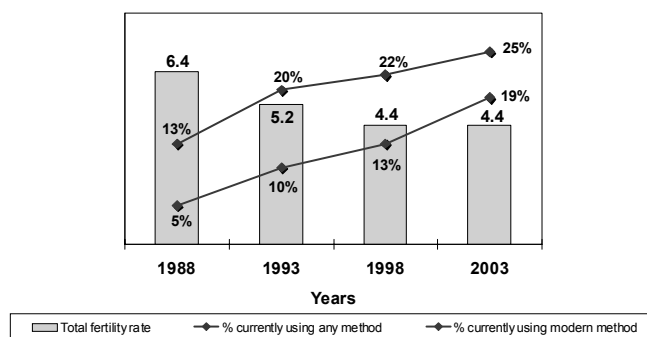
Timeline (cont.)

Year	Key Policy and Program Activities	Impact	Context
1999 ⇒	<ul style="list-style-type: none"> • <i>National Reproductive Health Service Protocols</i> are established. 		
2000 ⇒	<ul style="list-style-type: none"> • <i>Adolescent Reproductive Health Policy</i> is established. • Government of Ghana adopts findings of CHFP into national health policy entitled Ghana Community-based Health Planning and Services (CHPS initiative) 		<ul style="list-style-type: none"> • Third multiparty election and smooth transition to another political party
2001 ⇒	<ul style="list-style-type: none"> • Life Choices behavior change campaign for family planning is launched. 		
2002 ⇒	<ul style="list-style-type: none"> • Service Provision Assessment is conducted. 		
2003 ⇒	<ul style="list-style-type: none"> • <i>National Reproductive Health Service Policy and Standards</i> are revised. • A DHS is conducted 	TFR: 4.4 CPR: 18.7%	
2004 ⇒	<ul style="list-style-type: none"> • “Get a Permanent Smile” vasectomy promotion campaign begins. 		

What Was Achieved?

During the past 15 years, Ghana has made significant progress in reducing its fertility. Between 1988 and 2003, there was a two-birth drop in the total fertility rate (TFR), from 6.4 to 4.4 lifetime births per woman.¹ Ghana’s fertility rate is now one of the lowest in Sub-Saharan Africa. Since 1988, current use of contraception among currently married women has doubled (to 25.2%), and use of modern methods has more than tripled (to 18.7%) (Figure 1). The country is well on the way to meeting the goals set forth in the National Population Policy of 1994: to reduce the TFR to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020, and to increase modern contraceptive prevalence rate to 15% by 2000, 28% by 2010, and 50% by 2020.

Figure 1. TFR and use of any contraceptive method or a modern contraceptive method, Ghana 1988–2003



Although the TFR has declined and contraceptive prevalence has increased, unmet need remains high and women continue to have more children than they desire. There has been good progress, but respondents felt that “19% is nothing to shout about. It needs to be increased tremendously.” In addition, there are important issues of inequity in the improvements in terms of bringing services to the poor and to the whole nation.

¹ Total fertility rates are calculated for women aged 15–49 and are based on births in the three-year period preceding the survey. Rates may differ slightly from those published in 1988, 1993, and 1998, as these were based on births in the five years preceding the survey.

Fertility levels vary by region, from a high of 7.0 births in the Northern region to a low of 2.9 births in Greater Accra (Table 1). The TFR for rural areas (5.6) is more than two births higher than the rate for urban areas (3.1). Fertility is inversely related to education and wealth. Women with no education give birth to more than twice as many children as women with at least a secondary education (6.0 vs. 2.5). Fertility decreases with increasing wealth, from 6.4 births among women in the lowest wealth quintile to 2.8 births among women in the highest wealth quintile.

Current use of contraception varies with urban-rural and regional residence, and level of education and wealth. Women in urban areas are more likely to use modern methods of contraception than women in rural areas (24.2% vs. 14.9%). Use of condoms, IUDs and female sterilization in urban areas is two to three time higher than use in rural Ghana. The prevalence of modern method use ranges from lows of 7.7% and 9.7% in Northern and Upper East to highs of 24.8% and 26.0% in Brong-Ahafo and Greater Accra.

Table 1. Use of modern contraceptive methods among married women, by region, 1988–2003

Region	1988	1993	1998	2003
Western	3.2	14.4	8.7	17.7
Central	4.9	7.6	13.1	13.2
Greater Accra	10.6	18.0	17.4	26.0
Volta	5.8	7.7	12.1	19.3
Eastern	3.9	12.9	19.6	21.5
Ashanti	6.5	8.0	14.0	21.0
Brong-Ahafo	5.2	14.0	14.8	24.8
Northern	N/A	5.1	5.6	7.7
Upper East	N/A	7.2	7.5	9.7
Upper West	N/A	5.1	9.1	19.5
Total	5.2	10.1	13.3	18.7

Use of contraception increased noticeably between 1988 and 2003, but total unmet need has changed little between 1988 and 2003, actually increasing slightly from 31.5% to 34%. Unmet need is greatest among women who have the least access to contraception— young women (age 15–19), rural women, women with less than a secondary education and women in the lowest wealth quintile. Rural women have a higher unmet need for family planning than their urban counterparts (38% compared to 28%). In 1988, there was little difference in unmet need between rural and urban women; however, there is now a widening gap in unmet need between the two populations. In the past 15 years, while the unmet need in rural areas has increased by 16%, unmet need in urban areas declined by 9%.

Figure 2. Prevalence of modern contraceptive use, by wealth quintile, 1993, 1998, and 2003

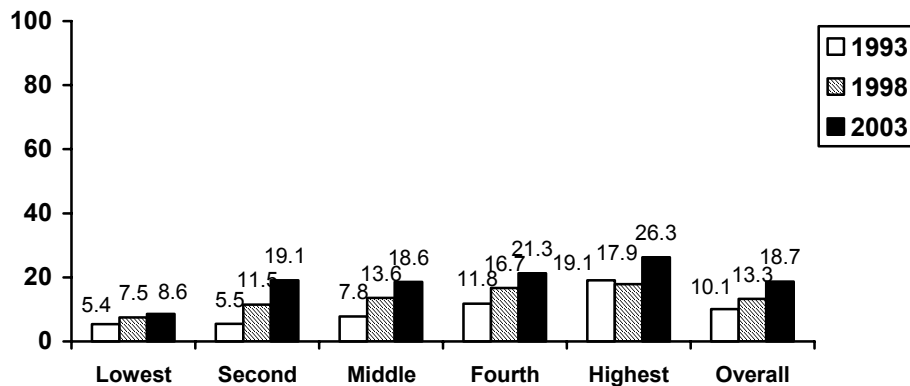


Figure 2 shows that there have been only minimal gains in contraceptive use among the poorest women in Ghana. The modern method CPR for the lowest wealth quintile has only increased from 5.4% in 1993 to 8.6 in 2003, while the wealthiest have experienced an increase in CPR from 19.1 to 26.3 over the same 10-year period.

One of the unanswered questions about Ghana is why the fertility decline from 1988 to 2003 is greater than would be expected on the basis of reported increases in contraceptive prevalence. Blanc and Gray (2000) explored several possible explanations, including potential overestimates of the fertility decline, underestimates of contraceptive prevalence, and trends in other fertility determinants. Although the authors were unable to come up with a clear explanation, they did identify several factors that could contribute to this discrepancy, including:

- A shift from traditional to modern methods of contraception
- Underreporting of contraceptive use (For example, in Navrongo, comparative analysis of survey data with service statistics has shown that 20% of known contraceptive users who were interviewed in surveys denied that they were using a method [Phillips et al., 1997].)
- Induced abortion (Although this is difficult to assess due to the lack of reliable data on the rates of abortion in the country.)
- Changes in behavior other than contraceptive use (e.g. coital frequency) as the desired number of children decreases

The continuing puzzle of the TFR-CPR relationship in Ghana highlights that it is important to look at multiple endpoints for success, as either TFR or CPR on its own would not give a complete picture of the achievements of the family planning program in Ghana.

What Was Done?

Context

A number of factors in Ghana had an impact on the implementation, the success, and the challenges of its family planning program, including the sociocultural and religious

environment, rural-urban migration, the political and economic environment, gender issues and girls' education, and HIV/AIDS.

Sociocultural and religious environment

Ghana's population of 21.4 million people is made up of many different ethnic groups which originate from various parts of the West African subcontinent. These groups all have distinct histories, languages and cultures. For the sake of practicality about six major ethnic groups can be identified. Within these six however, are numerous different branches each of which has their own linguistic and cultural variations.

There are significant and divisive differences between the north and south of Ghana. The terrain and climate are different as are the ethnic groups. In terms of development and infrastructure the north lags behind the south. Officially, 63% of Ghana's population is Christian, 16% Muslim and 21% animist. Islam is most concentrated among the ethnic groups originating from the north of Ghana.

Figure 3. Map of Ghana



In a setting in which property, resources and offspring belong to men, women make their living and earn their status by helping men manage their households and resources and by giving them offspring. Childbearing is their single most important role in life. The emphasis on prolific childbearing stems from various factors such as the agrarian lifestyle which necessitates a large manual workforce, the tradition of having children fostered by relatives to strengthen ties across the extended family and high rates of child mortality.

The practice of polygamy is traditionally endemic to most ethnic groups in Ghana. Although rejected by the Christian church it is acceptable in both Islamic and animistic religions and is still widespread among certain sectors of the population. The polygamous environment places a woman in a competitive position with her rivals in which the natural way to gain precedence is to have as many children as possible.

When women want to practice family planning, their husbands and in-laws will often not agree and they may be punished if they are caught, sometimes with physical violence. The fear of opposition and punishment has thus led to women using modern contraceptives in secret. Research has shown that the most popular modern contraceptives in areas where women have least control over their fertility are the ones that cannot easily be detected in particular, injectables (Wright, 2002). According to the 2003 DHS, 11% of married women with no education currently use any modern methods of contraception as against 28.1% of women with secondary education and above. In line with this trend, the majority of individual modern methods show significantly higher figures for educated women. With injectables, however, 4.6% of women with no education use them as against 4.0% of women with secondary education and above.

The effects of rural-urban migration

It is estimated that 44% of Ghana's population lives in urban areas. The poverty of the subsistence farming lifestyle, the lack of infrastructure and services in the rural areas and the absence of job opportunities have driven millions of people to the urban centers to seek better opportunities.

A number of factors in urban life contribute to lowering fertility, such as cramped living conditions and expensive housing. In addition, the birth of a child outside a supportive family structure places the burden of its welfare on its mother and compels her to be economically active. This is a strong incentive for her to control her fertility, a task that is in any case much easier when she is the main decision maker about her fertility. In addition, women in urban settings generally have more exposure and access to family planning and they are more likely to be in the workforce. Rural-urban migration also impacts fertility rates from another angle. Many male migrants leave their wives behind in the rural areas for prolonged periods. Without their husbands at home, the reproductive capacity of these women is significantly reduced. Meanwhile their husbands are more likely to use contraceptives in extramarital sexual encounters in the urban areas than they would with their wives back home.

Political and economic environment

The prevailing climate of political stability in Ghana has played its part in the progress achieved in family planning over the past decade. This hard-won stability is enjoyed by few other countries in the West African subregion and can be viewed as one of Ghana's advantages in the family planning arena as in other areas of development.

After gaining independence from Britain in 1957, Ghana went through two and one-half decades of cyclical coups d'état and revolutions. The year 1982 saw the beginning of a consistent political process in the country which started as a military dictatorship and

evolved by 1992, into the civilian, democratically elected, constitutionally based republic now in place. Since 1992 there have been three multiparty democratic elections in succession with the fourth due in December 2004. Transitions between political administrations have occurred smoothly, the most significant being a transition from one political party to another in the year 2000.

A process of decentralization began in 1987 and, although still incomplete, has made significant progress. Today the government is divided into 138 local government areas called district assemblies. This process has brought decision making around many development initiatives much closer to the general populace.

The establishment of the Fourth Republic and the 1992 Constitution freed up the political environment, ushering in a new era of freedom of speech and a concurrent expansion of the media sector. There was a dramatic expansion of newspapers from all sections of the political spectrum, an increase in television channels and a veritable explosion of FM radio stations. This growth in the media sector has fostered the open expression of views and national dialogue on political, social and cultural issues. Family planning, among other topical issues, has featured fairly prominently in this national dialogue.

The stability of the political system in Ghana over the past two decades has allowed for significant improvements in development and economic opportunities and for the consequent growth of the private sector. Ghana now has roughly twice the per capita output of the poorer countries in West Africa (CIA, no date). In addition, there has been a high level of investment and intervention by bilateral and multilateral development partners. Programs in health, education, trade and agriculture, implemented in conjunction with the Government of Ghana's line ministries, have been a major focus of these interventions.

However, development and economic prosperity have not been spread equally over the country. Indeed, poverty has deepened over the past decade for significant sectors of the population. The cost of health services, education, transport, public utilities, property rates and housing have all increased. According to the Ghana Poverty Reduction Strategy (GPRS), Ghana has experienced growing and deepening poverty particularly in the north of the country and in the Central Region over the past ten years. A 1998 survey found that 39.5% of the population lived below the poverty line, with a large discrepancy between urban (18.6%) and rural (49.9%) populations (World Bank, 2004). Poverty levels have played a role in declining fertility rates over the past decade, as the effects of poverty are forcing people to control the size of their families.

Gender issues and girls' education

Reflecting international trends and development priorities, the issue of gender equity has gathered significant momentum in Ghana over the past decade. The first national development plan drawn up in response to the 1992 constitution included in its medium-term and long-term objectives the increase of female enrolments and completion rates at all levels in the educational system. As a result of this gender emphasis the Girls' Education Unit, a special division within the Ministry of Education, was established in 1997. In 2001, the Ministry of Women and Children's Affairs was created, fulfilling a

campaign promise of the current administration. In discussions with staff of this Ministry, they emphasized the need for economic empowerment of women and that “when women and children develop, then the country develops.” As noted earlier, education is strongly linked with increasing contraceptive use and lower fertility.

Over the past decade, other initiatives to promote women’s welfare and to defend their rights have included the creation of the Women’s and Juvenile’s Unit (WAJU) within the Ghana Police Force and the passing of the Children’s Act of 1998, in which Section 14 sets the minimum age of marriage at 18 years. This has been particularly beneficial to women in the Muslim community, who are at risk of being forcibly married off while still of school-going age. Another relevant factor in the area of formal education has been the incorporation of family life education into the life skills curriculum. This was piloted in 1995 and mainstreamed in 2000.

HIV/AIDS

Approximately 3.4% of Ghana’s adult population aged 15–49 is infected with HIV, translating into roughly 400,000 people living with HIV/AIDS, according to the National AIDS Control Program (USAID, Bureau for Global Health, 2003). While this prevalence is fairly low, especially as compared with East and Southern Africa, it is of course still a significant concern for the government of Ghana. A National AIDS/STI Control Program was established in 1987, and in 2000, the Ghana AIDS Commission was established under the leadership of the President as the coordinating body for all HIV/AIDS activities. While the condom promotion activities for HIV prevention clearly have an impact on increasing contraceptive use and potentially on reducing fertility, to date there has been minimal formal integration between family planning and HIV/AIDS activities.

Policy

When asked about the achievements of the family planning program in Ghana, in addition to mentioning the success in lowering TFR and increasing CPR, respondents talked about the important political commitment. While there are impressive policies in place, often there is a gap between what is on paper and what is happening in practice. Advocacy has played a key role in raising the profile of family planning, and will be important in coming years in ensuring that family planning remains a priority in the various aspects of health sector reform.

Ghana was one of the first countries in Africa to have a population policy, and as one of the country’s leading experts in reproductive health explained, “The comprehensiveness of that policy at that time was tremendous.” Entitled *Population Planning for National Progress and Prosperity: Ghana Population Policy*, it was issued in March 1969. Population was seen as an important part of the economic development process in the country.

Although the policy existed for many years, respondents pointed out the difficulties in implementation; “it is one thing to have it on paper, but it is another to actually implement, operationalize, and move from theory to practice.” A blunt assessment in 1989 documented the lack of progress made on the 1969 Population Policy and identified several reasons (Adamchak et al., 1995; interviews with key informants, 2004). First of

all, the policy was developed by technocrats at the national level with little grassroots involvement so that it felt imposed rather than having buy-in from all levels. Second, there were clear guidelines for family planning, but not for the other elements of population. Instead, it was left up to various ministries, and there was frequently interagency rivalry, “interpersonal squabbles and turf struggles,” and inadequate coordination. Other respondents explain that although the policy existed, there was only lukewarm support from political leadership for this area; “we want to continue having the number of children we want and we don’t want people to talk about sex.” Overall, the policy was generally seen as a “document on a shelf, but not a strategic plan for implementation.”

When the policy was revised in 1994, these factors were taken into account. This time a draft policy was developed by a multisectoral team and was then sent to all districts for input. As described in the preface to the revised policy, “it represents an innovative experiment in grassroots participation in policy formation” (National Population Council, 1994). In addition, the National Population Council was set up and clearer action plans were developed.

There were important advocacy efforts in the 1990s. For example, the RAPID tool was used to help influence policy makers by showing the impact of population growth on the education and health sector in terms of numbers of schools and hospitals that would be needed. This “was very revealing” and prior to these presentations, many said that they had not seen family planning as an important issue. The way the information was presented was also important. High-level former Ministry people gave the information so that it was “colleagues talking with colleagues” rather than outsiders pushing an idea.

Another factor that constrains implementation of policy is funding. Until recently, financial commitment from the government did not follow the commitment expressed in policies. This began to change around 2000–2001, when the government included some funding for family planning in its budget. Many respondents stated that there is increasing support from the current government, as shown, for example, by the fact that the Life Choices IEC campaign was launched by the President of Ghana. It is hoped that this will also translate into increased financial support.

In addition to the national population policy, dissemination of the *National Reproductive Health Service Policy and Standards*, developed in 1996 and revised in 2003, was an important step in removing medical barriers to services and, more generally, raising the profile of reproductive health. As stated in the revised edition, “the first edition of this document paved the way for development and expansion of reproductive health. It helped crystallize the uniqueness and the importance of reproductive health as a priority area in the health sector” (GHS, 2003a). Findings from the 1993 Situation Analysis study were an important impetus in bringing about the development of standardized family planning guidelines (Adamchak et al., 1995). In particular, this study found that almost 90% of service providers would not give any contraceptive method to a woman with fewer than three children, and that many would require spousal consent or that a woman be married before they would provide methods. Such attitudes can be a significant barrier to

services; “Old attitudes concerning the ‘dangers’ of hormonal contraceptives persist and keep these contraceptives from wide distribution” (Adamchak et al, 1995).

Respondents highlighted the need for continuous education about the population policy. In advocacy, it is important to get the right message to the right people. As one reproductive health expert explained, “with a maternal health approach, they (policy makers] are becoming more open—looking at a woman and her health rather than a demographic or economic argument.... We have learned the different ways of presenting and humanizing the discourse.” And this discourse will change depending on whether one is speaking with a policy maker, a doctor, or a family planning client. Of course, messages at the policy level will be very different from messages to the general population; “this country needs to know the rate at which it is growing, but that doesn’t convince Mr. X in the field. When I decided to have four children, I wasn’t thinking of the national growth rate.” The issue of raising awareness among the general population is addressed in the section on program interventions.

There can be a problem with mixed messages, which several respondents called attention to. Currently in Ghana, antenatal care and delivery services are offered for free, but there are fees for family planning. This sends a message that encourages child bearing over family planning. It is important when changing one policy (for example, making delivery services free to encourage more women to deliver at a health facility) to consider the potential broader implications of that change.

In a review of priority setting in health sector reform in Ghana, Mayhew and Adjei (2004) find that sexual and reproductive health (SRH) donors (primarily USAID and UNFPA) and advocates had minimal involvement. They looked at three reform components—decentralization, essential package, and sector-wide approach (SWAp). The authors of this review, as well as several respondents in this case study, point out that the SWAp and the Poverty Reduction Strategy tend to be strongly oriented towards the Millennium Development Goals (MDGs). Therefore, in terms of reproductive health, they focus on HIV and maternal mortality, with only limited attention to family planning.

Although the SRH program in Ghana is strong, there is concern regarding sustainability if it remains somewhat outside of the health sector reform processes. For example, in early budget planning for the SWAp, condoms were left out because at that time, they were funded by USAID and UNFPA and so “they were not considered to be a ‘system’ issue despite being a critical component of public health services.” Mayhew and Adjei (2004) conclude that “While it is tempting for a strong program like Ghana’s SRH programme to remain independent, we argue that closer involvement in system-wide reforms is a preferable long-term objective.”

In particular, it is important to forge stronger and clearer linkages between family planning and HIV/AIDS, “to evolve the kinds of strategies which really integrate the two arms,” as one respondent explained. One suggestion was that this be done through a central-level task force; “we need to have this integration at a higher level before bringing it to a lower level.”

Program

Having supportive policies is a key aspect of a successful family planning program, but it is only through their implementation that there is an impact on reproductive health; “a good document doesn’t make a woman have good access to contraceptives.” There have been a number of activities to improve family planning services in Ghana, in both the public and private sector. Interestingly, over the past fifteen years there has been a shift in the source of modern contraceptives from the public to the private sector. The proportion of current users relying on the private sector has increased from 43% in 1988 to 54% in 2003.

Major program initiatives funded by USAID beginning in 1968 and through the mid-1980s supported a range of activities from demographic data collection and analysis, to the provision of contraceptive supplies and international and national training efforts. These initiatives have included:

- The Contraceptive Social Marketing Project (1987–1990)
- The Ghana Family Planning and Health Program (FPHP) (1990–1996)
- The Ghana Population and AIDS Project (GHANAPA) (1996–2002).

Beginning in the mid-1980s, the focus of the program was on increasing demand and access of modern methods through social marketing. The FPHP continued social marketing strategies in addition to their work to expand the capacity of the public and private sectors. Beginning in 1993 and continuing until the present, the public and private sectors recognized the importance of improving access and quality of services for permanent and long-term methods (male and female sterilization, implants, IUDs). With support from USAID, UNFPA, and other donors and with technical assistance from EngenderHealth, the program has always focused on extending the range of family planning services offered to the public, providing more choice in methods, ensuring informed choice and consent, and developing strategies to reach special groups such as adolescents and men.

Situation analysis studies carried out in 1993, 1996, and 2002 allow one to look at changes in readiness and service quality in family planning services. Overall, infrastructure and service availability have improved, with almost all facilities (96%) offering family planning services five or more days a week and having improved privacy for clients (59% of facilities in 1993 had a private examination room as compared with 83% in 2002). Choice of methods has also improved, although IUD availability has decreased and stock outs continue, and for some methods, have gotten worse. Although more family planning providers have received in-service training on counseling, there are mixed results in terms of improved quality of care. (Hong et al., 2005).

Recent programmatic interventions highlight the importance not just of what you do, but how you do it. For example, EngenderHealth and the GHS set up an innovative and effective system of working through subagreements directly with the country’s 10 regions to enhance local ownership. This also allowed the program to have a strong focus on sustainability, take a comprehensive approach and be flexible and responsive to

opportunities and changes in the environment. Workplans were developed collaboratively between EngenderHealth and the regions, with the regions selecting the sites and participants for training. In this way, the project was not seen as being imposed from the outside, but rather as a project that was owned and run by the MOH. As a representative from the MOH explained, “when you sign the agreement with them [the regions], they are committed more.” As EngenderHealth staff explained, “We give them the power. We play the role we’re expected to play—we give technical assistance, help them—it is not like we come and say we have a program, here it is. So they feel that it is their program and so they take ownership.” This way of working is important for creating trust: “sometimes they think you don’t trust them, so they won’t help make the program succeed. You need to show them you trust them.” The MOH spoke highly of this process, and how no other project used this mechanism, although they would like to see it replicated in other projects (EngenderHealth, 2004).

Wider method choice

Increased availability of methods has included the introduction of implants (1996), combined injectables (1992), the female condom (2000), and emergency contraception (2003) in both the public and private sectors.

Table 2. Contraceptive method use among married women, 1988–2003

Method	1988	1993	1998	2003
Pill	1.8	3.2	3.9	5.5
IUD	0.5	0.9	0.7	0.9
Injectable	0.3	1.6	3.1	5.4
Male condom	0.3	2.2	2.7	3.1
Female sterilization	1.0	0.9	1.3	1.9
Implants	0	0	0.1	1.0
Other modern	1.3	1.2	1.4	0.9
Traditional	7.7	10.1	8.7	6.5
Any method	12.9	20.3	22.0	25.2
Any modern method	5.2	10.1	13.3	18.7

Between 1988 and 2003, there was a shift from reliance on traditional methods to greater use of modern methods, with the use of modern methods increasing from 5.2% in 1988 to 18.7% in 2003 (Table 2). In 1988, condoms and injectables each accounted for 2% of the method mix. In 2003, nearly one in five family planning users relied on condoms and one in six users relied on injectables. IUD use accounted for 4% of the method mix in 1988 and only 3% in 2003. A study was undertaken in 2002 to explore the trends in IUD use and better understand why its use has stagnated (Gyapong et al., 2003). Reasons for limited IUD use included negative perceptions and rumors, insufficient promotion of the method, and inadequate numbers of providers with practical experience.

Ghana has had a modicum of success with two methods of family planning—Norplant[®] and vasectomy—that elsewhere in Africa are vastly underutilized. With Norplant[®] prevalence of the method increased 10-fold, from 0.1% in 1998 to 1% in 2003. With vasectomy, though prevalence remains less than 0.1%, awareness of the method has

doubled in the past five years, and in the first four months of a recent initiative in Accra and Kumasi, there were more than twice as many procedures performed as compared to national figures for all of 2003. With both of these methods, as well as other methods and services over the past decade, the Ministry's strategic approach was similar and addressed both the demand and supply side of the equation, highlighting the following (Kanlisi et al., 2004):

- Emphasis on effective promotion (IEC and advocacy)
- Attention to clients needs
- Attention to developing providers' skills and overcoming provider bias
- Identification of champions
- Emphasis on instilling ownership

Contraceptive security

As a member of the Ghana Health Service stated, "Even if I get educated [about family planning], if there are no commodities there, I will get pregnant." Over the years, a significant proportion of the support from USAID and UNFPA has been spent on procurement of contraceptive methods. Along with this support, there have been important efforts to improve the logistics system. Before 1998, there were stockouts because MOH staff needed additional training in logistics management, and so USAID provided support for training and improving the system. Since 2000, respondents state that there have been no natural stockouts, only "artificial because of maldistribution," meaning that it has not been an issue of not having the methods, but whether they are moved effectively and efficiently from the central level to the regions and districts.

There is a long-term issue of sustainability regarding contraceptive supplies. As one respondent explained, "demand is increasing but in terms of funding to supply contraceptives, it is flat, and so there is a gap between supply and demand" and there is a need to do something to fill that gap. In May 2002, the MOH hosted a two-day meeting entitled Meeting the Commodity Challenge to draw attention to this issue. Participants identified priority issues for contraceptive supplies, establishing Ghana as one of the first developing countries to incorporate contraceptive security into its family planning policy (DELIVER, 2002). In addition, the Interagency Coordinating Committee for Contraceptive Security (ICCCS) was formed. From 2003, the Government of Ghana has assumed some of the costs of commodities, and there are efforts to advocate for the government to cover more of the costs in the future.

Training providers

In addition to ensuring that methods are available at health facilities, it is also essential that providers are adequately trained to provide these methods, including overcoming their biases. The idea of testimonials from satisfied clients was first successfully used in the training of service providers who were biased about minilaparotomy. It was after this success that "satisfied clients" were then trained in public speaking and communication so that they could also conduct activities in the community. Similarly, training in vasectomy also focused on changing attitudes and not just imparting information.

The training of more than 600 nurses in Norplant[®] insertion and removal has had a significant impact on the acceptor rate, quality of services, and number of sites providing such services. When introduced in the mid-1990s, training was restricted to physicians, in part because the existing policy was not explicit about whether nurses could perform this surgical procedure.² When women initially came for Norplant[®] services, there was often a long line and no doctor available, and as such the method was there but not really accessible. These difficulties were documented and were used to help bring about the necessary policy change. As a result, the 1996 *National Reproductive Health Service Policy and Standards* clearly spelled out that nurses were allowed to provide Norplant[®].

By integrating the training of physicians and nurses into the existing minilaparotomy training program, the GHS ensured the training was sustainable and reduced resistance that facility administrators and providers often have to training that is perceived to take them away from their work. The training strengthened counseling and interpersonal communication skills, and emphasized management of side effects.

Over the past 10 years, the Ghana Health Service has given particular attention to training providers in counseling and interpersonal communication skills with over 3,000 providers trained. The proportion of family planning providers who had received in-service training on counseling for family planning during the preceding five years increased significantly, from 38% and 39% in 1993 and 1996, respectively, to 60% in 2002. A larger percentage of new clients were encouraged to ask questions or to share concerns about methods (from 31% to 71% of observed new clients in 1993 and 2002, respectively). However, providers were less likely to explain to clients about side effects (Hong et al., 2005). This remains a significant challenge in the family planning program, as fear of side effects was the most cited method-related reason for nonuse among all women and has increased from 18% in 1998 to 26% in 2003. Respondents pointed out the need to improve interpersonal communication in order to address these lingering misperceptions; “we spent so much time in media campaigns, but it [fear of side effects] didn’t move. We need to look at the way we are presenting information. The media has done a lot, but now awareness is very high and it’s only one-on-one where you change people’s minds and behavior.”

The GHS has embraced facilitative supervision, where there are efforts to make supervision more supportive and friendly, and more like coaching. As a nurse supervisor commented, “Facilitative supervision has helped me a lot. Supervisors are challenged to be up to date. People are now happy to see me, and no longer try to hide away. We always have something to share. We sit down and discuss issues. I make suggestions on how staff can solve their problems” (Jain et al., 2003). The 2002 Service Provision Assessment noted that supervision of family planning providers is common, with at least half of the interviewed family planning providers being supervised in the past 6 months in 63% of the facilities and 59% of the individual providers being supervised in the six months preceding the survey.

² Although no formal policy forbid nurses from inserting Norplant[®], there was more of an “unwritten law” against this practice.

There have also been important efforts to strengthen preservice training. Since the late 1980s, JHPIEGO has collaborated with the Ministry of Health (MOH) in Ghana to strengthen the national family planning training system. Beginning in 1998 the collaboration has focused on strengthening preservice education for nurses and midwives. The 250–300 midwives who graduate annually from the 12 midwifery preservice programs in Ghana are now better prepared to provide family planning services. An evaluation of the program has shown that graduates not only perform better as healthcare providers, but also can sustain their high-level performance. Two years after graduation, midwives trained at preservice facilities had significantly better total knowledge and skills than midwives in the comparison group. Midwives receiving the preservice training had a higher knowledge of family planning methods and were more likely to provide information on method side effects during counseling. Additionally, 73% of clinical sites surveyed reported that the quality of service delivery had improved and cited the use of JHPIEGO learning guides for skills development as a major reason (Fogarty et al., 2003)

Keys to the success of this initiative have been improving the clinical knowledge and skills of tutors, preceptors, and trainers and strengthening the service sites used for clinical practice. Within the 12 preservice institutions, 391 tutors and preceptors have had the opportunity to update their family planning and infection prevention knowledge and skills as well as develop their training abilities. Seventy-two of the clinical training sites affiliated with the 12 midwifery schools have implemented new practices such as consistent hand washing by staff and posting of job aids to remind students and staff of appropriate clinical protocol.

Social marketing

Ghana has a vibrant social marketing program that networks with pharmacies and chemical sellers, private clinics and maternity homes as well as major NGOs, such as the Planned Parenthood Federation of Ghana (PPAG). GSMF International (formerly known as the Ghana Social Marketing Foundation) is the largest private-sector supplier of contraceptives with a distribution network delivering products to more than 4,000 outlets nationwide. It promotes and distributes nine socially marketed products including pills, male and female condoms, vaginal foaming tablets and injectable contraceptives. From 1985 to the present, USAID/Ghana has supported GSMF. The goals of the earliest programs (1985–1991) were to increase the supply and to expand the advertising of contraceptives throughout the country. The continued success of GSMF was based on successful targeting of Ghanaian style messages and products to specific markets of couples who wanted contraception and who could pay. GSMF also utilized private sector structures to make oral rehydration salts and other health products available, accessible and affordable.

The market share of socially marketed pills and condoms increased between 1998 and 2003. In 1998, GSMF's pills and condoms accounted for over one-third (37%) of current pill users and one-half (50%) of current condom users. By 2003, 50% of pill users used Secure (the GSMF brand) and almost two-thirds (63%) of men who reported condom use mentioned GSMF brands (Protector, Champion, and Panther). The deregulation of the pill in 1993 was a “shot in the arm” for social marketing programs in that it allowed level

‘c’ chemist shops to stock products and paved the way for training chemical sellers and for the community-based distribution of products.

IEC and demand creation

Under the Ghana Family Planning and Health Program (1991–1996), IEC activities addressed constraints identified by the 1993 DHS and the Consumer Baseline Survey (CBS), including widespread myths, rumors, and health fears. The Health Education Unit of the MOH coordinated a campaign that involved both the private and public sector. However, a lack of funding limited regional efforts and some of the advertising materials developed by GSMF created controversy, leading to the television ads being cancelled and then only allowed to air after 10:00 pm; “A negative reaction came from a vocal minority who interpreted the ads as encouraging promiscuity. Part of the problem stemmed from the lack of legitimizing mass media support from the public sector” (Adamchak, et al., 1995).

Program experience in Ghana shows that individuals who are exposed to a message from multiple sources—such as mass and community-based media and interpersonal communication—are more likely to take action than are those exposed to a message from a single source (Parr, 2002). Promotion efforts in Ghana over the past five years have included mass media—billboards, newspaper/magazine ads, radio/TV spots (featuring Ghanaians of varying social and economic strata, e.g., a business woman, an auto mechanic, a seamstress, etc.), telephone hotlines, community channels (community network rallies, discussion sessions with women’s groups, testimonials by satisfied clients), interpersonal communication (counseling training), and production and distribution of IEC materials to the Ministry of Health, various NGOs, and community groups. Using testimonials from clients who are satisfied with a method appears to have increased the effectiveness of community information/communication activities and outreach.³

Knowledge of any contraceptive method is almost universal in Ghana with 98% of women and 99% of men knowing at least one method of contraception. (GSS, NMIMR, and ORC Macro, 2004) Awareness of specific contraceptive methods has increased significantly over time among both women and men. Among currently married women, knowledge of implants increased 12-fold, from 4.7% in 1993 to 24.3% in 1998 and to 61.5% in 2003. For injectables, knowledge has doubled, rising from 46.5% in 1988 to 79.4% in 1993 and to 91.8% in 2003. Knowledge of condoms went from 49.5% in 1988 to 78.2% in 1993 and to 95.3% in 2003. Among men, knowledge of specific methods rose markedly between 1993 and 2003. For example, knowledge of vasectomy went from 32.4% in 1998 to 59.6%, implants from 5.5% to 58%, and injectables from 74.2% to 93.1%.

The goal of the Ghana Health Service and private sector partners’ Life Choices behavior change campaign was to reposition family planning in people’s mind and to dispel rumors about methods. With the rallying cry “It’s your life, it’s your choice,” the

³ A formal evaluation of the satisfied clients program has not been undertaken and, as they are volunteers, recurring problems with their availability have occurred.

campaign gave people the knowledge and tools to see that family planning was directly related to their lives and personal aspirations for a better future. Beginning in 2001, vans with information, materials and songs moved throughout the country, enlivening community meetings and sparking debate on family planning issues. Sessions were held for women’s groups, clinic attendees and larger communities (including men, women and adolescents). In the women’s target group alone, 42 organizations in each of the 10 regional capitals held Life Choices sessions. In all, over 8,300 people heard entertaining presentations and received activity kits that enabled them to hold discussions on their own (USAID Semi-Annual Portfolio Review, 2003).

Most importantly, the community meetings went into details about coping with side effects and how attendees could share the benefits of family planning with friends and neighbors. Nearly seven out of 10 men and half of the women interviewed in the 2003 GDHS reported they had heard the key slogan of the campaign—“Life Choices: It’s your life, it’s your choice.” The percentage of women and men who had heard the slogan was higher among urban residents than among rural residents, increased with levels of education and wealth, and was lower in the three northern regions.

Figure 4. Logo and slogan of “Life Choices” campaign



The Life Choices campaign focused on factual information and perceptions to overcome myths or rumors. This was especially a challenge with vasectomy. The 2004 campaign created a positive and upbeat image for the method with the slogans “Get a permanent smile” and “*Wo ye berimah*” [You’re a real man]. Key messages were that the procedure is fast and simple and that virility is not affected. A panel study among 200 men in Accra before and after the campaign noted that the number of men “willing to consider vasectomy” increased three-fold and that the number who said they “would not consider a vasectomy” decreased.

Reaching out to communities: Bringing health to the doorstep

“In the 70s and early 80s, when you talked about family planning, it was ‘go to the clinic and get a pill,’ but in the past 10 years, we have moved to the community.”—PPAG staff

The Planned Parenthood Association of Ghana (PPAG), a dynamic nongovernmental organization affiliated with International Planned Parenthood Federation, was established in 1967 with a vision to bring family planning services to all couples in need in Ghana.

Since then, PPAG has been in the forefront of advocating for reproductive health rights and delivering services at the clinic and community levels.

PPAG pioneered the introduction of a small community-based distribution (CBD) program in 1974. The program continued to expand with support from various sources, including USAID. In 1994, USAID made a significant investment in PPAG's CBD program through its Ghana Population and AIDS Project (GHANAPA). USAID's support focused on expanding the number of volunteer agents that fanned out into the rural communities, supported by improved training and supervision. PPAG's strategy at the time reoriented the concept of contraceptive distribution to community-based services (CBS). The difference between the earlier distribution of contraceptives and CBS was a more holistic approach to reproductive health. Volunteers and nurses took into account the needs of the clients, made more information available, and increased referrals for clinical services beyond family planning (sexual health, maternal and child health, and STI prevention).

At its height in 2000–2002, the USAID-sponsored program with PPAG operated via 1,684 volunteer agents working at the district level in seven regions of Ghana. The CBS project achieved increasing levels of couple-years of protection over the years, from 61,000 in 1995 to 96,000 in 1998 and more than 128,000 in September 2002. Until 2003, PPAG was recognized as the most successful agency operating community-based programs in Ghana.

Clinics and maternity homes associated with the Ghana Registered Midwives Association (GRMA) received USAID-sponsored assistance to establish outreach and community based programs in rural, semi-urban, and urban environments. Their volunteer agents provide family planning, antenatal, postnatal, and delivery information and referrals to clients at the community level. GRMA, PPAG, and other NGOs recruit younger agents as peer educators for sexual and reproductive health. In addition to the outreach, community rallies, drama, video shows, and group discussions provide information to communities.

Moslem Family Counseling Services was also involved in providing services through CBDs. This NGO became interested in the issue of family planning because they saw the problems in their community, such as drug use, as effects of the problem of large families, and they aimed to address the cause. For their work, it was essential to start by sensitizing and partnering with the leadership of the Muslim community. There were negative perceptions of family planning as a western imposition and something to suppress the growth of the Muslim population, so they began with workshops with Imams to get their support by having scholars show Koranic verses that talked about child spacing and breastfeeding, to show that Islam was not against family planning. It was only at that point that they trained CBDs—"otherwise they would not be received kindly."

After the reintroduction of the Mexico City Policy and PPAG's agreement to stay under the IPPF umbrella, PPAG lost its USAID funding. Losing PPAG as a cooperating agency, and the resulting dismantling of a huge operation of contraceptive services and

distribution, certainly had a negative effect on family planning coverage in Ghana. In 2003, 17% of all contraceptive sales were from the PPAG system, and most importantly, from rural areas. More than half of PPAG's 192 staff members were laid off, and more than 1,000 volunteers were without the structure that kept them motivated and supplied.

In 2003, USAID took the loss of PPAG as a major player in family planning into account and tried to find ways to meet the reproductive health needs of rural men and women. One important way was to expand the innovative activities in rural service delivery and community involvement that had been taking place in Navrongo in Northern Ghana.

Although CBD agents had been deployed in Ghana, this was “without systematic investigation into how CBD should be organized and whether it actually works.” The Community Health and Family Planning Project (CHFP) set out to measure the relative impact of different types of health delivery strategies in a rural community in northern Ghana. In 1993, the Navrongo Health Research Centre (NHRC) began testing various health intervention strategies and measuring their social and demographic impact. NHRC hoped to find the best approach to increasing access to quality health services in underserved areas and to identify techniques for achieving community participation in practical terms.

Located in a rural Sahelian setting, the Navrongo district has high mortality levels and cultural traditions that sustain high fertility. The economy is dominated by subsistence agriculture, low literacy, and traditions that value large families. Health decision making is strongly influenced by traditional beliefs, men, animist rites, and poverty.

The Navrongo experiment was a four-cell quasi-experimental study that tested mobilizing either the Ministry of Health outreach, traditional community organization, or both, as compared with a control area with no additional intervention. After several experimental years, NHRC documented a positive impact, in increasing contraceptive prevalence from 3% to 20% and reducing fertility by nearly one birth. In addition, childhood immunization coverage increased from 30% to 83%, and childhood mortality fell by 40%, from 141 to 96 per 1,000 live births (Ghana MOH, 2004). Findings demonstrated that the most effective intervention was community mobilization combined with community-based deployment of nurses.

These research findings tied into the Ministry of Health's efforts to improve primary health care services and encourage partnerships with communities. During the 1990s, the Ministry of Health was seriously reviewing their pro-poor strategy and how community-level activities could boost health care coverage. Thus, to address the needs of the poor, the key strategic approach in the Five-Year Program of Work was to improve community access to basic health care through the Community-based Health Planning and Services (CHPS) initiative. The CHPS initiative is an innovative program intended to improve health equity in Ghana through decentralized health care adapted to local circumstances. CHPS uses community health nurses, local investments and resources, community health committees, and volunteers to reach clients.

Lessons learned from Navrongo led to the development of several “CHPS Principles,” to clearly articulate how regions and districts should proceed. First, CHPS should be demand driven, where District Health Management Teams (DHMTs) demonstrate their initiative and interest in the program by making use of available resources in the district. Support to CHPS should come in stages, starting with technical support and following with material support only after the district has demonstrated commitment to CHPS by relocating nurses into communities.

An important step in scaling up the strategies identified to be effective in Navrongo took place in Nkwanta District. There is often skepticism about the feasibility of scaling up a program that has been developed in a well-funded research setting. The successful adaptation of the Navrongo service model in Nkwanta District provided strong and persuasive evidence and helped convince policymakers of the feasibility of a national CHPS program to work towards universal access to health care (Awoonor-Williams et al., 2004).

At each level—national, regional, district and community—CHPS is organized, managed, and controlled by Ghana Health Service cadres and local political authorities. A clearly defined leadership of CHPS at these levels is important for sustainability. Starting small and gaining some success is also important. A well-defined plan to start with one or two communities using available district resources, no matter how small, is also important. CHPS can then grow progressively to cover more communities as resources expand, more lessons are learned, and relevant experiences are acquired. Of course, additional resources may be needed. USAID and other donors’ technical support enable members of district health management teams and community health officers to acquire and improve their skills in community mobilization and participation, primary health care services, interpersonal communication and counseling in reproductive health, and monitoring and supervision.

The implementation of CHPS has encountered challenges, with relatively few districts reaching the stage of launching services. In addition, there has been difficulty in ensuring adequate attention to the necessary community dialogue and consultation at the beginning of the process: “What people seem to be doing currently regarding CHPS is putting a nurse in the community and saying they are implementing CHPS... The first step in getting this going is building understanding in the community. First of all you must understand that you are going to make a major change in the pattern of service delivery... If you don’t go through that process thoroughly to get the community to understand and accept this new concept of health care delivery, they will be dissatisfied with the nurse when she eventually comes to live in the community.”

Study tours have had an important impact in helping to address the implementation gap. Through peer learning or counterpart systems training, groups visit Navrongo and the system is demonstrated by expert participants to counterparts, who observe operations and adapt lessons to their own local circumstances and needs. The practical demonstration “puts participants at ease with the CHPS initiative and develops consensus for CHPS implementation... districts where remarkable progress has been recorded are

all led by DHMT members who have visited Navrongo, Nkwanta, or other districts where the programme is operating and have received practical training in how to launch the programme.”

The idea of sharing information regionally has been raised (what has been called “CHPS without borders”), but there is still a need to identify funding, both for the study tours and for maintaining the setup in Navrongo. As one of the leaders in the work in Navrongo explains, “CHPS would lose its rudder if it were not for Navrongo and places like Nkwanta, where the model is clear, communication is sound, and demonstration is continuous.” Although South-to-South exchanges sometimes have a bad reputation (“too much per diem-per diem”), they can be effective “if it’s thought through properly and implementation-based.” For example, a very effective study tour was conducted in Ghana in 1997 for teams from four African countries to see a project that had trained midwives to provide postabortion care; this led to the development of midwifery training in South Africa and policy changes and training in Kenya and Uganda (Billings, 1998).

Part of meeting clients’ needs is appreciating local culture and ensuring that programs are appropriate to the environment. The most important lesson in moving family planning into rural communities in Africa was community involvement and continued participation from chiefs and elders and appropriate outreach to men. “Community-based delivery will fail unless traditional leaders, lineage heads, and men are mobilized to support the program.” The process involves listening to the community, adapting services to local realities and needs, and developing training approaches that involve both health workers and community members. Throughout this process, the community is the basis for all learning about what works and what fails. “Community commitment is essential to the success of the program.” The order of activities is also important, and CHPS must begin with community dialogue: “Community health care fails when the service-delivery cart is placed before the community-entry horse.”

A key to the success of CHFP and CHPS has been local ownership both at the community level and at the national level, in terms of their being truly Ghanaian programs. A leader in the work in Navrongo explains that “what is unique about CHPS is that it is the first homegrown intervention that we have developed ourselves. It is not something that was found somewhere and a donor is trying to introduce in Ghana.” As another reproductive health expert explains, “Because it is Ghanaian owned, Ghanaians have been anxious to see to it that the lessons are applied as soon as they are learned.” Respondents highlighted that having “ownership in meaningful sense” means having resources controlled by local groups. There also needs to be a careful balance between community ownership and external support: “A community mobilization strategy that depends entirely on community resources is often fraught with delays. Alternatively, a community outreach program that is externally supported can induce community conflict or apathy. Small, external resources are therefore needed as incentives for community action rather than as replacements for it.”

Lessons Learned: Some Keys to Success

- **Policies are only effective through their implementation, and this requires a clear implementation plan and grassroots involvement in their initial development.** Although Ghana had a strong national population policy as early as 1969, success in the 20 years following this policy was only minimal. The revised policy in 1994 addressed the weaknesses of the earlier policy—in particular, the inadequate implementation plans and structures and the lack of grassroots involvement in policy development, highlighting the need for ownership at all levels.
- **Training must address attitudes as well as teaching skills, and using satisfied clients can be an effective way to address providers' bias toward specific methods.**
- **Social marketing can be a very effective complement to public-sector services.** This highlights the importance of a good public-private partnership; the government has national coverage, while social marketing is an important complement. In addition, as shown in early IEC efforts, the government also plays an important legitimizing role.
- **Bringing health to the doorstep of rural people is essential to improve access.** The experience and evidence from Navrongo highlights the impressive achievements in improving health when services are brought closer to people in need: “Because of social constraints, we need to get services as close to the client as possible for family planning. That is what works—decentralizing access and bringing it to the doorstep.”
- **Programs must be responsive to the local context, for example by placing family planning in a broader health context.** For example, the project in Navrongo began with a survey about community needs that emphasized the importance of child survival, so this became a part of the experiment and family planning was placed within the context of primary health care. Community members trust “their nurse” and the larger health service delivery system since it is responsive to their needs. Under such conditions of mutual trust, acceptance of family planning makes sense, and opposition to it becomes minimal, even among men.
- **Ensure ownership of programs, at the national level, at the regional and district levels, and in the community: “Give them the power.”** Efforts in Ghana to ensure ownership of programs, at the national level, at the regional and district levels, and in the community, have been impressive. Programs have worked effectively in a decentralized system both by involving the central level and by building capacity at lower levels. Both the CHPS program and EngenderHealth’s quality improvement activities have worked through subawards, giving local partners control over resources, a key aspect of real ownership. In training, there has been a focus on building the capacity of Ghanaians, rather than bringing in external trainers. Ultimately, to achieve greater success in family planning—and in development more broadly—women must also have more power: “When women and children develop, then the country develops.”
- **It is not just what you do, but how you do it.** For example, it is not enough to just train someone in a skill; training will be more effective if it also addresses attitudes and biases and if it builds local capacity to continue the training in the future. The

importance of process is particularly clear from the experiences in expanding CHPS and from the need to give adequate attention and time to community dialogue and involvement. One good symbol of the importance of the process and not just the endpoint is the construction of community health compounds in Navrongo—it is not just the building per se that is so important, but it is the process of community involvement and ownership that truly makes the program successful.

- **It is necessary to give attention to both supply and demand.** Both creating demand and ensuring better access are needed, as was shown by EngenderHealth’s efforts promoting vasectomy, as well as by the work in Navrongo, where mobilizing both the health care system and social institutions and networks was the most effective intervention.
- **Method mix matters.** The introduction of new methods into the family planning program—particularly injectables, which women can use without necessarily informing their partner—has been a factor in raising contraceptive prevalence
- **Advocacy should be tied with evidence.** For example, evidence from research in Navrongo helped change national policy with the creation of CHPS, use of the RAPID tool raised awareness of the importance of population activities, and evidence of problems with access to Norplant[®] led to a policy change allowing nurses to provide the method. What was important about the work in Navrongo was that it was guided by “embedding research in a change process,” as opposed to having the research conducted and viewed as something external and separate.
- **Male involvement should receive more than lip service.** While many talk about the importance of addressing men’s concerns, the family planning program in Ghana made some very concrete steps in addressing this, including the innovative and essential work with men in Navrongo and the “Get a Permanent Smile” vasectomy campaign. This was important in the Ghanaian context. Members of the Ministry of Women’s and Children’s Affairs explain that “we need to address the concerns of men.... The family planning program initially targeted only women and left out men completely.”

Recommendations

Specific recommendations arising from the results of this case study include the following:

1. **Family planning/reproductive health advocates and programs should become more involved in health-sector reform.** As more donor money goes through mechanisms such as the SWAp, it is essential that there be advocates to ensure that family planning remains a priority.
2. **Better linkages between family planning and HIV/AIDS are needed.**
3. **We need to work toward greater sustainability of contraceptive supplies and logistics, with government gradually increasing its contribution and donors ensuring adequate support.**
4. **Distribution problems with regard to contraceptive supplies must be reduced, so that contraceptives are regularly and reliably available at the health facility level.**
5. **The persistent fear of side effects must be addressed.** Fear of side effects remains a major reason for nonuse of family planning. As was pointed out by several respondents, this problem needs to be addressed at the interpersonal level, which calls attention to the continuing need to improve the quality of family planning counseling.

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Appendix I: List of Contacts

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